Clinical Inquiry Conference

Annual Nursing Research and
Evidence-Based Practice Conference

Closing the Equity Gap in Hospital-to-Home Care Transitions through Tailored Outreach

Anna Hoyt, RN, BSN

Office of Population Health

Care Transitions Outreach Program

Disclosures

None of the individuals who participated in this quality improvement project have relevant financial relationships or affiliations with commercial interests to disclose.

Anna Hoyt, RN, BSN

Office of Population Health, UCSF Health

- RN for 15 years
- Joined UCSF in 2013
- OPH in 2017
- Passion: improving outcomes and experience after discharge

CLINICAL INQUIRY CONFERENCE

Learning Objectives

- Examine a post-discharge outreach program with a health equity lens
- Discover new tactics to increase reach rates and decrease a disparity in Black/African American population

Background

UCSF's Care Transitions Outreach Program

- Provides a safety net through discharge follow-up phone calls
- Expanding and improving since September 2013

Manager

Registered Nurses

Social Worker

Partnership with UCSF School of Pharmacy

CLINICAL INQUIRY CONFERENCE

Background

Goals of the Care Transitions Outreach Program

Support patients during transitions to home	Reduce patient/caregiver anxiety & improve experience[1]
Complete the discharge process	Follow-up on plans of care & reinforce discharge instructions
Facilitate the right care at the right time	Prevent unnecessary utilization & expedite care when needed
Prevent harm & report opportunities	Zero Harm and increased patient satisfaction

CLINICAL INQUIRY CONFERENCE

Current State

How the Program Works

- Expectation setting
- Automated call within 3 days
- Patient/family responds
- Outreach team is notified
- RN calls patient
- RN documents & communicates

Current State

Transitions Questions

- Symptoms
- Medications
  - Access
  - Understanding
- Discharge Instructions
- Follow-up Plan
- Satisfaction
- Other Clinical Issue

Languages

- English
- Spanish
- Cantonese

CLINICAL INQUIRY CONFERENCE

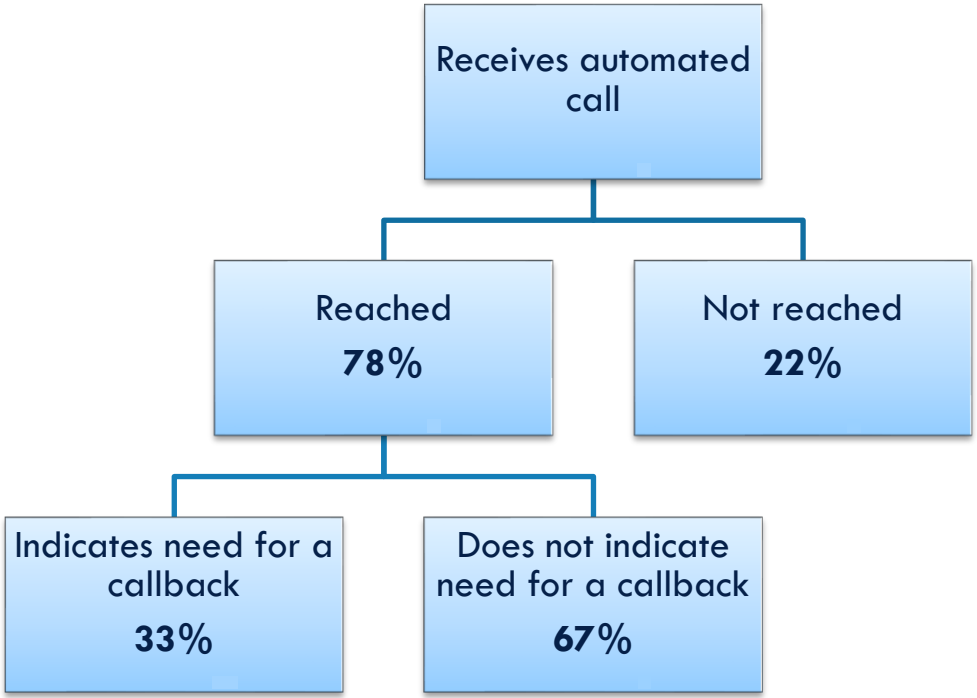
Current State

Total Volume 2022:

- 27,823 patients/discharges called
- 78% reached (21,702)
- 33% self-identified issues (7,161)

