

CASE STUDY

# Transitional Care Clinic and post-discharge calls boost patient-centered care effectiveness and cost savings.

OUR WORK WITH

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Via Christi Health

## Overview

With its long-standing commitment to providing safe, high-quality and effective care across the continuum, Kansas' largest provider of health care services, Via Christi Health, understands that a significant number of patients will always require post-discharge support. Because even with excellent care and intensive discharge preparation, factors such as the patient's current health condition, and circumstances such as unemployment, lack of insurance or the inability to access a primary care provider often trigger the need for additional support.

In addition, Via Christi's post-discharge call process was decentralized and relied on already busy units throughout the health system to conduct calls—requiring significant staff time away from the bedside and resulting in a non-standard process for resolving patient issues or sharing information that was gathered during calls.

Still, its priority of promoting smooth transitions from the hospital drove Via Christi to develop programs and services that would enable them to provide more personalized post-discharge care, increase access to health care and reduce readmissions. As part of its overall readmission strategy, Via Christi appointed a multi-disciplinary team, which identified several opportunities:

### 01 Address the needs of high-risk patients with chronic health conditions

To reduce the frequency of readmissions as the result of the severity of illness or the inability to manage their conditions outside the hospital, the team revamped the Heart Failure Program to offer home-based health and palliative care and created Community Cares to provide home-based APRN provider visits to patients with chronic obstructive pulmonary disorder (COPD).

### 02 Target a broader population of patients

The team established the Transitional Care Clinic to provide post-discharge health care to patients without access to primary care providers. Although the majority of the patients treated in the clinic do not impact readmission penalties, Via Christi felt that it was imperative to make these patients part of their care strategy to better address the needs of underserved patients in their community—with the right care in the right setting.


### 03 Implement a mechanism to catch patients who fall through the cracks

To ensure patients get the post-discharge support they need—consistently and efficiently—and that they are placed in the appropriate program for ongoing care, a centralized process and discharge call program needed to be implemented as well.



-  Based In Wichita, Kansas


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-  Member of Ascension Health

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-  12 fully and partially owned or managed hospitals

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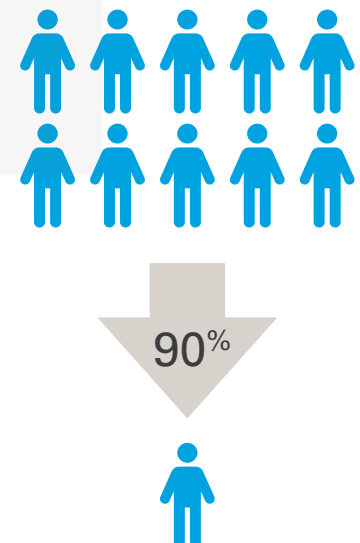
-  1530 licensed beds

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-  45,000 inpatient admissions, 171,000 emergency department and 745,000 outpatient visits annually

FIGURE 1

Via Christi's Transitional Care Clinic and Community Cares program helped more than 500 patients in 2015 recover from hospital stays and remain in their homes, reducing avoidable hospital readmissions by 90 percent



## Solution

To successfully achieve its goals, Via Christi combined the resources of its Transitional Care Clinic with a standardized, centralized discharge call process developed by NRC Health.

The facility-based Transitional Care Clinic is staffed with a team that includes a nurse, a medical assistant, an APRN and a social worker who provide care to patients without a primary care provider. The clinic is a key component of the patient discharge planning process. If a patient does not have a provider or cannot be seen by their provider or a specialist, the patient is scheduled for an appointment at the clinic. This reduces the likelihood of the patient seeking care in the emergency department or allowing their condition to worsen, thus increasing the risk of hospital readmission.

The team of health care providers then follows the patient through their care plan for up to 45 days. The team works to stabilize the patient's health condition and assists in identifying the psychosocial determinants of health, such as access to insurance (completing Medicaid applications); community resources for basic needs like utilities, transportation and housing; obtaining and managing medications; managing acute and chronic health problems; and health education. A major goal is to teach the patient to manage and be responsible for their own health conditions. An important aspect of this is working with patients and providers within the community to ensure that each patient has a primary care physician for future health care needs.

While the availability of health care services and support through the Transitional Care Clinic is critical, so is the ability to identify the patients that require these services post-discharge and those who are experiencing obstacles in accessing care. That's where Transitions was able to make a difference as part of the system-wide, centralized discharge call program. Via Christi implemented Transitions to contact all patients, resolve clinical and service issues and collect information to improve the delivery of care.

