CASE STUDY

Post-discharge calls:

Learn how four different organizations found the right way to do the right thing for their patients

OUR WORK WITH

University of Maryland Medical Center (UMMC), Sparrow Health, Via Christi, and Nebraska Medicine

Post-discharge calls:

Learn how four different organizations found the right way to do the right thing for their patients

Following up with patients post-discharge is, or should be, a standard in every hospital across the country. Post-discharge calls continue the connection between the organization and the patient, alleviate patient anxieties, and help providers rapidly address issues that, without a phone call, may result in a worsening of the patient's health, a readmission, or even an adverse event.

For most healthcare leaders, post-discharge calls seem like a no-brainer—a simple phone call can have such a positive impact on patients' perceptions of the organization, as well as its HCAHPS scores, quality outcomes, and readmission rates. However, what seems simple in theory is often nearly impossible for organizations to operationalize.

In the majority of hospitals, which are already operating on thin resources, pulling high-valued staff away from the bedside to call every patient who was discharged the day before is not a feasible option. As a result, high-risk patients remain invisible to the organization.

To find a balance between utilizing staff in the best way to provide the highest-quality patient care, and identifying all patients who may be in need of a quick call from the hospital for clinical or service recovery, organizations are leveraging NRC Health's Transitions platform to support their post-discharge-call efforts and ensure that 100% of patients receive a phone call.

NRC Health Transitions conducts initial phone calls to all recently discharged patients. In the calls, patients are asked a short series of questions proven to determine whether they require additional follow-up from the organization. Should the patient's answers placed them in a high-risk category, the organization receives an immediate notification to follow up. Because over 80% of patients are not in need of any clinical follow-up or service recovery, the Transitions program saves organizations significant time, energy, and resources.

Because over 80% of patients are not in need of any clinical follow-up or service recovery, the Transitions program saves organizations significant time, energy, and resources.

In addition to significantly reducing the number of follow-up calls that need to be made, the Transitions program can be easily managed and integrated using resources that organizations already have available. And while best practices do exist to help organizations optimize results, post-discharge calls through the Transitions program do not have to follow a one-size-fits-all model. The following examples show a few ways in which organizations have used Transitions to achieve their own particular desired results.

University of Maryland Medical Center (UMMC):

EQUIP FRONT-LINE STAFF AND MANAGERS ON THE UNIT WITH THE RESOURCES TO CONDUCT FOLLOW-UP WITH HIGH-RISK PATIENTS

UMMC's size and patient volumes—two major hospital campuses with over 900 beds between them—made the organization's first internal efforts at implementing a post-discharge-call program impractical. Not only were they unable to contact more than a small fraction of their patients, but their internal process lacked standardization, as each service unit took a different approach to how they conducted calls, the questions they asked patients, and how they documented the results.

Despite moving invaluable nursing resources away from the bedside—some nurses ended up devoting entire shifts to making calls—UMMC did not see the desired impact on readmissions, because they were unable to reach all of their patients and their sporadic approach left feedback scattered and difficult to interpret as a whole.

To add consistency and efficiency to their program, UMMC turned to Transitions. Now confident that every patient would be receiving a phone call, staff were able to educate patients about the calls and their importance ahead of time, which helped increase response rates and keep patients at ease.

With Transitions serving as a "first line of contact" with patients, UMMC can now easily manage following up with the small percentage of high-risk patients who need personal support, drawing on nursing staff on the units to conduct those additional calls. Transitions also provides the organization with an additional layer of reporting and documentation that helps UMMC leaders improve the delivery of care for future patients.

Before Transitions, UMMC lacked the resources to effectively conduct post-discharge calls. Not only was leadership not seeing the desired outcomes, but they also lacked visibility into the number of patients they did reach. With Transitions, they are now confident that 100% of discharged patients will receive a call, that nursing staff on the units will be able to follow up as needed, and that feedback collected from the calls can be used effectively for process improvement.