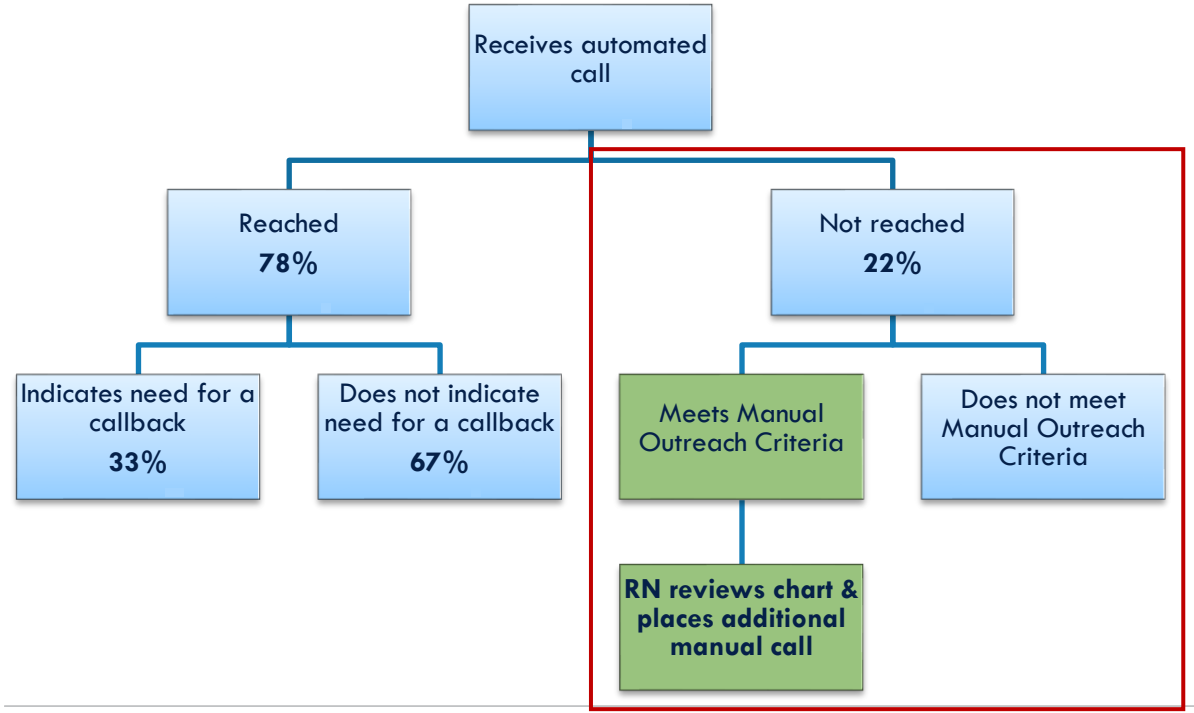
CLINICAL INQUIRY CONFERENCE

Current State



Current State

Manual Outreach Process



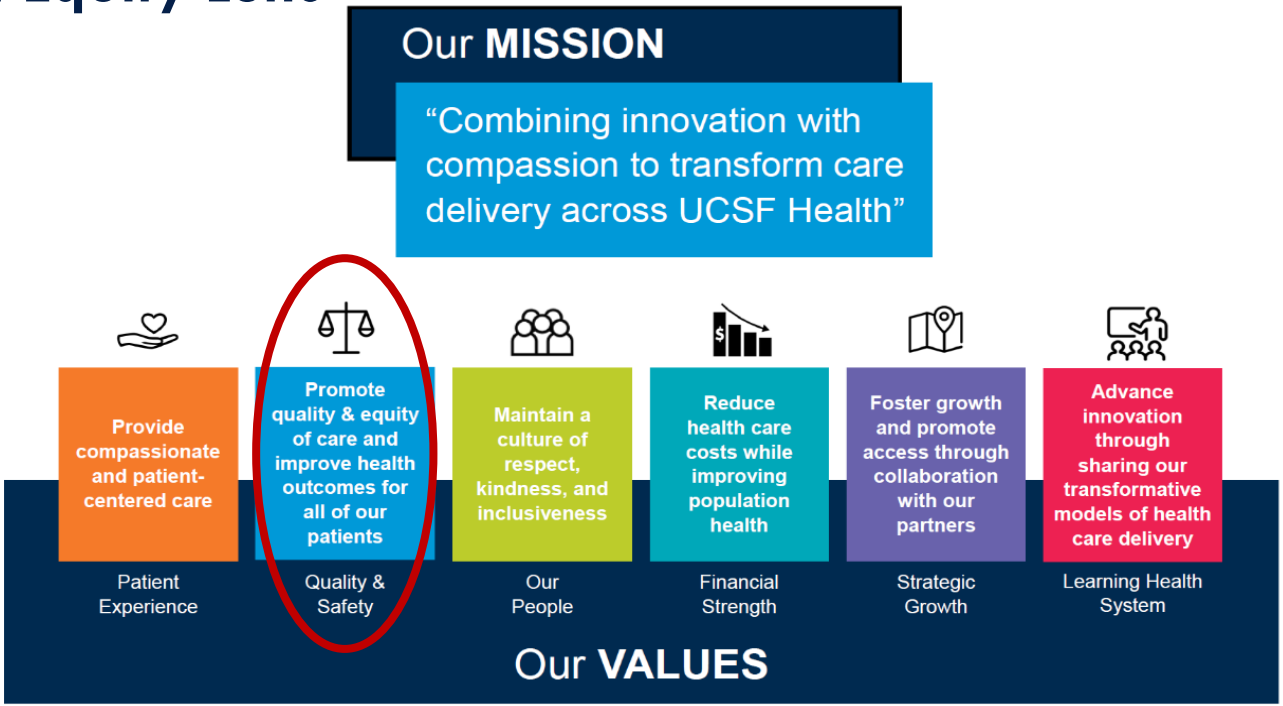
Manual Outreach Criteria

- Age 85 and older
- Primary language other than English
- Home health ordered at discharge

CLINICAL INQUIRY CONFERENCE

Current State

Health Equity Lens



"Charity" icon by Vladimir, "Balance" icon by Marta Ambrosetti, "People" icon by Anastasia Latysheva, "Finance Chart" icon by Davo Sime, "Map" icon by Pictohaven, and "Teacher" icon by Gregor Cresnar, from thenounproject.com

