Abstract Submission to CSHM 2011 - Quality and Safety in Hospital Medicine

Lauren Linett

Lakeridge Health Corporation –Oshawa

1 Hospital Court

Oshawa, ON

L1G 2B9

W: 905-576-8711 ext. 4579

F: 905-721-7763

llinett@gmail.com

Vandad Yousefi

Lakeridge Health Corporation – Oshawa

1 Hospital Court

Oshawa, ON

L1G 2B9

W: 905-576-8711 ext. 4579

F: 905-721-7763

Vyousefi@lakeridgehealth.on.ca

Carl Reid

Lakeridge Health Corporation – Oshawa

1 Hospital Court

Oshawa, ON

L1G 2B9

W: 905-576-8711 ext. 6210

creid@lakeridgehealth.on.ca

BOOSTing the Discharge Process: Findings of Post-Discharge Follow Up Phone Calls

Lauren Linett, Vandad Yousefi, Carl Reid, Donna Shea, Karen O'Donnell

Background:

Readmissions to hospital and care transitions have been a recent area of focus for quality improvement. Studies suggest that one in five patients discharged from hospital will be re-admitted within thirty days. Moreover, patients who have not visited their primary care physician are more likely to be readmitted to hospital. As it stands, the hospital discharge process is considered to be a poorly organized, rushed and stressful period of time for patients. This often un-standardized process, results in patient's leaving hospital without a clear understanding of their post hospitalization care instructions. Project BOOST (Better Outcomes for Older Adults through Safe Transitions) developed by the Society of Hospital Medicine (SHM) is designed to optimize the transition from hospital to home. With the use of a toolkit bundle, Project BOOST focuses on risk reducing measures for high-risk patients, patient-centered learning and improving the flow of information between inpatient and outpatient providers. Project BOOST also incorporates follow up phone calls after discharge that help to identify a patient's understanding of his/her course in hospital, discharge instructions, common potential problems post hospitalization and overall patient satisfaction with the discharge process. Lakeridge Health (LH) enrolled in project BOOST in 2010, as the first Canadian hospital in this improvement collaborative. With leadership of the LH hospitalist program, we have been implementing various tools developed by the BOOST program.

Methods:

We conducted a 6-month pilot on a single medical unit at Lakeridge Health Oshawa, a large community-based hospital. Prior to this, we surveyed primary care physicians in our area aimed at better understanding the challenges that existed in optimal communication and flow of information between the inpatient and outpatient providers. We then created a tailored version of the Project BOOST tools taking into account our unique internal processes and resources. The tools consist of a specific risk assessment form used at the time of admission (8 P's), teach back learning methodology implemented throughout the hospitalization, discharge checklists [Universal Checklist and General Assessment of Preparedness (GAP)] prior to discharge, as well as both a written and verbal discharge care plan for patients with specific follow up instructions prior to leaving hospital. After discharge, our BOOST CARE (Call Assessment Review and Education) team, consisting of 2 registered nurses with previous discharge planning experience placed calls to all patients enrolled in Project BOOST. All patients received 3 phone call attempts within 72 hours of leaving the hospital and at 28 days. The BOOST CARE team followed a standard script to address patients understanding of their discharge plan, questions arising after hospital discharge, and overall patient satisfaction. Patients were not included if they were managed by a palliative care team, transferred to

a long-term care facility, readmitted to hospital, unreachable by phone or refused to participate in the follow-up call. Their findings were then documented. If an intervention was required, the BOOST CARE team performed and documented an additional phone call to assess the success of the intervention. Subsequently, the BOOST CARE caller results were shared with the pilot floor through existing daily rounds, posters and electronic communication tools to provide immediate feedback and support to the team.

Results:

During the 6-month period, the BOOST CARE team conducted 157 phone calls. The total completion of calls to the patient and/or their caregivers was 97 (62%). If the respondent could not answer any of the questions asked, their information was not included in the data collection for that particular question. 80 out of 84 patients (95%) were able to explain why they were in hospital and 61 out of 70 patients (87%) said they understood their discharge instructions. Most patients successfully filled their prescriptions after discharge, 81 out of 84 patients (96%) and 81% (61 out of 75 patients) had all their home care services and equipment. In total, the team intervened on 54 issues for 80 patients. Callers provided clarification on 9 interventions (16.7%) regarding discharge instructions and 19 interventions (35.2%) were made for medication related issues. Regarding blood-work/tests, 8 interventions (14.8%) were carried out and for home care related services and equipment, 5 interventions (9.3%) were made. In cases where new or exacerbating symptoms were identified, the BOOST CARE team independently triaged with outpatient physicians in 5 cases (9.3%) and arranged appointments in 5 cases (9.3%). With respect to patient satisfaction regarding their hospital stay and discharge we found that 45 out of 51 patients (88%) thought their service was excellent/good and 44 out of 49 patients (90%) felt they transitioned well from hospital back home. This was similarly consistent with the qualitative analysis of the feedback received from patients that showed that patients were transitioning well and even responded favourably to the follow-up phone call.

Conclusions:

The tools used from Project BOOST have helped increase patients' understanding of their post-hospitalization instructions. Additionally, the majority of issues encountered by patients' involved discharge and medication instructions, appointments and tests and symptom management. Moreover, the BOOST CARE team was successful in independently managing most post-discharge related issues. This may prove to be a cost-effective strategy to reduce unnecessary readmissions to hospital or urgent care visits. We also found that one of the greatest opportunities for improvement involved ensuring that patients visited their primary care physician after discharge. There is strong evidence this is positively correlated with a reduction of readmissions to hospital. Also, despite the need for further work, our results suggest that patients are generally satisfied with their hospital care experience and respond favourably to the follow-up phone call, which may

be in part reflective of the patient centered model of care that is inherent to Project BOOST.

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