# Increasing Patient Satisfaction During the Discharge Process

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- A review of 2009 HCAHPS scores reflected a decreased level of satisfaction regarding patient discharge from the hospital and transition home. An Ineffective/Inefficient discharge leads to decreased medical compliance, poor clinical outcomes, increased hospital readmissions, and increased hospital costs.
  - "Discharge planning is the development of an *individualized* discharge plan for the patient prior to leaving hospital, with the aim of containing costs and improving patient outcomes. Discharge planning should ensure that patients are discharged from hospital at an appropriate time in their care and that, with adequate notice, the provision of other services will be organized."

(The Cochrane Collaboration, 2010)

# Identified Problems

- Lack of patient involvement in their plan of care after hospitalization
- Patients need more education in their plan of care post hospitalization
- Patients need to have another clinical resource for follow-up questions besides physician
- The questions who, what, where, and why need to be addressed with patient by Clinical Nurse Leader (CNL) before discharge from hospital

# Measurements of Success

- The goal of the project is to improve our HCAHPS discharge satisfaction scores from **76%** to **85%**. The target goal was set by comparison analysis of similar reporting units.
- Our analysis would be based on changes in delivery of care regarding HCAHPS reporting specific to question 20:
  - During your hospital stay, did you get information in writing about what symptoms or health problems to look out for after you left the hospital? (Question 20)

# Project Goals

- **Increase patient satisfaction with the discharge process and simplify the transition home after a hospital stay**
  - Our process change was Two-fold
    - 1st--All 3 East patients would receive a white "discharge education folder" upon discharge from the unit
      - Each folder is broken down into 3 sections, correlating with question #20 in the HCAHPS survey: Reason for Hospital Stay, Discharge/Follow up Instructions, and Medication Information.
      - An explanatory letter is also provided that includes management team contact information for any additional discharge concerns and/or questions
      - All disciplines involved with the patient (nutrition, social services, hospice, cardiac rehab, etc) are encouraged to add their education materials to the patients folder
      - Medication discharge list will be reviewed with the patient upon discharge and any NEW medications will be discussed and additional literature regarding those medications will be provided via clinical pharmacology or Beacon Patient Education Leaflet
      - Nursing would review the materials and answer any questions that may arise *prior* to discharge

# Project Goals

- **Process change (cont.)**
  - 2nd--Any patient who receives a cardiac stent during their hospital admission would receive not only the **white discharge folder**, but follow up **correspondence** from the Patient Care Leaders (PCL) as well
  - These correspondences were first developed as an email system, generating an email at 1 week, 1 month and 3 months post discharge
    - If email was unavailable or not preferred by the patient, a written letter was sent to their home instead

# Project Evolvement

- During the time of this individual units project development and implementation another project was initiated on another unit addressing similar discharge improvement initiatives
  - This project was titled "Project Boost" and was developed by an individual unit within the hospital along with the six-sigma black belt team in 2011
  - The development of Project Boost was incorporated into our discharge improvement project resulting in a change of process in our correspondences

