In the era of chronic illness and historically long lifespans, patient care transitions to home or another facility have become commonplace. Unfortunately, what lies between these exchange points is a kind of gray area, a healthcare limbo where risks for lapses in communication, coordination, quality, and safety are at their highest.

The result, too often, is that patients lose the level of care management they need, which can result in a return trip to the hospital or worse. Additionally, provider organizations are left vulnerable to considerable financial penalties for failing to reduce preventable readmissions—a key goal in the shift to value-based care.

The Centers for Medicare & Medicaid Services' (CMS) Hospital Readmissions Reduction Program docks hospitals with a three percent reduction in Medicare payments for high rates of 30-day post-discharge readmissions for a defined set of diagnoses. According to some estimates more than 2,600 of the 3,400 hospitals subject to the program will be penalized by CMS in 2016.¹

CARROT VS. STICK

Reducing preventable readmissions is often framed in a negative light; leveraging a financial threat in order to goad provider organizations into action. But perhaps it’s more productive to view this challenge as an opportunity to maintain a high level of patient quality; improve the efficacy of—or successfully build from scratch—a transition care management program; and open a generous and consistent vein of revenue.

While it’s true that CMS is penalizing hospitals, it also rewards them. Through CMS’ transition care management (TCM) program, hospitals can earn between $160 and $230 per patient simply by fulfilling the program’s requirements.²

CMS estimates that TCM reimbursements would generate a four percent increase in payments to family practice physicians, three percent each for internal medicine and pediatrics, and two percent each for gerontologists, nurse practitioners and physician assistants.³

GIVING TCM A LITTLE TLC

Consistent, multi-faceted patient engagement is the optimal way to mitigate hospital readmissions and facilitate care transitions. This can be accomplished by starting as early after discharge as possible and using communication technology and clinical resources to keep tabs on treatments and follow up care, as well as to monitor and address any complications.

This white paper from West Corporation’s Healthcare Practice will describe the significant clinical, demographic, and logistical barriers to successful care transitions before moving into the six communication best practices at the heart of every thriving TCM program. Providers will understand the key strategies and tactics for enabling robust communication throughout the continuum of care; complying with CMS’ TCM guidelines; and the role of automation in patient outreach and improved provider workflow.
Transition Care Management: Key Barriers & Considerations

Alper, O’Malley, and Greenwald note that nearly 20 percent of Medicare patients discharged from hospitals in 2004 were readmitted within 30 days, costing hospitals more than $17 billion.4

A lack of comprehensive communication certainly plays a role, but other considerations—clinical, demographic and logistical factors—also need to be considered serious suspects in current rates of readmissions.

CLINICAL FACTORS
Incidence of chronic disease is a large—and growing—problem in the United States. According to the Partnership to Fight Chronic Disease, 45 percent of the American population is managing one or more chronic illnesses, such as advanced COPD and diabetes.5 This population also consumes “81 percent of hospital admissions; 91 percent of all prescriptions filled; and 76 percent of all physician visits.”6

Those with chronic conditions are at a higher risk for preventable readmissions. Co-morbidities usually come with multiple medications; it’s not unusual for patients to not take medications as prescribed, either through neglect or confusion by the number of medications prescribed. Often, the medications themselves—antibiotics, glucocorticoids, anticoagulants, narcotics, antiepileptic medications, antipsychotics, antidepressants, and hypoglycemic agents—are additional clinical risks for preventable readmission.

DEMOGRAPHIC AND LOGISTICAL FACTORS
Demographics and patient history also play a significant role in readmission risk. For example, prior hospitalization, typically including unplanned hospitalizations within the past six to 12 months; low health literacy; reduced social network indicators like being alone most of the day with limited or no family or friend contact by phone or in person; and lower socioeconomic status can contribute to problems in transition care management and readmission reduction.

COMMUNICATION AND EDUCATION
Communication is another critical factor. Some patients may find strict adherence complicated or long-term care plans easy to abandon if follow up communication and education from the provider is not consistent. The lack of health literacy among patients—for example, the ability to recognize or react to ‘red flags’ or worsening conditions until critical—is a potent recipe for early and preventable readmission.
At the heart of every comprehensive TCM program are six cost-effective communication best practices. Collectively, these best practices span the continuum of care and leverage critical communication tactics that will help provider organizations comply with CMS guidelines; ensure regular communication with patients in their channel of choice; and leverage automation technology for scalability, consistent outreach, and optimized care provider workflow.

