Capsule Commentary on Tang et al., Evaluation of a Primary Care-Based Post-Discharge Phone Call Program: Keeping the Primary Care Practice at the Center of Post-Hospitalization Care Transition

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Post-hospital care transitions are potentially complex clinical events. A significant number of patients experience confusion or discontinuity of their care, which has important implications for patient safety and cost containment. In this issue, Tang and colleagues report a study of post-discharge phone calls from a primary care office.¹ Among 486 full-scripted calls, nurses uncovered at least one problem in 371 discharges, of which 25 % included new symptoms and 47 % included medication issues. Discharges with full-scripted and message-scripted encounters were associated with higher rates of follow-up appointment attendance, but there was no significant difference in 30-day readmission rates.

Post-discharge telephone follow-up plays a valuable role in many situations, including post-discharge emergency department visits and hospital admissions.² Many discharge transitions are inadequately orchestrated, as unanticipated medical problems occur on nights or weekends and involve clinicians who may not have an ongoing relationship with the patient. The phone call becomes an opportunity for the patient to engage their chronic care team and inform them of current issues in what may be an evolving situation. Although primary care-based calls achieve some clinical goals, it has not been proven that this model is superior to calls from other comprehensive practices such as dialysis, transplant, or cancer centers. With the new CMS reimbursement for transitional care services, such calls should become an important self-sustaining component of the patient-centered medical home or neighborhood.

Despite the growing use of primary care-based telephone follow-up in the post-discharge period, there are few high-quality studies demonstrating its full potential benefit.^{2,3} Recurrent hospitalizations are responsible for significant health care expenses, and a substantial proportion of readmissions are preventable through effective discharge planning and patient follow-up. Patients at high risk for readmission can be identified using data available at the time of hospital discharge, and all patients may benefit from a call. High-risk patients who receive a discharge call seem most likely to benefit from lower rates of readmission and reduced costs.⁴

Conflict of Interest: The author declares that he has no conflict of interest.

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