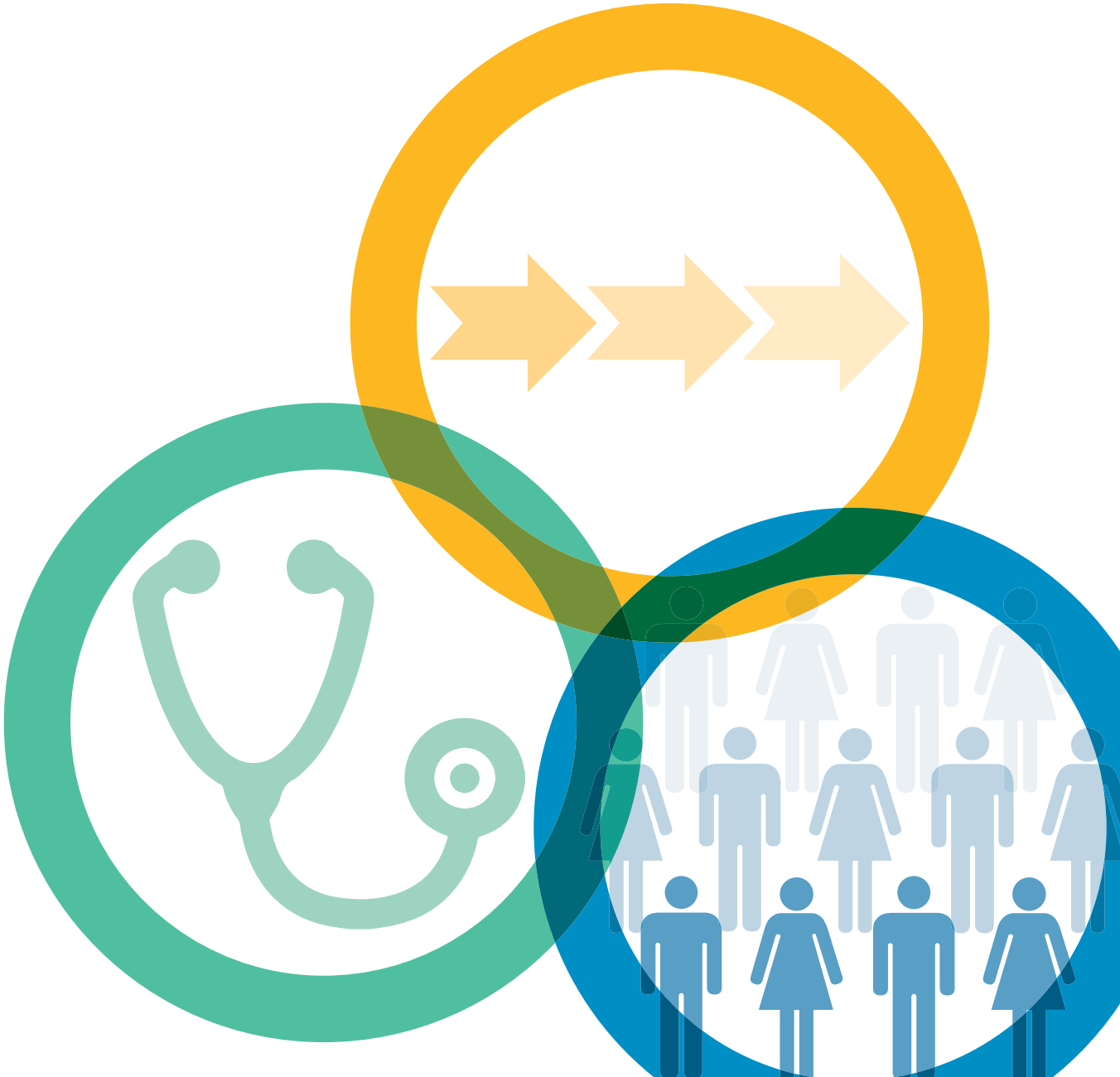
Driving Quality Care Transitions

How Four Leading Healthcare Organizations Improved Operations and Outcomes



INTRODUCTION

Care transitions involve the movement of patients between locations, providers or different levels of care, and a smooth, well-coordinated transition is crucial to patient and provider outcomes. Unfortunately, this transition does not always go smoothly. The 2001 Institute of Medicine (IOM) report titled, "Crossing the Quality Chasm", described the US system as exhibiting "layers of processes and handoffs that patients and families find bewildering and clinicians view as wasteful."[1] This is the root problem with transitions of care. Processes need to be scalable for clinicians, but better coordinated and of higher quality for patients so that they have the tools and support necessary to take active roles in their health post-discharge.