**BEST PRACTICE #1: LAY THE GROUNDWORK PRIOR TO DISCHARGE**

The first step in TCM management occurs while the patient is still in the hospital. One of the keys to transitional care success is planning communication prior to the patient’s discharge, and this includes evaluating their cognitive skills. A few key determinations the provider needs to make include:

- Is the patient able to understand instructions from a care coordinator and effectively answer questions about their health and make arrangements for transportation to their follow up appointment?
- Who will be handling the communications on behalf of the patient? Will it be the patient themselves or someone else?

This cognition assessment is important, because if the patient demonstrates that they are not capable of handling post-discharge communication, then a proxy will have to be identified. This proxy will be the one that will act on behalf of the patient with the care coordinator.

With the patient facing the provider, it is the ideal time to capture permission to discuss the patient’s health and also the preferred means of communication from the patient or proxy. This might even include the best time of day to call, the preferred method of communication, and the frequency of communication.

Basic health literacy also is important. Train the patient to identify red flags in their health. Teach them how to communicate these red flags to their care coordinator. Engage the patient to make them a proactive advocate in their health evaluation, rather than a passive participant that might let complications linger.

Finally, before discharging the patient, set up their follow-up TCM appointment. Communicate the date and time of the appointment to the appropriate contact, as well as the channel (i.e., text, home phone, e-mail). Take this time to also inquire as to whether transportation or obtaining medication prescriptions will be an issue. Arrangements to address these issues can be made as the policies of the hospital allow.

**BEST PRACTICE #2: PROVIDE CONSTANT CONTACT**

Per CMS guidelines, providers must make two attempts to connect with a patient within 48 hours of discharge. Reach out the first time within 24 hours. If the patient cannot be reached, then follow up the second day with another outreach.

The purpose of this initial call is to:

1. Reconcile medications;
2. Assess the patient’s status post-discharge;
3. Determine whether a referral or labs are needed; and
4. Verify that the patient has obtained their medications and is taking them as prescribed.

Take this opportunity to confirm the upcoming appointment, travel arrangements and so forth so that issues may be addressed in the event something has come up. See Best Practice #5 for how automation can make this process more efficient.

These initial attempts at contacting the patient are essential to qualify for a TCM reimbursement. CMS will allow providers to collect for a TCM visit without having made contact within the first 48 hours so long as they can prove the attempts at outreach were made.

**BEST PRACTICE #3: CAPTURE PATIENT PREFERENCES**

The key to effective outreach is to communicate to patients using their channel of choice. Fortunately, most EHRs today support the capture of patient communication preference. However, it is important to remember to verify and update this preference as part of the pre-discharge process, based upon their current capabilities. For example, can a patient that prefers email get to and operate a computer?

It is smart to collect expressed consent and HIPAA waivers from patients and care proxies in order to protect the provider and the organization. This step safeguards the healthcare organization against any concern of violating TCPA or HIPAA when making an outreach. Capturing channel preference, time of day and so forth maximizes the engagement with patients. (See the sidebar ‘Patient Preference in Action’ for a real-world success story).
BEST PRACTICE #4: BE PERSISTENT

CMS expects two attempts be made to connect with a patient within 48 hours of discharge.

What happens when providers have made these attempts but have not contacted the patient or their proxy? Don’t give up! Remember that if the patient keeps their TCM follow-up appointment, providers can still claim the higher reimbursement.

After 48 hours, the notification messaging can change in purpose to become a more focused appointment reminder. So, the provider’s strategy shifts to getting the patient in for his/her appointment.

Providers should continue outreach to both the patient and the care provider. The plan would be to send both the patient and their proxy a simple outbound reminder a few days out from their appointment. (See the sidebar ‘Appointment Reminders in Action’ for a real-world success story.)