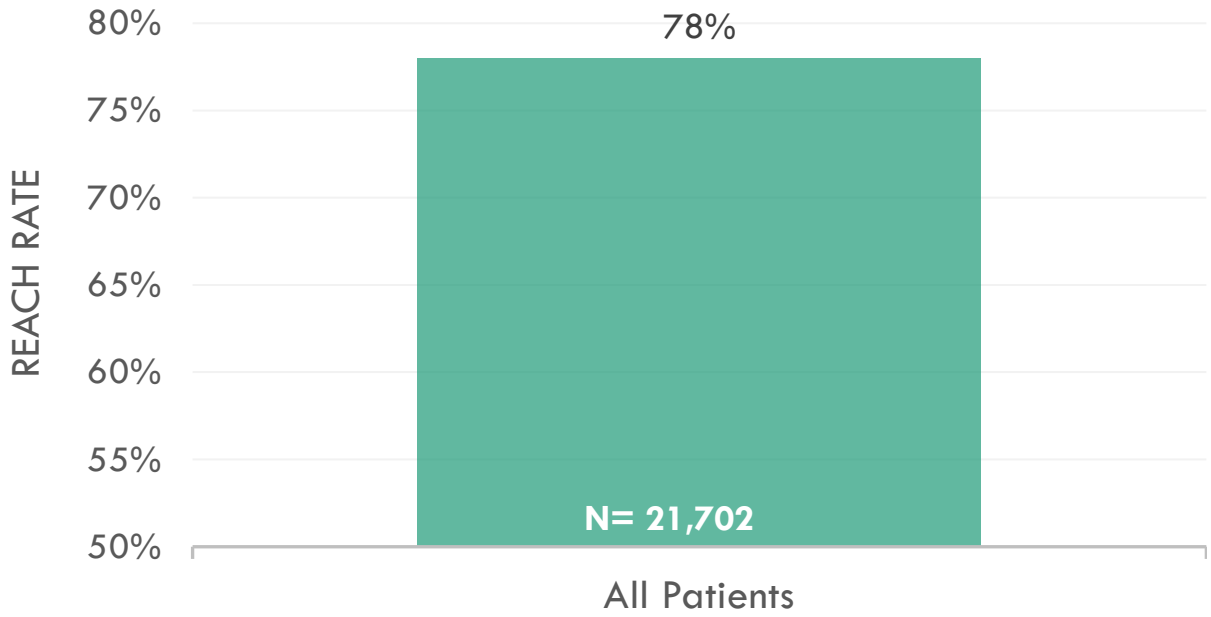
CLINICAL INQUIRY CONFERENCE

Problem Statement

While post-discharge phone calls are a best-practice, they are resource intensive and may not reach patients equitably.

Gap Analysis

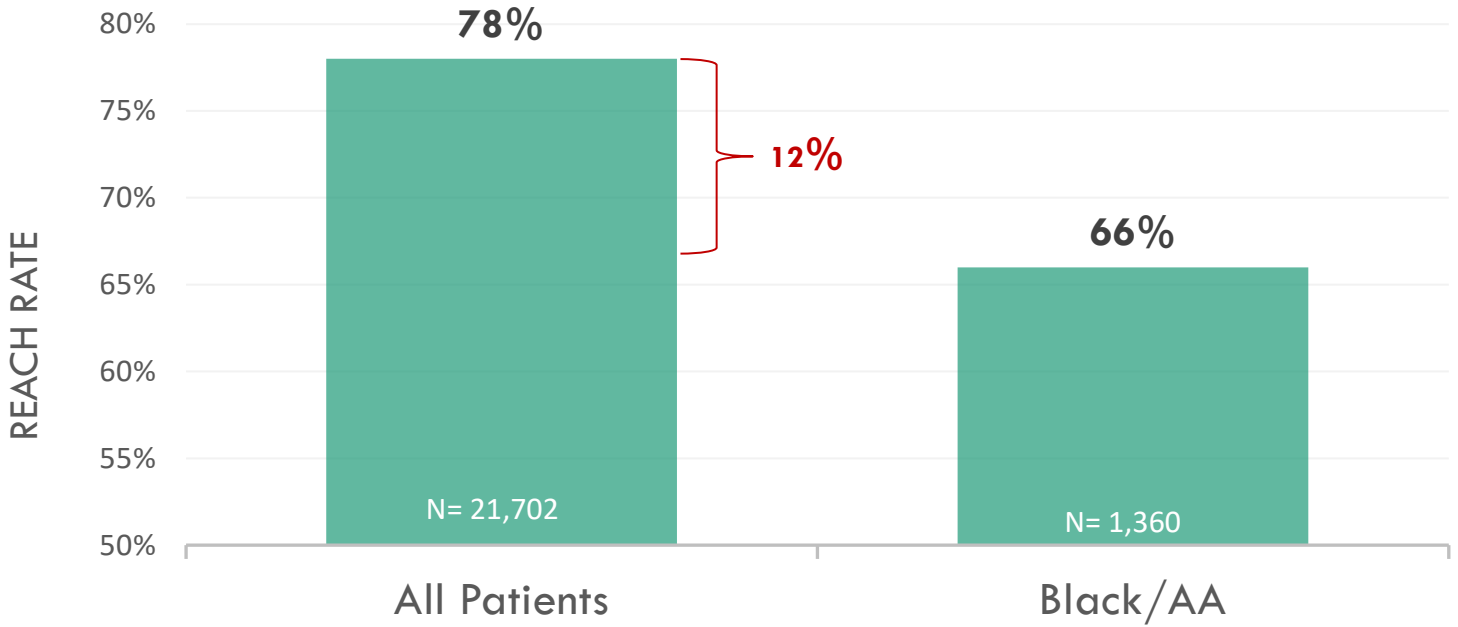
Pre-intervention Baseline: Calendar Year 2022