For example, despite information being key to a patient's ability to properly manage their care, the Journal of the American Medical Association published a report that noted discharge summaries at the first post-discharge visit were only available 12-34% of the time[2]. And, subsequently, such poorly managed transitions result in errors. One study estimated that 80% of serious medical errors involve miscommunication.[3]

Effective care transitions require proper medication management, timely patient follow-up as well as proper health coaching and self-management. Yet, when attempting to do all of this effectively and at scale for entire populations, most healthcare organizations are left unsure of where to start or uncertain of the resources required. However, the most underutilized resource in achieving these objectives is the patient. Research shows that patients who lack knowledge, skills and confidence to manage their own care after discharge are twice as likely to be readmitted.[4] But, when patients are motivated and empowered to manage their health, large improvements in their health outcomes are observed.

When patients are engaged, there is clear communication about expectations and actions necessary to stay healthy and out of the hospital. Patients are more likely to be adherent with medication, they feel comforted by follow-up calls knowing someone is concerned for their well-being, they are more likely to ask for assistance from care transition staff if necessary and they're more likely to attend follow-up appointments that are vital to their continued recovery.

Therefore, engaged patients are essential to quality care transitions and, while there is no one-size-fits-all approach, there are lessons to be learned from leading healthcare organizations who have improved care coordination and patient engagement by utilizing the expertise of both clinical staff and technology. Whether a healthcare payer or provider, effective transitions of care require timely follow-up that empower patients to self-manage and the use cases highlighted in this Ebook serve as a resource to discover an approach that may help you meet your clinical and business objectives.

Improving the Transition Process: Healthcare Providers

For healthcare providers, the largest incentive to improve the transition process comes from the Affordable Care Act (ACA), and avoiding the penalty placed on hospitals for high rates of 30-day readmissions. The Hospital Readmission Reduction Program (HRRP), a provision of the ACA, requires Medicare to reduce payments in cases where hospitals have high readmission rates for enrollees, and a brief from researchers at the Henry J. Kaiser Family Foundation found the share of hospitals receiving such penalties for 30-day readmissions are higher in 2015 compared to prior years[5]. Therefore, it's crucial for hospitals to attempt to reduce their avoidable Medicare readmissions.

Improving the Transition Process: Healthcare Payers

Similarly, for healthcare payers, readmissions and medical complications due to poor transitions of care are of significant concern, as they represent additional (and largely preventable) costs. Poor transitions result in miscommunication about medications and increased rates of non-adherence, which represent $300 billion in avoidable medical spending, a cost which payers struggle to manage.[6] Additionally, poor adherence practices can result in readmissions that can reduce CMS' Five-Star Quality Ratings for Medicare Advantage plans.

Therefore, it is crucial for healthcare payers to be able to effectively engage their members post-discharge to manage their recovery and health.

The following use cases highlight how four organizations are engaging patients post-discharge to attain measureable improvements in operations and outcomes. References in these use cases to any specific product, process or service by trade name, trademark, service or manufacturer does not constitute or imply endorsement.

USE CASES

Click to view

	USE CASE #1	USE CASE #2	USE CASE #3	USE CASE #4
ORGANIZATION	UAB Medicine	Houston Methodist Hospital	Memorial Hospital at Gulfport	Triad HealthCare Network
CHALLENGES	• Managing High-Risk Patients • Reducing Readmissions • Improve Care Coordination	• Managing High-Risk Patients • Reducing Readmissions • Improve Care Coordination	• Increasing Scalability • Improving Care Coordination • Managing High-Risk Patients	• Meeting ACO Requirements • Reducing Readmissions • Managing High-Risk Patients
RESULTS	"Our program allows us to continue care with patients post-discharge in a meaningful and interactive way."	"Patient reports help us intervene early and avoid readmissions."	"Our approach has helped us plan for the unexpected with patients."	"Our data driven approach has allowed us to identify and assist our high risk COPD patient population through increased quality of life and reduced hospital stays."

UAB Medicine

Organization: UAB Hospital
Health System: UAB Health System
Bed Count: 1,157
Location: Birmingham, Alabama

UAB MEDICINE

University of Alabama at Birmingham (UAB) Health System is one of the largest academic medical centers in the nation, with more than 16,000 employees, 1,100 faculty, 99,000 discharges and 1.2 million outpatient visits annually. The centerpiece of the UAB Health System is UAB Hospital, a 1,157-bed facility that provides patients with a complete range of primary and specialty care services, as well as the most up-to-date treatments and innovations in healthcare.

