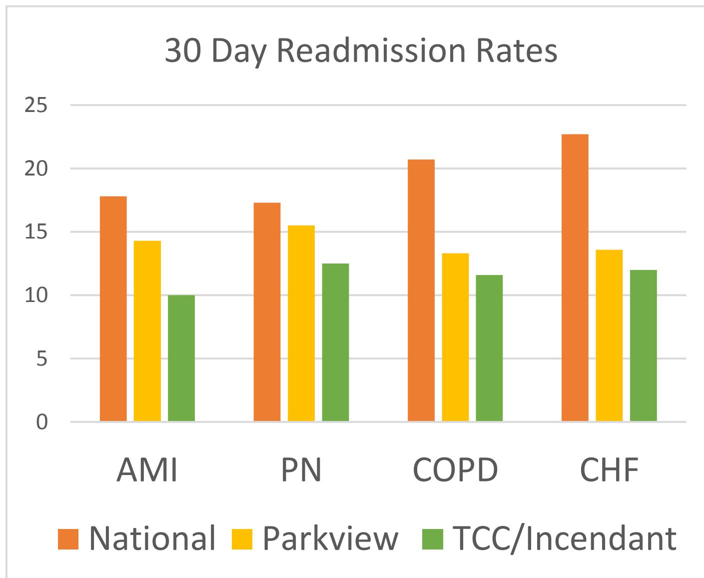
Parkview Medical Center

Reducing Readmissions

Incendant & Transition Care

REDUCING READMISSIONS AT PARKVIEW MEDICAL CENTER WITH INCENDANT & TRANSITION CARE

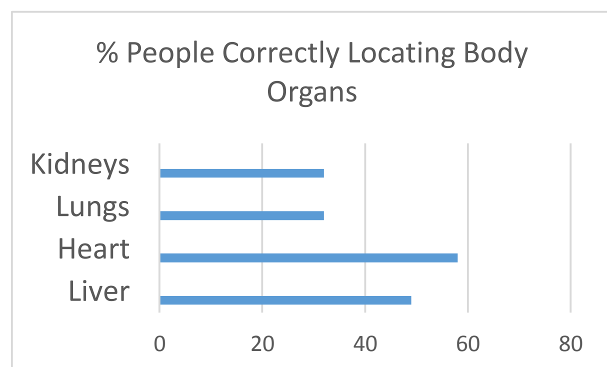
Introduction



Failing 1 out of every 5 customers is bad business. Yet that's the 30 day readmission rate for patients treated in hospitals nationwide for acute myocardial infarction (AMI), pneumonia (PN), and congestive heart failure (CHF) (1). There's no question that patient outcomes are partly the result of the quality of care received in hospitals. However, once at home the ultimate outcome depends on the patient's actions as their own caregiver. Effectively addressing that reality – patients as their own caregivers – can reduce readmissions. **When Parkview Medical Center and Incendant Inc. developed a program of personalized and automated post-discharge patient guidance, their readmission rates for AMI, Pneumonia, COPD and CHF dropped 35%, 21%, 13% and 12% respectively.**

Background

When most people can't locate their major body organs, it should be little wonder that many fail as their own caregivers (2). In the US, health literacy is so poor that only about 1 in 10 people have the skills necessary to manage their health (3). One emergency department study showed 78% of patients left the facility confused about their condition, treatment, or steps to recovery (4).



Meanwhile there is little incentive for physicians to take time to effectively educate their patients. Payment structures and organizational necessities put pressure on doctors to see the next patient rather than help the last patient understand their condition. In fact, in the US only 65% of patients report "staff always explained about medicines" and even fewer - 52% - reported they understood their care when leaving the hospital (1).

Solution

During hospitalization patients are sick or injured, medicated, and uncomfortable. Yet this is when facilities try to educate. In reality, *after* discharge patients are very interested in recovery, making it prime time for support and instruction. And while hospitals archaically continue to hand out paper discharge instructions, people send and receive over 196 billion emails and view 4 billion YouTube videos per day (5, 6)! **Patients – even boomers – actually prefer email over phone calls (7). And videos are a superior solution for educating people (8).**

Until July, 2014 every nurse at Parkview Medical Center was tasked with calling "their" patients post discharge. While somewhat effective, only about 30% of calls reached patients and even just five, 7 minute phone calls kept nurses from their bedside care of other patients. To increase the effectiveness of post discharge contact a group of 3 nurses were designated as the Transition Care Center (TCC). To increase their efficiency the TCC nurses were given Incendant software and videos to better educate patients. **With 3 nurses and Incendant, the TCC was able to increase post discharge contact from 30% to 81% (15,000 patients/year) while reducing readmissions for AMI from 14.3% to 10%, Pneumonia from 15.5% to 12.5%, COPD from 13.3% to 11.6%, CHF from 13.6% to 12% and all readmission from 11.6% to 9%.**

Incendant Technology & Videos

With enough money any facility could reach and educate every patient post discharge. But Parkview's choice of Incendant made post discharge care both effective and efficient. **Incendant software made it easy to send patients emails or SMS with over 200 disease, medication and procedure specific videos. Incendant software monitors and reports the patient's attention to the material. The reports focused the TCC nurses' efforts on patients more likely to have bad outcomes.** With the Incendant technology, groups of patients can easily be enrolled to automatically receive a series of video/emails (care paths) or individuals can be sent video/emails or SMS to answer specific questions. The videos are professionally produced with actors, animations, and images. The content is evidence based and vetted by medical experts and educators to put the right information at the right literacy level in front of each patient. Emails, SMS, and video make every interaction simpler for clinicians and better understood by patients.

> *"Low readmission rates are a priority goal for us at Parkview. The Incendant team and the Transition Care program have been invaluable in helping us exceed our all cause readmission goal."*
>
> Greg Bowman, MD, MBA, FACS
> Chief Quality Officer Parkview

Parkview's Transition Care Center

While Parkview's previous attempt to have unit nurses contact their patients the day after discharge was noteworthy, the logistical realities were a nightmare. Nurses were busy addressing the needs of their new patients. Patients were often difficult to reach by phone or unwilling/able to talk with the nurses when called. Messages were often left, but when patients returned calls they would be unable to connect with the correct person. Trying to train every nurse in every unit (>900) in good post discharge care and customer service added additional complications.

By designating a small group of nurses as the TCC nurses, Parkview was better able to contact and educate more patients. The small group of TCC nurses were easier to train regarding 4 critical post discharge factors: medication reconciliation/purpose, primary care physician follow ups, disease specific education and management and community resources. These factors have consistently been shown to affect outcomes like readmissions (9). With Incendant the TCC nurses were able to more effectively and efficiently address questions about medications and disease management. Additionally, the phone calls, emails and SMS from the TCC, connected patients to a hospital resource ready and willing to answer their questions while accessing their visit history.

Conclusion

The readmission problem is multi-factorial. However, all patients discharged home ultimately must understand their condition and treatments to avoid bad outcomes like readmission. A small, designated team is superior for post discharge care because they are more easily trained and focused on discharged patients. Using software to deliver videos via email and SMS is more effective and efficient for contacting and educating discharged patient. At Parkview Medical Center a designated transition care team, using Incendant software and videos, has proven that the combination improves patient understanding and self-care resulting in significant reductions in readmissions.

Sources

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