### TRANSITIONAL CLINIC LEADS TO A DRAMATIC DROP IN READMISSIONS OF THE MOST EXPENSIVE SETTINGS OF HEALTH CARE

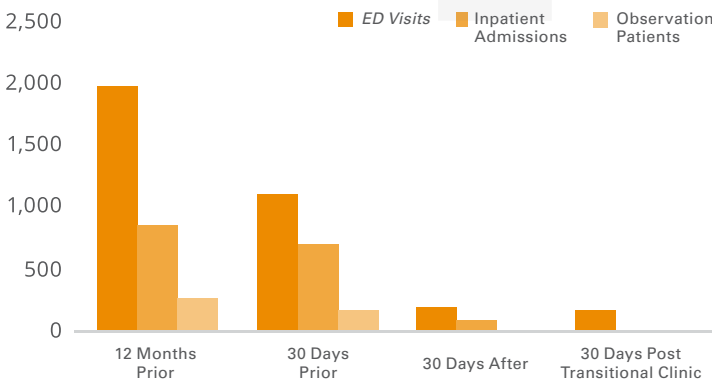


FIGURE 2

### Goals of Transitional Care Clinic for the patient

- **Stabilize** patient's condition
- **Educate** patient on how manage their condition
- **Provide** resources to empower patient to take control of their condition and health care needs



Financial counseling



Medication assistance



Access to medical equipment

- **Acquire** a primary care physician for patient



### Case In Point

#### VIA CHRISTI HEALTH

"The Transitional Clinic empowers patients to take control and manage their health care and condition. As a result, our patients get healthier, Via Christi's readmissions rates have declined, and we have been able to reduce unnecessary utilization of the most expensive settings of healthcare."

#### Robyn Chadwick, LSCSW

Senior Director, Operations  
Via Christi Health, Inc.

As patients are discharged, they are told they will receive a follow up call as part of their care plan and the importance of participating in that call. Within 72 hours of discharge, the patient receives a quick phone call and is asked five questions to determine if they need additional help from Via Christi due to health status or inability to comply with their care plan. Should a patient self-select that they do need additional support, Via Christi is immediately notified to contact that patient. The process ensures that 100% of patients are contacted consistently and that at-risk patients are identified and triaged back to Via Christi for follow up. On average, less than 17% of patients require follow-up.

## Integrating discharge calls into Transitional Care Clinic

The integration of the Transitions clinical and service recovery process into the Transitional Care Clinic is vital to the success of Via Christi’s program. A part-time position was created to address the follow-up with the small percentage of patients discharged, the Connect RN Care coordinator. The Connect RN’s critical care background ensures sharp clinical skills, excellent critical thinking and the ability to problem solve—which are ideal for resolving the variety of issues that may arise post-discharge. Being located in the Transitional Care Clinic ensures easy access to additional nursing and social work resources.

Transitions makes the initial outreach calls to patients daily between 11 a.m. and 1 p.m. The Connect RN has immediate access to the list of patients requiring follow-up. She can see why follow-up is needed, then prioritize her calls based on the patients most in need of additional support. As she communicates with patients, she is able to quickly answer questions, assist with prescriptions, coordinate follow-up care and provide service recovery, if needed.

Additionally, all information gathered from the initial Transitions calls and the Connect RN’s follow up is tracked in Via Christi’s Transitions database. Leadership and staff then have access to reporting tools that identify where things are working well in the hospital, as well as where gaps in the delivery of care exist.

The Via Christi process is smart. It utilizes the Transitions program to find patients that fall through the cracks and identify process errors at the provider, unit and hospital levels. As a result, Via Christi not only resolves current patient needs, but also uses patient issues and concerns to improve the delivery of care for future patients.

## Outcomes

Within the first nine months of the program, Transitions contacted nearly 19,000 patients and identified 3,200 patients needing additional follow-up from Via Christi. Without these calls and access to the Connect RN, it is likely that many of these patients would have experienced health issues resulting in longer recovery periods or complications leading to an emergency department visit or readmission. Via Christi can attribute the reduction in overall readmissions in part to Transitions because data supports that patients participating in the Transitions call have an average readmission rate of 5% while those that do not have a 9% readmission rate.

FIGURE 3

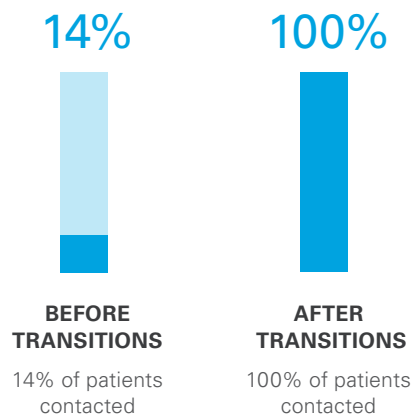
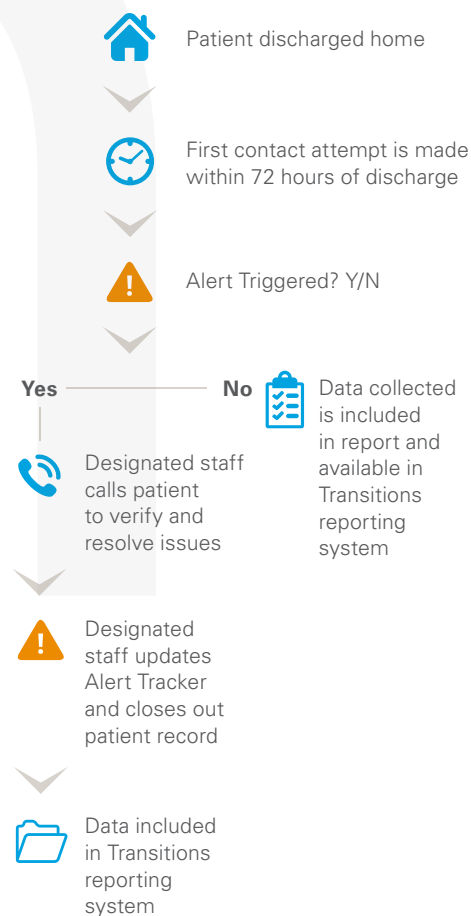


