TRANSCRIPT OF MEDIA- From hospital to home: A 24/7 lifeline for patients after discharge

Rose Smith, RN, manager of Digital Care, OSF OnCall

Smith says individuals enrolled in the OSF OnCall Post Hospital Discharge program receive daily check-in messages and education.

"It's just asking, 'Do you have your appointments? Do you have transportation? Do you have your meds? How is your condition?' And then from there our team of nurses and medical assistants will read those responses; reach out to the patient if needed and then also if they have a change in condition, we have advanced practice providers who can do a video visit to see if we can keep these patients home instead of going back to the hospital." (:24)

For people who have received a new diagnosis, Smith says the Post Hospital Discharge program can offer easy access to answers.

"This just really gives them the opportunity to send us those questions. If they want to talk to a provider, maybe they're unsure if their medications changed, this gives them an opportunity to have 24 hour access to a nurse, to a provider if maybe something comes up – that we can keep them from needing to go back to the hospital." (:19)

Smith says having an instant connection before a follow-up appointment can be important.

"Do they need extra support? Are they trying to contact someone? Do they not know who to contact? Maybe they have new specialists. Maybe they're waiting for the referral to go through. So really looking at how we can give them support in between those appointments." (:15)

Smith says one of the biggest needs is transportation and OSF OnCall digital health navigators are helping connect people with what they need.

"We have our digital health navigator team who anytime a patient says they're needing help at home – they might need help getting equipment, picking it up, picking up prescriptions, getting transportation – then we're able to escalate that to those team members and they're able to help find resources." (:16)