

# Discharge phone calls: using person-centred communication to improve outcomes

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## Discharge phone calls: using person-centred communication to improve outcomes

**Aim** This article describes the Clinical Nurse Leader role in implementing person-centred care bundles to improve patient outcomes through an innovative culture of caring.

**Background** Demonstrating the financial value of introducing the Clinical Nurse Leader role into an organisation is essential for sustainability. Previous authors have established the Clinical Nurse Leaders' influence on patient satisfaction and have suggested that Clinical Nurse Leaders improve the continuity of care after discharge.

**Evaluation** Descriptive data are shared to illustrate the effectiveness of implementing the patient care bundles and a Clinical Nurse Leader-driven discharge phone call process.

**Key issues** Clinical Nurse Leaders who practise from a caring lens are uniquely situated to lead initiatives that drive person-centred care with the goal of reducing readmission rates. Patients who receive person-centred care have an improved perception of the hospital experience and are more likely to return to the facility.

**Conclusions** Clinical Nurse Leaders establish relationships with patients that increase the likelihood of successful outcomes from the discharge phone call process. Further evaluation of the Clinical Nurse Leader's role and potential impact on patient outcomes is warranted.

**Implications for nursing management** Clinical Nurse Leaders are uniquely prepared to lead transformational change within an organisation. Clinical Nurse Leader interventions that are developed at the microsystem level in response to problems may have system-wide implications.

**Keywords:** clinical nurse leader, Hospital Consumer Assessment of Healthcare Providers and Systems, patient outcomes, person-centred caring, transitions in care

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## Introduction

In 2005, the St Lucie Medical Center (SLMC) made the critical decision to implement the new role of the

Clinical Nurse Leader (CNL). The CNLs are accountable for patient outcomes by integrating and evaluating research and leading care in a specific microsystem. The CNL role differs from that of a

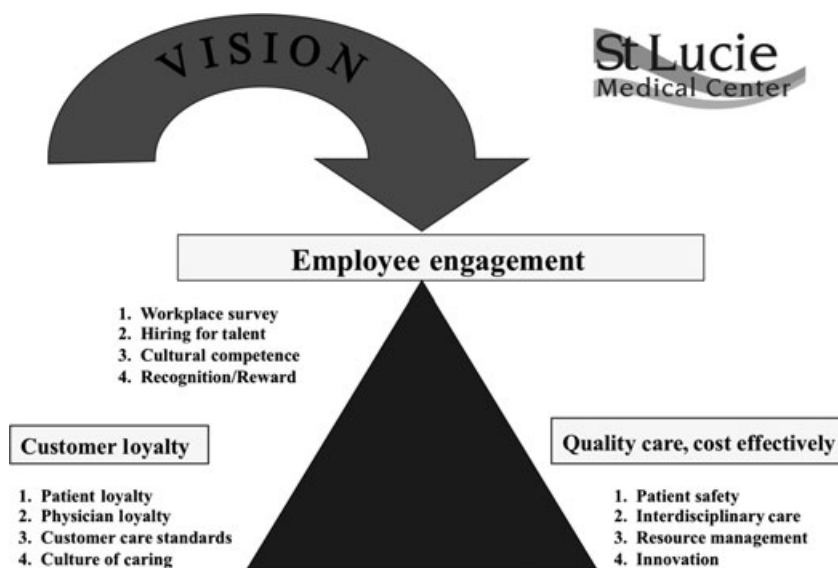
Clinical Nurse Specialist in that the CNL is a generalist. Whereas this role is specific to the United States, there may be similarities with other international roles. The American Association of Colleges of Nursing (2007) White Paper on the Education and Role of the CNL provides an excellent overview of CNL competencies. As one of 190 clinical sites across the country to join with an academic partner, nursing leadership at SLMC changed the face of nursing at their hospital with the introduction of this new Master's prepared nurse. Simultaneously, knowing that it was not possible to hardwire new processes in nursing without the strong foundation of a nursing theory, the Nursing Professional Practice Council selected Boykin and Schoenhofer's (2001) 'Nursing as Caring' theory to guide their endeavour to focus on person-centred caring and a new model of care delivery. The hospital executives also knew that it would not be enough to focus their efforts only on nursing; they needed a caring framework to ground the entire hospital. Hence, the Culture of Caring was born, incorporating all of the staff, physicians, volunteers, patients, families and the community in transforming both the workplace environment and patient care experiences by recognising that 'an entire healthcare organisation can be transformed by intentionally grounding it in a perspective of caring values' (Pross *et al.* 2011, p. 25).

