Pediatric Focus
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Implementing and Operationalizing a Discharge Call Program

The following article is revised from a Webinar presented to NRC Health Clients in August, 2020 by Mary Daymont, RN, M.S.N., CCM, Vice President of Revenue Cycle and Care Management, Children's National Health System.

Background

Children's National participates in Solutions for Patient Safety, a national health engagement network specifically for pediatric providers set up by CMS. The program includes a bundle of best practices: scheduling follow-up appointments, identifying high-risk patients for readmission, having an escalation plan, having clinician feedback, and conducting post-discharge phone calls. Children's National decided to focus efforts on post-discharge phone calls, as leaders had already implemented many of the other components of this program, as well as Project RED (Reengineered Discharge Program), an effort supported by AHRQ, that develops and tests strategies to improve the hospital discharge process to promote patient safety and reduce rehospitalization rates.

"We saw this as an area of opportunity where we did not yet have a deep penetration," explained Mary Daymont, Vice President of Revenue Cycle and Care Management. "So, when we first started with our discharge call journey, we hired case management associates that helped with other aspects of the Reengineered Discharge bundle, but also focused on doing the post-discharge phone calls." Prior to deploying an automated process, the "pre-work" to gather patient demographics, discharge information, and prepare for the phone call usually took about five minutes. Under their current workload, nurses (2.5 FTE) were able to call 5 percent of discharge patients, but they only actually connected with 1 percent.

The logical next step was to automate their work. "We implemented an access database which reduced the pre-work down to 15 seconds," said Daymont. "We were able to use fewer FTEs to call 20 percent of the discharges, and get direct contact with 6 percent of patients discharged." While they were headed in the right direction, the case management team learned about the possibility of conducting fully-automated discharge phone calls. The team conducted due diligence and research, and decided to pilot an automated post-discharge call process.

Their six-month pilot targeted a general pediatric hospitalist unit with 1,200 discharges per month, encompassing a wide range of patients. They set up automated calls to take place between 11:00

Key Board Takeaways

Children's hospital boards need to discuss with management the high-level impacts of the organization's discharge process on readmissions, and whether implementing an automated call system can help the organization meet more rigorous targets. Pediatric discharges require a deeper level of communication and education to ensure that the patient's family is capable of following the necessary steps on behalf of the patient. Discussion questions include:

- What does the discharge process entail and has it been assessed or updated recently? How do we track its effectiveness?
- What do our peers do in this area?
- What are our strategic goals related to this issue and how can this initiative help us meet our strategic goals related to improving patient safety, experience, and outcomes?
- Is this something our patients and families need, and if so, what are the reasons we would not choose to implement such a program?

Sample post-discharge questions:

- Is the child's health better, worse, or the same?
- Do you have any questions about the follow-up care instructions?
- Is there any reason you might not be able to get your child's new prescriptions?
- Do you have any questions about any of your child's medications?
- Do you have any questions about any of your child's follow-up appointments?
- Are you satisfied with the quality of care that your child received at the facility?
- Are there any employees or doctors you would like to recognize for doing an excellent job?

a.m. and 1:00 p.m. on the day after discharge. If there was no answer, two more call attempts would be made. On the third attempt, the system would leave a voicemail with call back instructions to complete an eight-question, two-minute survey. Calls could be made in English and Spanish.

During the pilot phase, the biggest obstacle to the program was nurse leadership. Some tried to block the pilot from going forward, concerned with anticipating a high volume of calls that would increase their burden and workload. "Actually, what we found is that it did not," explained Daymont. They began to move forward with hospital-wide expansion because the pilot was successful. In the end, it was embraced by nursing. The costs to implement the program were funded through Children's patient experience special purpose fund. The technology implementation was "light," according to Daymont, and thus it was very easy to get the buy-in from the IT department and move ahead.

