CASE STUDY

Hallmarks of the success of Care Transitions

Discover how the University of Maryland Medical Center reduced readmissions and improved satisfaction scores with NRC Health's Care Transitions program.

Hallmarks of the success of Care Transitions

EXECUTIVE SUMMARY

Driven to improve the state of their care, leaders at the University of Maryland Medical Center (UMMC) wanted to reduce rates of readmission. It's a pursuit shared by many health systems, and evidence has shown that post-discharge follow-up with patients is an effective way to drive unnecessary readmissions down.

UMMC's leaders tried to implement a post-discharge call program, but the organization's size and volumes—two major hospital campuses with over 900 beds between them—made their internal efforts impractical. That's why they turned to NRC Health.

In three months of piloting NRC Health's Care Transitions solution in their Medicine service line, UMMS was able to reach 530 patients across 11 units, including Family Medicine, Cardiology, and Trauma, catch important opportunities for intervention, and ultimately reduce readmissions—all while improving HCAHPS satisfaction scores.

Opportunity

Post-discharge calls come with much to recommend them. Academic research has proven out their ability to improve compliance with discharge instructions, to bolster patient satisfaction, and—perhaps most importantly—to reduce unnecessary readmissions.

These benefits were not lost on leadership at University of Maryland Medical Center (UMMC), a large academic hospital system with two major campuses in downtown and midtown Baltimore. They knew that post-discharge calls could be an integral part of their quality-improvement initiatives, if they could just find a workable system with which to deploy them.

DISPARATE PROCESSES

There was no disagreement from anyone within the organization regarding the value of post-discharge calls. The trouble was that each of UMMC's service units took a different approach to them. No two units followed the same standards for educating patients about follow-up calls, for the format those calls would take, or for documenting their findings. As a result, UMMC

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didn't see the desired impact on outcomes, as the service units only managed to make contact with a small fraction of their patients, and there was limited exchange of information about what was learned.

COSTLY PROCEDURES

These individualized approaches were also very time-consuming. All of UMMC's outreach efforts were conducted by nursing staff, which meant either that nurses divided their time between clinical work and making phone calls, or that certain nurses would dedicate entire shifts to calling patients. Both approaches took invaluable nurse-hours away from patient care.

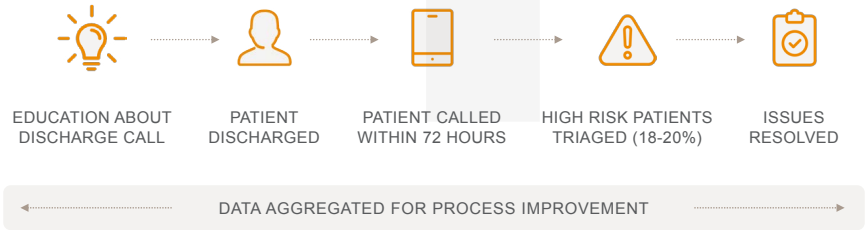
LIMITED VALUE

Finally, because UMMC lacked any formalized system for post-discharge call documentation, all post-discharge notes were recorded by hand, on paper. This was not just onerous for staff collecting the data. It also made the data much harder to interpret. Long-term trends, buried within binders of handwritten notes, often went unnoticed. And perhaps more seriously, UMMC's staff missed potential opportunities to intervene, when patients could have used input from their providers.

Approach

This is why UMMC turned to NRC Health's Care Transitions solution.

Transitions is an automated platform that uses Interactive Voice Recognition (IVR) technology to reach 100% of patients, within 24–72 hours of discharge. Its quick, convenient assessments invite high response rates from patients, and rapidly identify who may need extra clinical support or service recovery. Once Transitions finds a patient in need, NRC Health staff immediately notifies providers, enabling them to reach out and guide the patient through their health episode—thereby preventing unnecessary readmissions.



Transitions also elevates post-discharge documentation. It seamlessly captures feedback data from each call and reports important findings to a centralized reporting portal, which pushes reports to leadership so they can spot developing trends in near real-time and plan strategic initiatives. This makes it an asset for long-term planning, as well as for in-the-moment interventions.

"We were originally interested in Transitions because we were looking to reduce readmissions. What I like about it is that it helps us catch things early, so we can intervene before a health need becomes an emergency."

—**Karen E. Doyle**, MBA, MS, RN, NEA-BC, FAAN, Senior Vice President, Nursing and Operations, R Adams Cowley Shock Trauma Center, Care Management, University of Maryland Medical Center

UMMC EDUCATES PATIENTS ABOUT THE TRANSITIONS CALL PRIOR TO DISCHARGE

100%

of patients contacted in 24-72 hours of discharge

Outcomes

These features motivated UMMC's leadership to pilot Transitions on the organization's Medicine units, in their downtown campus, starting in February of 2018. It wasn't long before Transitions transformed their work.

FORMALIZED PROCESS

First, Transitions brought consistency to the Medicine units' calling process. Instead of each unit's process varying, depending on who conducted it, every Transitions call had an identical format. Since UMMC knew that every patient would receive a call, they were able to educate patients about the calls and their importance, and leave them knowing what to expect. Not only did this drive up response rates (patients were less likely to reject calls that they knew were coming), but it also put patients at ease, knowing that UMMC was putting in the effort to expand their care.

Even more importantly, Transitions served as a "first line" of contact with patients, so that nurses could reserve their personal outreach efforts for patients who really needed their support. UMMC was thereby able to reduce the number of staff dedicated to post-discharge calls, while simultaneously increasing the number of patients contacted.