FIGURE 4

### NRC Health Transitions process and alert management



Having a centralized process in place is also helping Via Christi drive process improvement, so the care provided at the bedside continues to excel. By spending time with patients that have issues post-discharge, the Connect RN is able to provide more personalized post-discharge care and identify trends, pitfalls and gaps in the delivery of care. The Connect RN is able to analyze this information and make process improvement recommendations based on patient feedback regarding care delivery and discharge process.

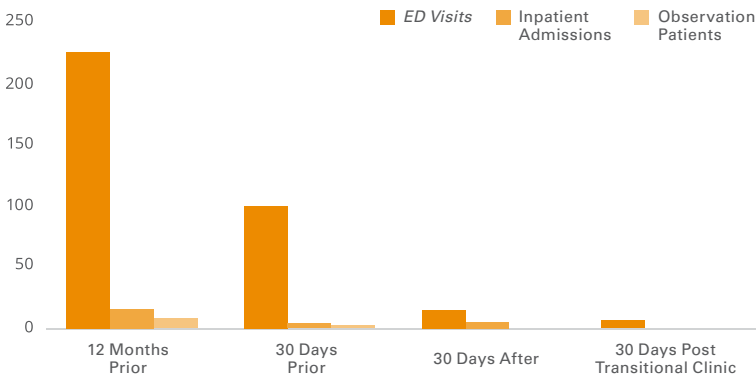
In conclusion, readmission rates are lower, HCAHPS scores are higher, and most importantly, patients have greater trust and confidence in their relationship with Via Christi.

The Transitional Care Clinic is also an important part of that story. Funded in full by Via Christi at a cost of \$300,000 a year for clinic staffing, the investment has already seen a significant return in both readmissions and financial outcomes. Comparing patient health care usage in the clinic this year to the previous year, Via Christi saw a 93% reduction in the utilization of the emergency department and inpatient care by these patients. At an average cost of \$1,932.00 per patient to utilize these health care settings, the reduction in readmissions resulted in an estimated \$1.6 million cost avoidance for Via Christi.

To further reduce unnecessary emergency department visits, Via Christi expanded Transitional Care Clinic resources in January 2016 to include patients discharged from the emergency room. These patients receive a follow-up medical call with access to an appointment at the clinic. The goals remain consistent with the inpatient population—to stabilize the patient’s condition, to empower them to manage their condition and to connect them with a primary care physician to serve non-emergency health care needs. In a matter of months, simply reaching out to these patients at discharge has resulted in a 98% reduction of emergency visits.

While these savings alone would be reason enough for the average health care system to continue operating the clinic, Via Christi proves it is definitely above average. When asked, staff and leadership said they are prouder of the hundreds of patients that now receive better quality care and live healthier lives.

**EXPANSION OF TRANSITIONAL CLINIC RESOURCES TO PATIENTS DISCHARGED FROM THE EMERGENCY DEPARTMENT RESULTS IN DRAMATIC DROP IN EMERGENCY DEPARTMENT VISITS**



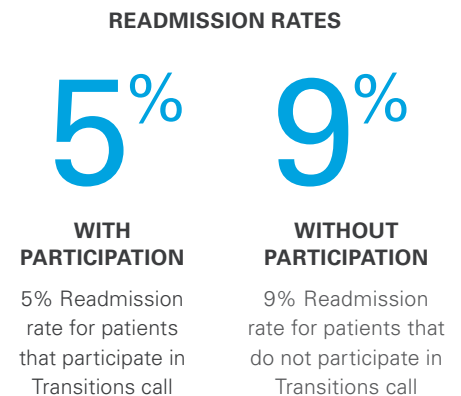
**FIGURE 5**

**Connect RN and access to Transitions database provide leadership with insight into how to improve the delivery of care from the patient’s perspective**



**FIGURE 6**

**Transitions has positive impact on Via Christi’s readmission rates**





Via Christi's commitment to discharge calls and improving the service recovery process demonstrates their commitment to human understanding. Via Christi's patients and families want to be given a voice and have the ability to share their opinions and be given clarity on their post-discharge instructions.

The needs and situations vary between each patient and their family, however something profound unites them all. They're each trusting you with their health. To care for them well, you need to know them well. This is Human Understanding.