Improving Patient Satisfaction with Post-Visit Phone Calls

Pender Community Hospital

MEET THE PRESENTERS

- Krista Trimble, Quality Improvement Project Coordinator
- Katie Peterson, RN, CNO
- Traci Haglund, RN, Med Surg Manager
- Shay Petersen, RN, Discharge Planner / Utilization Review
- Jamie Kaup, RN, Med Surg Coordinator
- Lisa Schuetze, RN, Health Coach Coordinator

OBJECTIVES

- ABOUT THE FACILITY – LEADERSHIP / PLANNING
- PROJECT DEVELOPMENT – LEAN TRAINING
- CREATING THE DREAM TEAM
- SETTING GOALS
- ESTABLISHING PARAMETERES FOR MEASUREMENT
- HOW & WHY
- LESSONS LEARNED
- PROOF IN THE PERFORMANCE – ADDING BUY-IN

PENDER COMMUNITY HOSPITAL DISTRICT

- 21-Bed Critical Access Hospital
  - 3 Critical Care Unit Beds
  - 2 Trauma Bays + 2 Treatment Rooms
  - 2 Obstetrics (LDRP) Rooms
  - 2 Surgical Suites
- 4 Rural Health Clinics
- Long Term Care Facility & Assisted Living
- 2 Retail Pharmacies
- Child Development Center

PCH VISION: To be the best place to get care, the best place give care.

MISSION & LEADERSHIP

- Mission: To provide a continuum of exceptional healthcare services in a healing environment for everyone.
- Leadership: Dedicated to continual improvement efforts by goal setting and transparency
  - Develop staff skills in process improvement, data mining, action plan management, and sustaining results
  - Offered LEAN Training for select staff to learn the science of process improvement

PROJECT DEVELOPMENT

- LEAN Green-Belt Training encouraged participants to develop and implement a process improvement project
- HCAHPS Review areas noted for improvement:
  - Discharge Instruction
  - "Understanding of Managing Health" at home.
- Integrated clinic based Health Coaches into the LEAN project
  - Provide a continuum of care after discharge
- *How can we develop change to ensure a continuity of care throughout our facilities?*

RESEARCH

- Poor discharge experiences can lead to
  - decrease in patient adherence to plan of care
  - additional risk of adverse events
  - increase in hospital readmissions
- Press Ganey examined HCAHPS survey returns and determined patients who receive a post-visit phone call are more likely to rate their overall care experience more positively
  - Can increase overall patient satisfaction scores by a difference of 55 percentile ranks

RESOURCES

- PCH is in a unique with different facilities under one umbrella
  - Hospital, Clinics, Pharmacies, LTC Facility, Assisted Living, Child Development Center
- Hospital and Clinic are on the same EHR
- Pharmacy is connected to the clinic
- Health Coach Involvement in post-discharge process
- *Even with the connection of our facilities, there was a struggle to offer good continuum of care for patients moving through different levels of care*

DEVELOPING THE TEAM

CORE TEAM MEMBERS

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

ADDITIONAL TEAM MEMBERS

Asked to attend when appropriate for the topic of discussion

- Clinical Pharmacist
- Pharmacy Nurse
- Retail Pharmacy Manager
- Medical Executive Staff

SETTING GOALS

OVERALL GOAL:

To implement post-visit phone calls to ensure continuity of care

- increase in patient satisfaction scores related to discharge processes and transitions of care
- decrease patient harm events including readmission rates.

- Broken down into 5 specific measurable and actionable objectives

MEASURABLE OBJECTIVES

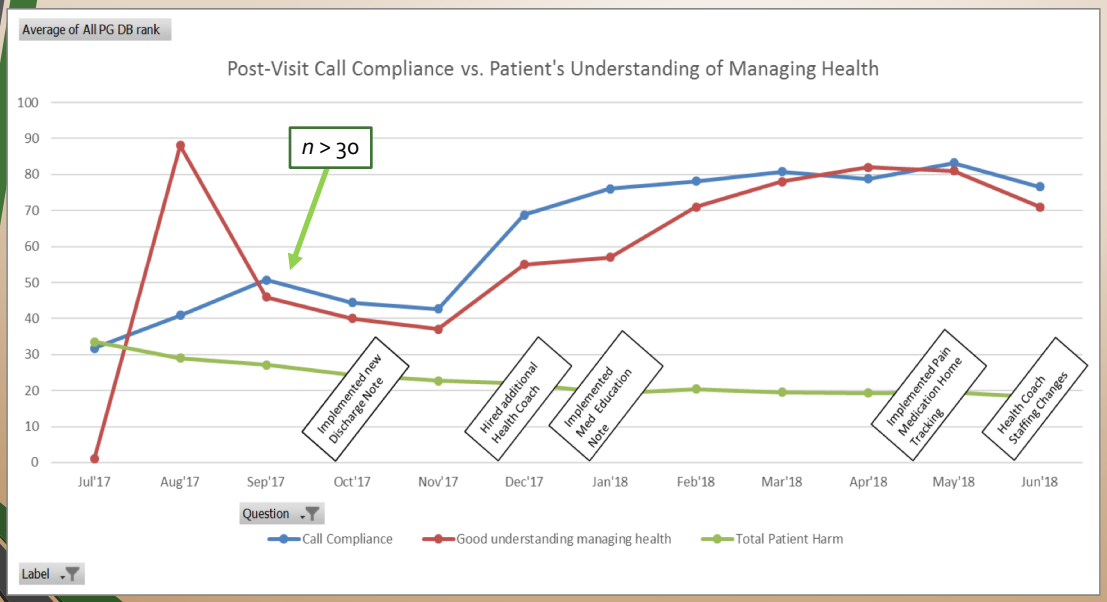
1. Increase HCAHPS Overall Patient Satisfaction Score to the 94th Percentile
   - Previous FY End score was 93
2. Increase HCAHPS Standard Discharge Patient Satisfaction Score to the 91st Percentile
   - Previous FY End score was 82
3. Increase HCAHPS "Good Understanding of Managing Health" score to the 71st Percentile
   - Previous FY End score was 62

MEASURABLE OBJECTIVES CONT.

