et there be no doubt: This is going to be an important year. In 2011, health care stakeholders tackled new technologies, developed innovative care management strategies and heavily debated health care reform. In 2012, amid all of these changes, the market is asking for one thing: simplicity.

It won’t be easy. Every potential solution to a health care problem can add a layer of complexity. Yet technology and quality care initiatives can help reduce costs, improve quality and ease the burden of care. At Optum, we are working to address this complexity and provide solutions that can make it easier for stakeholders to collaborate.

At the most basic level, it is important for stakeholders to align with the goals of collaboration and a simplified health care system. In this issue of Ignite, we examine opportunities to improve care coordination, exploring data from the Optum Institute for Sustainable Health’s first report. In addition to helping guide Ignite’s editorial agenda to ensure its content is most relevant to our clients, the Optum Institute produces research and works in partnerships with health care communities, academic institutions and health organizations.

This issue also examines innovations to improve (and perhaps simplify) health care, including care transitions and interoperability. Look for our Q&A with Judy Rich, president and CEO of Tucson Medical Center, to learn about three new care transitions initiatives the Center is adopting. Rounding out the issue, we’ve included a column by Todd Cozzens, CEO of Accountable Care Solutions at Optum, who explains how a new core of health information technologies can help providers manage a broader population of patients.

You can find additional information on all of these and other topics by visiting our website at ignite.optuminsight.com. Look for a recent article exploring telehealth as a means to reduce readmissions as well as a video roundtable in which experts discuss the results of the Optum Institute study.

I hope you enjoy this latest issue of Ignite, and as always, I look forward to the conversations that ensue.

Sincerely,
Andy Slavitt
Group Executive Vice President, Optum
Interoperability is key to an effective, coordinated health care system. But is enough being done to foster it?

Improving care transitions can help improve outcomes while reducing readmissions.

The Optum Institute for Sustainable Health explores opportunities to improve care coordination.

A new core of health IT tools can help stakeholders manage a broader population.

Judy Rich describes three care transitions strategies to reduce preventable readmissions.
**Online Exclusives**

**Expert Roundtable on Health Care Sustainability**

[ignite.optuminsight.com/instituteRoundtable](ignite.optuminsight.com/instituteRoundtable)

Optum experts discuss the findings from the Optum Institute for Sustainable Health’s inaugural report, revealing opportunities to improve alignment among physicians and increase transparency for patients.

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**Telehealth Is Calling**

[ignite.optuminsight.com/telehealth](ignite.optuminsight.com/telehealth)

Telehealth can help care managers connect to patients remotely and reduce readmissions. Optum experts reveal the challenges to widespread adoption of the technology and offer tips for telehealth success.

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**HIGHLIGHTS**

**Podcast: The Right Time for Interoperability**

[ignite.optuminsight.com/ShlainPodcast](ignite.optuminsight.com/ShlainPodcast)

Jordan Shlain, MD, of OptumInsight’s Physician Advisory Board, speaks frankly about the challenges of a health care system that is not interoperable and explains how cloud computing can help solve the problem.

**Web Exclusive: End-of-Life Care in an Accountable Care Environment**

[ignite.optuminsight.com/EndofLife](ignite.optuminsight.com/EndofLife)

The most dollars spent in health care are spent on end-of-life care. Optum experts explore how costs can be curbed and reimbursements can be made, even when the outcomes might not always be positive.

**Web Exclusive: Community-Based Care Transitions**

[ignite.optuminsight.com/CommunityCare](ignite.optuminsight.com/CommunityCare)

The Centers for Medicare & Medicaid Services is funding a Community-Based Care Transitions Program. Find out what makes these models effective.

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**SOCIAL SPACES**

**LinkedIn:** Network with your peers on the Ignite Health Transformation Forum. Recent topics include the future of health care reform and prescription drug prices. Search “Ignite Health Forum” and join today.

**Twitter:** Stay up-to-date when new content is added to the Ignite website and on other news happening at Optum. Follow us at twitter.com/optuminsight.
Shaping the Future

The Optum Institute for Sustainable Health’s inaugural study makes the case for improvements to care coordination and preventive care.