The early phases of the transformation process at SLMC occurred in 2008 as a result of the introduction of both the CNL role and the Culture of Caring. St Lucie Medical Center is a 229-bed community hospital located on the Treasure Coast of Florida, and

is a part of HCA, a for-profit organisation. The Vision (see Figure 1) at the hospital has been in place for over 12 years and still guides the hospital on each step of its journey, including the adoption of a Culture of Caring. Nothing significant is done at SLMC unless it ties back to the vision of fostering Employee Engagement, Customer Loyalty and Quality Care, Cost Effectively. Over the past 6 years, the CNL role has supported all three tenets of this vision.

### The CNL role

In 2005 the Chief Nursing Officer (CNO) presented information to illustrate how the CNL role could directly impact outcome indicators such as core measures, pay for performance, lengths of stay, and recruitment and retention of nurses (Gabuat *et al.* 2008). Additional factors for why the organisation should consider implementation of the CNL role were to improve professional development of staff and to enhance team collaboration (Sherman *et al.* 2009). As in many other hospitals, nursing was at a crossroads at SLMC. The CNO advocated to the administrative team and the Board of Trustees that nursing was ready to lead the challenge of improving employee engagement, customer loyalty and patient safety. This process had to begin with promoting further education for nurses who wanted to advance their practice, but desired that practice to remain focused on person-centred care. The CNL role allowed the 'best and the brightest' to remain at the bedside (p. 266). The CNL role was first introduced in 2006 with four CNLs on two pilot units. Today there are five CNLs at SLMC



**Figure 1**  
SLMC vision.

with two more nurses enrolled in the CNL Master's programme, but already functioning in the role with support from the certified CNLs.

### Person-centred caring

The nurses at SLMC participated in a research study with Boykin and Pross to infuse caring values throughout the organisation and to ground their nursing practice from the lens of 'Nursing as Caring' (Pross *et al.* 2010). 'Nursing as Caring' includes the major assumptions that all 'persons are caring, moment to moment', and their 'personhood is enhanced through participating in nurturing relationships with caring others' (Boykin & Schoenhofer 2001, p. 1). All disciplines were invited to share stories from practice that supported knowing self as caring in scheduled dialogues and poster presentations. These caring behaviours were then recognised as living the values in the 'Dance of Caring Persons' and awards were disseminated (Pross *et al.* 2011, p. 27). All members of staff were encouraged to sustain the values as they focused on delivering person-centred caring. Everyone was invited to join in a commitment to creating and living this Culture of Caring during Hospital Week in 2008 when employees, physicians, the community and patients and their families were invited to engage together in the 'Dance of Caring Persons'. This resulted in participants representing all the groups coming together and forming a live circle of persons embracing the entire hospital. The CNL group embraced this mode of relating and the model began to drive future CNL-led initiatives that would influence patient outcomes.

### CNL impact on patient outcomes

Harris and Ott (2008) discussed the need to document a business case for the CNL to ensure that the broad implementation of the role becomes a reality. The current fragmentation of care within complex acute care environments that are subject to enhanced reimbursement regulations and pay-for-performance is ripe for the CNL role of integrating quality-enhancing interventions to promote person-centred care. The recent IOM (2010) report called for front line nursing leaders to improve health care and to be full participants in redesigning health care across the continuum by seeking solutions to problems including transitioning patients from hospitals to home. By function, the CNL is prepared to assume a leadership role in achieving target outcomes through lateral care coordination,

innovation, implementation of change and clinical outcomes management (AACN 2007).

Previous reports of patient outcome improvements from CNL-led initiatives include reductions in falls, pressure ulcers, ventilator acquired pneumonias, fewer procedure cancellations and improved discharge teaching (Ott *et al.* 2009), decreased blood transfusions after total knee surgeries and increased venous thromboembolism prophylaxis (Hix *et al.* 2009). Other researchers have documented improvements in core measures and patient satisfaction (Gabaat *et al.* 2008; Stanley *et al.* 2008), increased collaboration with physicians and care coordination, and decreased costs and lengths of stay (Stanley *et al.* 2008).

Sherman (2010) interviewed CNLs who described their role as 'keeping things from falling through the cracks' (p.551) through their efforts at coordinating care. These CNLs felt that problems identified at the microsystem level were frequently found to have system impact and that CNLs added value in their facilities by reducing readmissions and improving satisfaction, collaboration and communication.

