Follow-up Telephone Contact following Discharge from Long-Term Acute Care Hospitals

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Follow-up Telephone Contact following Discharge from

Long-Term Acute Care Hospitals

Submitted in partial fulfillment of the requirements for the degree of Doctor of Nursing Practice

at Eastern Kentucky University

By

Tonja Williams

Lexington, KY

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Abstract

Readmissions to acute care hospitals within 30 days post discharge are a burden to healthcare economy. Medicare Payment Advisory Commission (2007) estimated a cost of $12 billion dollars is spent each year on Medicare patients who are readmitted to an acute care hospital within 30 days post discharge. MedPAC (2007) estimated that 75% of those readmissions are avoidable. A review of the literature was conducted. Thirteen studies were reviewed and analyzed and the results of the literature review indicated there is evidence supportive of implementing telephone follow-up contact with patients discharged from the LTACH to assess for additional needs and to intervene early in the event of health deterioration. The purpose of this project was to implement the post discharge telephone follow up contact for patients discharged from an LTACH that is part of a larger health system. One of the interventions in Project RED was used to implement the post discharge telephone contact. Tools used to collect data were those contained in the Project RED toolkit (Boston University Medical School, 2014). Statistical analyses included frequency distribution tables for demographic data and readmission rate outcome data; and independent t tests to analyze the differences between the baseline group and the intervention group. Results indicated that there was no difference in the mean age or LOS between the Baseline and Intervention groups. The results indicated a lower readmission rate in the intervention group compared to the baseline group.
Follow-up Telephone Contact following Discharge from
Long-Term Acute Care Hospitals

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**Background and Significance**

**Problem identification**

People are living longer with multiple chronic conditions as a result of more knowledge and better technology to treat illnesses. The use of inpatient resources and costs of treating acute illnesses complicated by chronic conditions can be staggering. Steiner and Friedman (2013) estimated there were 20 million adults discharged from acute care hospitals in 2009 with two or more chronic conditions. This consists of 66% of all adult discharges, with nine million of those adults having four or more chronic conditions. Costs of care, length of stay, and mortality are substantially greater for patients with four or more chronic conditions compared to patients with only one chronic condition (Steiner & Friedman, 2013).

Readmissions to the acute care hospital within 30 days of discharge increase the cost of health care. It was estimated that almost 20% of Medicare patients discharged from an acute care hospital are readmitted in 30 days or less (Jencks, Williams, & Coleman, 2009). The Medicare Payment Advisory Commission (MedPAC), in its Report to Congress in 2007, stated that 75% of the readmissions are avoidable, yet carry an annual cost of $12 billion dollars. Based on these statistics, the Centers for Medicare and Medicaid Services (CMS) have included reductions in readmissions to acute care hospitals in its value-based purchasing models of reimbursement (Centers for Medicare and Medicaid Services, 2013). CMS does not reimburse acute care hospitals for patients who are discharged and readmitted within 30 days of discharge. Patients with multiple chronic conditions are at highest risk of readmissions to acute care hospitals and avoidable rehospitalizations can increase morbidity and mortality for the patient (Segal, Rollins, Hodges, & Roozeboom, 2014). The Department of Health and Human Services (DHHS) and
CMS, published a proposed rule in the Federal Register, on November 3, 2015, in response to the discharge planning requirements of the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT 2014). The goal of this proposed rule is to reduce patient readmissions by improving the discharge planning process in hospitals, critical access hospitals, LTACHs, and home health agencies (HHAs). This proposed discharge planning process is comprehensive and includes post-discharge follow-up with patients who are discharged from hospitals, critical access hospitals, and LTACHs (Department of Health and Human Services, 2015).

Long-Term Acute Care Hospitals (LTACHs) are acute care hospitals that specialize in caring for the chronically critically ill (CCI) medically complex patient type. It is important for LTACHs to develop processes, which will assist the CCI patient population in maintaining an optimum level of health and preventing a readmission to an acute care hospital. LTACHs provide acute care inpatient hospital services to patients under the same conditions of participation as those provided in an acute care hospital over an average of 25 days. The LTACH patient is defined as one who is medically complex and chronically critically ill and the majority are >65 years of age.

Long-Term Acute Care Hospitals (LTACHs) are an important part of the post-acute continuum of care. LTACHs specialize in treating patients in an acute care setting who are chronically critically ill (CCI) and need a longer length of stay than the average four-day acute care stay. LTACH leaders should establish evidence-based protocols and guidelines that improve the patient’s health to a level at which they can manage their health after discharge. This includes providing resources after discharge that will help patients prevent exacerbation of chronic conditions that might result in readmissions to acute care hospitals within 30 days post discharge. Provision of these resources are important to provide patients with resources and knowledge to manage their chronic conditions and maintain an optimum level of health to prevent hospital
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readmissions where costs of care are much higher than health care services provided in an outpatient setting.

**Evidence-based intervention**

Implementation of post-discharge telephone calls to the patient or the patient’s primary caregiver was implemented to ensure patients had the resources and information needed to manage their level of health post discharge to prevent readmission.

**Purpose**

The purpose of this project was to implement post-discharge follow-up phone calls to patients discharged from the LTACH. Post-discharge calls at specifically defined intervals allow nurses to assess whether the patient is using the discharge resources outlined in the discharge plan and provide nurses with an opportunity to intervene early, in the event the patient’s health is deteriorating.

**Process Framework**

The intervention of the telephone follow up contact after discharge from the LTACH was implemented using the Plan, Do, Study, Act (PDSA) process improvement model. The PDSA model was developed by W. Edwards Deming and is sometimes called the Deming Wheel or Deming Cycle (The W. Edwards Deming Institute, 2014). As the title of the model suggests, there are four steps to this process improvement model.

The Planning phase is the phase where the goal or plan for the project is developed. In this phase of the cycle, the goal was to collect data and plan the implementation of the intervention. The Do phase is where the intervention is defined and implemented. The intervention in this project was to call all patients who are discharged from the LTACH to home using a script to assess the patient’s health status and resource needs and to intervene if there were barriers to the patient meeting the discharge goals set by the discharge planner on the day
of discharge. Some of those barriers may be the patient not having transportation to get to his or her follow up primary care appointment; not understanding how to take his or her medications as prescribed; or not having family support available to assist with care. The Study phase is analyzing the data related to the outcomes to determine whether the goal established in the planning phase is being met. The final phase of the PDSA cycle is the Act phase where analysis of the process improvement project occurred. In this phase, questions were asked such as: Is the readmission rate decreasing as expected? Was the appropriate data being collected during the telephone contact to address the health needs of the patients? During the Act phase, an analysis of the data occurred and a determination of whether changes needed to be made to the goal or the intervention.

The PDSA Cycle is circular and measuring the outcomes continued to occur after small cycles of change were made in either the goal or interventions until the process was achieved and the goal was maintained. This process improvement model worked well with the proposed project because of the ability to analyze the small cycles of change necessary to achieve the goal. It does not require long periods of time to determine whether a change was effective.

**Literature Review**

A search of the literature was conducted to locate evidence in support of telephone follow-up calls post discharge from the LTACH to aid the patient in maintaining his or her level of health and prevent readmission to an acute care facility within 30 days post discharge. The following question was used to search the Cochrane Library, PubMed, and CINAHL databases: For patients discharged home after an LTACH stay, how will post-discharge phone calls compared to no post-discharge phone calls affect 30-day all cause readmission rates to the acute care hospital? The following summaries are from studies focused on using post-discharge
telephone contact to patients to determine if this intervention reduces hospital readmission, within 30 days post discharge.

Naylor, Aiken, Kurtzman, Olds, and Hirschman (2011) analyzed RCTs that included an intervention that met the definition of transitional care and included post-discharge follow-up. The purpose of the review was to analyze effective transitions of care interventions within the context of the Affordable Care Act. The targeted population was adults with at least one chronic condition. The systematic review identified 587 studies in the initial electronic database query. Of the 587, studies, 566 studies were excluded if the target population was children, the study was published in a language other than English, or if the study was not an RCT. The studies were reviewed at the title and abstract levels and then at the text level for a target population of adults with at least one chronic condition and contained an intervention that met the definition of transitional care. Twenty-one randomized controlled trials (RCTs) conducted in the United States focused on chronically ill adults who were transitioned from an acute care hospital to other settings and included post discharge follow-up where the intervention had a specific effect on readmissions were selected for review for the purpose of this systematic review.

Fourteen of the 21 studies (67%) were single-site studies and seven studies (33%) were multi-site studies. Eighteen (85%) studies’ target population were inpatients and three (115%) studies’ population included patients who were admitted to the emergency room. All 21 (100%) studies were RCT design but the rigor was uneven. Eight (38%) of the studies used block randomization, which could lead to selection bias and a few of the studies lacked power due to small sample sizes. Among all of the studies there were 1,396 subjects (mean = 377). Nine (43%) of the studies reported demographic data. The mean age was 64.7 years (range: 32.7-76.0 years). Twenty (96%) of the studies targeted elderly patients with chronic conditions.
The interventions varied in the studies. Seven (33.33%) of the 21 studies included comprehensive discharge planning with follow-up post discharge. Four (20%) included disease management, two (10%) included education, two (10%) included peer support, and the final four studies included telehealth facilitation (5%), mobile crisis (5%), post discharge geriatric assessment (5%) or intensive primary care (5%). Fourteen of the 21 interventions began before discharge. Twelve interventions included a home visit and three studies considered an office visit as a post discharge visit. The majority of the studies (18 of 21 or 86%) designated a clinical nurse leader and the remaining three (14%) designated a nurse, social worker, patient as a peer mentor, or clinical drug trial experienced personnel.