LEGIBLE—AND ACTIONABLE—DATA

As the pilot went on, UMMC's leadership began to see just what a difference Transitions's seamless, digital documentation could make. Transitions obviated the need for paper reporting, ensuring that meaningful data came directly to relevant stakeholders. Reports came in digitally on a weekly basis, with robust, prescriptive outputs that pointed clear paths to process improvement. And critically, unlike many data products in healthcare, these reports required zero additional training for leaders to read and understand.

POTENTIALLY LIFE-SAVING INTERVENTIONS

Transitions improved UMMC's clinical care as well, by identifying emergent health problems shortly after they arose. In one dramatic case, an automated Transitions call managed to identify an ailing patient with asthma, who was struggling because they didn't understand how to properly use their inhaler. (Many clinical leaders will recognize this as a common care scenario.) Because UMMC's staff received a Transitions alert, a nurse was able to follow up with the patient on the phone, and instruct them in the inhaler's proper use. This almost certainly kept the patient from needing a second hospitalization—or worse.

MEASURABLE IMPACT: READMISSIONS AND HCAHPS

Individual episodes like that make an enormous difference in patient welfare. Taken in the aggregate, they make an enormous difference for institutions as well. As hoped, with the Transitions solution at work,

"Where Transitions is really valuable to me is in its data. We don't have to guess anymore at problems. We can identify them with quantifiable precision."

—**Karen E. Doyle**, MBA, MS, RN, NEA-BC, FAAN, Senior Vice President, Nursing and Operations, R Adams Cowley Shock Trauma Center, Care Management, University of Maryland Medical Center

FIGURE 1

MORE THAN HALF OF THE PATIENTS COMPLETED THE TRANSITIONS SURVEY

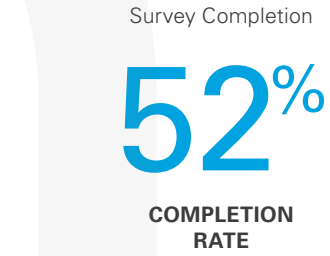
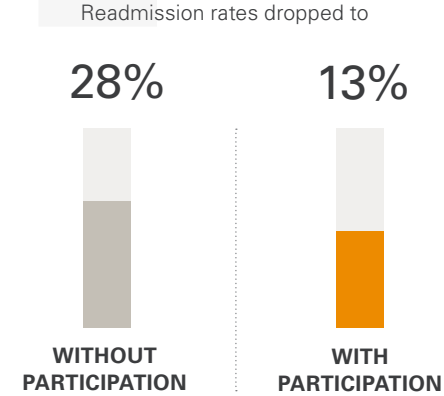


FIGURE 2

NRC HEALTH TRANSITIONS HELPED DECREASE UMMC'S READMISSION RATES



UMMC's 11 pilot units saw an increased number of patients contacted, and reduced rates of readmission among patients who successfully completed Transitions surveys:

- In just three months, Transitions reached out to 1020 patients. 530 of them—52%—completed the Transitions survey. This is far higher than the rate of patient contacts prior to Transitions. FIGURE 1

- When compared with patients who did not complete the survey, these patients were less than half as likely to be readmitted. Successfully surveyed patients had a readmission rate of 13%, while those who didn't complete the surveys had a readmission rate of 28%. FIGURE 2

- Finally, unit-wide, Transitions also had a measurable impact on patient-satisfaction scores. UMMC observed a noticeable improvement across various HCAHPS questions. This was especially true for the "Hospital staff took my preferences into account" question, which saw an 11% increase in just three months.

- Understandably, UMMC's scores for the HCAHPS Care Transitions Composite increased by 5.6%—a major feat for a short period of time. FIGURE 3

GOING FORWARD

The pilot's promising results motived UMMC to greatly expand the scope of Transitions. At their downtown campus, they went on to implement it in the entire Shock Trauma Center and Cardiac Surgery unit. In October of 2018, it went live at UMMC's midtown campus as well.

This vote of confidence came because UMMC's leadership recognized Transitions's potential to transform their care. Now the team is using Transitions to specifically examine issues with medication, garnering data to see whether it would be productive to divert additional resources to UMMC's pharmacists. By doing this, UMMC's leaders hope to address most potential medication issues before patients even leave the facility.

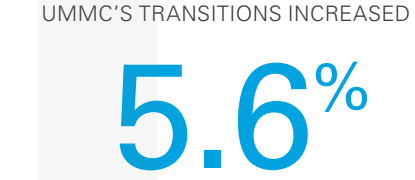
And that's only the start. UMMC's leaders believe that Transitions's alerts—and its invaluable reporting tools—will be instrumental to the organization's broader progress.

"This project was a success from the start because, all the stakeholders were in the right place at the right time to take this project in the direction that it should go. We met often to meet deadlines and to stay organized. Finally, the major benefits were the ability to get real time feedback to our patients as well as staff education when gaps were recognized."

—**Shawn Hendricks** MSN, RN Ed
Director of Medicine & Cardiac Services, University of Maryland Medical Center

FIGURE 3

UMMC'S SCORES FOR THE HCAHPS CARE TRANSITIONS COMPOSITE INCREASED



"I like to get a lot of eyes on Transitions reports, from the executive team down to the managers. It helps us gain visibility into our issues and come up with targeted, strategic solutions."

—**Karen E. Doyle**, MBA, MS, RN, NEA-BC, FAAN, Senior Vice President, Nursing and Operations, R Adams Cowley Shock Trauma Center, Care Management, University of Maryland Medical Center

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