CLINICAL INQUIRY CONFERENCE

Gap Analysis

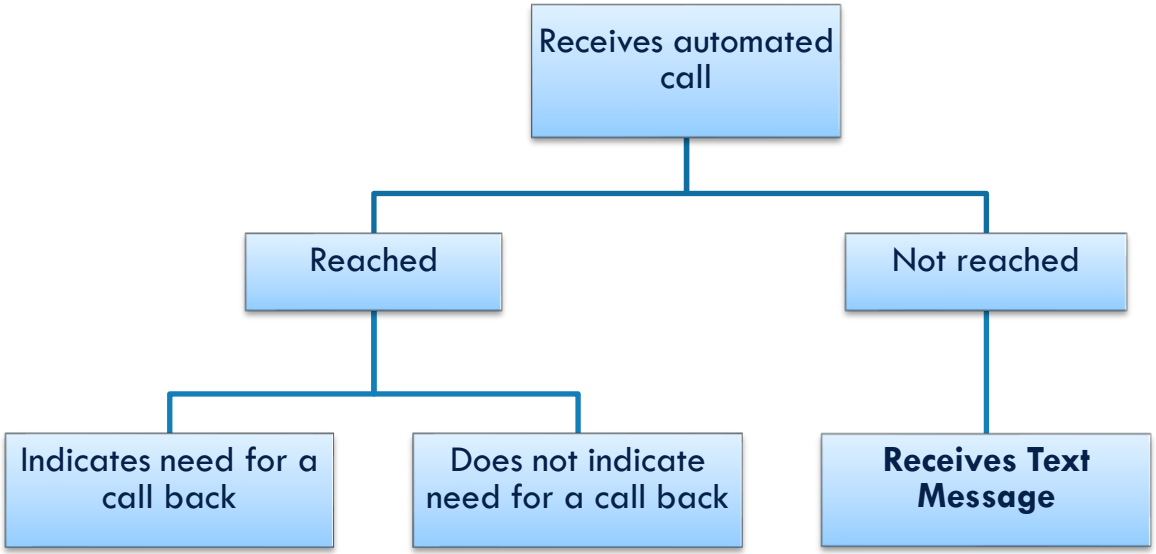
Pre-intervention Baseline: Calendar Year 2022