THE CHALLENGE

Improve Patient Outcomes and Reduce Readmissions

Four years ago, a forward-thinking researcher at UAB suggested it could use automated telephone outreach to conduct effective follow-up calls with COPD and heart failure patients to reduce readmissions. A grant was provided to build the necessary technology, and initial outreach proved to be helpful. However, with no additional funding, UAB Medicine required another method of outreach. During its investigation of viable technologies, they determined it would utilize Emmi Solutions automated phone calls and supplemental multimedia programs to educate patients about their conditions, monitor patient status and identify patients at-risk. Initial use of the technology was successful, and it would later be applied to even more condition areas, beginning with high-risk patients and then moving more broadly to its entire general discharge population.

THE METHOD

A Coordinated Approach

The process begins with case managers educating patients about the automated calls and multimedia programs prior to discharge, and bed-side nurses reinforce the importance of participation with each resource. Then, care transition coaches enroll the patients to receive the appropriate calls and programs, while also distributing their patient discharge plans. Calls and programs are then sent to reinforce instructions and assess patient status.

Interactions are reported back to the UAB team, with patients flagged if at potential risk for readmission or complication. The care transition coaches manually follow-up one-on-one with these potentially at-risk patients to offer additional assistance.

Heart failure patients report weighing themselves more consistently post-discharge.

Organization: UAB Hospital

Health System: UAB Health System

Bed Count: 1,157

Location: Birmingham, Alabama

UAB MEDICINE

THE RESULTS

Improved Patient Satisfaction and Altered Behaviors

Patient feedback with this transition approach has been overwhelmingly positive at UAB, especially in terms of driving patient self-management. For example, the hospital frequently struggled to drive heart failure patients to weigh themselves daily. If a patient's weight increases too quickly, it is a potential sign of complication. With their coordinated approach, it is taking less time to convince patients to start weighing themselves daily.

And, patients who engage consistently are more likely to weigh daily.

"Our approach has helped our patients avoid real problems, and it has helped us coordinate more effective care."

-Joann Clough, Transitional Care Coordinator

of patients said they received new or helpful information

of patients said they had an improved opinion of their provider

of patients said they were better prepared to manage their health

Houston Methodist Hospital

Organization: Houston Methodist Hospital
Health System: Houston Methodist
Bed Count: 828
Location: Houston, Texas

Houston Methodist is comprised of a leading academic medical center in the Texas Medical Center® and six community hospitals serving the Greater Houston area. Houston Methodist Hospital, the system's flagship, is consistently listed among *U.S. News & World Report's* best hospitals.

THE CHALLENGE — Reducing Waste and Complications

Houston Methodist Hospital, like so many organizations, was experiencing inefficiencies in regards to transition of care. Because patients admitted with surgical or medical conditions with a secondary diagnosis of major mental health or substance-abuse disorders are 83% more likely to be readmitted, the hospital felt it could pinpoint several underlying causes of its inefficiencies by starting with that patient group.[8] By doing so, it discovered 14% of patient reporting included discrepancies regarding medications and, subsequently, they were experiencing high rates of readmission.

The hospital desired to empower these patients. They sought tools to reduce readmissions by 20% by 2016, to discharge 60% of high-risk patients with customized care plans, to screen 60% of patients for mental health and substance abuse issues, and educate 50% of staff on this initiative.

THE METHOD — Multi-Faceted Approach to Supporting Care Transitions

In order to improve readmissions and care metrics, the hospital has instituted several new initiatives, including the Coleman Care Transitions Program®, a risk stratification tool from RightCare Solutions, and automated interactive telephone calls and multimedia programs from Emmi Solutions. These initiatives are supported by a variety of staff including, nurse educators, home health aides, pharmacists and care navigators.

The risk stratification tool identifies patients with primary or secondary behavioral health diagnoses, and the automated calls contact those patients to ask self-reporting questions about symptoms, comorbidities and cognitive status. Additionally, the patients watch the supplemental multimedia programs to learn about their condition and how to manage their health. Patient interactions are tracked, documented and sent back to the provider so that staff can intercept any patients at-risk of readmission or complication. If in need of additional assistance, staff helps direct patients to care appointments, driving them to non-emergency acute care clinics where and when appropriate.