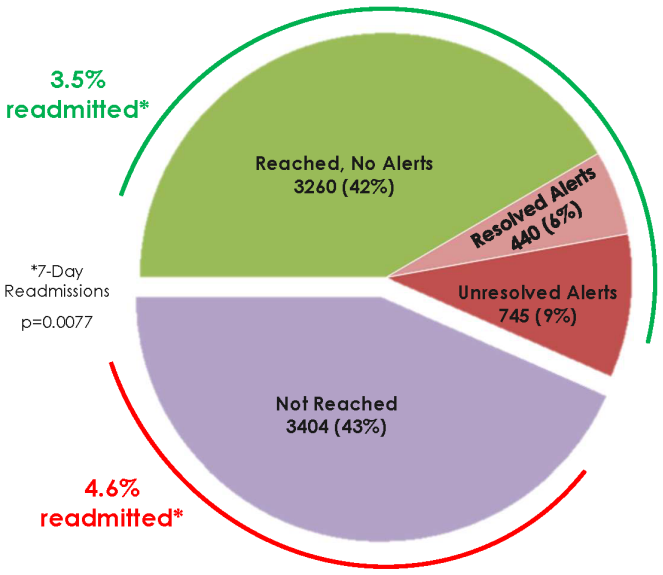
Results and Benefits

The program reduced the pre-work time from five minutes to 15 seconds, and the FTE burden from 2.5 to–0.1. While previously the system was reaching only 6 percent of all patients discharged, the automated discharge call process enables the system to contact 100 percent of all patients discharged from the hospital, and connect with 57 percent of all discharges with a 26 percent alert rate. On average, only four cases per month required provider involvement.

Lowered the seven-day readmission rate among call respondents: Out of 8,000 patient discharges from October 1, 2019 to June 30, 2020, the seven-day readmission rate was 4.6 percent from those that did not answer, and 3.5 percent among the group that answered the phone call. (While Medicare focuses on 30-day readmissions; pediatric hospitals usually focus on seven-day readmissions, not diagnosis-specific, including inpatient or observation discharges and readmissions.)

Engagement & Readmissions (n=7,849)

Oct 1, 2019-June 30, 2020; no data for Feb. 10-April 27, 2020



Decreased cold calls to the nursing units: Prior to this program, the hospital would receive multiple cold calls per day; this decreased to only two to three per week. When patients call in after discharge, the nurse or care team that managed that discharge is usually not available to intercede and answer questions. The nurses would have to stop everything, look up the patient information, and try to understand what they needed to do to solve the issue that was being presented to them.

Shared opportunities: The reporting capabilities from the post-discharge phone calls is very robust. Weekly and monthly reports go out to the unit leadership and patient engagement team.

Lessons Learned

Engagement

It is critical to gain the up-front support of physicians and nurses with an initiative such as this. The successful pilot made it easier to engage with medical unit directors and the nursing director. Those who participated in the pilot became true believers in and promoters of the technology. "They believed in effectiveness of the process and became excellent spokespersons in terms of going out to other units, rolling it out, and getting everyone excited about implementing it," said Daymont.

Part of this engagement effort involved helping the licensed independent practitioners, nurse practitioners, and physicians also understand that it wasn't going to increase their workload and would, in fact, reduce physician call-backs as well. Frequently, discharge calls involve questions about discharge prescriptions. The nurse would page the discharge physician, who usually wasn't the one on call, so then the nurse would page the attending physician. The automated call-back system minimized such workflow interruptions.

Finally, Daymont emphasized the importance of bedside engagement and education with patients and families in order to increase the call answer rate.