Common outcomes included resource utilization (including acute care readmissions), level of health and quality of life of the patient, the patient’s satisfaction with the inpatient stay and cost effectiveness of the interventions. Nine of the 21 studies (43%) identified a positive effect on all-cause readmissions, time to first readmission, or length of the readmission stay by implementing a clinical nurse led comprehensive discharge plan with post discharge follow up contact.

Hansen, Young, Hinami, Leung, and Williams (2011) analyzed RCTs, cohort studies and noncontrolled pre-post studies to describe interventions evaluated in studies aimed at reducing rehospitalization within 30 days of discharge. Hansen et al. (2011) conducted an exhaustive Cochran review. The systematic review identified 4,013 studies in the initial electronic database query. Of the 4,013 studies, 3,627 studies were excluded based on pre-established criteria: obstetric, pediatric, or psychiatric population; review or editorial; case report; disease-specific intervention not relevant to general hospital population; or absence of a 30-day readmission end point. There were 386 studies submitted for full-text review by 2 physician reviewers. The full-text review excluded 345 studies based on the pre-established exclusion criteria. Two additional
studies were identified based on the reference lists of previously identified articles. The systematic analysis review included a total of 43 studies. The reviewers developed a taxonomy to categorize the interventions into three domains inclusive of 12 distinct activities.

The first domain, pre-discharge interventions, included the following distinct activities: patient education, medication reconciliation, discharge planning, and scheduling of a follow-up appointment before discharge. Patient education and discharge planning were the most commonly evaluated interventions (22 of 43 studies or 51%) and of the 22 studies three studies were significant with a \( p \) value of <0.05. The second domain, post-discharge interventions included the distinct activities of follow-up telephone calls which was the most commonly evaluated intervention (17 of 43 studies or 40%) and of the 17 studies four studies were significant with a \( p \) value of <0.05, patient-activated hotlines, timely communication with ambulatory providers; timely ambulatory provider follow-up, and post discharge home visits. The third domain, bridging interventions included the following distinct activities: transition coaches, physician continuity across the inpatient and outpatient setting, and patient-centered discharge instruction which was the most commonly evaluated intervention (8 of 43 studies or 19%) and six of the eight studies demonstrated significant results with a \( p \) value of <0.05.

The demographic characteristics of the patients included in the 43 studies were adults with various diagnoses. The majority of the studies evaluated included a geriatric or general medical/surgical inpatient population (59%) and were set in the United States (66%). The limitations of the systematic review were inadequate descriptions of the interventions in each of the studies resulting in the inability to complete a meta-analysis of the effects of those interventions; the majority of the studies were quality improvement projects rather than experimental studies; and the interventions were studied as a part of a discharge bundle rather
than individually. The conclusion of the systematic review was that no individual intervention implemented resulted in a reduction in the risk of 30-day readmission rates.

Mistiaen and Poot (2008) analyzed 33 studies including RCTs and quasi-RCTs involving a total of 5,110 patients to assess the effects of follow-up telephone calls in the first month post discharge from an acute care hospital inpatient stay. An exhaustive search of 16 databases was conducted yielding an initial 14,572 citations. After removing duplicative citations, 12,140 citations were available. The selection criteria used was that the study had to be randomized or quasi-randomized where the intervention was telephone contact to patients within thirty days post discharge from an acute care hospital setting. The telephone followup had to be the only intervention or the effect of the telephone followup was analyzed separately. The data was collected by one author and reviewed by a second author. Homogeneity was analyzed and the criteria used for data extraction was the Cochrane Effective Practice and Organization of Care Review Group and the data collection tool was developed by the Cochrane Consumers and Communication Review Group.

Variances were noted in who made the telephone followup call (nurses made the calls in 67% of the studies); the goals of the intervention (improved patient satisfaction, better quality of life, fewer complications, less resource utilization and less readmissions); the time (85% within first week post discharge) and frequency (14% received a single call) after discharge when the calls were made; the format and duration of the calls (ranging from highly structured format in 9% of the studies to no format at all in 3% of the studies).

There were many different outcomes in the 33 studies varying between one and six per study (mean=2.5). There were a total of 82 outcomes in the 33 studies: Psychosocial health outcomes (61% of studies); Other consumer-oriented health outcomes (43% of studies); and Health-services-oriented outcomes (34%); Physical health outcomes (31% of studies). The effect
of the telephone followup intervention identified there was no statistically significant differences between the intervention and control groups in 12 of 33 (37%) of the studies and 21 of 33 (64%) identified favorable results of the telephone followup on outcomes [25 of 82 outcomes (31%) had favorable results].

To summarize the results of these three systematic reviews, all three (100%) indicated there was a decrease in 30-day readmission rates with the implementation of post discharge telephone contact follow-up in conjunction with other discharge planning interventions. The following individual studies provide for additional evidence to support this project.

Altfeld et al. (2012) conducted an RCT to test the effect of an enhanced discharge planning program (EDPP) to identify transitional care needs encountered by older adult patients after hospital discharge and assess the impact of a telephone transitional care intervention on patient and caregiver stress, health care utilization, readmission, and mortality. The RCT included 720 older adult (>65 years of age) acute care inpatient discharges from an academic medical center in Illinois. The results of this RCT identified there was no statistical difference ($p=0.69$) in 30-day readmission rates (OR=1.11, 95% CI 0.76 – 1.62). See Table A4.

Dedhia et al. (2009) conducted a quasi-experimental pre-post study in three different types of hospitals—academic, community teaching, and community nonteaching. The study included a sample size of 238 older adult (>65 years of age) patients in the pre-intervention group and 184 older adult (>65 years of age) patients in the intervention group admitted to hospitalist services on general medicine wards in the three different types of hospitals. The purpose was to study the feasibility and effectiveness of Safe and Successful Transition of Elderly Patients Study (Safe STEPS) intervention reviewing five components related to discharge planning including follow-up telephone calls that occurred at one week and 30 days post discharge. The results of the study identified 14% of patients in the intervention group
readmitted to the hospital compared to 22% of patients in the pre-intervention group (OR = 0.55, 95% CI = 0.32 – 0.94). See Table A5.

Balaban, Weissman, Samuel, & Woolhandler (2008) conducted a RCT to evaluate the use of a patient discharge form during hospitalization and a follow-up telephone call from a nurse post discharge to promptly reconnect the discharged patient to his or her medical home after hospital discharge. The sample size was 100 linguistically and culturally diverse patients from a medical-surgical floor of a community teaching hospital. The results were that only 25.5% of the intervention group had one or more undesirable outcomes compared to 55.1% of the concurrent control group and 55% of the historical control group (p=.003) and only 14.9% of the intervention group failed to follow-up within 21 days of discharge compared to 40.8% of the concurrent control group and 35% of the historical control group (p=.005). There was no statistically significant difference in the readmission rates of the groups—8.5% of the intervention group was readmitted to the hospital within 31 days post discharge compared to 8.2% of the concurrent control group and 14% of the historical control group (p=.96). See Table A6.

Jack et al. (2009) studied the effects of a coordinated discharge plan with telephone follow-up contacts on readmissions to either an emergency room or acute care inpatient. This RCT included a sample size of 749 adult patients with a mean age of 49.9 years discharged from a general medical service inpatient hospital stay at a large urban academic hospital. A nurse discharge advocate completed the discharge plan in collaboration with the patient and a pharmacist to reinforce the discharge plan and review medications completed the follow-up telephone calls. The results identified a lower rate of hospital use compared to the control group, 0.314 visits per month for the intervention group compared to 0.451 visits per month for the control group (p=0.009, 95% CI=0.515 - 0.937). See Table A7.
Riegel, Carlson, Glaser, Kopp, and Romero (2002) evaluated the effects of a standardized telephonic disease management intervention on acute care resource use and cost after hospital discharge in 93 Hispanic patients with heart failure. There were a total of 358 study participants. The results compared the Hispanic intervention group to the non-Hispanic intervention group. The intervention was telephone contact post discharge by a registered nurse to provide advice, solve problems, encourage adherence and facilitate access to needed services. The results identified there were less hospital readmissions in both intervention groups (Hispanic and non-Hispanic intervention groups) compared to the control or usual care group but the results were not statistically significant at three and six months ($p=0.24$ and $0.19$, respectively).

Tranmer and Parry (2004) conducted an RCT to test the effect of advanced practice nursing support by telephone on cardiac surgery patients following hospital discharge. Outcome measures were health-related quality of life, symptom distress, satisfaction of care, and unexpected health care use (readmissions). The RCT included 184 adult acute cardiac surgery inpatient discharges from an academic medical center in Illinois. The results of this RCT identified no statistical difference between the intervention group (mean 9, SD 9.9) and the control group (mean 8, SD 8.7) ($p=0.85$) in 30-day readmission rates.