# Project Evolvement (cont)

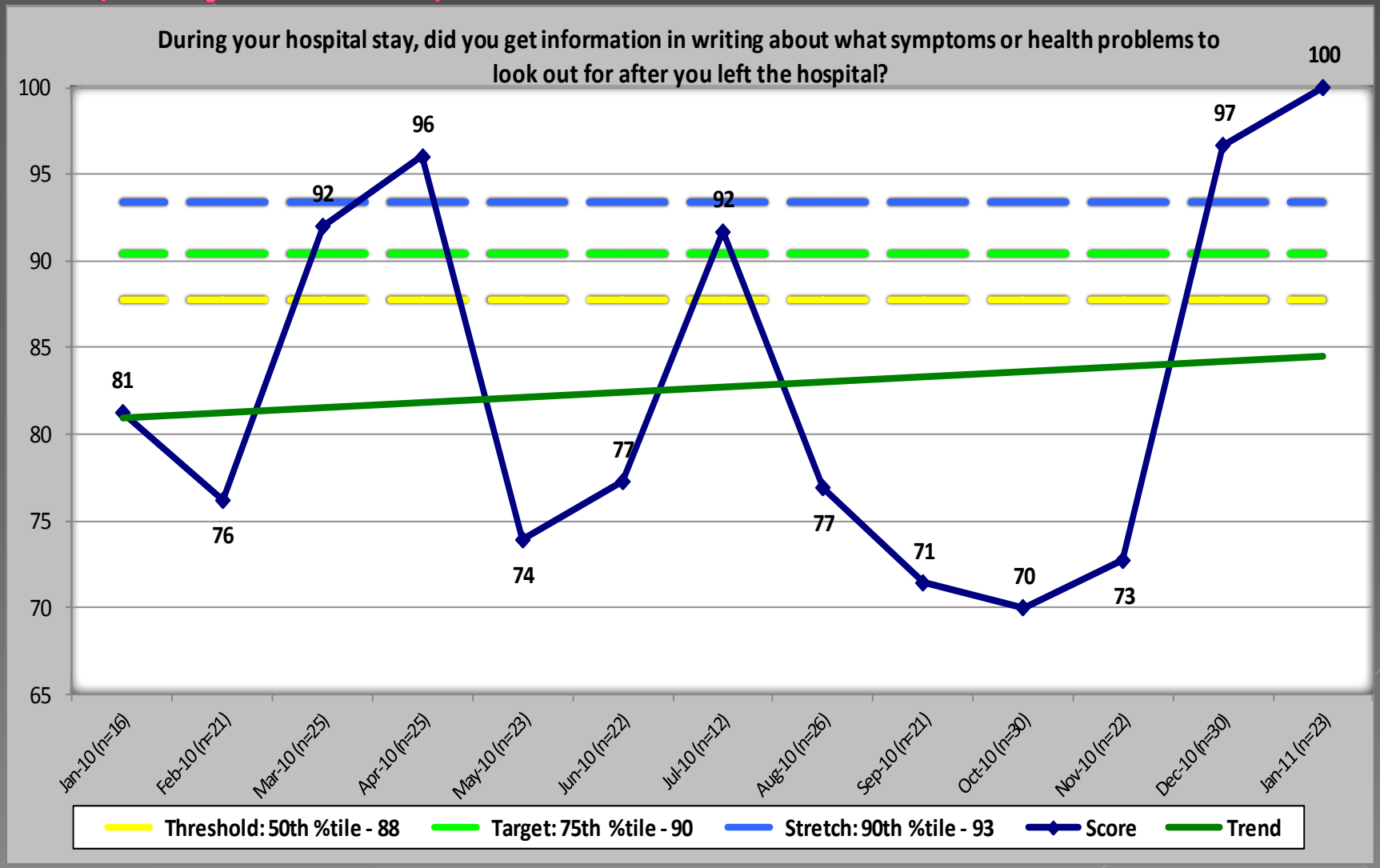
- Due to minimal response from patients that received emails/letters post discharge our process changed to a call back format (in adaptation with Project Boost)
  - A follow up phone call is placed to this selected population within 1-2 weeks of patients discharge home
    - Discharge questions are discussed and clarified, along with the following topics:
      - Medications (side effects, compliance, etc)
      - Follow up appointments/lab work/tests
      - Concerns regarding hospital stay
      - Concerns/Education regarding diagnosis
      - Home health concerns (if applicable)

