



Pender Community Hospital

Quest for Excellence

IMPLEMENTATION OF POST-VISIT CALLS TO IMPROVE
PATIENT SATISFACTION AND ENSURE CONTINUITY OF CARE

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PENDER COMMUNITY HOSPITAL, PENDER, NE

Identifying the Need

- A study by Press Ganey, a patient experience organization designed to distribute and analyze patient satisfaction surveys, indicated that post-visit phone calls can increase the overall patient satisfaction score by 55 percentile ranks.
- Identified that there was a need to increase patient satisfaction scores in areas of discharge and managing health at home.
- Pender Community Hospital FY2017 Press Ganey Patient Satisfaction Scores
 - Overall Percentile Rank – 93
 - Discharge Satisfaction Percentile Rank – 82
 - HCAHPS “Good Understanding of Managing Health” Percentile Rank – 62

Process Improvement Methods

■ Multi-Disciplinary Team:

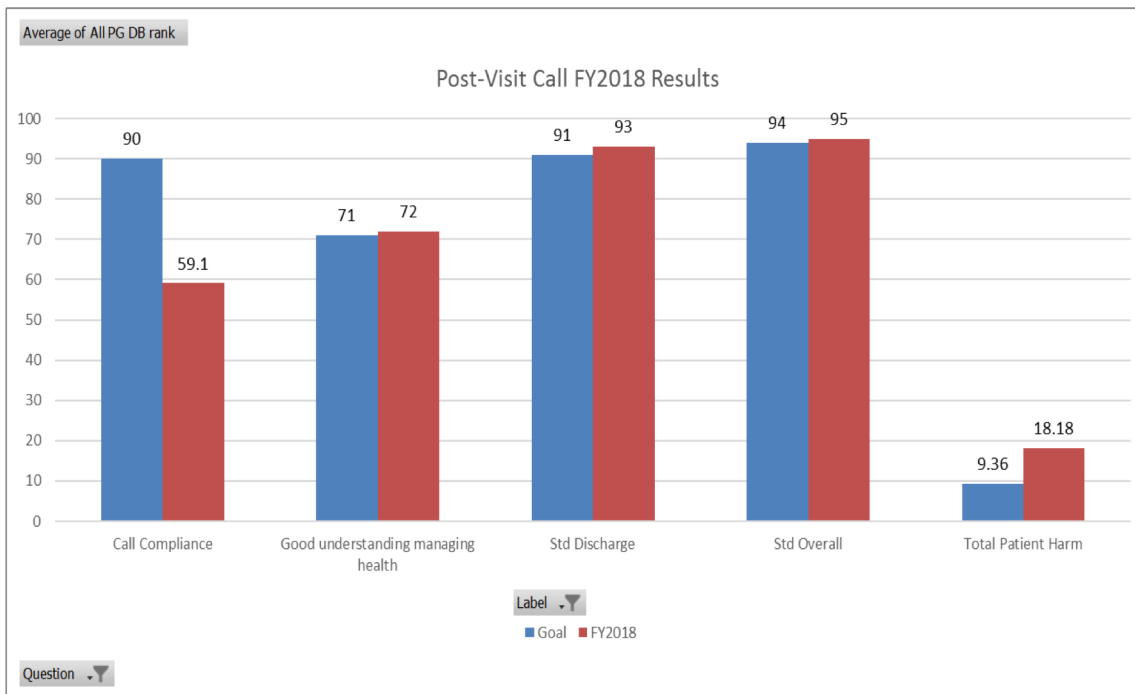
- Quality Improvement Project Coordinator
- Chief Nursing Officer
- QRM Manager
- Medical Clinic Health Coaches
- Inpatient Nurse Manager
- Discharge / Utilization Review Coordinator
- Medical Surgical Coordinator

- LEAN Project Charter created and 5 goals were identified – PDSA cycles were utilized throughout the project to test implemented changes

Project Goals:

1. Increase HCAHPS Overall Patient Satisfaction percentile rank from 93 to 94 as measured by Press Ganey
2. Increase HCAHPS Standard Patient Discharge Satisfaction percentile rank from 82 to 91 as measured by Press Ganey
3. Increase HCAHPS “Good Understanding of Managing Health” percentile rank from 62 to 71 as measured by Press Ganey
4. To decrease the patient harm rate (which includes the readmission rate) at PCH from 10.73 events to 9.36 events per 1,000 patient days.
5. To have a 90% compliance of post-visit phone calls for all ER, inpatient, OB, and inpatient surgical patients.