Kind et al. (2012) tested the effects of the Coordinated-Transitional Care (C-TraC) Program on rehospitalizations within 30 days after discharge. The clinical quality improvement study was conducted in a Wisconsin Veterans hospital and included 708 adult patients. The results of the study identified 23% of patients in the intervention group readmitted to the hospital compared to 34% of patients in the baseline group ($OR = 0.55$, 95% CI $= 0.33 – 0.90$).

Courtney et al. (2009) evaluated the effect of an exercise model, nurse-conducted home visit and telephone follow-up post discharge on health related quality scores and hospital readmissions to either the Emergency Department or as an inpatient. This RCT was conducted in
an Australian tertiary metropolitan hospital and included 128 adult patients who were discharged from a medical ward. The results of the study identified there was a statistically significant decrease in the mean readmission rates of the intervention group (mean=22%) compared to the mean readmission rates of the control group (mean=47%) \((p=0.007)\).

Abad-Corpa et al. (2012) conducted a quasi-experimental study to test the effect of a discharge plan with post discharge telephone follow up on outcome variables of readmission rates, patient satisfaction, quality of life, and level of knowledge about chronic obstructive pulmonary disease (COPD). This study was conducted in two tertiary-level public hospitals in Spain and included a total of 143 patients admitted with COPD and discharged home after their inpatient hospitalization. The results of this study identified a decrease in readmission rates by 4% in the intervention group compared to the control group.

D’Amore, Murray, Powers, & Johnson (2011) examined the effects of telephone follow-up on health system. Outcome variables measured in this observational study were patient satisfaction and 30-day readmission rates. The sample included 4,951 adult inpatients and observation patients discharged from the hospitals. The results of this study identified a decrease in the 30-day readmission rates in the intervention group (mean 9.5%) compared to the control group (mean-10.8%) \((p=0.04)\). There was no statistically significant difference in the patient satisfaction scores for patients who received the post discharge telephone call and the patients who did not received the post discharge telephone calls \((L=2.24, \text{ df } 2, p >0.25)\).

Seven of the ten studies (70%) summarized above indicated that discharge planning with telephone contact to the patient or caregiver post discharge from an acute care inpatient hospital stay decreased readmission rates. All ten (100%) of the studies included telephone contact post discharge from an acute inpatient stay, measured readmission rates to acute care hospitals, and included a discharge plan created while the patient was an inpatient in an acute care hospital.
There was wide variation in the post discharge telephone contact process in the studies reviewed. These variances in the interventions did not yield differing results.

The evidence indicated positive outcomes for patients as a result of a discharge plan with telephone contact post discharge to assess for health care needs and provide early intervention in the event of deterioration in the patient’s health status. The LTACH patient population is chronically critically ill and would benefit from an intervention such as telephone follow-up contact post discharge, which improves health outcomes and prevents frequent readmissions to an acute care hospital. All of the studies included in this review described the interventions used to affect the desired outcomes of decreased use of acute care resources, either emergency department visits or readmissions as an inpatient. Although there is no standardized script, all studies in this review included telephone follow-up contact post discharge with the common theme of assessing needs of the patients early post discharge. The telephone follow-up contacts described in the proposed project are for patients discharged from an LTACH. The evidence provided in this review is easily applied to the LTACH patient population.

Agency Description

Setting

LTACHs are an important part of the continuum of care and specialize in treating patients in an acute care setting who are medically complex and need a longer length of stay than the average four-day acute care stay. The project coordinator of this project is the President and CEO of a 57-bed LTACH located in central Kentucky. The LTACH is a part of a larger Kentucky health system and is aligned with the strategic goals and quality outcomes of the larger health system. The primary goal was for patients achieving an optimum level of health to live a productive life without having to be admitted and readmitted to a hospital. The LTACH is a
hospital within hospital and leases the space it occupies from two of its sister facilities called host facilities.

**Target population**

The target population were patients discharged home from the LTACH, during the time period of October 1, 2015, through November 30, 2015. Only patients discharged home were included in the intervention follow-up phone calls.

**Description of stakeholders**

The LTACH President and CEO is responsible for leading change to continuously improve patient outcomes. Key stakeholders to assist in driving the change in preventing LTACH discharged patients from being readmitted is the LTACH team. The LTACH team included the Case Management team, which includes the Director of Case Management, care managers and discharge planners; Nursing staff, which includes the Director of Nursing; Quality Improvement staff led by the Director of Quality and Risk Management; and the medical staff led by the President of the Medical Staff. The discharge planners who are a part of the LTACH’s case management department plan the patients’ discharge during their inpatient stay. There are two discharge planners: one located at each of the LTACH’s campuses. The discharge planners are responsible for meeting with the patients and/or patient families during the inpatient stay. The discharge planners develop a relationship with the patients and families. The two discharge planners were responsible for conducting the post-discharge telephone contacts with patients who were discharged home.

The LTACH team is focused on providing high quality and safe patient care while the patient is admitted to the hospital. The team works together to manage the patient’s care so that the patient achieves a level of health to be safely discharged to a lower level of care such as back home, home with home health services, skilled nursing facility, or inpatient rehabilitation
hospital. The team ensures the patient has the resources available after discharge to aid the patient in continuing the healing process. Before this project, there was no process in place to determine whether the patient had the capability of accessing the resources provided at the time of discharge or whether the patient actually followed the discharge plan as set by the LTACH team prior to discharge.

**Project Design and Project Methods**

The telephone follow-up post discharge process was developed based on the Project RED toolkit provided through participation in the K-HEN collaboration (Kentucky Hospital Engagement Network, 2014). RED is an acronym for the Re-Engineered Discharge developed by Boston University Medical Center and funded by the Agency for Healthcare Research and Quality (AHRQ). Project RED is a 12-intervention process improvement project (Boston University Medical Center, 2014). DHHS in its proposed rule for hospitals (including critical access hospitals and LTACHs) and HHAs to develop and implement a robust discharge planning process published November 3, 2015, used Project RED as a recommendation for development of the discharge planning process (Department of Health and Human Services, 2015). The LTACH has implemented several of the interventions and implemented the post discharge telephone follow-up piece in the fall of 2015.

The primary outcome for this project was to decrease the readmission rates to the health system’s short-term acute care hospitals within 30 days post discharge from the LTACH. Secondary outcomes of this project were:

1. Percentage of patients who followed up with a primary care provider within seven days post discharge; and
2. Whether interventions were required based on the patient’s needs as a result of the post-discharge telephone contact.
Procedure

**IRB submission process.**

It was determined that an expedited institutional review board (IRB) review and approval was necessary for the project. The IRB application (Appendix A) was submitted to Eastern Kentucky University and approval of the project was granted September 21, 2015. The facility where the project took place is a part of a larger health system. The health system granted a deferral to Eastern Kentucky University’s IRB August 20, 2015 (Appendix B).

**Measures, instruments and implementation plan.**

The post discharge telephone call follow up was developed according to the model found in the Project RED toolkit (Boston University Medical Center, 2014). There are five components in the toolkit: (1) Purpose of the Tool; (2) Preparing for the Phone Call; (3) Conducting the Phone Call; (4) Documenting the Call; and (5) Communicating with the Provider. Also included in the Toolkit are forms needed to complete the components.

The Purpose of the Tool component states that the post discharge telephone call should occur two to three days after discharge. The purpose of the phone call was to allow the patient/caregiver the opportunity to ask questions, clarify misunderstandings regarding the discharge plan, or obtain additional information not provided during the inpatient hospital stay. The discharge planners reviewed the current health status of the patient, medications, appointments, any home services provided or needed, and assisted the patient in planning for what to do in the event a problem occurs.

In the Preparing for the Phone Call component, the content reviewed from the data gathered was to provide for continuity of care; learning how to confirm understanding by using the teach-back method; gathered and reviewed necessary documentation needed during the phone call such as the discharge plan; checked the accuracy and safety of medications and
identified any problems the patient was having with the medication regimen; and arranged for interpreter services if needed. The discharge planners were the most familiar with the patient’s discharge plan and developed a relationship with the patient during the inpatient hospital stay. Having the discharge planners conduct the post discharge telephone calls prevented miscommunication errors that might occur as a result of a handoff of care. Project RED Contact Sheet (Appendix C) was used to obtain the needed information prior to discharge.

The Conducting the Phone Call component included planning the appropriate time to call. The discharge planners worked with the patient/caregiver to set a convenient time to talk with the patient two to three days after the date of the discharge. This date and time was written on the contact sheet and given to the patient at the time of discharge. It was important for the discharge planners to inform the patient/caregiver that the call would occur, the purpose of the call, and that to expect the call to last anywhere from 20 minutes to one hour. The call was conducted using the Post Discharge Follow Up Phone Call Script for talking directly to the patient or the Post Discharge Follow Up Phone Call Script for talking to a care provider on behalf of the patient (Appendices D and E, respectively) provided in the Project RED toolkit (Boston University Medical Center, 2014).