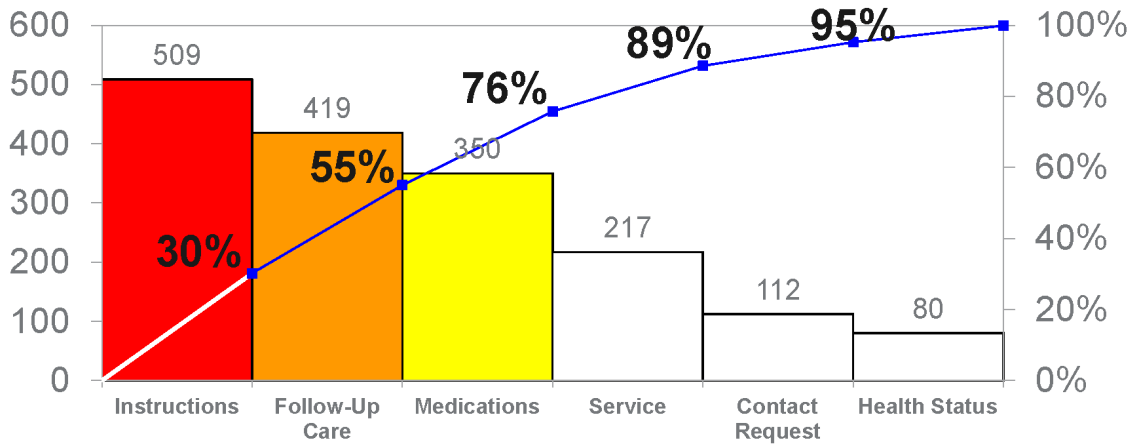
Accountability

This program required building in a standard escalation protocol that hard-wires a process to send any issues that the calls identified to the right place: nurse, physician, or case manager. Depending on the alert, the escalation protocol sends the issue to the appropriate party, instead of tying up two or three people with a single phone call.

Communication Strategy

"You can never over-communicate when you're implementing a new change in practice," said Daymont. The case management team presented to various hospital committees along with the medical unit directors and nursing directors. Presentations were made about the program to the nursing operations team meeting, along with a nursing education congress that includes all levels of nursing. The patient experience committee was key and very supportive of this

Patient Alerts by Category



"The improved outcomes really drove me to be such a big believer in the automated call process."
—*Mary Daymont*

effort. Finally, the communication about the program was integrated into central nursing orientation. The result is that now, every time a new nurse comes to the hospital, their orientation includes education on the call-back program. "We want every nurse to talk about it with families, prepare the family, encourage the family to answer the phone call," said Daymont. "We also put out posters on all nursing units, next to elevators, and in other key, high-traffic locations for patients and families to advertise the phone call the day after discharge and that we look forward to receiving their feedback."

Patient Safety, Outcomes, and Experience

The core goal of this program is to improve patient safety, clinical outcomes, and patient experience. "Aligning the staff around doing the right thing for the patient is always a recipe of success for us and our organization," said Daymont.

One of the first lessons learned after hospital-wide implementation was that the most frequent reason for alerts was confusion around discharge instructions. "I was surprised by this. We use teach back on our nursing units. We have spent a lot of time making sure that we really have culturally appropriate, educational-level appropriate instructions for patients and families," said Daymont. The second highest category was questions around follow up care and scheduling follow-up appointments.

Service concerns, such as concern with the quality of care received, are triaged to the nurse manager of the unit by which the patient was discharged. Health status (whether the child's health is better, worse, or about the same) goes to either a case manager or a pediatrician; if it's something very acute it can go to the emergency department. "We find this is really robust data," said Daymont. "As clinicians, we're excited because it does reduce our readmission rate, but also from a patient engagement and patient experience it does allow us to do more immediate service recovery. Within 24 hours of discharge, we're able to reach out to families that might not have had a good experience and work on that service recovery."

Children's National Health System, in Washington, D.C., is known for quaternary care, specialty care, and general pediatrics, with a Level IV NICU and a Level I trauma center, 323 beds, and 21,000 discharges annually. It includes a primary care medical home that serves 42,000 children. Mary Daymont, RN, M.S.N., CCM, Vice President of Revenue Cycle and Care Management, can be reached at mdaymont@childrensnational.org.