Kizziar *et al.* (2012) discussed how patients require support after they have returned home. Frequently their medications have been changed and after discharge they are unclear which pills to take, those from before or those after they were hospitalised. At times they have no transportation to the pharmacy or to follow-up visits. Within the continuum of care, the discharge process offers an array of opportunities for measureable improvement when transitioning to person-centred care. The Veteran's Health Administration (Ott *et al.* 2009) identified hospital readmission rates as an area where the implementation of CNLs could make a potential impact, as did the Tennessee Valley Healthcare System (Hix *et al.* 2009). As many as 20% of hospitalisations are due to readmissions within 30 days of discharge, frequently the result of ineffective communication among the healthcare team and with the patient (Lacker 2011). Post hospital care follow-up and continuity of care through the use of discharge phone calls has been suggested as a means to decrease these readmissions (Poulin-Tabor *et al.* 2008, Lacker 2011).

At the St Lucie Medical Center, CNLs sought to describe their effect on establishing person-centred caring through the implementation of patient care bundles that began with the evidence-based Master's capstone projects of two CNLs. Poulin-Tabor *et al.* (2008) suggested that the CNL was uniquely positioned to reflect person-centred care because they 'know the patients' stories' (p. 626) and are able to

'focus on the patients as a whole' (p. 628). As one CNL at St Lucie commented, 'When we call, they know who we are' (H. Garrison, Personal communication, 30 July 2012). As was true in many facilities, the readmission rates for the core measure discharges were higher than expected when compared with the national readmission rates and the CNLs sought to use newly developed patient care bundles, which included discharge calls as a method to come to know the patient as caring, to further their goal of improving patient outcomes and reducing readmission rates.

## Patient care bundles

As the nursing leadership contemplated implementing patient care bundles in order to live person-centred caring in nursing practice at SLMC, they wanted to avoid the perception of 'another flavour of the month'. The CNLs provided a mechanism for mentoring and sustaining caring values due to their unique academic preparation from Florida Atlantic University Christine E. Lynn College of Nursing and its caring philosophy and curriculum. The CNL enhancements to the patient care experience through implementation of the patient care bundles offered one means of measuring the impact of valuing caring on patient outcomes. The CNLs could devise ways to integrate the bundles into the model of care delivery and into their daily routine. Data could then be analysed and synthesised to evaluate the effectiveness of implementing the patient care bundles.

To ensure person-centredness and to improve communication as well as safety, the CNLs used proven evidence-based practices and developed their own patient care bundles. The SLMC innovated model of patient care bundles consists of four components: bedside shift report, care boards, intentional hourly rounding and discharge phone calls (see Figure 2). Initially, two of the CNLs used 'Nursing as Caring' (Boykin & Schoenhofer 2001) as the theoretical framework to restructure bedside shift report. Bedside shift report keeps the patient at the centre of care by bringing the nurse-to-nurse handoff to the patient's bedside. This new process of nursing report was grounded in 'the belief that through knowing oneself and others as caring and through the commitment to nurture and support that which matters, impersonal systems of care have the potential to be transformed' (Pross *et al.* 2011, p. 30). The CNLs transformed bedside shift report to promote patient safety as well as to ascertain that the patient's calls for nursing, or calls for expressions of caring for the next 12 hours,



**Figure 2**  
SLMC patient care bundles.

were discussed (Boykin & Schoenhofer 2001). Hearing these calls requires the nurse to be authentically present and to want to come to know the patient as a caring person. Within this dialogue nurses are actively seeking out how best to support the patient. The patient is invited to participate in this report twice daily with the nurses as they transition care responsibilities. Patients are reassured as they are included in this communication process and nurses are able to ensure continuity of care. Once the bedside shift report was hardwired, the other elements of the patient care bundles were researched and established.

The care boards, white dry erase boards mounted on the patient's wall, help to improve communication between the hospital staff, the patient and the patient's family. Care boards include the nurse's name and phone number, the preferred name of the patient and their care partner, the primary physician as well as important things to remember such as diet restrictions, whether assistance is needed to get out of bed, and the anticipated discharge date. The care board also provides a place to make the patient's calls for nursing visible, and includes the patient prioritised goals, with 'what matters most to the patient' becoming the number one goal (Boykin & Schoenhofer 2001). Intentional hourly rounding, which is conducted at the top of the hour, focuses on eliciting the patient's needs and safety concerns. Staff sign up for intentional hourly rounding at the beginning of each shift. The fourth component of the patient care bundles, the discharge phone call, enables the CNLs to continue managing the care environment and focus on person-centred care after the patient leaves the hospital. The discharge phone call reaches beyond the hospital setting, enhancing the transition of care to the next level.