As with any care provided, documentation was very important during the phone call. The fourth component of the post discharge telephone follow-up contact was Documenting the Call. The documentation included the number of call attempts, the patient’s perception of health status, any problems reported by the patient related to medication regimen, the patient’s intent for follow-up appointments, any health actions taken by the patient post discharge, and any actions taken by the discharge planners during the telephone call or as a result of the telephone call. The Post Discharge Follow Up Phone Call Documentation Form (Appendix F) provided in the Project RED toolkit was used to record the phone call. The fifth and final component of the
FOLLOW-UP TELEPHONE CONTACT

post discharge telephone follow-up contact was communicating with the patient’s primary care provider if needed based on the information obtained during the phone call. Project RED recommended this communication occur by letter or email to the primary care provider. These recommendations were used in this project for any contact with the patient’s primary care provider.

The Discharge Planners were educated by the project coordinator on the five components of Project Red Completing the Follow Up Phone Call using the teach back method recommended by Project RED (Boston University Medical Center, 2014). The project coordinator was present during the first post discharge telephone contact made to evaluate the effectiveness of the education provided and confirm tools were used as directed in the education.

Data collection and analysis.

Retrospective and current data were collected for this project. Retrospective baseline data collected consisted of readmission rates for patients discharged from the LTACH and readmitted within 30 days of that discharge date to the short-term acute care hospital for the time period of October and November 2014. The baseline data included aggregated data from the admission/discharge/transfer system of the health system, of which the LTACH is a part. Data were analyzed using a frequency distribution table. The readmission rate was a percentage calculated by using the total number of LTACH discharges for the specified time period as the denominator and the number of LTACH discharges readmitted to the LTACH’s host facilities within 30 days post discharge as the numerator multiplied by 100.

Concurrent information was collected during the months of October and November 2015 by the case managers performing the post discharge telephone call follow up. Data collected included patient demographic data, whether the patient followed up with a primary care provider (PCP) or if any interventions occurred as a result of the phone call based on the Project RED
tools. Demographic data were de-identified and analyzed using a frequency distribution table with graphs. The means of the baseline readmissions and post intervention readmissions were shown in a bar graph. The differences in the mean age and LOS of the patients in the Baseline and Intervention groups were analyzed by using independent $t$ tests.

**Timeline of Project Phases**

Implementation of the post discharge telephone contact follow up began October 1, 2015. Data collection began October 1, 2015, and continued for 2 months with an end date of November 30, 2015. The 30-day readmission data was collected during the time period from November 1 through December 31, 2015. The project facility discharges an average of 30 patients per month and an average of 51% of those discharged patients are discharged to home. Statistical tests and data analysis occurred in the month of January 2016 using Statistical Package for the Social Sciences (SPSS).

**Results**

There were two groups of discharged patients: (1) the Baseline group, which consisted of 41 patients who were discharged between October 1, 2014, and November 30, 2014; and (2) the Intervention Group, which consisted of 24 patients who were discharged between October 1, 2015, and November 30, 2015. In the Baseline group, the majority of patients were male (61%) compared to female (39%) as shown in Table 1; had a mean age of 58.5 (SD, 14.66); and the mean length of stay (LOS) in the LTACH was 24.4 days (SD, 10.50) as shown in Table 2.
Table 1

*Baseline Group: Gender*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency (n = 41)</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>25</td>
<td>61%</td>
<td>61%</td>
<td>61%</td>
</tr>
<tr>
<td>Female</td>
<td>16</td>
<td>39%</td>
<td>39%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Table 2

*Baseline Group: Age and LOS in the LTACH*

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>Range</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>41</td>
<td>58</td>
<td>26</td>
<td>84</td>
<td>58.5</td>
<td>14.66</td>
</tr>
<tr>
<td>LOS</td>
<td>41</td>
<td>55</td>
<td>8</td>
<td>63</td>
<td>24.4</td>
<td>10.50</td>
</tr>
</tbody>
</table>

The majority of patients in the intervention group were females (54.2%) compared to males (45.8%) as shown in Table 3; had a mean age of 59.6 (SD, 14.63); and the mean LOS in the LTACH was 28.9 days (SD, 10.93) as shown in Table 4.

Table 3

*Intervention Group: Gender*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency (n = 24)</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>11</td>
<td>45.8%</td>
<td>45.8%</td>
<td>45.8%</td>
</tr>
<tr>
<td>Female</td>
<td>13</td>
<td>54.2%</td>
<td>54.2%</td>
<td>100%</td>
</tr>
</tbody>
</table>
Table 4

*Intervention Group: Age and LOS in the LTACH*

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>Range</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>24</td>
<td>65</td>
<td>22</td>
<td>87</td>
<td>59.6</td>
<td>14.63</td>
</tr>
<tr>
<td>LOS</td>
<td>24</td>
<td>40</td>
<td>9</td>
<td>49</td>
<td>28.9</td>
<td>10.93</td>
</tr>
</tbody>
</table>

The readmission rates for both groups were calculated by dividing the number of patients readmitted within 30 days post discharge by the total number of patients discharged home and multiplying by 100, to obtain the percentage of discharges to home that were readmitted within 30 days post discharge. In the Baseline group, there were a total of 5 patients readmitted out of 41 discharges to home (12%) and in the Intervention group, there were a total of 2 patients readmitted out of 24 discharges to home (8%). The readmission rate is shown in Figure 1.

Figure 1

*Bar Graph comparing 30-day readmissions post discharge between Baseline group and Intervention group.*
An independent t-test was conducted to determine if there was a difference in the mean ages between the Baseline group and Intervention group and if there was a difference in mean LOS between the Baseline group and Intervention group.

**Age**

An independent t test was conducted and there was no statistically significant difference in the mean ages of the patients in the Baseline group (Mean = 58.5, SD = 14.66) compared to those in the Intervention group (Mean = 59.6, SD = 14.63). The t value = -.300 and the p value = .765 (two-tailed). The mean difference was -1.13 (95% CI: -8.65 to 6.39). These results are presented in Table 5.

Table 5

*Differences in Mean Ages of Baseline and Intervention groups*

<table>
<thead>
<tr>
<th>Variable Group</th>
<th>Mean ± SD</th>
<th>t</th>
<th>df</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline Group (n= 41)</td>
<td>58.5 ±14.66</td>
<td>-.300</td>
<td>63</td>
<td>.765</td>
</tr>
<tr>
<td>Intervention Group (n= 24)</td>
<td>59.6 ±14.63</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**LOS**

An independent t test was conducted and there was no statistically significant difference in the mean LTACH LOS of the patients in the Baseline group (Mean = 24.4, SD = 10.50) compared to those in the Intervention group (Mean = 28.9, SD = 10.93). The t value = -1.649 and the p value = .10 (two-tailed). The mean difference was -4.51 (95% CI: -9.99 to .95. These results are presented in Table 6.
Table 6

*Differences in Mean LTACH LOS of Baseline and Intervention groups*

<table>
<thead>
<tr>
<th>Variable Group</th>
<th>Mean ± SD</th>
<th>t</th>
<th>df</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline Group (n= 41)</td>
<td>24.4 ±10.50</td>
<td>-1.649</td>
<td>63</td>
<td>.104</td>
</tr>
<tr>
<td>Intervention Group (n= 24)</td>
<td>28.9 ±10.93</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Discussion**

The data indicated that there was a difference in the readmission rates between the Baseline group (12%) and the Intervention group (8%) as a result of implementing the post discharge telephone contact to patients or the patients’ caregivers who were discharged home from the LTACH. There was a wide range in age and LOS in the LTACH for both the Baseline and Intervention groups. The statistical analyses indicated there was not a difference in the mean age or LOS between the Baseline group and the Intervention group. Of the 24 patients who received the post discharge telephone contact, all but two followed up with their primary care provider with seven days post discharge and eight of the 24 patients received an intervention from the discharge planner as part of the post discharge follow up. Because of the very small sample size, no statistical tests were conducted on this data. A further study might be whether following up with the primary care provider or providing interventions as a result of post discharge contact within a short timeframe after discharge will result in lower 30-day all-cause readmission rates.

These results are aligned with the evidence found in the literature review. Although there was no evidence that examined the implementation of post discharge telephone contact outside of other interventions, the evidence indicated that post discharge telephone contact was an important piece of the discharge process to aid patients in maintaining a level of health that
would prevent them from a 30-day post discharge readmission to an acute care facility. The LTACH had not made any changes in its discharge process during the time period when the baseline data was collected and the time period when the intervention data was collected to limit the possibility of another change affecting the readmission rates of the patients discharged. The results of the implementation of the intervention of post discharge telephone contact to patients discharged home from the LTACH indicated the intervention did reduce 30-day readmissions of chronically critically ill patients to an acute care facility.

**Implications**

This project indicated that post-discharge telephone contact with patients or patients’ caregivers is an important piece of a comprehensive discharge process for those patients discharged from an LTACH. The follow-up contact post discharge allowed an opportunity for the patient to ask clarifying questions regarding his/her discharge instructions and to provide information to the nurse or other individual conducting the call that could result in the person receiving additional information to prevent deterioration of the patient’s health. The data collected as a result of this project indicated that the post-discharge telephone contact did reduce 30-day readmissions to an acute care facility.