# Timeline of events

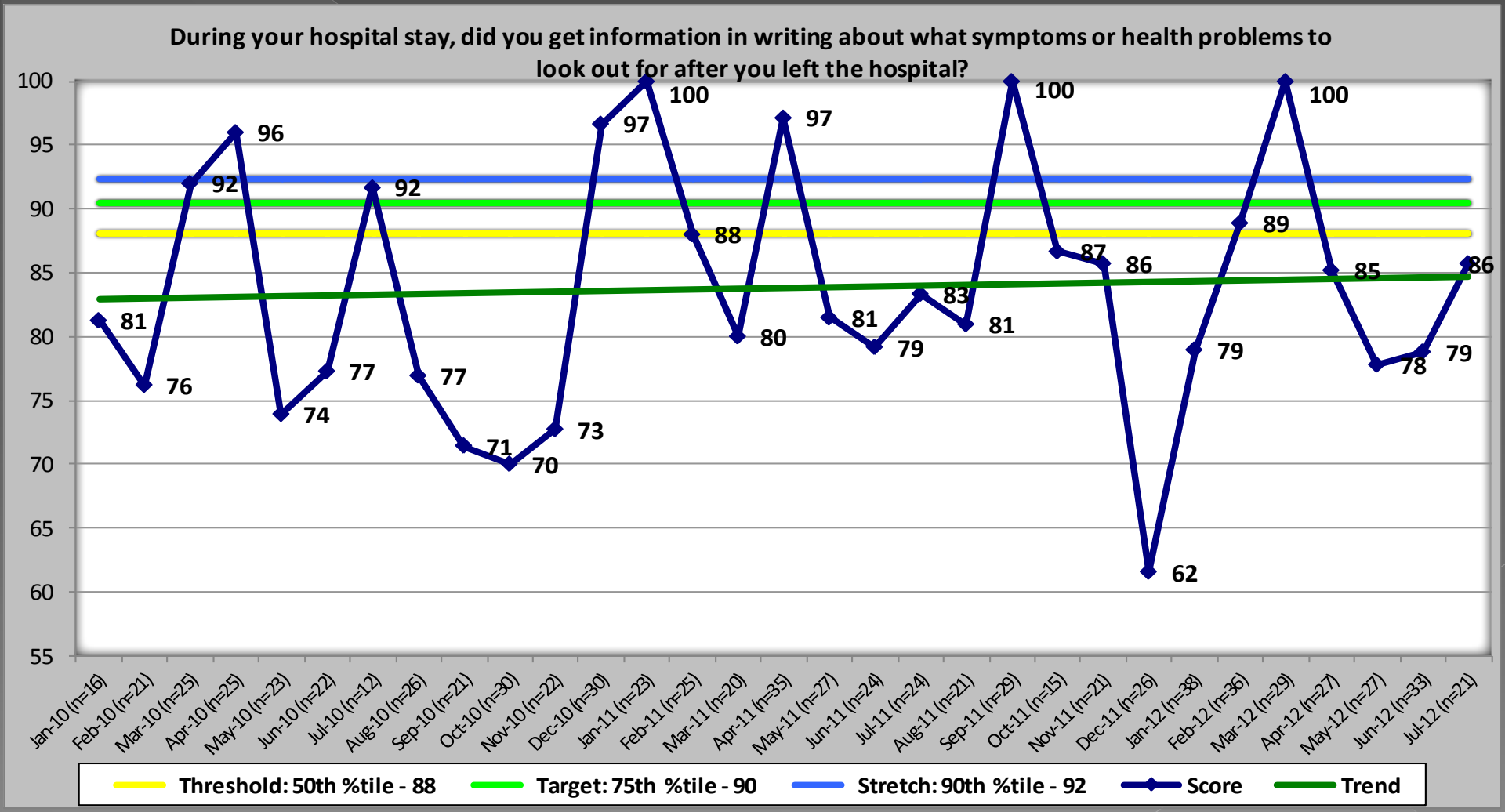
- August 2009
- January 2010
- June 2010
- September 2011
- February 2012-current

- Review of HCAHPS scores among management team—project developed
- Initiation of Discharge Education Folders to all patients
- Initiation of Email/Letter Correspondence to selected population
- Project Boost initiated by another unit (Level 4)
- Project Boost adopted and implemented hospital wide—correspondence changed accordingly to call back system

