THE Value Initiative

Members in Action: Redesigning the Delivery System

15 Hospitals in North Carolina and South Carolina

Transforming Care in the Carolinas

The AHA's Members in Action series highlights how hospitals and health systems are implementing new value-based strategies to improve health care affordability. This includes work to redesign the delivery system, manage risk and new payment models, improve quality and outcomes, and implement operational solutions.

Overview

Spurred by grant funding and collaboration, 15 hospitals in North Carolina and South Carolina are implementing financially sustainable initiatives to improve the patient experience, enhance care coordination and decrease avoidable readmissions.

The Duke Endowment provided a $5 million grant through the North Carolina Healthcare Association (NCHA) and the South Carolina Hospital Association (SCHA) to optimize care transitions and increase patient engagement. The associations collaborated to provide a forum to share best practices and

Self Regional Healthcare in South Carolina used patient navigators to reduce avoidable readmissions from 30.8% to 8.5%.

Impact

Approximately 80,000 patients were screened for the program, 15,000 of whom were deemed high risk, according to Laura Cole, manager of population health at SCHA. The intervention resulted in 496 avoided readmissions for a savings of $5 million in one year and a reduction of 20% to 50% of avoidable readmissions among the 15 hospitals.

Cole said the hospitals demonstrated that spending $1 in care coordination saved $2 in avoided health care costs. Patients also reported an increase in health confidence, feeling more empowered to call their doctors or ask questions about their medications.

Cyndi New, Manager of Accountable Care at Self Regional Healthcare (SRH) in Greenwood, S.C., reports that her hospital used patient navigators and decreased its avoidable readmission rate from 30.8% to 8.5%, saving $2 million during the intervention period. Because the pilot demonstrated such quality gains and cost savings, her system continues to fund the program on its own.

Similar quality improvements resulted at Carolinas HealthCare System Blue Ridge (CHSBR) in Morganton, N.C., according to William Minor, executive director of quality and clinical integration. A special study of 78 patients demonstrated reduced utilization in emergency, inpatient and observation care by 48%.

Hospitals' home visits identified barriers to care, such as a lack of phone service, mobility issues and illiteracy. CHSBR Lead Transitional Care Nurse Amber Summers said that in one instance, her team enlisted volunteers from a local church to install a ramp in front of a home, enabling a wheelchair-bound patient to go to her medical appointments without having to call an ambulance.

"It's been a great success for us," said Minor.

data, as well as offer education and technical assistance to the participating hospitals. The grant ran from 2016 to 2018.

Hospitals could implement customized approaches but were required to incorporate three actions when caring for inpatients, according to Trish Vandersea, NCHA's director of population health initiatives. Participants were required to perform: 1) risk assessments; 2) follow-up phone calls within three days of discharge, home visits within seven days and follow-up appointments within 14 days for high-risk patients; and 3) phone calls for moderate-risk patients. Hospitals also monitored patients' health confidence to measure their engagement in their care and to better understand patient needs.

Nurses from Carolinas HealthCare System Blue Ridge in North Carolina educate patients on their medications during home visits after discharge.

Lessons Learned

NCHA and SCHA representatives recommend developing a system for collecting and sharing data among collaborative members, such as databases, listservs and hospital highlights. At the hospital level, building trust with patients before they are discharged is important to enhance the effectiveness of the follow-up phone calls and home visits. Minor advises meeting with the patients before discharge, scheduling home visits in advance and giving patients brochures and business cards with photos of care team members coming to the home. His hospital also promoted the home visits via the television network broadcast to patient rooms to elevate familiarity about the outreach among patients and families.

Future Goals

Many hospitals in the collaborative are building on the success of the project and funding the support themselves. SRH's New said her hospital is considering expanding the navigator function to bundled Medicare programs and telehealth services. Minor said his hospital is attempting to turn the service into a revenue generator by embedding nurses into medical groups to assist with patient outreach from physicians' offices and using Medicare Transitional Care Management reimbursement codes.

Contact: Laura Cole, Manager of Population Health, South Carolina Hospital Association
Telephone: (803) 796-3080
Email: *lcole@scha.org*