The limitations of this project included a small convenient sample size from one LTACH. The readmission data was collected from the LTACH’s health system and did not include any patient who may have been readmitted to another acute care facility outside the LTACH’s health system. There was no data collected related to the diagnosis, comorbidities, or acuity of illness for the patients. Collection of these data could change the results of the statistical analyses if included. The data collected did not include outcomes such as morbidity and mortality related to the inpatient LTACH stay nor did it include longer periods of time such as 90-day, 180-day, or 365-day outcomes for the patient population to determine whether the positive outcomes
continue past the 30-day time period. Future studies should include larger sample sizes and should examine other outcomes related to morbidity and mortality for chronically critically ill patient populations. Although there were limitations to this project, implementing post discharge telephone contact to patients as part of a comprehensive discharge planning process caused no harm and was helpful to patients and their caregivers.

**Conclusion**

There is no evidence related to reducing 30-day post LTACH discharge readmissions to an acute care hospital. The literature review conducted contained several studies showing the effects of telephone follow up care provided after discharge from an acute care hospital on 30-day readmission rates. The LTACH patient population is defined as CCI patients and has the highest risk for multiple acute care readmissions. Patients discharged from the LTACH benefitted from a very comprehensive discharge plan and follow-up care after discharge. The LTACH where this project occurred had been involved in improving its discharge process for a period of one year and was ready to implement the Project RED intervention of post-discharge telephone contact.

The intervention of the post-discharge telephone follow up with the patient or the patient’s designee 48 hours after discharge was implemented. The goal of the telephone follow up was to assess the patient’s needs and provide additional resources for the patient to maintain his or her health without the need to seek either emergency department or acute hospital inpatient care. The impact of successful implementation of this intervention was a reduction in 30-day readmissions to the LTACH’s host facilities. This indicated improved health outcomes for the patient and decreased cost of healthcare to the patient and to third-party payers. Finally, by reducing hospital readmissions, additional inpatient capacity is added to the community preventing delays in patients being transitioned to an inpatient bed quickly and efficiently.
References


doi:10.1089/pop.2010.0045

Medicare and Medicaid programs; revisions to requirements for discharge planning for hospitals, critical access hospitals, and home health agencies; proposed rule. *Federal Register, 80*(212). 68126-68155.


greater efficiency in Medicare. Retrieved from


https://deming.org/theman/theories/pdsacycle
Appendix A

Eastern Kentucky University IRB Application/Approval

NOTICE OF IRB APPROVAL
Protocol Number: 16-034
Institutional Review Board IRB000002836, DHHS FWA00003332
Review Type:☐ Full ☑ Expedited
Approval Type: ☑ New ☐ Extension of Time ☐ Revision ☐ Continuing Review

Principal Investigator: Tonja Williams Faculty Advisor: Dr. Mary Clements
Project Title: Follow-Up Telephone Contact following Discharge from Long-Term Acute Care Hospitals
Approval Date: 09/21/2015 Expiration Date: 11/30/15
Approved by: Dr. Jim Gleason, IRB Member

This document confirms that the Institutional Review Board (IRB) has approved the above referenced research project as outlined in the application submitted for IRB review with an immediate effective date.

Principal Investigator Responsibilities: It is the responsibility of the principal investigator to ensure that all investigators and staff associated with this study meet the training requirements for conducting research involving human subjects, follow the approved protocol, use only the approved forms, keep appropriate research records, and comply with applicable University policies and state and federal regulations.

Consent Forms: All subjects must receive a copy of the consent form as approved with the EKU IRB approval stamp. Copies of the signed consent forms must be kept on file unless a waiver has been granted by the IRB.

Adverse Events: Any adverse or unexpected events that occur in conjunction with this study must be reported to the IRB within ten calendar days of the occurrence.

Research Records: Accurate and detailed research records must be maintained for a minimum of three years following the completion of the research and are subject to audit.

Changes to Approved Research Protocol: If changes to the approved research protocol become necessary, a description of those changes must be submitted for IRB review and approval prior to implementation. Some changes may be approved by expedited review while others may require full IRB review. Changes include, but are not limited to, those involving study personnel, consent forms, subjects, and procedures.

Annual IRB Continuing Review: This approval is valid through the expiration date noted above and is subject to continuing IRB review on an annual basis for as long as the study is active. It is the responsibility of the principal investigator to submit the annual continuing review request and receive approval prior to the anniversary date of the approval. Continuing reviews may be used to continue a project for up to three years from the original approval date, after which time a new application must be filed for IRB review and approval.

Final Report: Within 30 days from the expiration of the project, a final report must be filed with the IRB. A copy of the research results or an abstract from a resulting publication or presentation must be attached. If copies of significant new findings are provided to the research subjects, a copy must also be provided to the IRB with the final report.

Other Provisions of Approval, if applicable: None

Please contact Sponsored Programs at 859-622-3636 or send email to tiffany.hamblin@eku.edu or lisa.royalty@eku.edu with questions about this approval or reporting requirements.

Eastern Kentucky University is an Equal Opportunity/Affirmative Action Employer and Educational Institution
Appendix B

Saint Joseph Hospital IRB Deferral Letter

Saint Joseph Hospital
KentuckyOne Health

1 Saint Joseph Drive
Lexington, KY 40504

To Whom It May Concern:

Saint Joseph Hospital in Lexington, KY is authorizing the Catholic Health IRB to waive their review of the study entitled: “Follow-up Telephone Contact following Discharge from Long-Term Acute Care Hospitals.” The study PI, Tonja Williams, is an Eastern Kentucky University student, therefore, the Eastern Kentucky University Institutional Review Board has agreed to serve as the IRB of record for the above mentioned study.

Sincerely,

[Signature]
Rebecca S. Thomas, RN, BSN
Regional Research Manager – KentuckyOne Health
Appendix C

Contact Sheet

If possible, pull information from patient’s medical record. Confirm correct information with patient. Identify the best time of day or days to reach the patient and other contacts.

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>OK to send letter ( Y / N )</td>
<td></td>
</tr>
<tr>
<td><strong>Address</strong></td>
<td></td>
</tr>
<tr>
<td>Street</td>
<td>Apt#</td>
</tr>
<tr>
<td>City, State</td>
<td>Zip Code</td>
</tr>
<tr>
<td>Email Address</td>
<td></td>
</tr>
<tr>
<td><strong>Preferred Spoken Language</strong></td>
<td></td>
</tr>
<tr>
<td>Interpreter needed? ( Y / N )</td>
<td></td>
</tr>
<tr>
<td><strong>Preferred phone number:</strong></td>
<td>home</td>
</tr>
<tr>
<td><strong>Home Phone:</strong></td>
<td></td>
</tr>
<tr>
<td>Best time to call:</td>
<td></td>
</tr>
<tr>
<td><strong>Cell Phone:</strong></td>
<td></td>
</tr>
<tr>
<td>Best time to call:</td>
<td></td>
</tr>
<tr>
<td><strong>Work Phone:</strong></td>
<td></td>
</tr>
<tr>
<td>Best time to call:</td>
<td></td>
</tr>
</tbody>
</table>
### Contacts

**Name of Contact 1:** ________________________________________________________________

**Relationship:** ________________________________________________________________

Caregiver? (Y/N) _____

Proxy? (Y/N) _____

Designated to receive followup phone call? (Y/N) ____

**Notes:** ______________________________________________________________________
_____________________________________________________________________________

**Preferred Spoken Language**
_______________________________________________________

**Interpreter needed? ( Y / N )**

**Preferred phone number:** ___ home ___ cell phone ___ work

**Home Phone:** (____) ___________________________ OK to leave message? (Y/N) _____

Best time to call: _______________________________

**Cell Phone:** (____) ___________________________ OK to leave message? (Y/N) _____

Best time to call: _______________________________

**Work Phone:** (____) ___________________________ OK to leave message? (Y/N) _____

Best time to call: _______________________________
### Contacts

**Name of Contact 1:** ____________________________________________________________

**Relationship:** ______________________________________________________________

**Caregiver?** (Y/N) _____

**Proxy?** (Y/N) _____

**Designated to receive followup phone call?** (Y/N) _____

**Notes:** ______________________________________________________________________
______________________________________________________________________________

#### Preferred Spoken Language
______________________________________________________________________________

**Interpreter needed?** ( Y / N )

**Preferred phone number:** ___ home ___ cell phone ___ work

**Home Phone:** (____) ___________________________  OK to leave message? (Y/N) _____

Best time to call: ______________________________________________________________

**Cell Phone:** (____) ___________________________  OK to leave message? (Y/N) _____

Best time to call: ______________________________________________________________

**Work Phone:** (____) ___________________________  OK to leave message? (Y/N) _____

Best time to call: ___________________________
Appendix D

Postdischarge Followup Phone Call Script (Patient Version)

This form reinforces the information provided to the patient at discharge. The patient’s discharge information should be available to the interviewer at the time of this call.

**CALLER:** Hello Mr./Mrs. _______________________. I am [caller’s name], a discharge planner from Continuing Care Hospital. You may remember that when you left, the Continuing Care Hospital discharge planner, (discharge planner name), mentioned you’d receive a call checking in on things. I am hoping to talk to you about your medical issues, see how you are doing, and see if there is anything I can do to help you. Do you mind if I ask you a few questions so I can see if there is anything I can help you with?

Is this a good time to talk? It will probably take about 15 to 20 minutes, depending on the number of medicines you are taking.

**If yes,** continue.

**If no,** **CALLER:** Is there a better time that I can call you back?

A. Health Status Diagnosis

**CALLER:** Before you left the hospital (discharge planner name) spoke to you about your main problem during your hospital stay. This is also called your “primary discharge diagnosis.” Using your own words, can you explain to me what your main problem or diagnosis is?

