



UHN

Toronto
Rehabilitation
Institute



Telephone Follow Up

Staff Education Session

May 8, 2018

-Today's Objectives-

- ❑ Objectives of Telephone Follow Up and what has changed
- ❑ What feedback has been incorporated from the ABI group?
- ❑ What does the telephone follow up process look like now?
- ❑ Learn the in's and out's of carrying out the process.
- ❑ Questions and Feedback

How have the TFU objectives changed?

Old Objectives:

1. Improve transitions to independent community living
2. Identify and address barriers to community reintegration and facilitate access to resources and supports
3. Ensure referrals made to appropriate services
4. Support patient self-management and self-efficacy
5. Increase patient and caregiver safety through monitoring
6. Reduce hospital readmissions through prevention/health promotion
7. Support optimal rehab outcomes

New Objectives:

1. Improve **transitions** to independent community living
2. Encourage patients **self-management** and self-efficacy to identified barriers to community reintegration
3. Support optimal rehab outcomes


Feedback received from our ABI group...

- ✓ What should I do with all the problems they tell us?
- ✓ Takes too much time to share outcome of the call with the team – no formal debrief time
- ✓ What if I can't reach the patient?
- ✓ How do we set aside time to do the call?
- ✓ New staff do not have resources to help them learn the process
- ✓ How do we prep the patient for the phone call? Add information sheet in D/C Binder?
- ✓ What if the goal coordinator has not been very involved in the patient's care?
- ✓ The process is too time consuming and has too many steps

Important to remember...

- ✓ It is part of best practice guidelines!
- ✓ Not as often as you think! Maybe once a month.
- ✓ Calls should only take approximately 15 minutes and process is meant have minimal impact on daily workload
- ✓ Goal of call is **self management!**

Updated Screening Tool

 <input type="checkbox"/> RC <input type="checkbox"/> UC	
Telephone Follow-Up	

Part 1: COMPLETE WITH PATIENT AT TIME OF DISCHARGE

Discharge Date: _____ Telephone Screen Date/Time _____

Discharge Location: Home Other: _____

Person to contact: Patient Caregiver: _____ Phone No. _____

Verbal consent to contact caregiver: Yes No Alternate No.: _____

Email Address: (if consent on file): _____

OT: _____ PT: _____ SW: _____ SLP: _____ Phys MD: _____

1.1 Patient/Caregiver Concerns at Discharge:

1.	5.
2.	6.
3.	7.
4.	8.

1.2 Concerns Identified by Team at Discharge:

1.	5.
2.	6.
3.	7.
4.	8.

1.3

List appointments, community referrals, home equipment/modifications recommendations made at discharge OR <input type="checkbox"/> see attached copy of appointment list from discharge binder <input type="checkbox"/> see attached copy of page 8 of 8 from Interpretation at d/c summary	
1.	
2.	
3.	

Part 2: COMPLETE AT TIME OF TELEPHONE FOLLOW-UP

*Prep patient that the call will be approximately 15 minutes to set expectation

Questions	Comments/Recommendations Made
1a. Before you left Toronto Rehab, your concerns were (refer to 1.1) How have you been managing?	
1b. (Refer to 1.2) Screener to ask about concerns identified by the team if applicable.	
2. Do you have any questions or concerns about the referrals that have been made for you before you left Toronto Rehab? (cue pt to refer to list in their binder)	
3. Do you have any questions or concerns with the recommendations made by your team such as: equipment, home modifications, or help that you may need at home? (Refer to 1.3 or attached list)	Possible Prompts if concerns identified: contact Home & Community Care (LHIN) (previously CCAC), Contact Vendor
4. Do you have any new or worsening medical concerns that have not already been addressed such as pain, headaches, changes in mood, or recent falls?	
5a. Do you have plans to see your family Doctor?	
5b. Have you had a chance to refill your prescriptions?	
6. Do you have any questions about what we have discussed or how to address any concerns going forward?	

Print Name of Screener: _____ Date of Screen: _____

Signature of Screener: _____

Additional Notes/Comments: _____

- Telephone follow-up entered into Workload and PHS (outpatients only)
- Rounds report-back to team complete
- For patients with TRI physician follow-up: scan and send this form to outpatientphysicianclinics@uhn.ca and cc physiatrist
- Following Rounds report back, give original copy to health records for filing (attach a face sheet as necessary). Send via interoffice mail or bring down to health records (if at UC).

Patient Name: _____ MRN: _____

Who and When?

