TEAMHealth
MEDICAL CALL CENTER

BUSINESS CASESTUDY

Reducing Readmissions and Improving Care Through Clinical Post-Discharge Calls

Client Profile

Client

- 102-bed hospital in Northern California
- TeamHealth Medical Call Center partner since 2013

Solutions

- RN calls each patient within 24-32 hours of discharge
- Patients are asked about medication compliance, follow-up appointments and discharge instructions

ROI

- $1 Million in savings from 14% decrease in 30-day readmits

THE CHALLENGE

In 2013, the Centers for Medicare and Medicaid Services (CMS) began assessing financial penalties to hospitals for the readmission of Congestive Heart Failure (CHF), Pneumonia, and Myocardial Infarction (MI) patients.

A 102-bed hospital in Northern California needed to improve their current 30-day readmission rates to help avoid penalties. They wanted to reach patients post discharge and provide a clinical check-in, thereby improving the continuum of care. The hospital leadership determined that an in-house program to call patients was not feasible because the nursing staff was already at capacity with their current duties for in-house patient care.

THE SOLUTION

TeamHealth Medical Call Center offered a Readmission Reduction Program for all discharged patients that would provide special assistance and monitoring for patients in high-risk categories.

The program includes the following:

- A registered nurse calls each patient within 24 to 32 hours of discharge from the hospital.
- All patients are asked about their compliance with medications, whether they have scheduled a follow-up appointment, and whether they understand or have any questions about their discharge instructions.
- Real-time intervention is provided by TeamHealth nurses to clarify medication and discharge instructions, address questions or concerns, and reiterate the importance of keeping follow-up appointments.
- Real-time feedback is provided regarding any potential risks and patient experiences.
- High-risk patients are asked condition-specific questions in order to uncover potential areas of concern and to provide education that will help them manage their conditions.
- Dashboard reporting highlights trend areas that call for hospital improvement.
- A monthly "Shining Star" report is provided to staff who are recognized by patients.

THE RESULTS

The Readmission Reduction Program exceeded the anticipated results.

- $1 Million in savings from 14% decrease in 30-day readmits (per patient cost of preventable readmission is $7,200)
- 14% increase in patient understanding prescriptions
- 4.4% patient satisfaction increase in all physician measures
- 21% cost savings from outsourcing the program, plus the intangible value of keeping nurses on the floor caring for patients
- 34% increase in patients understanding discharge instructions
- 12% improvement in follow-up appointment compliance

METRIC	BEFORE	AFTER
30-Day Readmission Rate	14.0%	11.5%
Savings of $1mm in preventable readmissions		

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