In speaking with patients after discharge, the CNLs began to understand the struggles endured by the patient after leaving the hospital. The CNLs identified that the same fragmented care witnessed in the hospital carried over through discharge. Trends such as forgotten prescriptions, poor follow-up by home health care companies, lack of understanding of the discharge instructions as well as failure to fill prescriptions and make follow up appointments are not uncommon. During the discharge phone call, the CNL assesses the patient's understanding as well as compliance with the discharge instructions and has a unique opportunity to intervene. The CNLs are then able to use the information gathered regarding gaps in the discharge process to make system-wide changes. Such interventions have decreased readmission rates while increasing patient satisfaction.

In 2011, the CNL Council developed a dashboard that included the expectation of using discharge phone calls to reach 95% of patients who were discharged home within 48 hours. In early 2010, the phone call process to discharged patients was unstructured. At the time, the value of the discharge phone call was unrealised. Utilising a hit or miss process, the CNLs made only one attempt to reach the patient. To reach the new goal established in 2011 the CNLs redesigned the discharge phone process. First, the CNLs developed standardised scripting for conducting the discharge phone calls. Secondly, each CNL committed to making several attempts to reach each patient. On average, each CNL makes 30–40 discharge phone calls from Monday to Friday. The CNLs quickly met their goal of reaching 95% of discharged patients and have been able to sustain this level.

The short journey for the hospitalised patient can result in receiving a new diagnosis; changes in medications, diet and physicians; and a variety of recommendations for a healthier lifestyle. The average length of stay is approximately 4.8 days, which only allows the nursing staff a few days to lay the foundation for healing and wellness. Consequently, despite the entire healthcare team's efforts at providing education and communication, patients and families have insufficient time to absorb the extensive amount of information provided to them during their hospital stay. Inundated with information, patients frequently feel overwhelmed. Once the patient gets home and begins to digest and attempt to understand their hospital stay, questions and issues arise. The discharge phone call allows the CNLs to live Nursing as Caring (Boykin & Schoenhofer 2001) by reaching out to the patient beyond the hospital walls to improve the transition to

home care. It is not just the simple act of a phone call that makes the difference. Changes are also made at the macro and micro system level as a result of the identification of issues and concerns that can lead to potential complications.

Through journaling, the CNLs at SLMC review and evaluate patient care as well as illustrate the value of the CNL role. At times, the journaling results from a situation uncovered during a discharge phone call. The CNL's journal about nursing situations and the goal for each CNL is to journal on clinical interventions at least four times monthly. The journal entries frequently relate to discharge phone calls. The journals illustrate the far-reaching impact of the discharge phone call on the transition of care. Included below are several nursing situations from the journals of the CNLs that describe readmissions that were prevented as the CNL responded to the patient's calls for nursing.

12/22/2011 – A patient went home after thyroid surgery. I called the patient the day after discharge and was told he was having tingling in his arms, face and left leg. I asked the patient if he had called the doctor's office to let the MD know of his symptoms. He said, 'not yet because he is afraid that the MD would want him to go back to the hospital'. He doesn't want to be admitted because it's almost Christmas. I explained to the patient the importance of getting his calcium level checked especially after his thyroid surgery. He told me that he will go to the doctor's office tomorrow if symptoms worsen. I called the surgeon and left the MD a message regarding the above. MD called back and told me he called the patient at home and advised him to take an additional dose of the calcium tablet, see him tomorrow in his office, as well as going to the ED that day to get his calcium levels checked. I called the patient again at home to make sure he understood MD's instructions, talked to his wife; she said her husband will take additional dose of calcium and go to the ED tonight to check his calcium level.

**CNL intervention prevented readmission and poor patient outcome.**

10/03/2011 – During my discharge phone call today (Monday), I spoke with a patient who was discharged on Friday after a very complicated abdominal surgery. According to the discharge instructions the patient was to have home health care (HHC) come to her house for daily sterile

dressing changes. In speaking with the patient she shared that the HHC had not contacted her. She was very concerned about infection and was considering coming to the emergency room to have someone look at her dressing. I worked with the discharge planner and had home health come to her house that day.

