RelateCare

Communicating Better Health

Post Discharge Follow-up Program

Cleveland Clinic Case Study

Post Discharge Follow-up Program

Cleveland Clinic

The Client:

Cleveland Clinic

Located in Cleveland, Ohio, Cleveland Clinic is a non-profit, multi-specialty academic medical center that integrates clinical and hospital care with research and education.

Today, with more than 1,400 beds on Cleveland Clinic main campus and 4,435 beds system-wide, Cleveland Clinic is one of the largest and most respected hospitals in the country. Over the last decade, Cleveland has consistently been ranked among the leading hospitals in the USA by U.S. News and World Report, often being named the #1 heart hospital.

Client Challenge:

In recent years, managing, supporting, and caring for a patient as they transition from the hospital to home has become a central focus of the shift towards a more integrated, patient-centric model of care. Poorly managed care transitions can often lead to negative patient outcomes and unnecessary readmissions to hospital. Recently, under the Affordable Care Act, this has become even more financially relevant, since health systems can be financially penalized for unnecessary readmissions

The Cleveland Clinic sought a way to respond to this increased focus on transitions of care, while also avoiding financial penalties from avoidable readmissions and improving patient satisfaction.

RelateCare's Solution:

In 2011, RelateCare, in partnership with Cleveland Clinic leadership, developed an omni-channel (phone, web chat, email, text) Post Discharge Follow-up program to improve transitions of care for patients after discharge.

An outbound call is placed to patients 2-4 days post discharge by a RelateCare Registered or Student Nurse. Three attempts are made to contact the patient and all calls are logged into the Electronic Health Record system (Epic). Patients are asked a series of questions aimed at supporting the patient as they transition to home and to determine any risks or 'Red Flags' that may lead to readmission. Where necessary, calls are escalated to Advanced Practitioners and Registered Nurses for triage.

By communicating with patients about their discharge instructions, medications, follow up appointment, new or worsening symptoms, and overall experience, rates of readmissions can be reduced, while levels of patient satisfaction can be increased.

Post Discharge Program Impact

Since the program's inception, it has been responsible for consistently lower readmission rates for patients contacted in comparison to those not contacted. It has also been shown to be positively correlated with improvements in patient satisfaction scores.

Heart & Vascular Institute Readmission Rate:

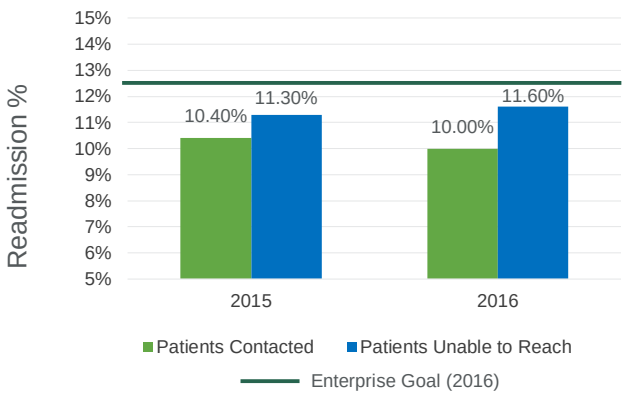
2011: 12.4%
2013: 8.2%

33.8%
readmission rate reduction (year of implementation)

In 2014, in the Heart and Vascular Institute, the readmission rate for contacted patients (5632) was **8%** (490) compared to those not contacted (3724) which was **13%** (508).

In 2015, enterprise-wide, the readmission rate for contacted patients (47,702) vs unable to contact (24,743) was **10.4%** (4,770) vs. **11.3%** (2,765).

In 2016, the rate of readmission for those contacted was **10%** versus those not contacted, **11.6%**, which was a **16%** improvement year on year.



Lower readmission rate for those contacted by RelateCare

2014	2015	2016
38%	8.6%	16%

Financial Return on Investment:

It is estimated that readmitting a patient costs somewhere between $8,000 and $13,000. In 2016, for example, RelateCare was responsible for 1000 patients who did not get readmitted due to the Post Discharge Program. This translates to between **$8 million and $13 million saved** for Cleveland Clinic in 2016 alone.

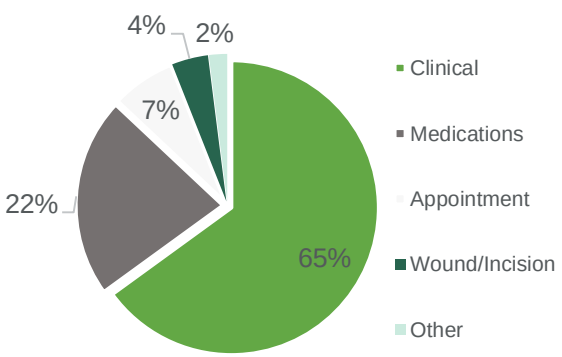
Escalations

In 2016, 16% of calls were escalated internally to RelateCare's Nurse on Call. The escalation reasons are broken down as follows: Clinical 65%, Medications 22%, Appointment 7%, Wound/Incision 4%, Other 2%. By addressing these patient issues early into their return to home or home health the Post Discharge Call-Back Program can catch any red flags and save on costly readmissions.

Total Percentage of Calls Escalated to Registered Nurse

2013	2014	2015	2016
10%	9%	7%	6%

Reasons for Escalation to RelateCare's Nurse on Call



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Patient Satisfaction

HCAHPS Scores	2011	2016	Difference
Patients who reported that their nurses "Always" communicated well	75%	83%	8%
Patients who reported that staff "Always" explained about medicines before giving it to them	59%	66%	7%
Patients who reported YES, they would definitely recommend the hospital	82%	86%	4%
Patients who reported that YES, they were given information about what to do during their recovery at home	83%	90%	7%
Patients who "Strongly Agree" they understood their care when they left the hospital	60%	60%	0%

Conclusion

The Post Discharge Call-Back Program enabled the Cleveland Clinic to avail of a simple, robust, and effective program to intervene on issues that may develop after a patient is discharged from the hospital. This poster illustrates how a comprehensive script, a well-resourced phone line staffed with caregivers/callers that are trained to the highest level in care coordination and communication can be used to reduce adverse events after discharge, potentially preventing readmissions.

RelateCare's Post Discharge Program Resulted in:

- ✓ Reduction in Unnecessary Readmissions
- ✓ Increased Patient Satisfaction
- ✓ Improved Care Transitions
- ✓ Better Health Outcomes

About RelateCare

RelateCare began as a joint venture between the Cleveland Clinic and Rigneydolphin. By combining Rigneydolphins excellence in contact center management and Cleveland Clinics expertise in healthcare delivery, RelateCare is uniquely positioned to provide the very best in patient access, telehealth, contact center and outsourcing solutions to healthcare organizations around the world.