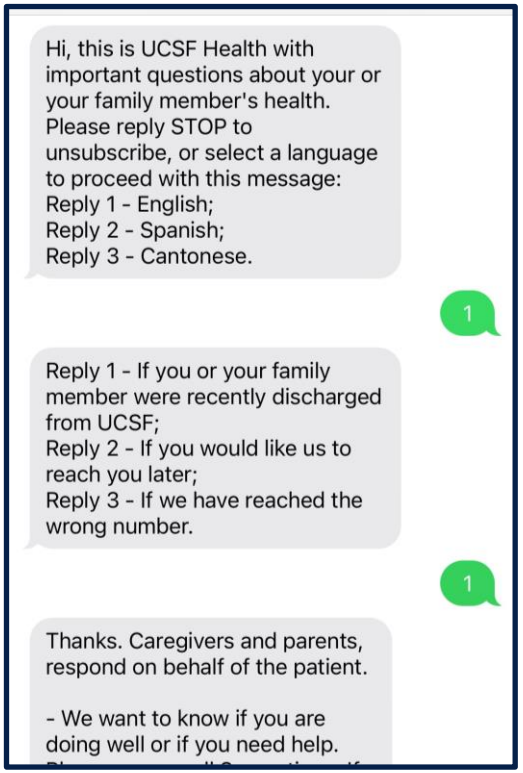


CLINICAL INQUIRY CONFERENCE

Project Plan

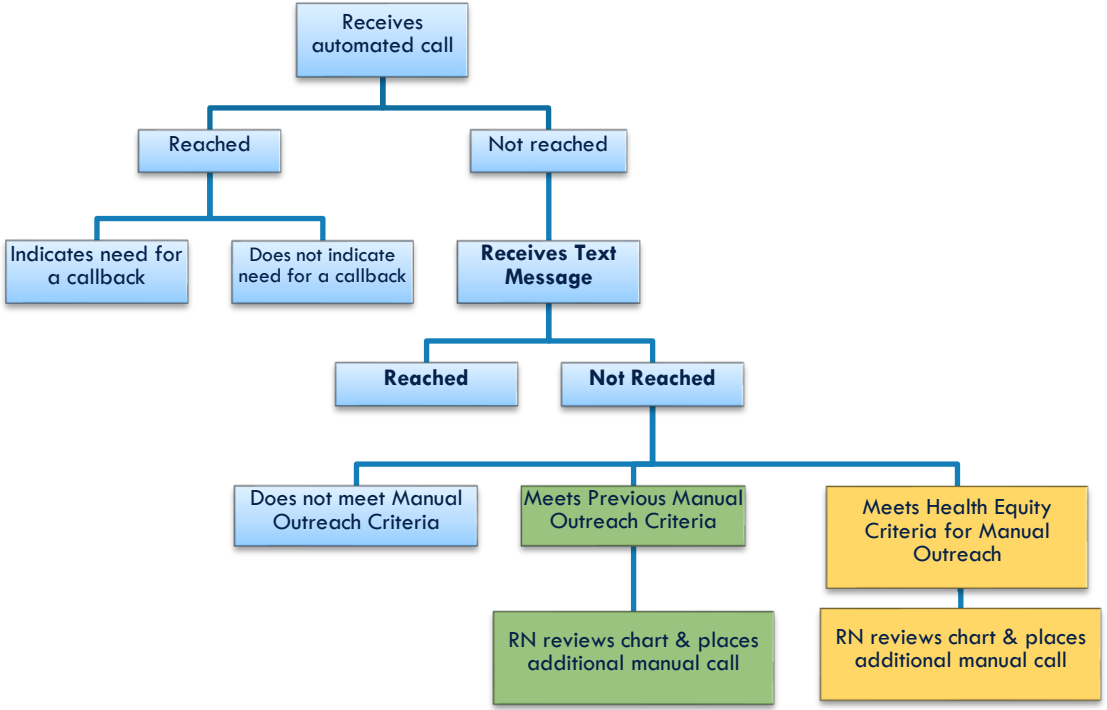
Adding Text Message Option





Project Plan

Text Message Option + Manual Outreach

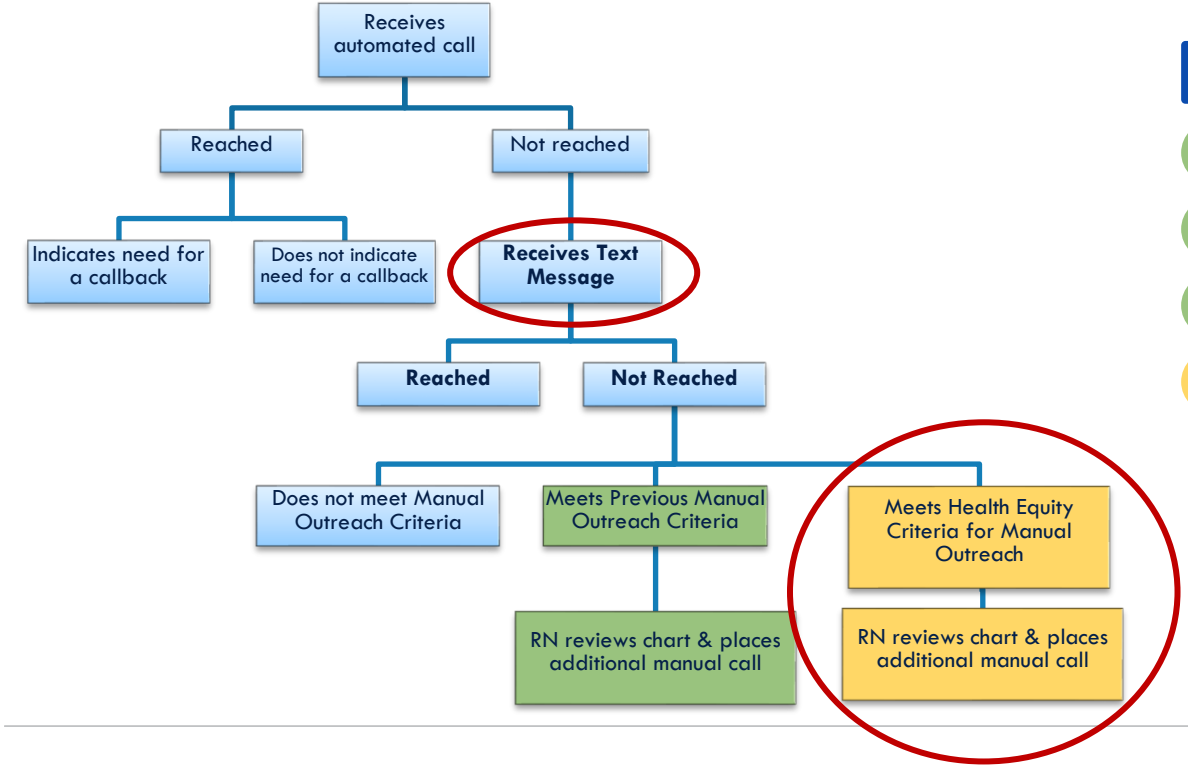


Manual Outreach Criteria

- Age 85 and Older
- Primary Language other than English
- Home Health Ordered at Discharge
- Black/African American Patients

