

Partnership Strategies For Success In Readmission Prevention

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By now all home health agencies recognize the value of a strong readmission prevention program. Unfortunately, the realities of budget and staffing challenges make it difficult for all agencies to develop such a program utilizing only their own resources. However, when agencies partner with the right company the combination of strong clinical resources and effective patient outreach technology can be used to significantly reduce readmissions cost effectively.

Residential Home Health is one of the largest independent home health care providers in the Midwest. With an expansive presence throughout Metro Detroit and Chicago's western suburbs, its census is well over 2000 patients. Residential consistently ranks among the top home health providers in the country and is continually searching for innovative ways to improve patient care.



Background

In 2011, with healthcare changing dramatically due to the PPACA legislation, Residential was evaluating ways to address avoidable readmissions. With an array of patient-centered initiatives already in place, Residential looked to leverage technology to compliment these efforts. Unfortunately, the cost of expanding technology and the staff needed to support it presented a challenge.

That summer, Residential began collaborating with Critical Signal Technologies, Inc. (CST) a leading developer and provider of patient monitoring solutions also based in Michigan. In addition to the technology hardware, CST also provides the trained staff to monitor the patient, taking action on issues in close collaboration with their client's clinical leadership. Together the companies developed and introduced a program they called, 'Residential Nurse Alert'. Residential began offering its patients Residential Nurse Alert in late 2011. The initial pilot generated a quick impact on readmission and care transitions, and as a result the program began expanding early in 2012. By the end of 2012, Residential began implementing Residential Nurse Alert throughout their entire patient base. "Patients going home from a hospital need a great deal of support, and we wanted to eliminate the barrier of a phone call to provide the best clinical support available. Residential Nurse Alert represents an innovative way in helping our hospital, skilled nursing facility and physician partners further reduce unnecessary hospital readmissions," said David Curtis of Residential Home Health.

How It Works

There were several goals associated with Residential Nurse Alert. Among them were:

1. Support the clinical objectives in place at Residential Home Health.
2. Reduce avoidable readmissions and the associated cost to healthcare.
3. Create visibility to the factors influencing negative transitions or readmission rates.
4. Improve patient satisfaction.
5. Achieve these goals in a financially realistic manner.

In order to achieve these goals, several key elements needed to be employed. Finding an organization like CST was critical. CST's ability to provide the support staff and call center, (CST calls theirs a Care Center) with a marketing plan allowing for low to no upfront cost to the agency creates a strong advantage. Residential's program consists of strong clinical management combined with customized patient monitoring protocols and patient outreach during the home health episode. Throughout the episode it is also important to have thorough reporting presented in consolidated fashion tracking specific information from all patient interactions.

At the outset of the program, Residential Home Health's clinical management worked with CST program managers to develop protocols addressing the different scenarios that might result in a patient encounter. As the program has developed, these protocols have been adjusted to meet the needs of individual patients and the providers and facilities who refer their patients to Residential.

When a patient is admitted to the agency, they are provided with monitoring and communication equipment. The equipment functions and can be described in much the same way as a call button would work in a hospital. This makes it a recognizable device and promotes compliance to the program. Residential Nurse Alert care center representatives are available 24/7. Any patient encounter is addressed according to the predetermined protocols developed by Residential clinical management. Furthermore, any key patient information including call interactions can be sent in real time to Residential Home Health to review.

Throughout the episode, Care Center representatives, primarily of social work background, make three proactive patient outreach calls. The scripting for these calls is altered as needed to reflect current initiatives of the agency. They could be used to ensure the patient has made their Primary Care Physician follow-up appointment, or to conduct patient satisfaction surveys. In addition a team of Residential Home Health nurses, reviews these call scripts daily and determines if the patient may need a clinical intervention in the hopes of preventing a hospital readmission.

Activity Reporting is key to the success of Residential's program. CST provides Residential Home Health with daily activity reports and a monthly readmission management summary. Regular conference calls and webinars are scheduled to analyze data. This information can be consolidated to create specific presentations for acute care referral sources.

Residential and CST worked to establish resolution codes to track all Residential Nurse Alert patient interactions. These codes address both emergent and non-emergent patient needs. All call interactions within CST's Care Center produce definitive

outcomes for Residential to track. Each resolution code pertains to three main areas. These include value proposition, economic impact, and quality scoring. "As we have reviewed the resolution code data, it was abundantly clear that caregiver support and intervention has been a key component to preventing many unnecessary hospital admissions. Unlike dialing 911 direct, this program allows the caregivers to be notified when EMS is dispatched. The caregiver often determines alternatives to an ER visit such as monitoring the patient themselves or contacting the patient's physician," said Teresa Spencer, Director of Residential Nurse Alert Services.