"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 Doyle, MBA, MSN, Senior Vice President of Nursing and Operations, University of Maryland Medical Center

Sparrow Health:

DEDICATE AND TRAIN ONE TEAM MEMBER TO FOLLOW UP WITH HIGH-RISK PATIENTS

In 2012, Sparrow Health's leadership set their sights on one of their most ambitious goals to date: giving follow-up phone calls to every one of its inpatients, emergency-department patients, and ambulatory-surgery patients. While this was an undeniably worthy goal, Sparrow Health boasts five hospitals with thousands of beds between them, so leaders knew that contacting every patient who passed through their doors was going to take massive institutional investment.

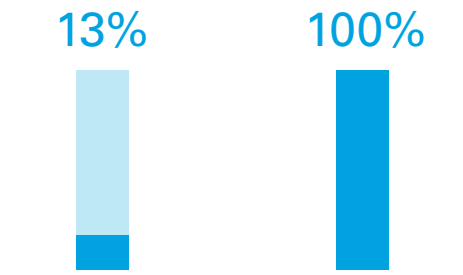
At first, Sparrow Health attempted to tackle the job with internal resources. They trained more than 700 nurses to make follow-up calls, and invested in expensive post-discharge-call software to track their progress.

Early excitement among the staff powered the initiative to early success, and they managed to contact 48% of patients in the first year of the program. However, juggling their nursing duties alongside their new role as follow-up callers, nurses soon found their enthusiasm fizzling out. Commitment to follow-up calls declined; and by 2014, contact rates had dropped to just 13%. Faced with a harried staff and undesired outcomes, Sparrow Health's leaders decided to partner with NRC Health and roll out the Transitions program.

With Transitions, Sparrow Health saw sharp improvements. Their contact rates immediately increased from 13% to 100%. While their internal program had required an enormous number of staff, by leveraging Transitions Sparrow Health was able to accomplish all of its necessary follow-up calls with just ONE in-house Patient Navigator.

Sparrow Health was not only able to resolve patient issues in a more effective and efficient manner, but the increased contact rate drew in troves of data that could be used to improve processes. Dedicating one team member to talk to patients—as opposed to 700 nurses—also made it easier to identify and address gaps in the delivery of care. As a result, Sparrow Health was able to put interventions in place that resulted in fewer high-risk patients over time.

Contact rates with internal process vs. Transitions



BEFORE TRANSITIONS

13% of patients contacted

AFTER TRANSITIONS

100% of patients contacted

Via Christi:

INTEGRATE POST-DISCHARGE CALLS INTO TRANSITIONAL CARE CLINIC EFFORTS

Leaders at Via Christi Health understand that a significant number of patients will always require post-discharge support. 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 underlie the need for additional support.

For years, 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-standardized process for resolving patient issues and sharing information. When Via Christi's leaders redefined and reprioritized their readmission strategy to include programs and services that provided more personalized post-discharge care, it was apparent that they needed a comprehensive process in place to ensure that 100% of patients were contacted post-discharge.

Via Christi already had a facility-based Transitional Care Clinic—staffed with a team that included a nurse, a medical assistant, an APRN, and a social worker—which was already responsible for ensuring safer care transitions. To achieve its goal of contacting 100% of patients post-discharge, it made sense for Via Christi to leverage these resources and the Transitions program together.

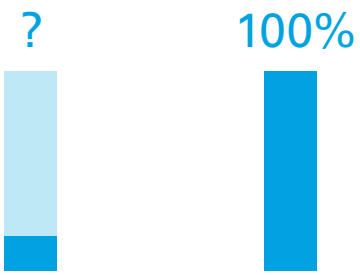
Since the Transitions program reduced the number of patients requiring follow-up to an average of 17%, Via Christi only needed to add one part-time position, its Connect RN Care Coordinator, to its Transitional Care Clinic team. Having a centralized person in place to conduct follow-up calls gave Via Christi's leadership confidence that high-risk patients' needs are being addressed, that the information collected from phone calls is being used for process improvement, and that additional nursing and social-work resources remain easily accessible.