**If yes,** confirm the patient’s knowledge of the discharge diagnosis using the “teach-back” method. After the patient describes his or her diagnosis, clarify any misconceptions or misunderstandings using a question and answer format to keep the patient engaged.

**If no,** use this opportunity to provide patient education about the discharge diagnosis. Then conduct teach-back to confirm the patient understood.

**CALLER:** What did the medical team at the hospital tell you to watch out for to make sure you’re o.k.?

Review specific symptoms to watch out for/things to do for this diagnosis (e.g., weigh self, check blood sugar, check blood pressure, create peak flow chart).

Measure patient’s understanding of disease-related symptoms or symptoms of relapse (e.g., review diagnosis pages from AHCP).

**CALLER:** Do you have any questions for me about your main problem [diagnosis]? Is there anything I can better explain for you?

**If yes,** explain, using plain language (no jargon or medical terms).
If no, continue.

**CALLER:** Since you left the hospital, do you feel your main problem, [diagnosis], has improved, worsened, or not changed? What does your family or caregiver think?

If improved or no change, continue below.

If primary condition has worsened,

**CALLER:** I'm sorry to hear that. How has it gotten worse? Have you spoken to or seen any doctors or nurses about this since you left the hospital?

If yes, **CALLER:** Who have you spoken with/seen? And what did they suggest you do? Have you done that?

Using clinical judgment, use this conversation to determine if further recommendations, teaching, or interventions are necessary.

Record any action patient/caregiver has taken and your recommendations on the documentation sheet.

**CALLER:** Have any new medical problems come up since you left the hospital?

If yes:

**CALLER:** What has happened?

**CALLER:** Is there anyone else involved in your care that I should talk to?

If yes, Name: _____________________________________________

Phone Number:  _______________________________________

**CALLER:** Have you spoken to anyone about this problem? Prompt if necessary: Has anyone:

- Contacted or seen PCP?
- Gone to the ER/Urgent Care?
- Gone to another hospital/provider?
- Spoken with visiting nurse?
- Other?
Following the conversation about the current state of the patient’s medical condition, consider recommendations to make to the caregiver, such as calling PCP, going to emergency department, etc. Record any actions and recommendations on documentation sheet.

B. Medicines
High Alert Medicines

Use the guide below to help monitor medicines with significant risk for adverse events.

<table>
<thead>
<tr>
<th>Drug Category</th>
<th>What to Look For</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anticoagulants</td>
<td>Bleeding; who is managing INR</td>
</tr>
<tr>
<td>Antibiotics</td>
<td>Diarrhea; backup method of birth control</td>
</tr>
<tr>
<td></td>
<td>Should not be taken at same time as calcium and multivitamin</td>
</tr>
<tr>
<td>Antiretrovirals</td>
<td>Review profile for drug interactions</td>
</tr>
<tr>
<td>Insulin</td>
<td>Inquire about fasting blood sugar</td>
</tr>
<tr>
<td>Antihypertensives</td>
<td>Dizziness</td>
</tr>
<tr>
<td></td>
<td>If yes, suggest patient space out medicines (keep diuretic in a.m.)</td>
</tr>
<tr>
<td>Medicines related to primary diagnosis</td>
<td>Focus on acquisition and medication adherence</td>
</tr>
</tbody>
</table>

Can you bring all of your medicines to the phone, please? We will review them during this call. Bring both prescription medicines and over-the-counter medicines, the ones you can buy at a drugstore without a prescription. Also, bring any supplements or traditional medicines, such as herbs, you are taking. Finally, could you also please bring to the phone the care plan that we gave you before you left the hospital?

**CALLER:** Do you have all of your medicines in front of you now?

**CALLER:** I’m going to ask you a few questions about each one of your medicines to see if there is anything I can help you with. We will go through your medicines one by one.

First of all, I want to make sure that the medicines you were given were the right ones. Then we’ll discuss how often you’ve been able to take them and any problems or questions you might have about any of them.

Choose one of your medicines to start with.

What is the name of this medicine? The name of it should be on the label. **If the patient is using a generic**, check that he or she understands that the brand and generic names are two names for the same medicine.

At what times during the day do you take this medicine?

How much do you take each time?

**If the patient answers in terms of how many pills, lozenges, suppositories, etc.** What
is the strength of the medicine? It should say a number and a unit such as mg or mcg.

How do you take this medicine? If **there are special instructions** (e.g., take with food), probe as to whether the patient knows the instructions and whether he or she is taking the medicine as instructed.

What do you take this medicine for?

Have you had any concerns or problems taking this medicine? Has anything gotten in the way of your being able to take it? Have you ever missed taking this medicine when you were supposed to? Why?

Do you think you are experiencing any side effects from the medicine?

**If yes,** Could you please describe these side effects?

Are you taking any other medicines? Repeat list of questions for each medicine.

After patient has described all medicines, ask: Are you taking any additional medicines that you haven’t already told me about, including other prescription medicines, over-the-counter medicines, that is, medicines you can get without a prescription, or herbal medicines, vitamins, or supplements?

If patient has been prescribed medicines that the patient hasn’t mentioned, ask whether he or she is taking that medicine.

**If yes,** go through the list of medicine questions.

**If not,** probe as to why not. **If patient is unaware of the medicine,** make a note to check with discharge physician as to whether patient is supposed to be taking it, whether a prescription was issued, etc.

**CALLER:** Have you been using the medicine calendar (in your care plan that was given to you when you left the hospital)?

**If yes,** provide positive reinforcement of this tool.

**If no,** suggest using this tool to help remember to take the medicines as directed. **If patient has lost care plan,** offer to send a new copy of AHCP by mail or email.

**CALLER:** Do you use a pill box?

**If yes,** provide positive reinforcement of using this tool.

**If no,** suggest using this tool to help remember to take the medicines as ordered.
CALLER: What questions do you have today regarding your medicines and medicine calendar (if using)?

CALLER: Does your family or caregiver have any questions or concerns about your medicines?

**Please note on the documentation sheet any recommendation you made to the patient and followup actions you took.**

C. Clarification of Appointments

CALLER: Now, I’m going to make sure you and I have the same information about your appointments and tests that are coming up. You were given appointments with your doctors [and for lab tests] when you left the hospital. Can you please tell me:

What is the next appointment you have scheduled?

Who is your appointment with?

What is your appointment for?

When is this appointment?

What is your plan for getting to your appointment?

Are you going to be able to make it to your appointment? Is there anything that might get in the way of your getting to this appointment?

If yes, Let’s talk about how we can work around these difficulties.

If patient plans to keep appointment, ask, Do you have the phone number to call if something unexpectedly comes up and you can’t make the appointment?

If patient can’t keep appointment, get the patient to reschedule: As soon as we hang up, can you call to reschedule your appointment? If patient is unable or unwilling to make the call to reschedule, offer to make the call: I can reschedule that appointment for you. What days and times would you be able to make an appointment? After you get several times, say, Thanks. I’ll call you back when I’ve been able to set up the appointment. If patient refuses to cooperate, consult the discharge planner and hospital team.

Do you have any other appointments scheduled? If yes, repeat the set of questions. If no, but other appointments are scheduled, ask, Are you looking at the care plan? Are there any other appointments listed there? Review these appointments.

D. Coordination of Postdischarge Home Services

CALLER: Have you been visited by [name of service, e.g., visiting nurse, respiratory therapist] since you came home?
If no, CALLER: I will call to make sure they are coming soon.

CALLER: Have you received the [name of equipment] that was supposed to be delivered?

If no, CALLER: I will call to make sure it is coming soon.

CALLER: I understand that [name of caregiver] was going to help you out at home. Has [name of caregiver] been able to provide the help you need?

If no, CALLER: Are you going to call [name of caregiver] to see if she [or he] is going to be able to help you?

    If no, Is there anyone else that could help you out? Can you call [him/her] to see when [she/he] could come?

E. What To Do If a Problem Arises

CALLER: Before we hang up, I want to make sure that if a medical problem arises, you know what to do. If you’re having an emergency, for example [give disease-specific examples, e.g., chest pain, trouble breathing], what would you do?

If patient does not say, “Call 911,” explain the need to get an ambulance so he or she can see a doctor right away, and confirm patient understanding.

CALLER: And what about if you [give example of urgent but not emergent problem] in the evening? What would you do then? Check if patient knows how to reach the doctor after hours. If discharge planner help line operates after hours, check that the patient knows that and can find the number on the AHCP. Confirm understanding.

CALLER: And what about if you are having a medical problem that is not an emergency, such as [give disease-specific examples] and want to be seen by your doctor before your next scheduled appointment, what would you do?

If patient does not know, instruct: You can call your doctor’s office directly and ask for an earlier appointment. Sometimes your doctor is very busy, so if you are having difficulty obtaining an appointment, ask if you can be seen by someone else in the office, such as a nurse, nurse practitioner, or physician’s assistant. Confirm understanding.

CALLER: Just to make sure we’re on the same page, can you tell me what you’d do if [create nonemergent scenario]?

If patient answer incorrectly, ask: Do you have your doctor’s phone number handy? If should be on the care plan on the appointments page. If patient can’t tell you the number, say, Let me give you the phone number for your primary care doctor just in case. Do you have a pen and paper to write this down? Do you need me to mail or email you another copy of your care plan?
If yes, confirm address or email.