Occasionally, providers may really push for human contact with their patients. In these cases, the organization should consider outsourcing their TCM follow up calls rather than add additional staff or build out infrastructure. Companies in the business of supporting manual outreach often have advanced dialing software, which maximizes the connect rate with patients and lowers cost of manual intervention. Use of these services saves staff from the inefficiencies of manual outreach, allowing them to focus on patient care.

BEST PRACTICE #5: AUTOMATE THE OUTREACH

The initial call out to a patient or their proxy can take the form of a voice call, text or email. Any of these channels can be used to have the patient call back into the organization, effectively freeing care coordinators to practice at “top of license” by handling inbound calls only. Messages can be customized to change in the event the outreach staff reaches an answering machine or voice mail.

The important thing is that an inexpensive technology is being applied to do time-consuming phone tag. Once the patient has been reached, the team can step in to speak with the patient.

Also, automation simplifies documentation of the outreach. Notification tools log results of calls, such as no answer, voice mail, or transferred into hospital. This greatly simplifies record keeping and can be integrated into the organization’s TCM workflows.

BEST PRACTICE #6: IMPLEMENT SMART REMINDER MESSAGING

As the provider’s strategy shifts from the TCM post-discharge follow up call to the appointment reminder, the organization will want to make use of smart reminders. These reminders are fully automated and are a very cost effective way of decreasing no-shows for a TCM post-discharge appointment.

Smart reminders are bi-directional, allowing provider organizations to receive confirmation that a patient intends on keeping their scheduled appointment. Automated messaging allows the patient or proxy to be immediately transferred into the organization’s call center for rescheduling while it is top of mind.

One of the most common questions after receiving an appointment is “where are you located”? A smart reminder will allow the patient to receive the address of the location for a follow up visit automatically. This cuts down on calls to the call center or practices while giving the patient a better overall experience with the provider organization.

PATIENT PREFERENCE IN ACTION

There are a number of ways to reach patients today—e-mail, text, and phone are just a few. Providers who gather the intelligence necessary to determine the best way to reach patients will often find the most dramatic success in the TCM program.

During the 2015 Annual HIMSS Conference & Exhibition in Chicago, a major Pennsylvania hospital presented the results of an internal study where automated texts, voice and email calls were used to follow up with heart failure patients.

By communicating in the channel and language of the patient’s choice, this hospital saw a nearly 25 percent improvement in readmissions vs. those patients that were not messaged. In this case, the hospital communicated two to three times with the patient and/or their care proxy—once right after discharge and a simple reminder right before the follow up appointment. The hospital saw readmissions drop to 16 percent for messaged patients from a baseline of 26.7 percent, far exceeding their expectations.

APPOINTMENT REMINDERS IN ACTION

Boston-based Joslin Diabetes Center implemented a TCM program for their patients, which included reminding the patient of their post-discharge appointment. Prior to rolling out this program, Joslin was experiencing a 50 percent no-show rate to these follow up visits. However, once reminders were put in place the no-shows dropped to seven percent in less than two years. This is dramatic improvement, which clearly results in better patient care, more revenue and prevents readmissions by keeping the patient engaged in their post-discharge care plan.

43% DROP IN NO SHOWS
If a healthcare practice or organization already has a TCM program in place, they may benefit from some of these best practices. If they are starting one from scratch, this white paper can serve as a blueprint for creating a sustainable, cost-effective, scalable program that enhances meaningful patient engagement without disrupting the workflow of the care team.

Consistent, multi-faceted patient engagement is the optimal way to mitigate hospital readmissions and facilitate care transitions. Start communication as early in the process as possible, balance automation and the human touch; and be mindful of patients’ communication preferences.

Use these six practices to map the path forward and remember that thoughtful strategies and enabling technologies are essential for the journey to success. Look for providers and partners with the right combination of technology, experience and vision with a proven track record of employing effective business practices for Transition Care Management.

REFERENCES
6. Ibid.

About West Healthcare
West helps healthcare providers, payers, employers, pharmacy organizations, and ACOs optimize communications, drive better patient activation, and lower the overall cost of delivering care. Whether you want to increase immunization and screening rates, reduce hospital re-admissions for patients with chronic disease, or improve the patient experience and operational efficiency in your patient access centers, the West Engagement Center™ is the communication linchpin for engaging and activating patient populations across the entire care continuum.