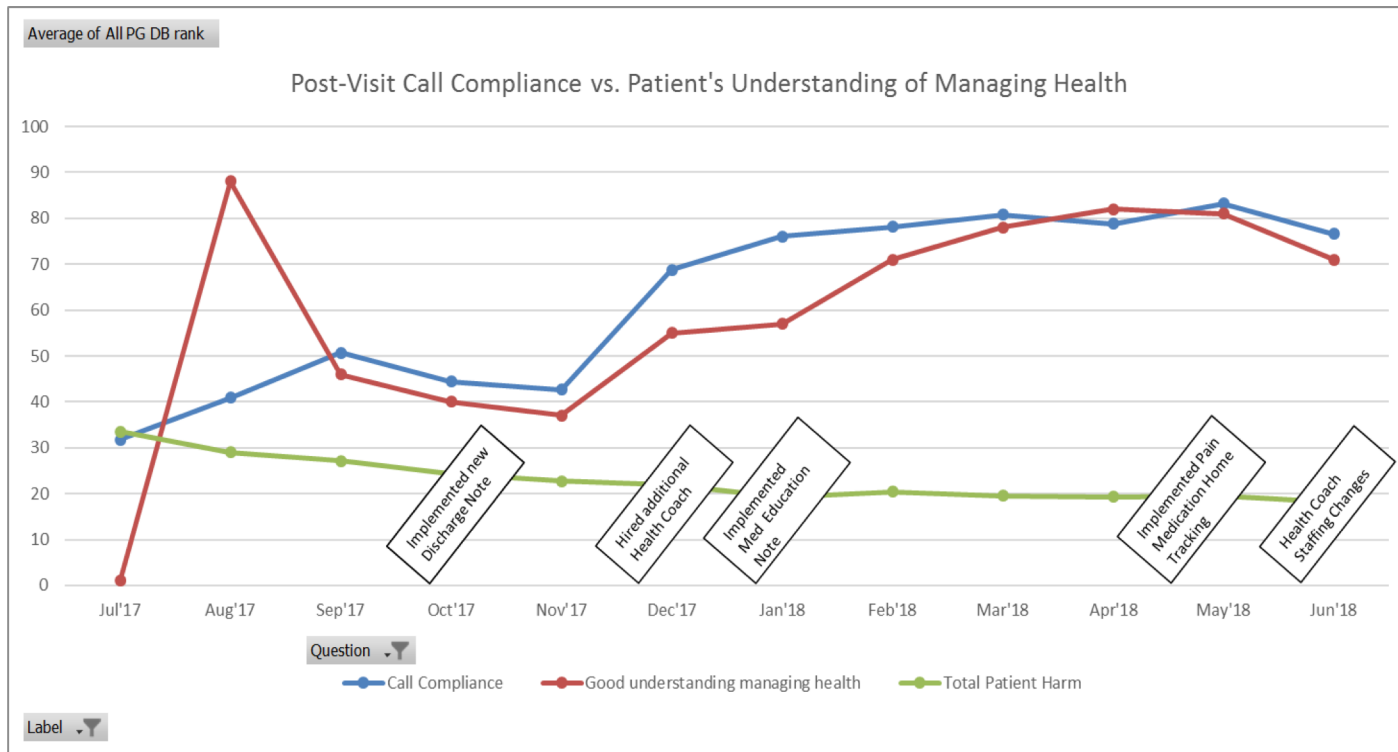
Results



Met 3 of the 5 Established Goals

1. Increase HCAHPS Overall Patient Satisfaction to the 94th Percentile Rank – **FY2018 end result at 95th Percentile**
2. Increase HCAHPS Standard Discharge to the 91st Percentile Rank – **FY2018 end result at 93rd Percentile**
3. Increase HCAHPS “Good Understanding of Managing Health” to the 71st Percentile Rank – **FY2018 end result at 72nd Percentile**
4. Decrease Total Patient Harm to 9.36 events per 1,000 patient days – goal not met; but trending in the right direction.
5. 90% call compliance rate – goal not met; but trending in the right direction.

Results



Small Tests of Change

- October of 2017 – Implemented a new discharge note for inpatients to include patient phone number, best time to call, persons able to speak with regarding health, and open-ended questions regarding the patients concerns when going home
 - Streamlined the Health Coach post-visit call process as necessary information was in one note
 - Increase in call compliance from 44% in October to 69% in December
 - Increase in the patients “understanding of managing health” from the 40th percentile in October to the 55th percentile in December
- December of 2017 – Additional Health Coach was hired at the Pender Medical Clinic
 - Increase in call compliance from 76% in January to 81% in March
 - Increase in the patients “understanding of managing health” from the 57th percentile in January to the 78th percentile in March
- January of 2018 – Implemented a Medication Education discharge note for inpatients
 - Streamlined the Health Coach post-visit call process as medication information was in one note
 - Increase noted in both call compliance and the patients “understanding of managing health”
- June of 2018 – Staffing changes in the Health Coach Department
 - Decrease in both call compliance and the patients “understanding of managing health”

Lessons Learned

- The patient's "understanding of managing health" at home is directly related to the post-visit call compliance. As the call compliance increased, the patient's satisfaction scores related to managing health increased.
- The total patient harm rate decreased as the post-visit call compliance rate increased.
- Post-Visit phone calls are a useful tool to ensure the continuum of care for our communities.

Next Steps

- Extend our follow-up care to include home visits by the Health Coaches
- Implement post-visit phone calls to outpatient service departments
- Continue to meet monthly – quarterly to modify plans and extend services