

At Cardinal Health, we support healthcare leaders as they implement best practices to transform patient care. A particular focus for many of them, as a result of a rapidly aging population and ever-increasing healthcare costs, is the prevention of avoidable hospital readmissions for high-risk patients.

Here, we visit with two such leaders, one a naviHealth (a Cardinal Health company) customer, and the other the recipient of a Cardinal Health Foundation E3 (Effectiveness, Efficiency and Excellence in Healthcare) Grant*. With very different approaches, each is working to help improve the quality of life for seniors with multiple chronic conditions, and, at the same time, is reducing healthcare costs.

Seamless, Patient-Centered Care

“In helping our highest-risk patients to avoid readmissions, one of the most significant things we can do is to break down the walls between healthcare providers and the community,” says Barbara J. Harding, RN, MPA, CCM, PAHM, Senior Director of [Post-Acute Care](#) Services at California-based Dignity Health, one of the country’s largest healthcare systems.

“Traditionally, once a provider created a patient’s discharge plan, the patient left and the provider’s work was done. But now we understand that the patient needs bridges from the point of discharge to RN case managers, social workers, care coordinators, and community health workers—all those who follow the patient through transitions of care and into the patient’s home.”

Harding is responsible for [post-acute care](#) transitions for patients of Dignity Health hospitals in Arizona, California and Nevada. She is currently building a [post-acute care](#) (PAC) network of preferred providers, focusing primarily on skilled nursing facilities (SNFs) and home-health agencies. “Our vetting processes ensure that we can refer patients to the highest-performing PAC providers,” Harding says. “The providers work with us to prevent hospital readmissions and help patients return to their homes as soon as possible.”

In order to manage this PAC network, Dignity Health has partnered with naviHealth to connect SNFs, home-health agencies, and even non-clinical community services on a single digital platform. “naviHealth helps weave together the post-acute world for our patients,” Harding says, “and shares our dual goal of improving outcomes and reducing costs.”

Harrison Frist, naviHealth’s Senior Vice President and President of Provider Solutions, works closely with Harding. “Barbara is a true visionary; she is a driving force behind Dignity Health’s push to manage patients’ seamless transitions across the continuum,” Frist

says. “naviHealth is fortunate to work with such a dedicated champion, focused on revolutionizing the way patients receive care, both in and out of the hospital.”

Community-Based Programming

Through its E3 Grants, the Cardinal Health Foundation has supported several senior services organizations that partner with area healthcare systems to successfully reduce hospital readmissions. (You can read more about this work [here](#).) One of these grantees is the Southwestern Indiana Regional Council on Aging (SWIRCA), based in Evansville, IN.

“The impact of preventing unnecessary re-hospitalizations reaches far beyond reducing healthcare costs,” says Jillian Hall, SWIRCA’s Special Programs Coordinator. “It means improving overall quality of life for seniors and their loved ones.”

SWIRCA created its Care Transitions Program to improve quality of life for patients being discharged from four area hospitals with diagnoses of heart failure, COPD, renal failure and/or pneumonia. Social workers were trained as transition coaches to work closely with these patients, first visiting with them while still in the hospital. Through home visits and follow-up phone calls, the transition coaches supported patients for 60 days post-discharge.

Coaches worked with the seniors on medication reconciliation, and helped patients communicate with their physician or pharmacist when they discovered discrepancies. Coaches also reinforced discharge instructions, helped plan for follow-up medical appointments and connected seniors to a variety of non-clinical community services.

Over one year of the grant-funded program, SWIRCA’s Care Transitions Program worked with 198 seniors. For these patients, 30-day readmissions dropped to just over 14 percent, compared to 20 percent for those who did not participate in the program. Sixty-day readmission rates for those in the program dropped to just over 18 percent, compared to nearly 29 percent for those who didn’t participate.

For its efficacy in improving quality of care, quality of health and reducing healthcare costs among Medicare patients, the Care Transitions Program was recognized with an Award of Excellence from Health Care Excel and the Medicare Quality Improvement Organization.

Empowering Patients’ Success

Hall and Harding agree that, no matter how seamless a transitions of care program is, or how many services it includes, it isn’t complete—and it may not succeed in helping avoid readmissions—without the key element of patient engagement.

“We can’t help patients be truly successful if we don’t engage them in their own care,” Harding says. “Engaging patients means that we listen to their problems and learn what their priorities are. We work with them to set realistic goals that allow them to live the best possible quality of life, then support them in achieving those goals. ”

Hall adds, “Someone with COPD might have a goal of walking by himself to the mailbox everyday. Another patient might tell us that she wants to be able to play with her grandchildren. Even these small goals can seem out of reach to someone with complex health issues. But when we work with patients on setting and achieving goals, the patients tend to get much more involved in their own care.”

“Engaging our patients means empowering their success,” Harding says.

A Commitment that Strengthens Communities

As these examples show, helping post-acute seniors live at home longer requires commitment and creativity from everyone involved in their care. But, as Hall notes, the upside goes far beyond reducing healthcare costs.

“When we empower individuals who live with chronic diseases to take control of their health, and stop the revolving door of repeated hospital readmissions,” she says, “we strengthen our entire community.”

**For more information about the E3 Grant Program, visit cardinalhealth.com/patientsafetygrants.*



In its first year, in caring for 400 patients, the Complex Care Clinic reduced hospital admissions by 44 percent and emergency department use by 38 percent, saving \$4 million. (See video highlights of the clinic’s model of care delivery [here](#).)

Note: The decreased readmission and cost savings results highlighted in this article are estimates that were prepared separately over a one-year period by the Complex Care Clinic and SWIRCA.

About the Cardinal Health Foundation

The Cardinal Health Foundation supports local, national and international programs that improve health care efficiency, effectiveness and excellence and the overall wellness of the communities where Cardinal Health’s (NYSE:CAH) nearly 37,000 employees live and work.

The Cardinal Health Foundation also offers grants to encourage community service among its employees and works through international agencies to donate much-needed medical supplies and funding to those who need them in times of disaster; because Cardinal Health is #AllInForGood. To learn more, visit www.CardinalHealth.com/community and visit the Facebook page at www.facebook.com/CardinalHealthFoundation.

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