Project Plan

Text Message Option + Manual Outreach

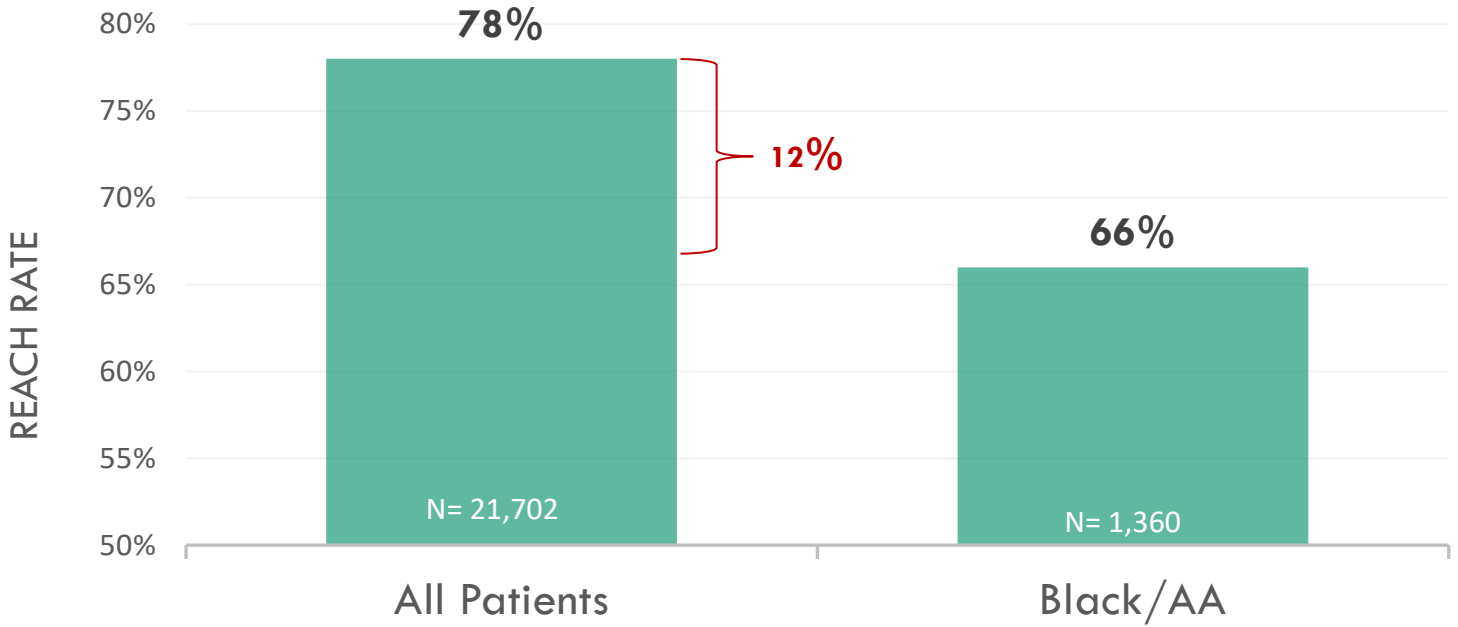


Manual Outreach Criteria

- Age 85 and Older
- Primary Language other than English
- Home Health Ordered at Discharge
- Black/African American Patients