This centralized process is also helping Via Christi drive process improvement, so the care provided at the bedside continues to excel. By only spending time with patients who have issues post-discharge, the organization's Connect RN is able to provide more personalized post-discharge care and easily identify trends, pitfalls, and gaps in the delivery of care.

The Transitional Care Clinic is an important part of the Via Christi 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 healthcare usage in the clinic this year to that of the previous year, Via Christi saw a 93% reduction in the utilization of emergency-department and inpatient care by these patients.

At an average cost of $1,932 per patient to utilize these healthcare settings, the reduction in readmissions—shown by organizational data to be attributable in part to the Transitions program—resulted in an estimated $1.6 million in savings for Via Christi.

Contact rates with internal process vs. Transitions



BEFORE TRANSITIONS

Prior to Connect Via Christi's discharge call process was random with limited visibility to how many patients were being contacted

AFTER TRANSITIONS

100% of patients contacted

$1.6 million

estimated savings for Via Christ after creating the Transitional Care clinic

Nebraska Medicine:

UTILIZE CURRENT CALL-CENTER RESOURCES TO FOLLOW UP WITH HIGH-RISK PATIENTS

Nebraska Medicine knows that continuity of care is an integral part of the commitment to high-quality care for which they are known. The organization invests in a variety of resources and services to ensure that patients continue to get the care they need even after they've left the hospital.

One such resource is the hospital's Medical Communications team. Staffed with eight RNs and a nurse coordinator, the call center provides inbound- and outbound-patient care services, including nurse triage and post-discharge follow-up calls.

As the largest provider of medical services in the state of Nebraska—caring for more than 120,000 patients in the hospital and emergency department annually—Nebraska Medicine faced a daunting task in committing to post-discharge calls. The sheer volume of calls overwhelmed the nurses staffed to follow up with patients, and they were simply unable to contact all of them.

When Transitions was introduced to Nebraska Medicine, it was clear it was an ideal way to supplement the organization's current workflow. Transitions' handling of initial calls took the burden of outbound post-discharge calls from 100% to an average of 26%—a much more manageable workload for the Medical Communications team. In fact, Nebraska Medicine was able to take post-discharge calls off the list of responsibilities for nurses working night and weekend shifts, and to reduce the number of daytime nurses tasked with post-discharge calls to just one or two.

By leveraging Transitions, Nebraska Medicine is now able not only to improve their workflow, but also to connect their high-valued nurses with only those patients who have specific questions or concerns, resulting in a more efficient use of their time. On average, a Medical Communications team member is able to address and resolve any issues identified by the Transitions program in five minutes or less per patient.

For Nebraska Medicine, it wasn't lack of leadership or resource commitment that hindered their post-discharge efforts, but sheer patient volumes. By integrating Transitions into their process, the organization's leaders were able to ensure follow-up with the right patients without increasing nursing resources or eliminating service lines.

By leveraging Transitions, Nebraska Medicine is now able not only to improve their workflow, but also to connect their high-valued nurses with only those patients who have specific questions or concerns, resulting in a more efficient use of their time.

For 37 years, NRC Health (NASDAQ: NRC) has been committed to achieving human understanding and bringing healthcare organizations closer to their customers than ever before by illuminating and improving the key moments that define an experience and build trust. Guided by their uniquely empathic heritage, proprietary methods, skilled associates, and holistic approach, NRC Health helps its customers design experiences that exceed expectations, inspire loyalty, and improve well-being among patients, residents, physicians, nurses, and staff.

NRC Health helps healthcare organizations better understand the people they care for and design experiences that inspire loyalty.

1 800 388 4264 | nrchealth.com
1245 Q Street | Lincoln, Nebraska | 68508

nrc HEALTH