4. Decrease Total Patient Harm (including Readmissions) to 9.36 events per 1,000 patient days
5. Make post-visit phone calls to 90% of patients discharged from inpatient, observation, skilled, and ER.
   - There was no historical data for this measure

RESULTS

Concluded that post-visit call compliance is directly related to the patients "understanding of managing health" and a gradual decline in patient harm events.



HOW and WHY

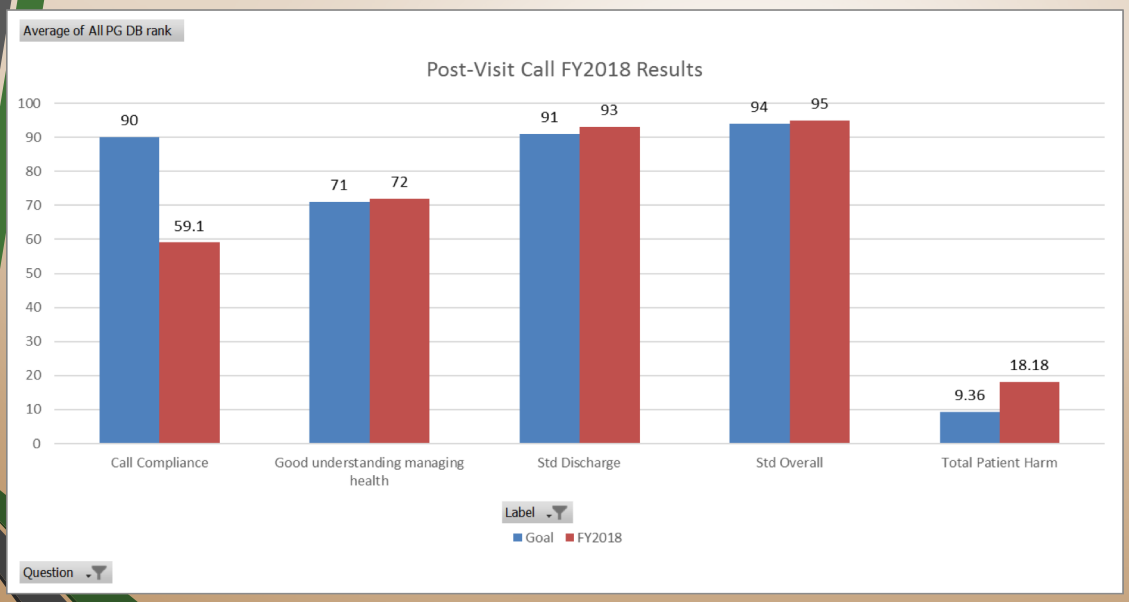
- October 2017 – Inpatient discharge note was re-formatted
  - Why? – Streamline data accessibility for Health Coaches
  - Enabled Health Coach to focus time on patient calls
- **Result of this change**
  - Increase in call compliance over only 2 months (44% - 69%)
  - Increase in "understanding of managing health" from 40th – 55th percentile in 2 months

HOW and WHY

- December 2017 – Additional Health Coach to the team to focus on transitions of care management (TCM)
- January 2018 – Implemented Medication Education Discharge Note
  - Discharge med reconciliation done on paper and not scanned in EHR within 48 hours
- **Result of this change**
  - Increase in call-compliance over the next three months from January – March (76% - 81%)
  - Increase in "understanding of managing health" percentile rank (57th – 78th)

ALL RESULTS

- 3 of 5 goals achieved.



LESSONS LEARNED

- There is a strong correlation between post-visit phone calls and how well patient's understand health management at home
- Do not set goals without baseline metrics
  - This was evident in the call compliance goal
  - Call-backs for ER patients were determined by acuity
  - It was estimated that 10% of ER visits were non-emergent prior to the project.
  - The actual number of non-emergent ER visits was closer to 40%

PROOF IN THE PERFORMANCE

- Sharing the data monthly and project success helped with staff buy-in
  - Inpatient nursing more receptive to completing a longer discharge questionnaire
  - Pharmacy and nursing due diligence to ensure proper medication teaching and education on discharge
  - Establishing a dedicated Health Coach to make post-visit calls
- Being able to demonstrate the success of post-visit phone calls in one area of care (inpatient), has given other departments a desire to utilize such calls
- To date, post-visit calls have been implemented in Lab, Radiology, and the Outpatient Clinic – with a goal to increase patient compliance and patient satisfaction

NEXT STEPS

- Broaden the Health Coach scope to include a single home visit
- Multi-Discipline work-group to streamline patient education during hospitalization through post-visit including all clinical departments
- Staff education and development on the impact of care coordination and patient outcomes
- Promoting use of teach-back in patient interactions every time

QUESTIONS ?

- Contact Information:

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