Strategy Implementation for a Large Health System's Pilot Program to Reduce Hospital Readmissions

As part of a large California-based health system's strategic initiative to coordinate care across the continuum and reduce hospital readmissions, they launched a pilot program to provide patients with post-discharge telephonic support.

In fiscal year 2016, many U.S. hospitals will face CMS' 30-day readmissions penalty. While the focus on reducing hospital readmissions is not new, the pressure on cost containment and quality improvement is reaching new heights.

The Readmission Reduction Program, created under the Affordable Care Act in 2012, initially targeted readmissions for patients with acute myocardial infarction, heart failure and pneumonia. As of the 2016 final rule, CMS expanded the target conditions to include chronic obstructive pulmonary disease, total hip arthroplasty, total knee arthroplasty, coronary artery bypass graft and additional pneumonia diagnoses.

As part of a large California-based health system's strategic initiative to coordinate care across the continuum and reduce hospital readmissions, they launched a six-month pilot program to provide patients with post-discharge telephonic support. The Transitions of Care pilot targeted high-risk patients over age 65 discharged to home without home care from two affiliate hospitals. In lieu of embedded hospital Case Managers providing transitions of care, the pilot involved post-discharge care hand-off to a centralized patient services call center. Modeled after best practices of the Coleman Care Transitions Intervention, the pilot involved registered nurses and pharmacists

providing patients with up to 30-days of post-discharge telephonic support. The outreach pattern included an initial call 24-48 hours post-discharge, a follow-up call within 4-7 days, a third call at 14 days and the final call at 30 days. Key areas of focus with the patient include medication reconciliation, patient education and checking for urgent/emergent symptoms.

Goal

Shortly prior to pilot go-live, the health system engaged Freed to support strategy implementation and ensure call center compliance with care standards developed for the pilot. Working closely with the call center and hospital teams, Freed supported the following pilot goals:

- Operationalize and Optimize Transitions of Care Hand-Offs: operationalize post-discharge care standards and optimize a transitions of care hand-off between hospitals and centralized call center
- Reduce Readmissions: for high-risk patients over age 65, discharged home without home care
- Pilot Evaluation: evaluate operational efficiency and effectiveness of centralizing post-discharge telephonic support through a call center. Evaluation was critical to assess and strategize spread of the program to other hospital affiliates within the system.

Strategy and Tactics

The pilot involved multiple stakeholders and various teams including patients, community physicians, patient services call center, pharmacy, case management, hospitalists, nursing as well as coordinating with other care transitions programs working with the hospitals. With the call center leading the implementation, Freed worked in close collaboration to help establish the strategy for communications with key stakeholders involved with pilot. Communications was a crucial thread to success throughout the pilot and varied by pilot phase, stakeholder type, and communication purpose including:

Go-Live

- Hospital memos reminding teams and leadership of pilot go-live and points of contact for issues and escalations.
- Onsite visits at the hospitals by the call center leadership to meet with key teams, ensure functional workflow operations and address any questions about the program.

Prior to Go-Live

- Community provider memos to notify community physicians about the pilot program and enlist their

collaboration to help improve quality of the patient care experience and reduce avoidable hospital readmissions. Patients attending post-discharge follow-up visits with their primary physician(s) are instrumental in avoiding readmissions.

Post Go-Live

- Ongoing operational and leadership check-in calls with call center, hospital teams and other care transition programs involved to discuss progress, address obstacles and barriers and identify risks and mitigation. Frequent team huddles allowed for proactive issues resolution and supported timely and effective decision-making. These check-ins facilitated improved case management and clinician communication, strengthened the discharge process and served as a critical feedback loop to share successes and areas of improvement.
- Performance review meetings a month after go-live to assess quality of patient calls and to ensure nurse compliance with care management standards developed for the pilot.
- Executive Status Report summarizing key accomplishments and challenges for hospital leadership as well as sharing data on volume of patients impacted and preliminary readmissions outcomes.
- Transitions of Care Overview Flyer providing high-level overview of the pilot and summarizing roles of key stakeholders involved. This served as an educational piece for hospital leadership and teams further removed from the program to understand the purpose and players involved.
- Patient Scripting within the After Visit Summary notifying patients about the program, what to expect and contact information in the interim. This helped drive patient awareness about transitions of care support post-discharge.

Pilot Evaluation

- Stakeholder feedback on critical success factors and lessons learned were collected as part of the overall pilot evaluation process. This feedback is valuable when considering scope expansion and future implementation of the program to other hospital locations.
- Patient experience survey to collect patient feedback on their overall experience with the transitions of care support provided by the call center. While the survey was not implemented during the pilot, collecting patient feedback is critical to consider opportunities for program improvement and to ensure a positive patient experience
- Evaluation report to assess pilot efficiency, effectiveness and feasibility for spread to other hospital affiliates.

Results

After 5 months of go-live, a total of 349 high-risk patients over age 65 discharged home without home care from the

two hospitals enrolled in the Transitions of Care pilot. This represents 23% of all high-risk patients over age 65 discharged from the hospitals during that time period. The majority of high-risk patients over age 65 were discharged from the hospital to a Skilled Nursing Facility or Home Health Program, thereby excluding them from the Transitions of Care pilot.

Prior to pilot go-live, readmissions rates for all high-risk patients over age 65 was 24% for hospital A and 29% for hospital B. Readmissions rates five months after pilot go-live reduced to 14% at hospital A and 21% at hospital B. The pilot is in the process of completing the evaluation to include pre- and post- readmission rates for the specific target population: high-risk patients over age 65 discharged without home care.

Through the course of the pilot, the patient services call center developed a per patient pricing model for spreading the program to other hospital locations. The pricing can also be leveraged for expanding the scope of transitions of care services to other patient populations.

Conclusion

The transition period from hospital to home is particularly vulnerable for patients, especially the elderly, who are at high-risk for readmissions. By providing patients with centralized post-discharge telephonic support and through close communication and collaboration between teams involved in the patient's continuum of care, improvements can be made to enhance the overall patient experience and reduce the risk of hospital readmissions. While this pilot targeted a specific patient population of those over age 65 discharged without home care, services can be expanded to support transitions of care for all other patients discharged from the hospital, regardless of discharge disposition.