Organization: Houston Methodist Hospital
Health System: Houston Methodist
Bed Count: 824
Location: Houston, Texas

THE RESULTS

Improved Patient Opinion and Satisfaction

While deploying this program, Houston Methodist Hospital has seen real improvements in operations and outcomes. For example, a 56-year-old female patient with bipolar disorder and schizoaffective disorder diagnoses was admitted to the psychiatric unit in June 2014. The patient also suffered from hypertension, back pain, breast cancer and had recently been diagnosed with Parkinson's disease. The hospital was able to provide and direct her to multiple levels of care, including psychiatrist referrals, assistance with wheelchair ramp installations, disease support groups, and detailed monitoring of her condition.

"Through this program, we've not only identified patients in need of assistance, but we've been able to reach them with real, valuable resources key to their recovery."

- Heather Chung,
Director, Behavioral Health Transition Program

And, in accordance with the programs goals, interim results revealed 770 of the expected 2710 patients have been stratified as high risk since June 2014. The educators and other program members have educated 73.1% of the clinical staff on the program and, of the 770 patients at high risk for ED visits or hospital readmissions, 382 patients (49.6%) were discharged with a customized care plan and 478 (62.1%) were screened for mental health and/or substance abuse disorders[8].

Overall, patients at Houston Methodist Hospital have reported improvements in satisfaction and confidence to manage their condition. As a patient survey reported[9]:

60% of patients said they received new or helpful information

89% of patients said they had an improved opinion of their provider

78% of patients said they were better prepared to manage their health

Memorial Hospital at Gulfport

Organization: Memorial Hospital at Gulfport
Health System: Memorial
Bed Count: 445
Location: Gulfport, Mississippi

Memorial

Memorial is a not-for profit medical complex in Gulfport, Mississippi, jointly owned by the City of Gulfport and Harrison County. Memorial is one of the most comprehensive healthcare systems in the state, licensed for 445-beds, including an inpatient rehabilitation unit, a behavioral health facility, satellite outpatient diagnostic and rehabilitation centers and more than 80 Memorial Physician Clinics.

THE CHALLENGE

Scalably Reduce Readmissions and Increase Satisfaction

The hospital management at Memorial Hospital at Gulfport desired to decrease readmissions while also improving Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores and Press Ganey scores. They needed to reach these goals without overextension of manual resources.

THE METHOD

Thoughtful and Personalized Follow Up

The team at Memorial Hospital at Gulfport put in place the Emmi Solutions platform to assist all patient discharges. It also brought nurses and home health staff deeper into transitions of care and provided them with Emmi-derived data to help patients on a more personal level.

As patients become discharged, the hospital prepares a batch file with patient names. The Emmi system then conducts automated outreach to each identified patient to monitor health status and notify staff if additional intervention is needed. Additionally, the hospital worked closely with Emmi Solutions to create customized questions ideal for their patient population.

80% of patients had an improved opinion of their provider.

Organization: Memorial Hospital at Gulfport
Health System: Memorial
Bed Count: 445
Location: Gulfport, MS

THE RESULTS

Improved Care Coordination

After implementation, the hospital saw immediate results from the initiative and the work of its nursing staff. Patients reported they appreciated the follow up calls and having their questions answered personally. Staff saw a correlation between their readmissions and the names of patients reported to be at-risk by the Emmi platform.

The platform also helped detect operational errors within a brand new EHR at Memorial Hospital at Gulfport. For example, when reports came back with several markers for non-adherence with medication instructions, the staff discovered a training issue with a few practitioners related to electronic prescription submissions and retrained as previously indicated.

Additionally, HCAHPS scores and overall patient satisfaction improved. As a survey, conducted by the follow up calls, revealed[10]:

49% of patients said they received new or helpful information

80% of patients said they had an improved opinion of their provider

74% of patients said they were better prepared to manage their health

"We thought this level of detailed outreach would be exhaustive to conduct but, because it's an automated process, we have real insight to our patients and their recovery without adding more to our busy schedules."

- Cindy Hise, Case Manager

Triad HealthCare Network

Health System: Cone Health

Accountable Care Organization: Triad HealthCare Network

Patient Population: High-Risk COPD Patients

Location: Greensboro, North Carolina

The Triad HealthCare Network is an Accountable Care Organization that offers value-added services to its physician members to enable their practices to demonstrate value and link reimbursement for better performance. Its services include the deployment of technology to capture and analyze data, reporting assistance, and quality measures submissions.

