Readmission Prevention

When your patients are discharged from the hospital, you want to be sure they have care support—and knowledge about their condition—so they don’t return. Yet readmission rates have remained high throughout the nation: a situation that has negative effects for both patients and clinicians. So how can you reduce readmission rates and avoid revenue losses due to penalties for not meeting standards or benchmarks for readmissions within 30 days?

Designed to address and optimize revenue and quality performance standards, our Readmission Prevention program gives patients the education and support they need as well as peace of mind. In 2010 we engaged more than 200,000 patients post discharge and cut the readmission rate in half for participants with targeted conditions.1

Targeting the Right Patients

We analyze each hospital admission using the following factors:

• Age and gender
• Current and prior admission diagnoses
• Social and economic conditions
• Behavioral health, cardiology, gastro intestinal (GI), iron deficiency (ID) and respiratory diagnosis confounders for current and prior admissions
• Prior out-patient, ER, home health and durable medical equipment services
• Current and prior prescription drug patterns; therapeutic class, compliance and mix

Then, we target those patients who may be likely to readmit, using adopted best practices and industry-leading components of programs that take the best practices of the Coleman model, Project RED and BOOST.

Did You Know?

• In 2008, 19 percent of all hospitalizations resulted in readmission within 30 days.2
• Of Medicare beneficiaries with 0 or 1 chronic condition, 9 percent had a readmission within 30 days; of those with 6 or more chronic conditions, more than 25 percent had a readmission within 30 days.2
An Engaging Onsite Program

We staff targeted facilities with onsite registered nurses, who establish communication with patients or caregivers/patients’ families as a trusted advisor within 24 hours of admission. The onsite nurses reach out to patients after discharge to provide support, answer questions and help triage symptoms if patients are considering a return to the emergency department.

Our onsite program supports continuity of care and can be complemented by telephonic care, telemedicine and home visits, as appropriate, to create a complete solution that activates patients to adhere to their medication, see their primary care physician within 5-7 days and seek future non-emergency care from appropriate sources.

Readmission by Engagement in Optum® Transitional Case Management Program³*

Our Readmission Prevention program showed remarkable results for one hospital:

- 72% engaged post-discharge; up from pre-implementation engagement rate of 45%⁴
- 2010 system-wide readmission rate declined to 6.1% from 8.3% in 2009⁴
- 2010 readmit rate declined 26% for system hospitals where we deployed while the readmit rate increased 17% for system hospitals without the Readmission Prevention program.⁴

Transform Today.
Thrive Tomorrow.

Discover how Optum can help your organization meet the demands of an ever-changing health care environment. Call 866.386.3409 or e-mail us at engage@optum.com.

Sources:

* Differences between the engaged and non-engaged groups were significant (P<.0001) for each time period.