Welcome Home

Post Hospital Discharge Program

Part of a text messaging-based digital coaching strategy enabling change at

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THE CHALLENGE

Reducing unnecessary hospital readmissions is a fundamental priority for improving healthcare quality. Readmission shortly after discharge negatively impacts the patient, is costly to the healthcare system and can also point to low quality of care. Sharp Rees-Stealy (SRS) aims to implement care transition programs that help patients recover, stay out of the hospital and build better health through self-care.

SRS's existing telephonic care management program provided support for 30-days following discharge with strong results. However, they wanted to engage more patients and stay more closely connected with them for a longer period of time to further reduce avoidable readmissions at 90 days and beyond, all while reducing their cost of service and improving patient satisfaction.

GOAL

Leverage text messaging to engage more patients to stay connected with their care team and focused on a successful recovery with lower costs, better outcomes and enhanced experience.

SRS had successfully implemented Agile Health's interactive text messaging program for diabetes self-care. The program engaged patients with diabetes for a six month period; helping them build the knowledge, motivation and skills to practice better self-care and utilize appropriate healthcare resources and services to manage their condition.

Building on the success of the diabetes self-care program, SRS partnered with Agile Health to deploy **Welcome Home** – a 90-day, interactive text-messaging based coaching program to help engage and support the nearly 163 patients discharging per day within the SRS population.

COMPANY OVERVIEW

Sharp Rees-Stealy Medical Centers, located in San Diego, California, is dedicated to delivering extraordinary care through a commitment to clinical excellence, advanced technology and patient health and well-being - The Sharp Experience.

21
locations

500
physicians

2,400
care professionals

1.2M
patient visits a year

244,000
patient population

- **189,000** managed care
  170,700 commercial
  18,300 seniors
- **55,000** ACO/PPO

DIGITAL DIALOGUES INCREASE SUSTAINED ENGAGEMENT

Year 1	Year 2
14-day Completion Rate	
72%	**81.3%**
90-day Completion Rate	
36%	**53.1%**
Average Number of Inbound Messages per Participant	
6.7	**20.5**

PROGRAM FOCUS

YEAR 1

Initial launch incorporated outbound messages focused on long term health and wellness skills as well as near-term recovery.

Patient feedback indicated the preference for more assistance with their immediate post-discharge needs, particularly in the first 30 days of the program.

The revised curriculum significantly improved participation and retention – enabling care managers to engage more patients, for longer periods, with no increase in clinical staffing levels.

YEAR 2

With the initial success in year 1, emphasis was placed on enrolling more patients by promoting the value of 1:1 support during recovery. Additionally, a stronger push was made toward maximizing personal touch points to further increase and sustain engagement.

As a result, enrollment in Year 2 increased 38.6% over year 1, while the average number of 'ad hoc' texts per patient more than tripled.

THE APPROACH

The **Welcome Home** program helps patients and their care team work together for optimal recovery. A blend of automated and real-time text messaging dialogue extends the reach of the care team and increases access to in-the-moment support for the patient.

The program's interactive curriculum of scheduled, evidenced-based messages is focused on:

Self-care management
Medication management
Follow up appointments
Diet and activity recommendations

The SRS care team organized and leveraged direct access to Agile Health's Digital Coaching platform to provide live coaching support, seamlessly augmenting the automated evidence-based curriculum. The staff engaged patients proactively, by personally texting each patient shortly after enrollment – reinforcing the value of staying connected through text messaging. Additionally, patient feedback was encouraged through periodic and personalized 'check-ins'.

The SRS care team developed an efficient process for managing inbound text messages from patients. A non-licensed care specialist monitored the dashboard and triaged all incoming messages, providing timely responses to non-clinical questions. Clinical concerns and requests were escalated to registered nurses for follow up keeping newly discharged patients connected to their care teams, when they needed clinical support. This process enabled the SRS care team members to work at the top of their licensure without the frustration of missed calls and unanswered voice messages.

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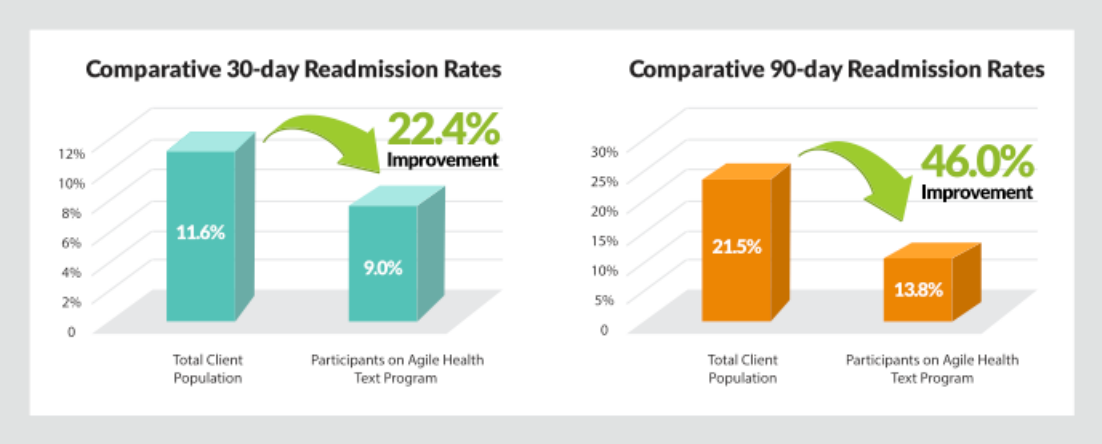
THE RESULTS

The deployment of the **Welcome Home** program and the care with which SRS implemented, measured and refined its engagement approach has contributed to SRS achieving a 36% increase in patient engagement, accompanied by significant marginal cost avoidance for each patient enrolled in the Welcome Home program, as well as substantial reductions in cost of service across the total managed population. Along with cost of service improvements and operational efficiencies, Welcome Home also contributed to marked improvement in short and longer term readmission rates, while helping to improve work-life quality within the SRS care team as well as the experience and quality of life for their patients.



"Thank u for all the help. It was a wonderful program and a comfort to me to know someone was keeping in touch. Again thanks."—Patricia C., ***Welcome Home participant***

"Hard to say goodbye, but I know if I'm in need you're just a text a way. This is a great service with amazing people. Thank you all for taking such good care of me ☺"
—Lyn M., ***Welcome Home participant***

"Both our patients and our care teams have benefited tremendously from Welcome Home program and Digital Coaching platform. It's been a real boost to our existing intensive 30-day post-discharge program. We are excited to give these patients extra clinical guidance and support materials – delivered directly to their phone - when and where they need it."
—Janet Appel, RN, MSN, ***Sharp Rees-Stealy Director of Population Health Management***

"I really believe this program enables my case managers to interact with the right patient at the right time. With our increasing patient population and current caseload numbers, the team feels like they can keep an eye out for all of their patients due to the texting support."
—Kelly Roberts, RN, MSN, ***Sharp Rees-Stealy Lead Primary Case Management***