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

A 168-bed hospital with a Texas health system needed to improve their current 30-day readmission rates in order to avoid penalties. They wanted to reach patients post discharge and provide a clinical check-in, but the hospital’s 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 CHALLENGE**

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

A 168-bed hospital with a Texas health system needed to improve their current 30-day readmission rates in order to avoid penalties. They wanted to reach patients post discharge and provide a clinical check-in, but the hospital’s 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 hospital contacted TeamHealth Medical Call Center (THMCC) because THMCC offered a readmission reduction program for discharged patients. As part of this program, TeamHealth nurses provide monitoring and special assistance to high-risk patients. The program includes:

- A registered nurse calls each patient within 24 to 32 hours of discharge from the hospital.
- All patients are asked whether they’re complying with medications, they’ve scheduled a follow-up appointment, and they understand or have questions about their discharge instructions.
- High-risk patients are asked condition-specific questions in order to determine any potential areas of concern and to provide education that will help patients manage their conditions.
- Real-time feedback is provided regarding any potential risks and the patient experience.
- TeamHealth nurses provide real-time intervention to clarify medication and discharge instructions, address patient questions or concerns, and reiterate the importance of follow-up appointments.
- Dashboard reporting highlights trend areas that can indicate a need for hospital improvements.
- A monthly recognition report is provided to staff that are recognized by patients for excellent service.

The Readmission Reduction Program exceeded anticipated results for the hospital.

- $1.2M in savings due to a 3% decrease in 30-day readmits -- a 24% improvement -- during the first seven months (based on an $11,771 per-patient cost of preventable readmission) and an estimated $2.1mm in annualized.
- 49% cost savings from outsourcing the program plus the intangible value of keeping nurses on the floor to provide patient care rather than being on the phone to discharged patients.
- An average of 4.2% increase in HCAHPS questions regarding patient satisfaction and likelihood to recommend the hospital.
- 3% improvement in follow-up appointment compliance.
- THMCC nurses resolved 94% of all necessary interventions, only 3% required escalation to hospital staff.

<table>
<thead>
<tr>
<th>30-Day Readmission Rate (168 - Bed Hospital)</th>
</tr>
</thead>
<tbody>
<tr>
<td>BEFORE</td>
</tr>
<tr>
<td>12.49%</td>
</tr>
</tbody>
</table>

Estimated Savings of $1.2M in Preventable Readmissions