Once risk of readmission is reduced to a manageable level, the patient is removed from the Residential Nurse Alert program. However in many cases, the patient or their family chooses to work directly with CST and remain on the program under a fee-based system.

Results

As you will see in the charts and graphs below, the results have been very significant. They represent a savings to the healthcare community and, according to the survey results, improve overall patient satisfaction as well.

Annual High-Level Snapshot:

Active Patients.....	357
Avoidable Readmissions.....	154
Distinct Count of Patients with incidents.....	104
ER and One Day Hospital Stay Expenses.....	\$1,848,000.00
EMS Transport Expenses.....	\$77,000.00
Service cost to patients.....	\$55,462.00

HealthCare Cost Savings Achieved....\$1,869,538.00

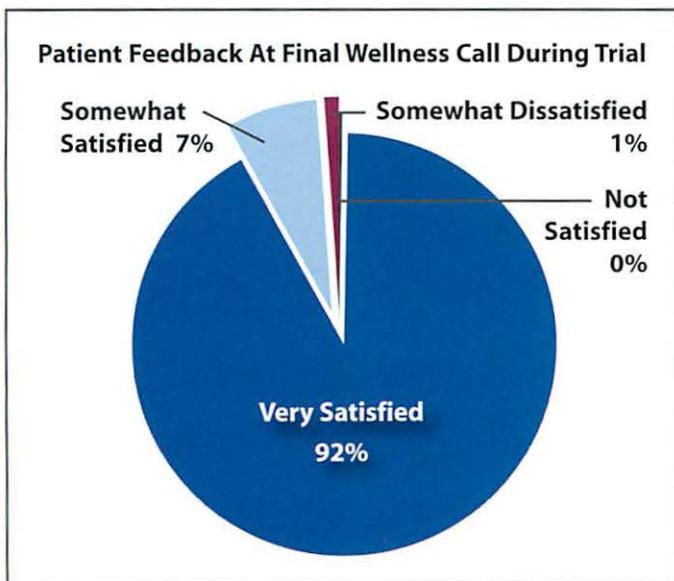
March 2013 High-Level Snapshot

Active Patients.....	684
Avoidable Readmissions.....	46
Distinct Count of Patients with incidents.....	27
ER and One Day Hospital Stay Expenses.....	\$552,000.00
EMS Transport Expenses.....	\$23,000.00
Service cost to patients.....	\$15,046.00

HealthCare Cost Savings Achieved.....\$ 559,952.00

Annualized Cost Savings Projected ...\$6,719,424.00

Patient Retention Rates Post Trial And Feedback Via Wellness Calls



Notes

- ER and One day in-hospital assumptions based on regional statistics which indicate average one day hospital stay for dual eligible patients is \$12,000 (range between \$10,000 and \$15,000)
- EMS Transport assumption based on regional statistics which estimate average EMS transport cost to be \$500.
- Retention rate is cumulative. As program has evolved conversion rate has increased.
- Patient feedback from Wellness calls began in summer 2012.

Lessons Learned

1. Optimal results were achieved when nurses began to reinforce the benefits of the program to the patient.
2. Residential Nurse Alert gained most of its new patients once it was fully integrated into the plan of care.
3. Residential Nurse Alert can be utilized to serve patients who are discharged from acute care partners with no home health benefit. This represents an opportunity for increased revenue or ongoing partnership opportunities with referral sources.
4. It was beneficial in some instances for Residential Home Health to evaluate paying for 'frequent flier' patients to retain the program beyond the 60 day initial period.
5. Expanding the number of patients on the program led to increased overall quality scores.

Due to the ongoing success from both a patient experience and outcomes standpoint, Residential Home Health is looking to grow Residential Nurse Alert beyond its census to reach 3000 patents by the end of 2013 according to Teresa Spencer, Director of Residential Nurse Alert Services.

At last year's National Association of Home Care meeting, Medline and CST announced the introduction of 'Smart Care'. Smart Care is a value added program available exclusively from Medline in partnership with CST. The goal is to help agencies of any size develop and implement a best in class readmission prevention program without the investment in technology or staffing resources. For more information on Smart Care please contact your local Medline representative or call Medline at 847-837-2758.



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