

Milford Regional Medical Center

MILFORD, MA

\$453,306

AWARD EXPENDED

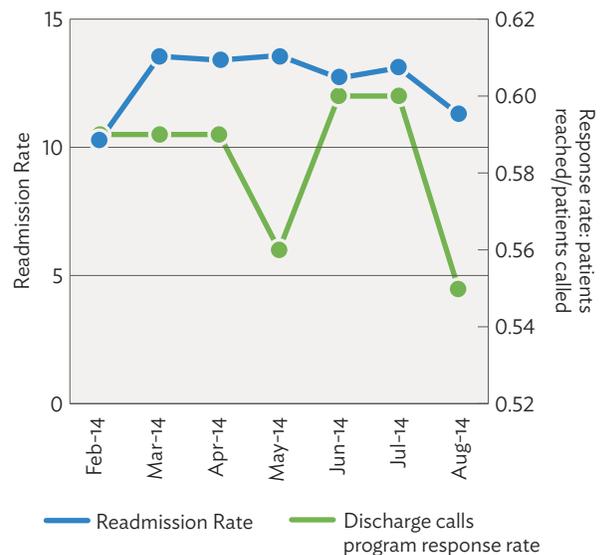
Recognizing that its readmission rate was higher than the national average, Milford Regional Medical Center sought to decrease readmissions by enhancing communication across the continuum of care and during transitions of care. Milford Regional Medical Center worked with external consultants to develop a care redesign plan and a health information exchange strategy for its readmission reduction program. The readmission reduction team was formed to bridge the gaps in care as identified in the care redesign plan. The team engaged in real-time improvements at the point of care, including the use of electronic notifications for the care of high-risk patients.

RAPID-CYCLE PILOT

The readmission reduction team’s primary goal was to support improved care coordination by way of enhanced communication and technology. The team partnered with an area elder services agency where patients were referred to engage in the Care Transitions Intervention (“Coleman coaching™”). The team also utilized the hospital’s discharge call program which sends automated phone calls to all patients discharged to home, within 24-72 hours following discharge, and records responses by the patient or family, which can subsequently trigger further follow-up.

Milford Regional Medical Center collected both process (call response rate) and outcome (readmissions) measures. The call response rate for the discharge phone program fluctuated over the period of performance of CHART Phase 1; this mirrors early findings in the CMS Community-based Care Transitions Program. Future work, including in CHART Phase 2, will work to increase patient engagement in the program. No notable change in readmissions was seen during CHART Phase 1.

All cause readmissions and response rate for the discharge call program



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REFERRALS TO THE LOCAL ELDER SERVICES AGENCY FOR TRANSITIONAL CARE.

CHART PHASE 2 AWARD

Milford Regional Medical Center will continue activities to reduce readmissions among inpatient high utilizers through a hospital-based, community-oriented high risk care team.