Post discharge phone calls to improve care transitions

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Aim

By December 1, 2013, we will improve care transitions for all general internal medicine patients discharged home as evidenced by a 5-point improvement in Care Transition Measure (CTM-3) scores.

Importance

- The transition from hospital to home can expose patients to adverse events during the post-discharge period.
- 1 in 5 patients discharged home experience an adverse event, half of which are preventable or ameliorable.
- Improved transitions of care processes may reduce potential for harm and improve the patient experience.

Background

- Post discharge phone calls and "discharge bundles" may result in safer discharges and reduce preventable readmission to hospital.
- Bundles include: patient education, structured discharge planning, PCP notification, medication reconciliation, and follow-up visits or phone calls
- DC bundles can improve patient experience, and reduce hospital utilization

Methods

- Cluster-randomized control trial
- 2 teams: 72-hr post dc phone call
- 2 teams: usual care
- Intervention: general concern, comprehension of dc plans/ medications, teach-back
- Setting: GIM inpatient unit
- Duration 8 months
- Sample size = 180 for 80% power

Outcome and Process Measures

1. CTM-3 scores (survey at 30-days)
2. self-reported adherence
3. 30-day ED visits
4. 30-day readmission rate
5. 72-hr post dc phone call completion rate

Balancing Measures

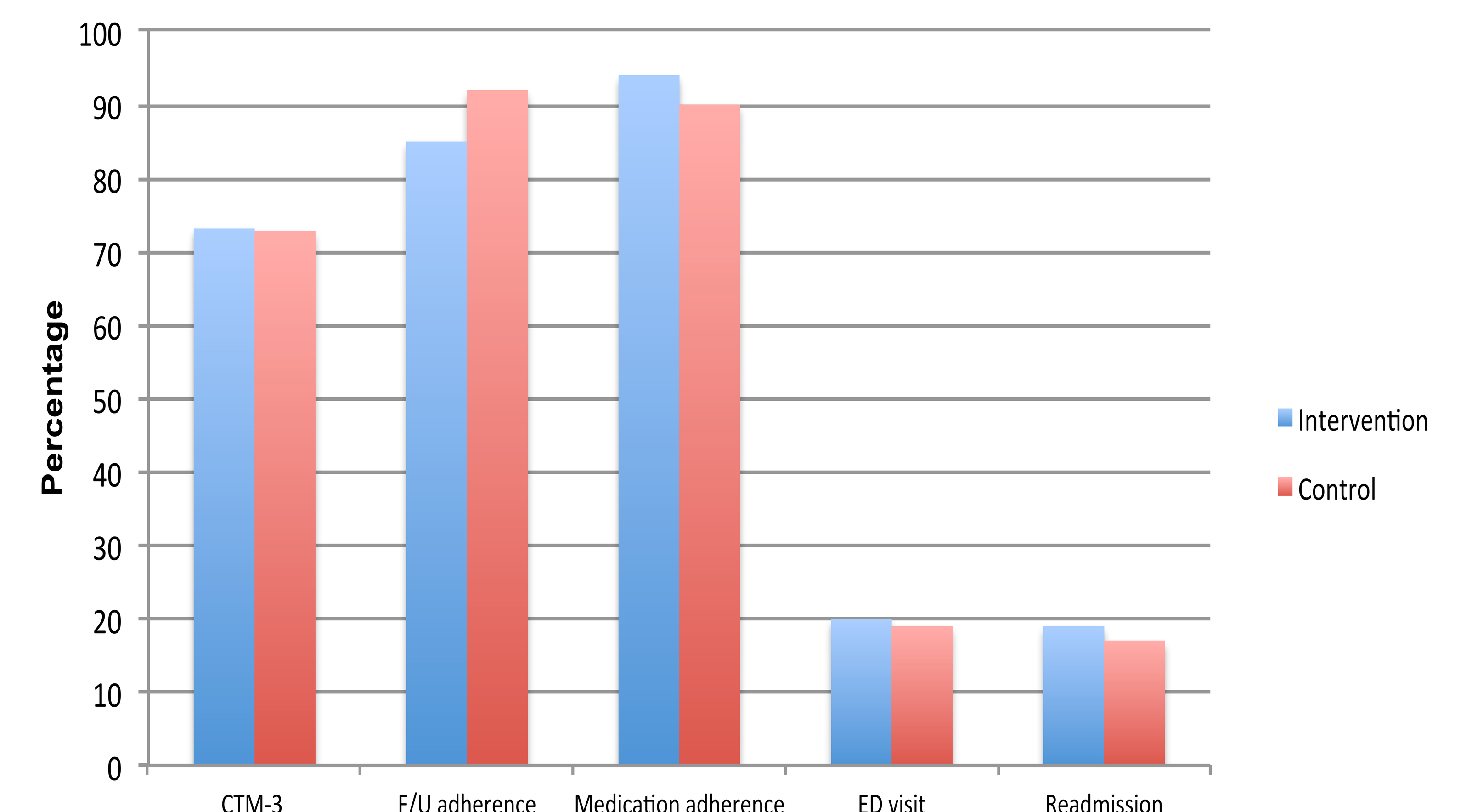
1. Rate of issues requiring physician response
2. Time required to complete calls
3. Number of attempts required to reach patient
4. LOS

Results

Baseline characteristics

Characteristic	Intervention (n=144)	Control (n=134)
Mean age at discharge, yr	64.8	62.7
Female, no (%)	90 (62)	81 (60)
Mean length of stay, days	7.5	8.0
Presence of family physician, no. (%)	123 (85)	105 (78)
Acute Care of the Elderly patient, no. (%)	44 (30)	31 (23)
Patients receiving 72-hr intervention phone call, n (%)	90 (62)	0
30-Day outcome survey response rate, n (%)	96 (67)	88 (66)

Outcomes between intervention and control groups



Discussion

- One post dc phone call did not impact on a measure of a patient's transition experience
- Challenging to maintain high intervention fidelity due to work-load
- Qualitative comments: expectation discordance between provider and patient, lack of dc summary review
- Targeting high-risk patients
- Unit leaders keenly interested in participating

Limitations

1. Low intervention fidelity
2. Effectiveness of one intervention vs multi-faceted
3. Recall bias of 30-day survey
4. Response rate 67%
5. Inclusion of low risk pts may have diluted intervention effects

Future direction

- Unit-based calls targeting high risk pts valued for feedback and as part of a dc bundle of interventions
- Synergy with COPD/CHF/stroke (QBP) initiatives
- Real-time feedback to front line staff
- Trial of integrated dc bundle using a checklist

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