**CNL intervention prevented readmission and poor patient outcome.**

8/30/2011 – During my discharge phone calls, I spoke with the son (caregiver). He explained to me that his mom had a UTI while in the hospital. She received one dose of Cipro and was discharged from the hospital the next day. Unfortunately, the patient was not sent home on antibiotics. The son shared with me that in the past, she had an untreated UTI which led to numerous complications and hospitalisations. I reviewed the record and agreed with the son. She was seen by one of our hospitalists. I contacted the hospitalist office and explained the situation. MD called a prescription into the pharmacy. I reviewed the same with the caregiver. While unhappy with the discharging physician, the son was very appreciative for my assistance and follow through.

**CNL intervention prevented complications, possible readmission for an unresolved UTI.**

04/8/2011 – Patient was discharged on 04/06/11, patient returns call today confused about his medications – was able to clarify medication for the patient along with teaching – pt could not get follow up appt until July – called MD's office and made a follow up appt for May 5th. Called pt back and verified everything with pt – reinforced medication teaching along with follow up appt information.

**CNL intervention prevented potential readmission due to lack of follow up and poor understanding of medications.**

The above journal entries illuminate the importance of the discharge phone call in preventing readmission. The CNL works closely with the patient and coordinates care with other disciplines if necessary to prevent readmission.

The development of pay for performance and subsequently the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey forced hospitals to look at the patients' perception of care received during their hospital stay. The Nursing as

Caring (Boykin & Schoenhofer 2001) theory adopted by SLMC laid the foundation for improving patient satisfaction by focusing on what matters most to the patient. Keeping the patient at the centre of care, the CNLs created the patient care bundles to begin changing the caring culture to improve the patient's perception of care. The first three patient care bundles (bedside shift report, care boards and intentional hourly rounding) bring the patient to the centre of care while hospitalised. As lateral integrators, the CNLs initiated the fourth patient care bundle, the discharge phone call, to bridge the gap between hospital and home. Even though discharge phone calls are designed to enhance the continuity of care, we believe there is also a positive correlation with the overall patient experience as SLMC has seen a significant increase in patient satisfaction scores from the bottom quartile to the 2nd quartile. For over a year now, the overall HCAHPS scores have been on average consistently higher than the Center for Medicare Services' national average of 70%.

In analysing their internal patient perception data from 2009 to 2011, the CNLs at SLMC felt that the discharge phone calls had the most effect on the three domains of providing discharge information, the patient's willingness to recommend the hospital and the overall rating of the hospital experience. With the redesign of the discharge phone call process the hospital's overall rating increased by 17.5% over a 2 year period. The patient perception of adequacy of discharge information increased by 4.7%, and their willingness to recommend the hospital increased by 4.4% during the same period. While not all of the increases in the satisfaction scores can be attributed to the discharge phone call interventions, this was a major initiative during that time period, which undoubtedly contributed to the rating increases.

Other measurements of improvements made through the use of discharge phone calls can be found. SLMC tracks additional indicators of customer loyalty to aid the facility in delivering high quality person-centered care. These customer engagement questions predict the patient's loyalty to the organisation. From 2009 to 2011, the SLMC's overall patient satisfaction score as well as the trustworthiness of the hospital both showed significant increases.

When reviewing the data, the impact of the discharge phone call intervention on hospital outcomes becomes clear. The descriptive data obtained through CNL journaling shows a decrease in readmissions, whereas the outcome measures reveal an increase in patient satisfaction and the patient's perception of

care received. Lateral integration through the use of the discharge phone call has proven to be a beneficial CNL intervention at SLMC. The relationship between the CNL and the patient is of paramount importance in achieving successful outcomes from the discharge phone call intervention. When the CNL calls the patient at home, the patient feels comfortable discussing their health care concerns. The patients remember the CNL by name, and if they require readmission to the hospital the patients request a certain floor because of the relationship developed with the CNL.

Each of the patient care bundles, bedside shift report, care boards, intentional hourly rounding and discharge phone calls, builds on and supports the others in the delivery of person-centred care. The bundles highlight the importance of communication and engaging in a relationship with the patient as the underpinning of all that is done to support a culture of caring. The CNL is uniquely prepared to track and trend issues related to patient outcome measures and is accountable for making recommendations for change. The CNLs at SLMC received the HCA Innovators Award in 2012 for making a financial impact on the organisation through the use of discharge phone calls. The community has slowly become more aware of the CNL role at SLMC and sees the CNLs as a reason to come to SLMC for their healthcare needs.

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