THE CHALLENGE

Improving Support for High-Risk Populations

Triad HealthCare Network launched an initiative in 2012 with engaged pulmonologists that would examine the efficiency of care transitions for high-risk COPD patients admitted through the emergency department. It targeted COPD patients that would come to the ER department. Many of these patients have multiple comorbidities, which prevents one-size fits all or efficiently scalable way to follow up with each patient post-discharge. Therefore, Triad HealthCare Network decided to employ interactive, automated phone calls through Emmi Solutions, as well as multimedia programs, to improve patient self-management, reduce costs and decrease readmissions for their COPD population.

THE METHOD

Frequent Follow-Up and Proactive

Phone calls and multimedia programs offer COPD patients guidance specifically tailored to their condition. Patients are enrolled to receive both technologies at discharge, most importantly receiving six follow-up automated calls within two weeks. All interactions with each technology are documented and tracked, with patient care reports sent directly to Triad HealthCare Network. The reports alert THN to patients with either yellow or red-flags, indicating they could be at-risk for readmission. These patients are then contacted by a THN Care Management nursing staff member to proactively aid with issue resolution. Patients that need further assistance may be instructed to see their primary care provider (PCP), seen same day by a dedicated care management nurse at home, or given the opportunity to review medication questions with an on-staff pharmacist.

74% of patients reported they were better prepared to self-manage their COPD.

Health System: Cone Health

Accountable Care Organization: Triad HealthCare Network

Patient Population: High-Risk COPD Patients

Location: Greensboro, North Carolina

THE RESULTS

Reduced Readmissions for High-Risk COPD Patients

The technology provided by Emmi Solutions has allowed Triad HealthCare Network to reach its COPD patients at scale, to intervene in their care when necessary and avoid costs associated with high-rates of readmission.

Additionally, the calls have produced significant gains for the system in terms of satisfaction and self-management, as one survey revealed[11]:

of patients said they received new or helpful information

of patients said they had an improved opinion of their provider

of patients said they were better prepared to manage their health

"We have a window into the world of our high-risk COPD patients after discharge, which gives us a chance to intervene before a potential readmission occurs."

- Elvin Perkins, Chronic Disease Project Manager

Getting Started

Each use case showcases similar problems and the significant role that clinical staff and technology can play in solving those issues. Each organization benefitted from improvements in its patient communications, specifically through proactive and frequent contact post-discharge that addressed personal patient needs.

The key for obtaining these desired improvements is access to timely information. When each organization was given vital daily feedback, high-risk patients were identified and assisted as soon as possible. And patients that had manageable concerns, such as the UAB Medicine patient that was taking the wrong dosage, were flagged and helped without coming back to the healthcare facility.

However, the outreach performed in each use case to engage whole patient populations could not be feasibly replicated with staff alone. Healthcare organizations can benefit by working with a patient engagement partner that has unique expertise in supporting patients during the care transition process.

