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It's So Hard to Say Good-bye with DCI (Discharge Instructions)

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Abstract & Introduction

Abstract

As a comprehensive stroke center, we strive to encompass the entire care continuum. This starts in the Emergency department and ends with return home. Recently, we have implemented a followup phone call process. Our call center nurses survey patients within 7 days of discharge. Within the survey, they inquire about: provider's appointments, prescription and therapy compliance, depression screening, and reinforcement of discharge instructions. Our review of patient data has also lead to Stroke Center RN interventions including: medication clarifications, depression identification and follow up appointments. It is through the eyes of our patients that we create simpler, specific discharge instructions. Our goal is to meet patient's and caregiver needs for adequate communication to enable smooth transitions after hospital discharge. An implementation of follow up phone call process has potential to reduce readmissions, discover depression after stroke and enable a more comprehensive patient experience.

Introduction

In 2012, The Joint Commission added multiple standards in the Disease-Specific Certification requirements that address the discharge process of stroke patients. In our journey for Comprehensive Stroke Center certification we needed to develop a process to monitor the percentage of stroke patients who receive a follow-up phone call within 7 days of discharge.

Learning Objectives

- Investigate specific deficits in current discharge instruction through a survey conducted within one week of discharge.
- Promote standard follow up phone call for stroke patients discharged to home or homecare from the hospital.
- Develop evaluation plan to capture data from survey results and initiate actions to ensure patients' compliance and safety.

Methods

The stroke center RN led a multidisciplinary team that included a call center RN, case manager, and unit staff to develop a standard survey to assess patient/caregiver follow through on discharge instructions. A pilot of the phone survey was revised to identify any stroke transition needs and included depression screening using the PHQ2 instrument. Ongoing review of survey results ensured capture used survey findings to improve patient post discharge experience and reduce early readmission.

Team Member Roles

- Stroke Center RN:
  - Identify stroke patients discharged to home/ home care
  - Provide list to call center RN
  - Triage call findings regarding d/c instructions, medication issues, follow-up appointments, follow-up positive depression screens
  - Communicates potential patient needs or issues to neurologist and primary care provider
  - Analyze findings
- Call Center RN:
  - Call to patient/caregiver within 7 days of discharge
  - Mail survey if unable to reach x 2 calls
  - Assists with making post hospital appointments and referrals to community resources
  - Refers to Stroke Center RN if PHQ 2 depression screen positive
  - Reinforce stroke education and ensures caregiver materials provided
  - Recruit patient / caregiver for stroke support group

Discharge Phone Call Process Flow

Stroke Center RN Identifies Eligible Stroke Patient

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Forward List to Call Center RN