CALLER: Do your caregivers have these numbers also?

If no, ask: Would you like me to email or mail a copy of your care plan to them?

If yes, confirm address or email.

CALLER: That’s all I needed to talk to you about. We’ve covered a lot of information. What questions can I answer for you?

If none, CALLER: Thank you and have a good day. If you have to follow up with patient on anything, remind him or her that you will be calling back.

If the patient has questions, answer them.
Appendix E

Postdischarge Followup Phone Call Script (Caregiver Version)

CALLER: Hello Mr./Mrs. ______________________. I am [caller’s name], a discharge planner from Continuing Care Hospital. When [patient’s name] was at Continuing Care Hospital, you were designated by [patient’s name] and medical care team as the patient’s caregiver. Before [patient’s name] left the Continuing Care Hospital discharge planner, (discharge planner name), mentioned you’d receive a call checking in on things and I’m glad to help with this call. I am hoping to talk to you about [patient’s name]’s medical issues, see how you and [patient’s name] are doing, and see if there is anything I can do to help you in his/her care.

Is this a good time to talk? It will probably take about 15 to 20 minutes, depending on the number of medicines [patient’s name] is taking.

If yes, continue.

If no, CALLER: Is there a better time that I can call you back?

Is [patient’s name] there? Would you like [patient’s name] to be involved in this call?

F. Health Status Diagnosis

CALLER: Before [patient’s name] left the hospital, a discharge planner (discharge planner name) spoke to [you, patient name, and/or another caregiver] about [patient’s name]’s main problem during his/her hospital stay. This is also called his/her “primary discharge diagnosis.”

Using your own words, can you explain to me what [patient’s name]’s main problem or diagnosis is?

If yes, confirm the caregiver’s knowledge of the discharge diagnosis using the “teach-back” method. After the caregiver describes the patient’s diagnosis, clarify any misconceptions or misunderstandings using a question and answer format to keep the caregiver engaged.

If no, use this opportunity to provide education about the patient’s discharge diagnosis and conduct teach-back to confirm the caregiver understood.

CALLER: What did the medical team at the hospital tell you to watch out for to make sure [patient’s name] is o.k.?

Review specific symptoms to watch out for/things to do for this diagnosis (e.g., weigh self, check blood sugar, check blood pressure, create peak flow chart).

Measure caregiver’s understanding of disease-related symptoms or symptoms of relapse (e.g., review diagnosis pages from AHCP).
**CALLER:** Do you have any questions for me about [patient’s name]’s diagnosis? Is there anything I can better explain for you?

If **yes**, explain, using plain language (no jargon or medical terms).

If **no**, continue.

**CALLER:** Since [he/she] left the hospital, do you feel [patient’s name]’s main problem, [diagnosis], has improved, worsened, or not changed?

If **improved or no change**, continue below.

If **primary condition has worsened,**

**CALLER:** I’m sorry to hear that. How has it gotten worse? Has [patient’s name] or you spoken to or seen any doctors or nurses about this since [he/she] left the hospital?

If **yes, CALLER:** Who have you or [patient’s name] spoken with/seen? And what did they suggest you do? Have you done that?

Using clinical judgment, use this conversation to determine if further recommendations, teaching, or interventions are necessary.

Record any action patient/caregiver has taken and your recommendations on the documentation sheet.

**CALLER:** Have any new medical problems come up with [patient’s name] since [he/she] left the hospital?

If **yes:**

**CALLER:** What has happened?

**CALLER:** Is there anyone else involved in [his/her] care that I should talk to?

If **yes,** Name: ____________________________________________

Phone Number: ____________________________________________

**CALLER:** Have you or [patient’s name] spoken to anyone about this problem? Prompt if necessary: Has anyone: Contacted or seen PCP?

Gone to the ER/Urgent Care?

Gone to another hospital/provider?
Spoken with visiting nurse?

Other?

Following the conversation about the current state of the patient’s medical condition, consider recommendations to make to the caregiver, such as calling PCP, going to emergency department, etc. Record any actions and recommendations on documentation sheet.

G. Medicines
High Alert Medicines

Use the guide below to help monitor medicines with significant risk for adverse events.

<table>
<thead>
<tr>
<th>Drug Category</th>
<th>What to Look For</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anticoagulants</td>
<td>Bleeding; who is managing INR</td>
</tr>
<tr>
<td>Antibiotics</td>
<td>Diarrhea; backup method of birth control</td>
</tr>
<tr>
<td></td>
<td>Should not be taken at same time as calcium and multivitamin</td>
</tr>
<tr>
<td>Antiretrovials</td>
<td>Review profile for drug interactions</td>
</tr>
<tr>
<td>Insulin</td>
<td>Inquire about fasting blood sugar</td>
</tr>
<tr>
<td>Antihypertensives</td>
<td>Dizziness</td>
</tr>
<tr>
<td></td>
<td>If yes, suggest patient space out medicines (keep diuretic in a.m.)</td>
</tr>
<tr>
<td>Medicines related to primary diagnosis</td>
<td>Focus on acquisition and medication adherence</td>
</tr>
</tbody>
</table>

Can you bring all of [patient’s name]’s medicines to the phone, please? We will review them during this call. Bring both prescription medicines and over-the-counter medicines, the ones you can buy at a drugstore without a prescription. Also, bring any supplements or traditional medicines, such as herbs, you are taking. Finally, could you also please bring to the phone the care plan that we gave [patient’s name] before [he/she] left the hospital?

CALLER: Do you have all of [patient’s name] medicines in front of you now?

CALLER: I’m going to ask you a few questions about each one of [patient’s name]’s medicines to see if there is anything I can help you with. We will go through [his/her] medicines one by one.

First of all, I want to make sure that the medicines [he/she] was given were the right ones. Then we’ll discuss how often [patient’s name] has been able to take them and any problems or questions you or [he/she] might have about any of them.

Choose one of [patient’s name]’s medicines to start with.

What is the name of this medicine? The name of it should be on the label. **If the patient is using a generic**, check that caregiver understands that the brand and generic names are two names for the same medicine.
At what times during the day does [patient’s name] take this medicine?

How much do [he/she] take each time?

If the caregiver answers in terms of how many pills, lozenges, suppositories, etc. What is the strength of the medicine? It should say a number and a unit such as mg or mcg.

How does [patient’s name] take this medicine? If there are special instructions (e.g., take with food), probe as to whether the patient knows the instructions and whether he or she is taking the medicine as instructed.

What does [patient’s name] take this medicine for?

Has [he/she] had any concerns or problems taking this medicine? Has anything gotten in the way of [him/her] being able to take it? Has [patient’s name] ever missed taking this medicine when [he/she] were supposed to? Why?

Do you think [patient’s name] is experiencing any side effects from the medicine?

If yes, Could you please describe these side effects?

Are you taking any other medicines? Repeat list of questions for each medicine.

After caregiver has described all medicines, Is [patient’s name] taking any additional medicines that you haven’t already told me about, including other prescription medicines, over-the-counter medicines, that is, medicines you can get without a prescription, or herbal medicines, vitamins, or supplements?

If patient has been prescribed medicines that the caregiver hasn’t mentioned, ask whether he or she is taking that medicine.

If yes, go through the list of medicine questions.

If not, probe as to why not. If patient is unaware of the medicine, make a note to check with discharge physician as to whether patient is supposed to be taking it, whether a prescription was issued, etc.

CALLER: Have you or [patient’s name] been using the medicine calendar (in the care plan that was given to [patient’s name] when [he/she] left the hospital?

If yes, provide positive reinforcement of this tool.

If no, suggest using this tool to help remember to take the medicines as directed. If patient has lost care plan, offer to send a new copy of AHCP by mail or email.
CALLER: Does [patient’s name] use a pill box?

If yes, provide positive reinforcement of using this tool.

If no, suggest using this tool to help remember to take the medicines as ordered.

CALLER: What questions do you have today regarding [patient’s name] medicines and medicine calendar (if using)?

CALLER: Does [patient’s name] have any questions or concerns?

**Please note on the documentation sheet any recommendation you made to the caregiver and followup actions you took.**

H. Clarification of Appointments

CALLER: Now, I’m going to make sure you and I have the same information about [patient’s name]’s appointments and tests that are coming up. You were given appointments with [patient’s name]’s doctors [and for lab tests] before [he/she] left the hospital. Can you please tell me:

What is the next appointment [patient’s name] has scheduled?

Who is your appointment with?

What is your appointment for?

When is this appointment?

What is your plan for getting [patient’s name] to the appointment?

Is there anything that might get in the way of [patient’s name] getting to this appointment?

If yes, Let’s talk about how we can work around these difficulties.

If patient plans to keep appointment, ask, Do you have the phone number to call if something unexpectedly comes up and [patient’s name] can’t make the appointment?

If patient can’t keep appointment, get the caregiver to reschedule: As soon as we hang up, can you call to reschedule [patient’s name]’s appointment? If patient is unable or unwilling to make the call to reschedule, offer to make the call: I can reschedule that appointment for [patient’s name]. What days and times would [he/she] be able to make an appointment? After you get several times, say, Thanks. I’ll call you back when I’ve been able to set up the appointment. If caregiver and/or patient refuses to cooperate, consult the discharge planner and hospital team.
Does [patient’s name] have any other appointments scheduled? **If yes,** repeat the set of questions. **If no,** but other appointments are scheduled, ask, Are you looking at the care plan? Are there any other appointments listed there? Review these appointments.