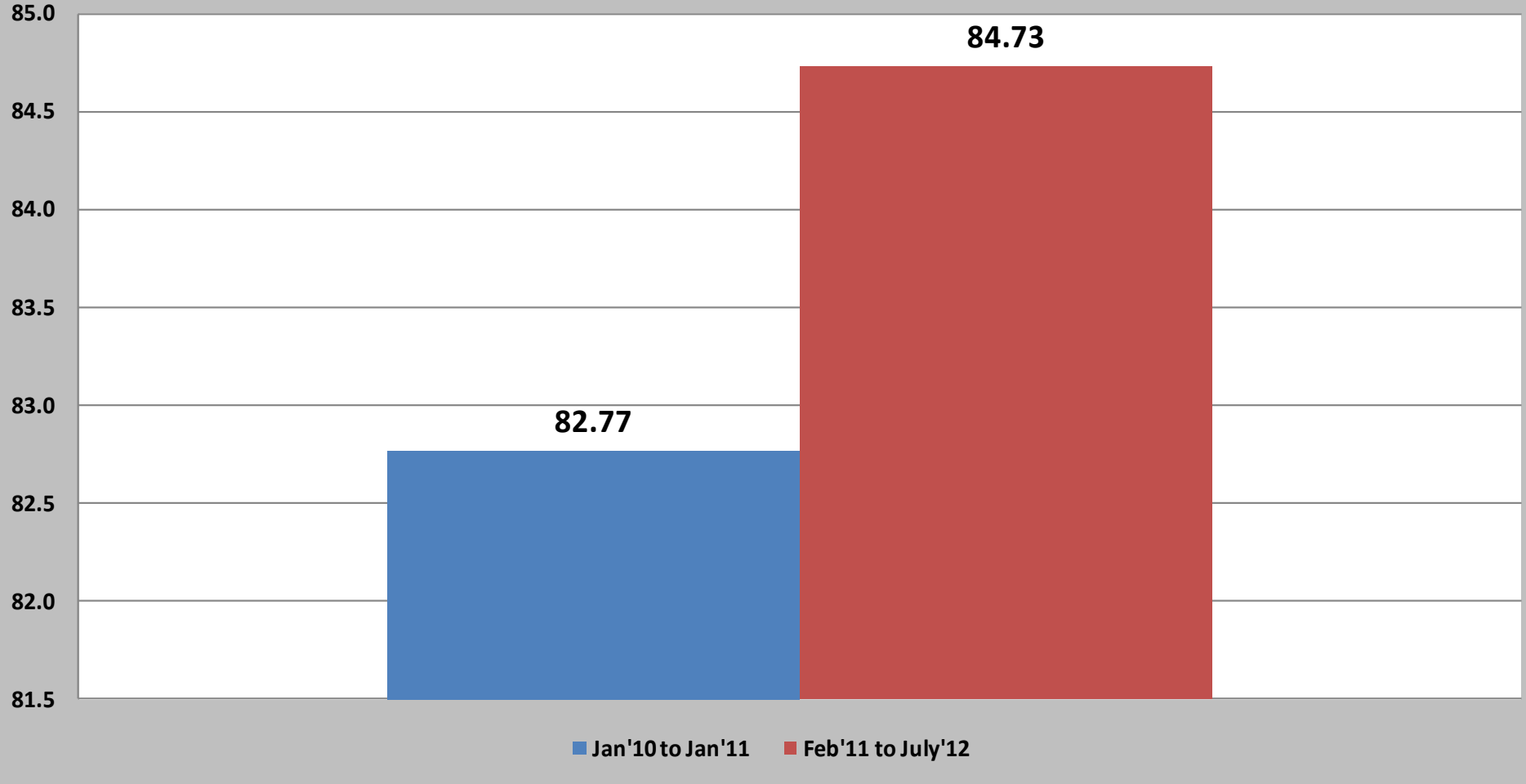
# Analysis of HCAHPS Scores 1 year post project implementation:



# Analysis of HCAHPS scores from project implementation to most current data set



# Another view of most current data set



# Examples of post discharge interventions from follow up calls

- Going above & beyond for a heart failure patient

  Patient was concerned due to a change in his living situation. Stated he was living with a "stranger" since he was not welcome back at his prior home. Had no transportation to follow-up appointments. Was able to fill his prescriptions but was experiencing SOB with minimal exertion similar to his prior AMI/CHF episode. Also stated that he had called his attending MD 4x with no return call, and his cardiology appointment was not for another 3 weeks. Nurse spoke with cardiologist who agreed to see the patient the same day. Nurse arranged for Carelift but they could not accommodate on such short notice. Nurse Manager authorized a cab to transport patient to the cardiologist today at our cost. Will continue to follow up with this high risk patient.