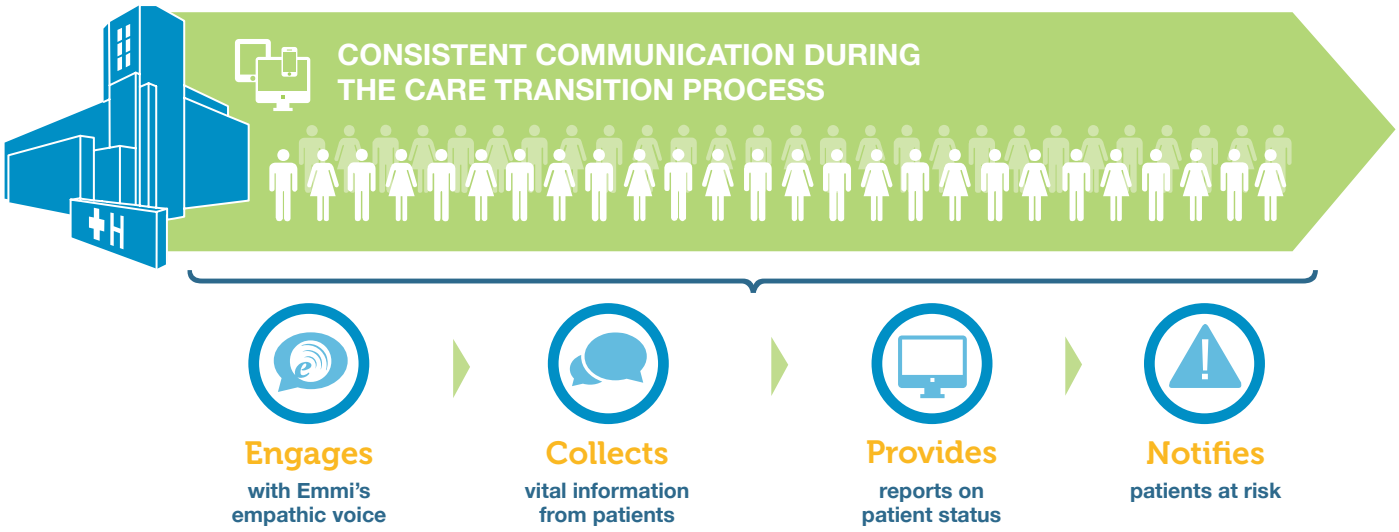
Engaging Patients with EmmiTransition

Patient engagement is crucial for proper transitional care—so it's not enough to just contact patients post-discharge or provide printed, post-discharge instructions. Providers need to identify patient status, encourage self-management and recognize those at-risk for readmission, without exhausting their resources. EmmiTransition® extends the efficacy of providers to empower patients during the care transition process.

What is EmmiTransition?

EmmiTransition is a combination of online multimedia programs and automated phone calls that interact with patients at key points post-discharge. The expertly-designed outreach improves patient competence to self-manage and asks self-reporting questions about status and adherence with instruction. Providers then receive reports that indicate who they've reached, how they're doing and whether they're at-risk for readmission or complication without requiring any additional resources from their staff.

And, because a patient's support system is key to recovery, EmmiTransition also contacts loved ones so they know how to help patients stay healthy and out of the hospital.



The Effectiveness of EmmiTransition[13]

Emmi sent 77,115 interactive, automated phone calls to **help providers reach 72% of identified patients**. Those patients also received supplemental multimedia programs. The calls and programs indicated they were supportive materials offered on behalf of the provider and they educated patients on self-management. The calls asked patients questions about recovery, and all interactions were tracked and reported back to the providers.

From those reports, it was identified that **82% of patients reached went on to engage** with EmmiTransition multiple times, sharing their status and receiving continued guidance for self-management.

Of the 82% of patients that interacted with EmmiTransition[14]:

said it gave them new or helpful information

said they're more comfortable calling their provider

said they were better prepared to manage their health

said it improved their opinion of their provider

AUTOMATED VS MANUEL OUTREACH

9,364 Patients Reached

77,115 Call Attempts

4 Min. Average Length per Call

8,559 staff hours

x $40 per hour for clinical staff

8,596 staff hours to replicate

$343,842 to replicate the outreach of EmmiTransition manually

Sources:

1. “Crossing the Quality Chasm: A New Health System for the 21st Century.” Institute of Medicine, 2001.

2. “Care Transitions.” BIM Foundation, American College of Physicians, Society of Hospital Medicine, The Physician Consortium for Performance Improvement®, 2009.

3. “Solet, Darrell J., MD, Norvell, Michael J., MD, Rutan, Gale H., MD, MPH, and Frankel, Richard M., PhD.” “Lost in Translation: Challenges and Opportunities in Physician-to-Physician Communication during Patient Handoffs,” *Academic Medicine*, 2005.

4. “Patients Engaged in Their Care Have Lower Readmission Rates.” Medscape Medical News. “Patient Activation and 30-Day Post-Discharge Hospital Utilization.” Boston University School of Medicine.

5. Boccuti, Cristina, Casillas, Giselle. “Aiming for Fewer Hospital U-turns: The Medicare Hospital Readmission Reduction Program.” The Henry J. Kaiser Family Foundation, 2015.

6. Stefanacci, Richard G., DO, MGH, MBA, AGSF, CMD, Guerin, Scott, PhD, “Why Medication Adherence Matters To Patients, Payers, Providers.” *Managed Care*, 2013.

7. Data captured from April 2015, with a sample size of 360 patients

8. Texas Medicaid & Healthcare Partnership. Potentially preventable readmissions in the Texas Medicaid population, state fiscal year 2012. Austin (TX): Health and Human Services Commission; 2013 Nov 25. 58 p.

9. Data captured from April 2015, with a sample size of 99 patients

10. Data captured from April 2015, with a sample size of 860 patients

11. Data captured from April 2015, with a sample size of 30 patients

12. Data captured from 27 hospitals from June 2013 through April 2015, with a sample size of 13,086 patients

13. Data captured from 27 hospitals from June 2013 through April 2015, with a sample size of 9,090 patients

.

emmi™ SOLUTIONS