I. Coordination of Postdischarge Home Services

**CALLER:** Has [patient’s name] been visited by [name of service, e.g., visiting nurse, respiratory therapist] since [he/she] came home?

**If no, CALLER:** I will call to make sure they are coming soon.

**CALLER:** Has [patient’s name] received the [name of equipment] that was supposed to be delivered?

**If no, CALLER:** I will call to make sure it is coming soon.

**CALLER:** I understand that you were going to help [patient’s name] out at home. Have you been able to provide the help [he/she] needs?

**If no, CALLER:** Is there anyone else that could help [patient’s name] out? Can you call [him/her] to see when [she/he] could come?

J. What To Do If a Problem Arises

**CALLER:** Before we hang up, I want to make sure that if a medical problem arises, you know what to do. If [patient’s name] is having an emergency, for example [give disease-specific examples, e.g., chest pain, trouble breathing], what would you do?

**If patient does not say, “Call 911,”** explain the need to get an ambulance so patient can see a doctor right away, and confirm caregiver understanding.

**CALLER:** And what about if [patient’s name] [give example of urgent but not emergent problem] in the evening? What would you do then? Check if caregiver knows how to reach the doctor after hours. **If discharge planner help line operates after hours,** check that the patient knows that and can find the number on the AHCP. Confirm understanding.

**CALLER:** And what about if [patient’s name] is having a medical problem that is not an emergency, such as [give disease-specific examples] and want to be seen by [his/her] doctor before [his/her] next scheduled appointment, what would you do?

**If caregiver does not know, instruct:** You can call [patient’s name]’s doctor’s office directly and ask for an earlier appointment. Sometimes [his/her] primary care doctor is very busy, so if you are having difficulty obtaining an appointment, ask if [patient’s name] can be seen by someone else in the office, such as a nurse, nurse practitioner, or physician’s assistant. Confirm understanding.
CALLER: Just to make sure we’re on the same page, can you tell me what you’d do if [create nonemergent scenario]?

If patient answer incorrectly, ask: Do you have [patient’s name]’s doctor’s phone number handy? If should be on the care plan on the appointments page. If caregiver can’t tell you the number, say, Let me give you the phone number for [patient’s name]’s primary care doctor just in case. Do you have a pen and paper to write this down? Do you need me to mail or email you another copy of [patient’s name]’s care plan?

If yes, confirm address or email.

CALLER: That’s all I needed to talk to you about. We’ve covered a lot of information. What questions can I answer for you?

If none, CALLER: Thank you and have a good day. If you have to follow up with caregiver on anything, remind him or her that you will be calling back.

If the caregiver has questions, answer them.
Appendix F

Postdischarge Followup Phone Call Documentation Form

Patient name: ____________________________________________________________

Caregiver(s) name(s): ____________________________________________________

Relationship to patient: __________________________________________________

Notes: ___________________________________________________________________

Discharge Date: __________________________________________________________

Principle discharge diagnosis: _____________________________________________

Interpreter needed? Y  N  Language/Dialect: ________________________________

Prior to phone call:

Review:

Health history

Medicine lists for consistency

Medicine list for appropriate dosing, drug-drug and drug-food interactions, and major side effects

Contact sheet

Discharge Planner notes

Discharge summary and AHCP

Call Completed: Y  N

With whom (patient, caregiver, both): _________________________________________

Number of hours between discharge and phone call: ____________________________

Consultations (if any) made prior to phone call:

None
Called MD

Called Discharge Planner

Called outpatient pharmacy

Other: ________________________________________________________________________

If any consultations, note to whom you spoke, regarding what, and with what outcome:

______________________________________________________________________________
Phone Call Attempts

Patient/Proxy

Alternate Contact 1

Alternate Contact 2
A. Diagnosis and Health Status

Ask patient about his or her diagnosis and comorbidities

Patient confirmed understanding

Further instruction was needed

If primary condition has worsened:

What, if any, actions had the patient taken?

Returned to see his/her clinician (name): ______________________________________

Called/contacted his/her clinician (name): ______________________________________

Gone to the ER/urgent care (specify): ________________________________________

Gone to another hospital/MD (name): ________________________________________

Spoken with visiting nurse (name): _________________________________________

Other: ___________________________________________________________________

What, if any, recommendations, teaching, or interventions did you provide?

If new problem since discharge:

Had the patient:

Contacted or seen clinician? (name): _______________________________________

Gone to the ER/urgent care (specify): _______________________________________

Gone to another hospital/MD (name): _______________________________________

Spoken with visiting nurse (name): _________________________________________

Other: ___________________________________________________________________

Following the conversation about the current state of the patient’s medical status:

What recommendations did you make?

Advised to call clinician (name): ___________________________________________

Advised to go to the ED: ___________________________________________________
Advised to call Discharge Planner (name): _____________________________

Advised to call specialist physician (name): ____________________________

Other: __________________________________________________________

What followup actions did you take?

Called clinician and called patient/caregiver back

Called discharge planner and called patient/caregiver back

Other:

B. Medicines

Document any medicines patient is taking that are NOT on AHCP and discharge summary:

___________________________________________________________________________

Document problems with medicines that are on the AHCP and discharge summary (e.g., has not obtained, is not taking correctly, has concerns, including side effects):

**Medicine 1:**

Problem:

Intentional nonadherence

Inadvertent nonadherence

System/provider error

What recommendation did you make to the patient/caregiver?

No change needed in discharge plan as it relates to the drug therapy

Educated patient/caregiver on proper administration, what to do about side effects, etc.

Advised to call PCP

Advised to go to the ED

Advised to call the Discharge Planner

Advised to call specialist physician
Other: _________________________________________________________________

What followup action did you take?

- Called hospital physician and called patient/caregiver back
- Called Discharge Planner and called patient/caregiver back
- Called outpatient pharmacy and called patient/caregiver back

Other: _________________________________________________________________

Medicine 2:

Problem:

Intentional nonadherence

Inadvertent nonadherence

System/provider error

What recommendation did you make to the patient/caregiver?

- No change needed in discharge plan as it relates to the drug therapy
- Educated patient/caregiver on proper administration, what to do about side effects, etc.
- Advised to call PCP
- Advised to go to the ED
- Advised to call the Discharge Planner
- Advised to call specialist physician
- Other: _________________________________________________________________

What followup action did you take?

- Called hospital physician and called patient/caregiver back
- Called Discharge Planner and called patient/caregiver back
- Called outpatient pharmacy and called patient/caregiver back
FOLLOW-UP TELEPHONE CONTACT

Other: __________________________________________________________________________

**Medicine 3:**

Problem:

Intentional nonadherence

Inadvertent nonadherence

System/provider error

  What recommendation did you make to the patient/caregiver?

  No change needed in discharge plan as it relates to the drug therapy

  Educated patient/caregiver on proper administration, what to do about side effects, etc.

  Advised to call PCP

  Advised to go to the ED

  Advised to call the Discharge Planner

  Advised to call specialist physician

Other: __________________________________________________________________________

What followup action did you take?

  Called hospital physician and called patient/caregiver back

  Called Discharge Planner and called patient/caregiver back

  Called outpatient pharmacy and called patient/caregiver back

Other: __________________________________________________________________________
FOLLOW-UP TELEPHONE CONTACT

**Medicine ____:**

Problem:

Intentional nonadherence

Inadvertent nonadherence

System/provider error

What recommendation did you make to the patient/caregiver?

No change needed in discharge plan as it relates to the drug therapy

Educated patient/caregiver on proper administration, what to do about side effects, etc.

Advised to call PCP

Advised to go to the ED

Advised to call the Discharge Planner

Advised to call specialist physician

Other: ____________________________

What followup action did you take?

Called hospital physician and called patient/caregiver back

Called Discharge Planner and called patient/caregiver back

Called outpatient pharmacy and called patient/caregiver back

Other: ____________________________

(Copy and insert as many of these as needed for the individual patient)
C. Clarification of Appointments

Potential barriers to attendance identified: □ Y □ N
List: ____________________________________________

Potential solutions/resources identified: □ Y □ N
List: ____________________________________________

Alternative plan made: □ Y □ N Details: ________________________________

Clinician/Discharge Planner informed: □ Y □ N Details: ____________________

D. Coordination of Postdischarge Home Services (if applicable)

Document any postdischarge services that need to be checked on and who will be doing that (caller/patient/caregiver)

E. Problems

Did patient/caregiver know what constituted an emergency and what to do if a nonemergent problem arose?
□ Yes □ No

If no, document source of confusion:

F. Additional Notes
G. Time

Time for reviewing information prior to phone call: ________________________________

Time for missed calls/attempt: _________________________________________________

Time for initial phone call: ____________________________________________________

Time for talking to other health care providers: _________________________________

Time for follow-up/subsequent phone calls to patient: ___________________________

Time for speaking with family or caregivers: ________________________________

Total time spent: _____________________________________________________________

Caller’s Signature: ___________________________________________________________