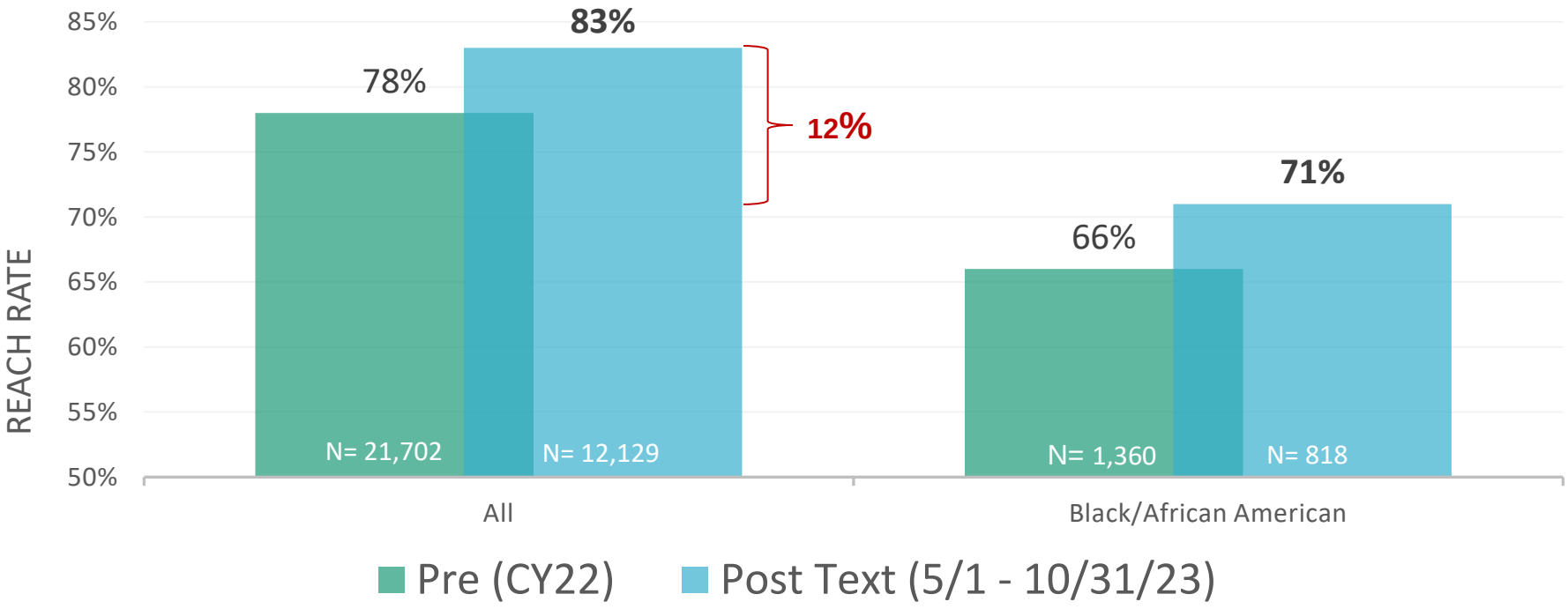
Results and Impact

Pre-intervention Baseline: Calendar Year 2022



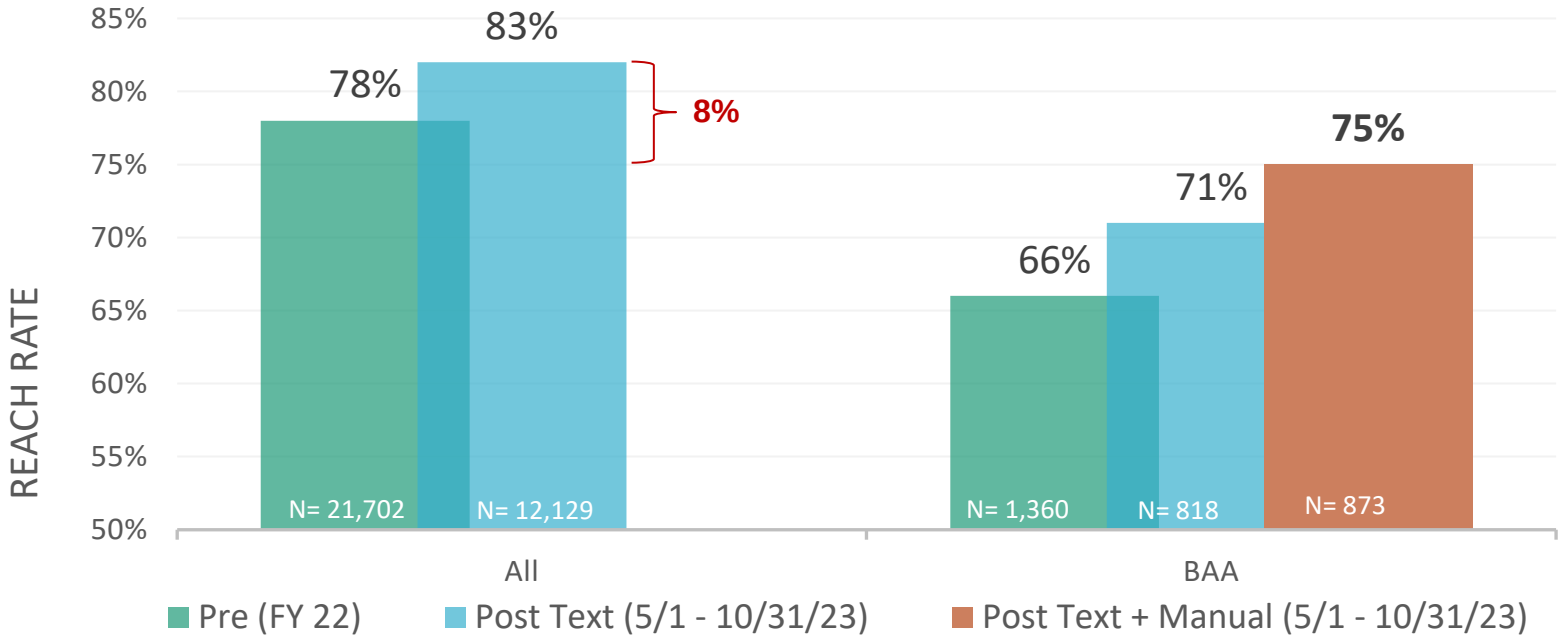
Results and Impact

Pre- and Post-Text Message Intervention



Results and Impact

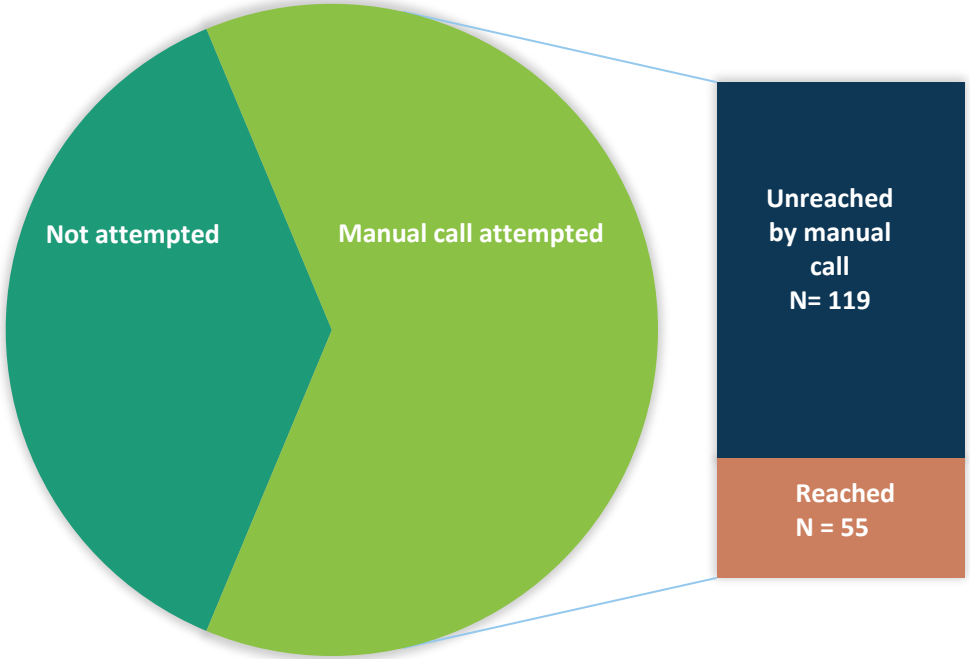
Pre- and Post-Text + Manual Outreach Intervention



Results and Impact

Manual Outreach Intervention

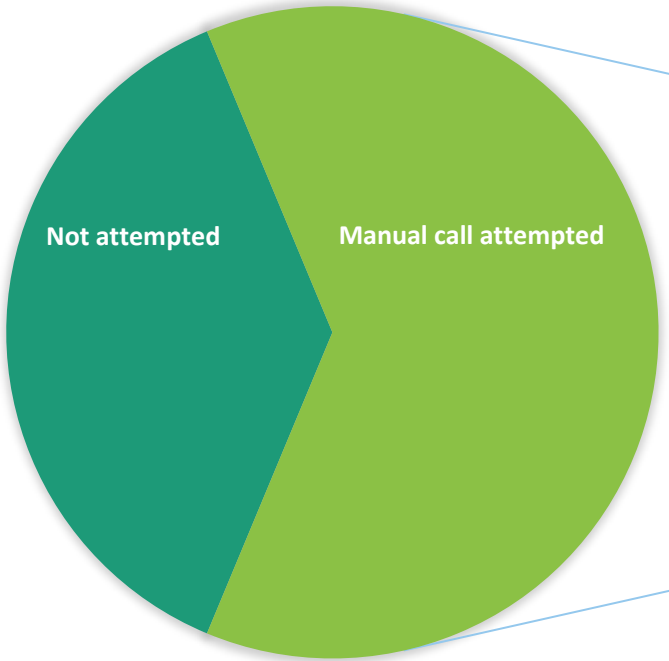
B/AA Unreached by automated call or text	N=314
Not attempted already had follow-up/ communication with provider or were readmitted/in ED	137
Attempted with Manual Call	174