- Who makes the call?
 - Goal coordinator
 - Or designated team member who had strong involvement with the patient during their admission
- When are we calling?
 - Approximately 3 weeks post discharge

Inclusion/Exclusion Criteria

- Who does NOT get the Call?
 1. Acute Care
 2. CCC
 3. LTLD
 4. MVC/WSIB
 - Call **NOT DONE** if private team follow-up is established.
 - Call **DONE** if private team follow-up *is not* established.
 5. Going to Rumsey or UC Day Hospital **within 3 weeks of inpatient discharge**
 - *If longer than 3 week wait, or start date not established by discharge, follow up call is done.*

**Exceptional cases may exist- use team discretion*

Before the call...

- PART A
- Week Prior to Discharge:
 - Meet with patient / caregiver
 - Review “*Pre-Discharge Telephone Follow Up information sheet*” with patient and place it in their discharge binder.
 - Determine the date and time of telephone follow up.
 - Record date and time on follow up appointment sheet in Discharge Binder.
 - Complete part 1.1 on form **with** patient/caregiver.

Before the call...

- PART B
 - During patient's last rounds discussion
 - Complete *part 1* of the follow up screen form
 - Incorporate *input from the team* and record on form
 - Keep the original form for the call & “*rounds report back*”

At the time of the call...

- Screener completes Part 2 of form.
- Remember – focus is on *Self-Management*.
 - Tip Sheets
 - CPR!!!!
 - Current Plan
 - Support People
 - Resources
- Record your recommendations or actions taken on the form.
- Screener to attempt to call patient a total of **3 times**.

Patient survey

- For the coming 2 months, ask survey questions attached to screening form to gather feedback from patients
- Please give to Brianna
 - *Do not send to Health Records*

Telephone Follow-Up

Brief survey questions at the end of the call:

1. It has been _____ weeks since you left our inpatient program. Was the timing of this phone call appropriate? Would you have felt better if the call was sooner after discharge? Later?

2. What do you feel you could have known before going home to prepare you for daily life after being in hospital?

3. Were the questions I asked today clear? Was there anything else you would have liked me to ask you about?

4. Do you feel better about your return to home after receiving this phone call? Did you find it to be valuable?

5. Do you have any other suggestions about how to make these phone calls better?

After the call...

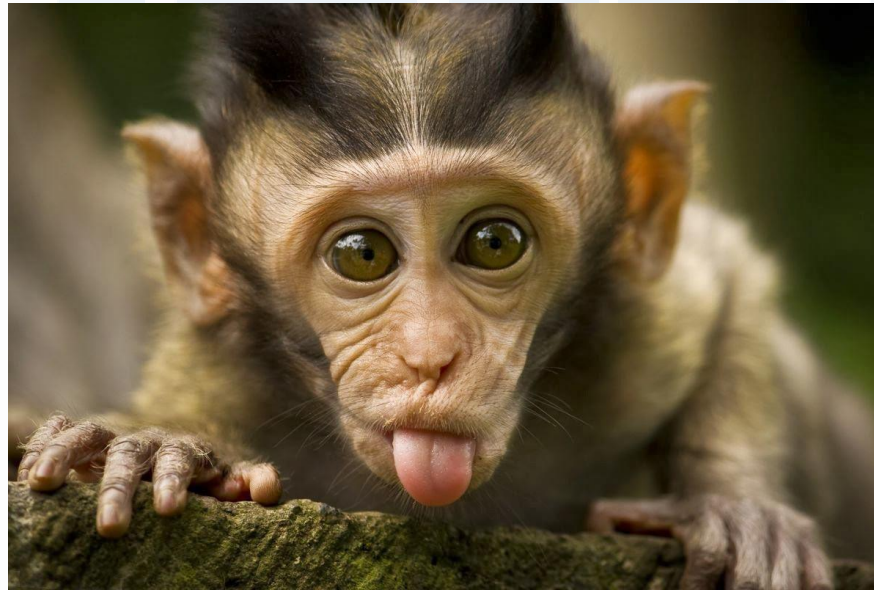
- If **issues are identified** during the call that require the input of others, liaise with the appropriate team member as needed.
 - *Record this on the form.*
- Enter Telephone follow-up into Workload

Closing the loop...

- Quick update at rounds
 - 4-5 weeks after discharge, patients will be listed on the rounds list for “report back”.
 - Census has a new column indicating date of report back discussion
 - Report Back (goal coordinator):
 - Was telephone follow up required?
 - Was call completed
 - Brief statement to help team close the loop including any ways in which you helped *support self-management*.
- After rounds report back
 - For patients with TRI Physiatry follow up, scan and send form to *outpatient clinics*
 - Send form to health records

Staff Survey

- *We need your feedback!!*
 - Survey monkey



Questions?

