Providing safe and quality patient care remains our primary focus in healthcare. At times, this has become increasingly more complex with the changes and shifts in industry regulations and standards. One area that requires an intense focus is providing care across the continuum.

Studer Group has long been a proponent of hardwiring key tactics at pivotal points in the patient care continuum. Hardwiring a transition of care call model is one of them. This model is proven to help organizations reduce readmissions, improve compliance, increase patient experience and perception of care, and improve clinical outcomes. These calls also provide an opportunity for leaders to recognize staff for completing calls, impacting patient results and most importantly, saving lives.

One organization that partners with Studer Group, Regional One Health in Memphis, TN, were already completing post-visit phone calls but wanted to increase the impact of their calls. They took a closer look at their readmissions and realized that the majority were sickle cell readmissions. So they quickly reevaluated their processes, and decided to create a more formalized care transition call that reached out to patients on multiple occasions (serial calls).

Through their coaching partnership with Studer Group, Regional One Health implemented The Patient Call ManagerSM: The Clinical Call System. Patient Call Manager (PCM) is one of our most important tools for making patients an integral part of the collaborative care team. It is designed to extend care outside the organization’s walls—both before patients enter your hospital or practice, and after they go home.

The centralized call model has several benefits, including:

- Recurring phone calls and special features for clinical follow-up to reduce preventable readmissions on high risk patient populations such as:
  - Congestive heart failure (CHF), diabetes mellitus (DM), and community-acquired pneumonia (CAP) patients are called every seven days after discharge for a total of three calls

- Using the PCM escalation of care allows:
  - Call documentation that meets medical record requirements and provides most recent information for next provider of care
  - The ability to identify and update patient registration information to optimize revenue cycle
  - Excellent data collection with detailed reports to better understand areas of opportunity to enhance the patient experience
  - Most importantly, the ability to assess the patient’s status post procedure and/or hospitalization, as well as, post treatment regimen to assure the continuance of safe and effective care

Once hardwired within Regional One Health, they started seeing remarkable results on their sickle cell patient readmissions. They looked at their baseline data from 12 months prior to implementing the centralized care transition call model. The readmission rate was 14.8%. They set a goal for 5% and in nine months’ time, they reduced their sickle cell readmissions to just 2.5%.
What’s more, the cost avoidance for the reduced readmissions was staggering. Regional One Health was able to realize an estimated cost avoidance of $1.5 million in that same nine month time frame.

Due to The Hospital Readmissions Reduction Program, created by the Patient Protection and Affordable Care Act, hospitals with excess readmissions 30-days post-discharge for heart attack, heart failure and pneumonia patients were penalized up to 1 percent in FY 2013 and 2 percent in FY 2014. The fine will continue to increase to 3 percent in FY 2015. In addition, chronic obstructive pulmonary disease and total hip and knee replacement readmissions were also added.

More than 2,600 will receive 30-day readmission penalties. Regional One Health is not one of them. In fact, they have reduced their 30-day readmission penalties and readmissions overall year-over-year from Fiscal Year 2013 through Fiscal Year 2015. The below data, as reported by Kaiser Health News and Modern Healthcare, shows the decrease.

<table>
<thead>
<tr>
<th>HOSPITAL</th>
<th>CITY</th>
<th>STATE</th>
<th>FY 2013 PENALTY</th>
<th>FY 2014 PENALTY</th>
<th>FY 2015 PENALTY</th>
<th>2014-2015 CHANGE IN PERCENTAGE OF MAX PENALTY (IN PERCENTAGE POINTS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regional Medical Center at Memphis</td>
<td>Memphis</td>
<td>TN</td>
<td>0%</td>
<td>0.03%</td>
<td>0.01%</td>
<td>-1.2</td>
</tr>
</tbody>
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You may already be making care transition calls. However, if you aren’t making them consistently, achieving high enough contact rates, or aligning questions specific to the patient to avert readmission, your process may not be effective enough to move or sustain results. When done effectively, care transition calls are shown to reduce readmissions, improve compliance, increase patient perception of care, provide the opportunity to recognize staff and improve clinical outcomes.

The case study from Regional One Health demonstrates the efficacy of a consistent, specifically focused, transition of care contact that, in this case, markedly improved the lives of Sickle Cell patients. More importantly, it showed that there are patient populations, beyond those under CMS review, who benefit through a very focused and well managed centralized call center. Regional One Health’s most recent contact rate was at an incredible 97% of all discharged patients home. Their work in improving safety, quality, and the overall experience has allowed them to be one of the few organization in the country not penalized by CMS for readmission rates. This only further lends credence to the understanding that money follows quality.

To continue the conversation about Patient Call Manager™ and care transition calls, contact Rachael Johnson at rachael.johnson@studergroup.com or visit StuderGroup.com/PCM.