Results and Impact

Manual Outreach Intervention

BAA Unreached by automated call or text	N=314
Not attempted already had follow-up/communication with provider or were readmitted/in ED	137
Attempted with Manual Call	174



Unreached by manual call N= 119

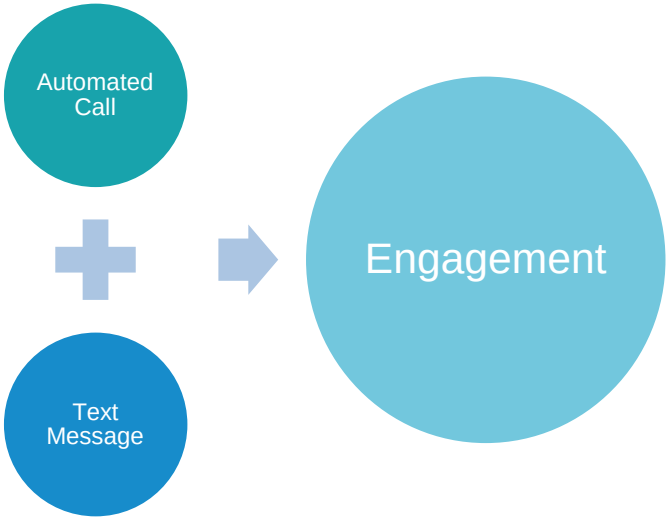
Of those unreached by manual call, **29** had phone #s that were busy, disconnected, or wrong #

Reached N = 55

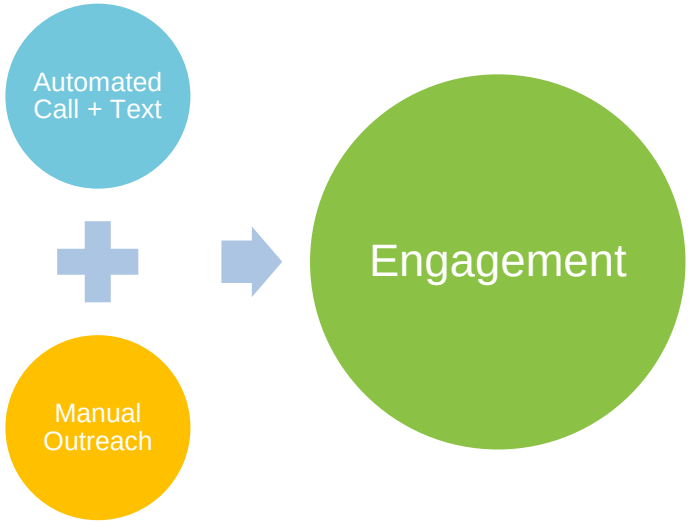
Of those reached by manual call, **41** had transitional care needs

Conclusions

Increased Overall Engagement

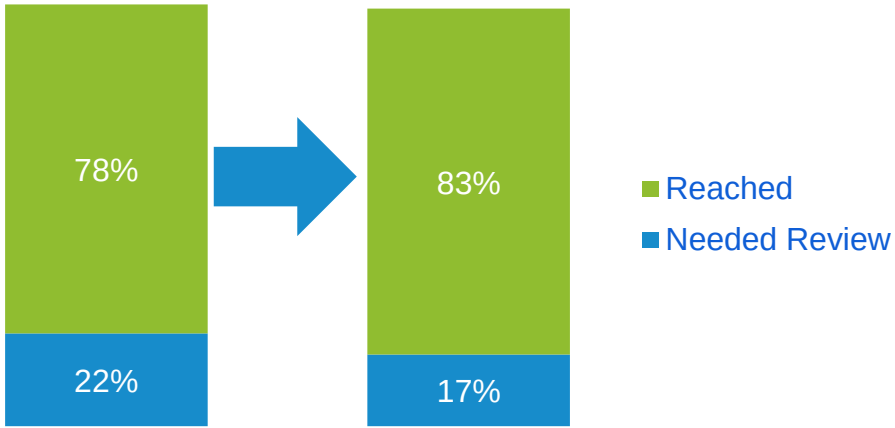


Increased Black/African American Engagement



Lessons Learned

- Technological enhancement to existing program
- Smart data capture
- Optimized efficiency & nursing scope



Next Steps

- Evaluate for other disparities
- Use UCSF's Equity First Playbook
- Continue to disseminate knowledge

CLINICAL INQUIRY CONFERENCE

Acknowledgements

- Population Health Analytics & Leadership Team
  - Marty Schroeder & Heather Leicester
  - Meg Wheeler, Manager of Care Transitions Programs
- UCSF Ambulatory Clinic Staff
  - RNs/APPs to receive escalations
- CipherHealth©
  - Automated call & text technology

References

1. Shupe, R. (2014). Post-visit phone calls: Reducing preventable readmissions and improving the patient experience. *Journal of Nursing Education and Practice. 4*. 10.5430/jnep.v4n4p45.
2. Leconte, D., Beloeil, H., Dreano, T., & Ecoffey, C. (2019). Post Ambulatory Discharge Follow-up Using Automated Text Messaging. *Journal of medical systems, 43(7)*, 217. https://doi.org/10.1007/s10916-019-1278-5
3. Bressman E, Long JA, Honig K, et al. Evaluation of an Automated Text Message–Based Program to Reduce Use of Acute Health Care Resources After Hospital Discharge. *JAMA Netw Open*. 2022;5(10):e2238293. doi:10.1001/jamanetworkopen.2022.38293

Thank you!

Anna Hoyt, RN
Care Transitions