# Interventions (cont)

- SunStar called during follow-up to take patient to the ED

  Patient stated during call that he had some confusion about his discharge instructions and they were difficult to follow. He had scheduled all his follow up appointments. He had called his PCP earlier that day because he wasn't feeling well. Complaining of chest pain, shortness of breath, and dizziness. Nurse reviewed med list and saw that Norvasc had been increased from 5 to 10mg. Nurse told patient she would call PCP to clarify instructions given to patient and call patient right back. MD office said they had advised him to go to the ED because of his history of PE/DVT. Called the patient back and he stated he had just fallen and hit his head. Told nurse he was home alone and his wife was out of town. Nurse called SunStar and told patient help was on the way.

# Barriers to project

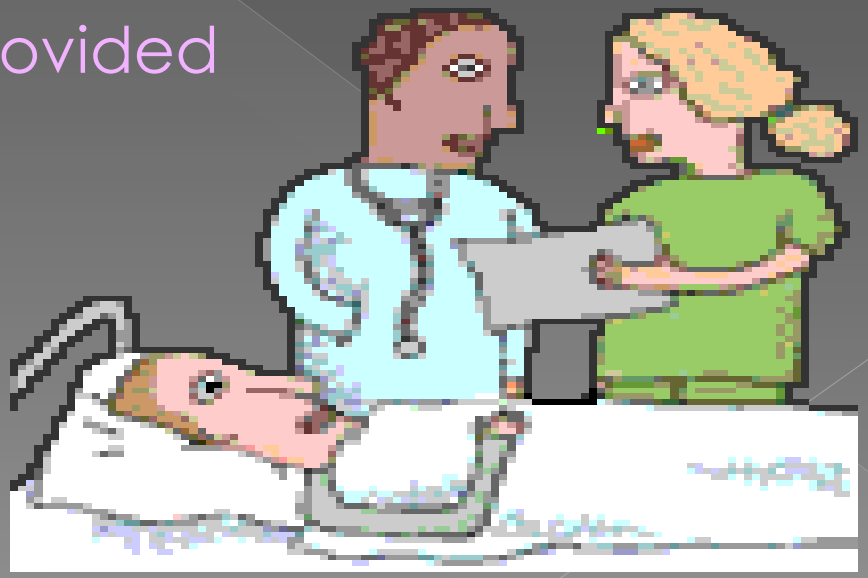
- Staff "buy in" (nursing and ancillary departments)
- Lack of communication (email) response/feedback
- EMR/Beacon phase 2 "Go live"(April 2011)—presented new challenges to nurses in adapting to a new delivery of care process
- Education Folder location—at first they were kept in various places in the patients but then moved to the chart so that they were not taken home early, damaged/destroyed/lost, and all departments would have access to them
- Periodic absence of Leadership (weekends, holidays, PTO/Sick time, etc)

# Barriers (cont.)

- EMR/Beacon phase 3 "Go live"(August 2012)—discharge process changed most profoundly in this phase, placing much of the responsibility of discharge information/instruction upon the PCP
- Incorrect patient contact information for follow up calls/correspondence
- Patient interest/engagement
- TIME!  Requirements of daily nursing tasks and patient care interactions often delay the opportunity to make calls to discharged patients

# Literature Review-

- - Does Physician/Nurse– patient communication that aims at empowering patients improve clinical outcome?
  - See Handouts Provided



# Summary of project results to date

- Implementing a process improvement project aimed at the post discharge transition period has proven to be a challenge, but also rewarding . Through creating a more organized discharge packet that includes leadership contact information, patients are able to understand important information about their acute care stay faster and are able to contact clinical leadership when questions arise.
- The project must remain flexible and willing to adapt to new formats to establish the best method of contact with the patient population that is served. Due to lack of response/interest in email and letter correspondence, it was determined best to adopt project BOOST's method of telephone call back system to our designated high risk population. Examples stated earlier demonstrate how direct contact with patients during the transition home can influence care, improve outcomes and save lives.
- Barriers must be constantly addressed and handled appropriately. Staff "buy in" and time constraints were the two most encountered barriers during this process improvement. This is a continual process change as we are always searching for new ways to educate our patients the best way possible as well as improving our processes based on our health systems model of dedication to service, outcome and cost.

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