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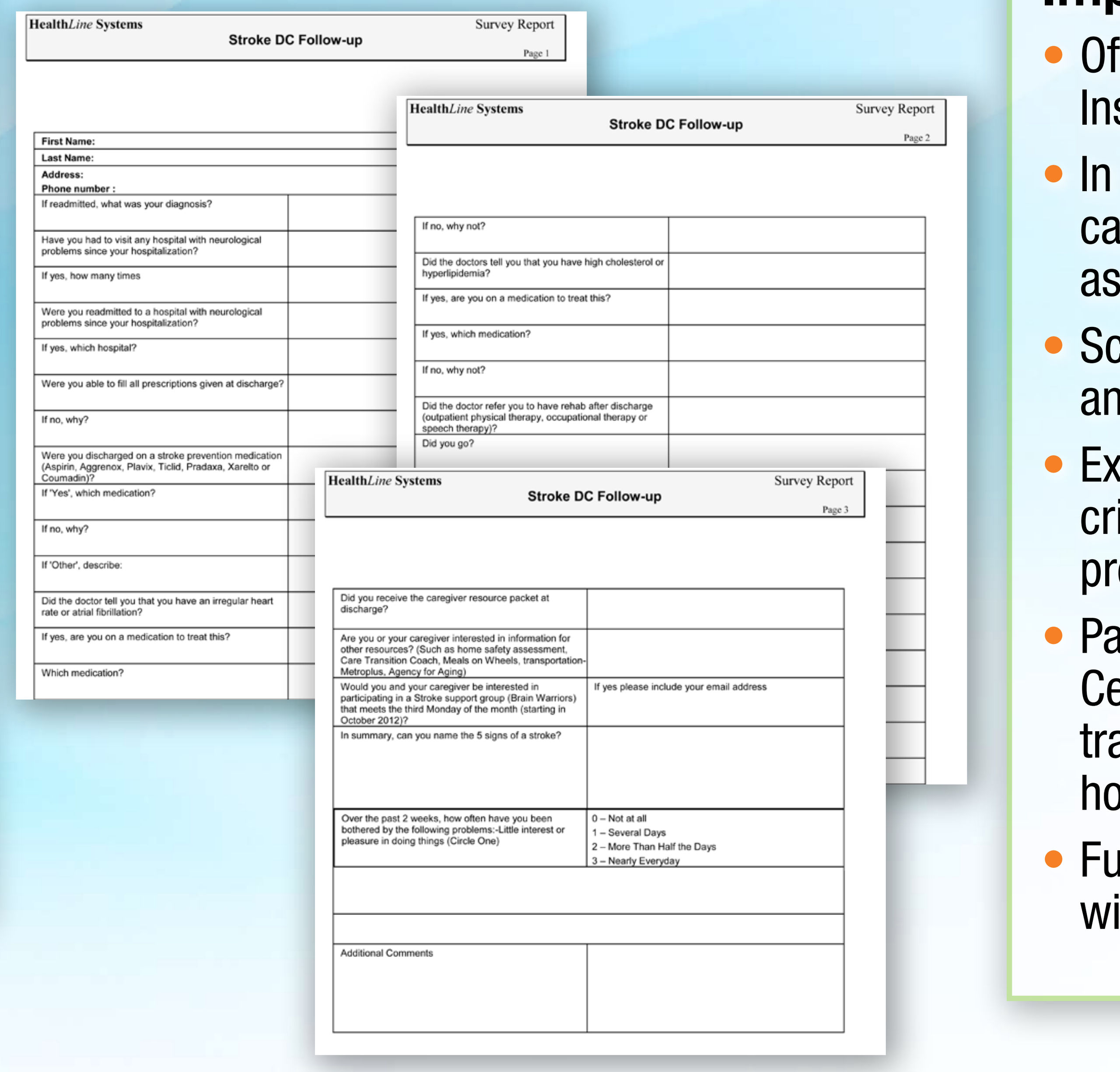
Call or Mail Survey to Patient

– If issues → (2nd call by) Stroke Center RN

– If no issues - Data Collected

Patient Survey



Outcomes/Results & Implications

- From Sept 2012 to Aug 2013, 413 eligible patients were identified with 66% participating in our survey process. 90% of patients reported compliance with filling prescriptions and making followup appointments. 11% of patients screened positive on PHQ2 depression screen prompting further assessment and referral for evaluation by provider.
- Commonly noted by Call Center RN's were questions related to discharge instructions, medication reconciliation and timeliness of scheduling outpatient appointments. Use of the Call Center RN provided immediate access to provider scheduling and referral to health management resources.

Implications for Practice

- Often patients do not fully understanding Discharge Instructions and have questions post hospitalization.
- In the first week after a hospitalization, patients and caregivers are often overwhelmed and appreciate assistance in navigating outpatient care.
- Screening for depression can help identify patients at risk and expedite appropriate evaluation.
- Extending the role of the Stroke Center RN bridges the critical period before patients are seen by primary care provider.
- Partnership between the acute care team and the Call Center RN has developed stronger processes to support transitions after hospitalization in patients discharged to home.
- Future work is needed to correlate impact of phone followup with readmission.

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