Care that is integrated and coordinated around the needs of patients—and not necessarily institutions—is essential to increasing the sustainability of health care. A growing body of research shows that failures in coordination of patient care can lead to unnecessary readmissions and procedures, gaps in care particularly during care transitions, avoidable costs, duplicative tests and so on. Stakeholders industry wide are now exploring ways to better coordinate care (including the use of technology and preventive care) to enable better patient monitoring and accountability for patient outcomes.

The Optum Institute for Sustainable Health conducted a survey with Harris Interactive to explore perceptions of U.S. adults, hospital executives and physicians on the future of health care. The data, released in the Optum Institute’s inaugural report, reveals a number of opportunities with regard to care coordination and a need to make changes now. “That’s the first step—understanding what’s happening in our own backyards,” says Carol Simon, senior vice president and director of the Optum Institute. “The next step will be distilling the experience of the health care community into best practices.”

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Hospital executives see opportunities for care coordination:

- **65%** of hospital executives say improving care coordination among physicians could increase quality of care.2

Survey results show that patient care can be better coordinated:

- **Only 29%** of physicians say that care is coordinated in their communities.1
- **Only 47%** of electronic medical record systems planned or in use will allow physicians to share patients’ medical records with hospitals.

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1 Optum Institute for Sustainable Health released the report, “Sustainable health communities: A manifesto for improvement.” To read the full report, visit institute.optum.com.

2 Optum Institute for Sustainable Health/Harris Interactive Multi-Stakeholder Community Healthcare Study, November 2011.
An Opportunity for Prevention

All stakeholders saw opportunities for improving access to preventive care in their communities. Only 35 percent of U.S. adults, and only 50 percent of physicians, felt that patients in their community “often or always” received needed preventive care.

Source: Optum Institute for Sustainable Health/Harris Interactive Multi-Stakeholder Community Healthcare Study, November 2011.

Preventable Hospitalizations

Preventable hospitalizations vary widely across the United States. States in the West rank the lowest in terms of preventable hospitalizations among the elderly, while states in the Midwest and South show an opportunity to decrease preventable admissions.

Source: America’s Health Rankings: www.americashealthrankings.org
The New Core and the ACO Impact

By Todd Cozzens
CEO, Accountable Care Solutions, Optum

The business of health care is changing. Over the past two years, virtually every aspect of business has undergone great transformation—and the pace of change continues to accelerate. Just one example is the Affordable Care Act of 2009, which led to the new Medicare Shared Savings Program (MSSP). With the release of final MSSP regulations by the Centers for Medicare & Medicaid Services (CMS) this past November, there is new energy around the creation of accountable care organizations (ACOs).

These regulations, among other risk-bearing models, are pushing organizations to take a hard look at how they run their businesses today, as well as how they’ll adapt to an evolving landscape tomorrow. To anticipate risks, meet the needs of future services and adopt new health care delivery models, organizations must embrace a new generation of health information technology (HIT).

And we certainly have the foundation in place. According to a recent survey commissioned by the Optum Institute for Sustainable Health, by the beginning of 2012, the hospital sector had made impressive progress in adopting electronic medical records, participating in health information exchanges (HIEs) and moving along the path toward attesting to “meaningful use.” But there is a broader health agenda in play and a need for HIT that focuses not just on patients currently seeing physicians and being admitted to hospitals, but on a much broader population of consumers. This more expansive view of the patient opens the door to a spectrum of analytics, clinical transformation tools, wellness/prevention solutions and automated care management systems for the comprehensive management of patients, especially those not currently seeking treatment. This is “the new core.”
These new tools, which focus on managing the health of populations, will enable a new age of care. This new age will see consumers who get much more engaged in their care. Health organizations will follow their patients from different risk categories as they migrate through the health system—from pre-hospital/ambulatory settings to post-acute care and home. And as government-sponsored health care expands, so, too, will the need to outsource the capabilities to manage the new lives covered. This can be a whole new world for physicians and other more empowered caregivers, who will get paid to take care of patients the way they were trained, instead of being handlers of “care transactions,” as in the past.

The ACO Impact

We’re seeing the momentum building from CMS-designated Pioneer ACOs (which test shared savings models at a higher rate of shared savings and risk than typical ACOs) as well as the number of large physician groups seeking MSSP status. Today, some 32 Pioneer ACOs are taking on risk for large populations of Medicare patients for which they weren’t previously responsible. As top-performing physician groups apply for MSSP status and invest in new tools, they’re recognizing that the future of bearing and managing risk is inevitable. Still, physicians feel they are more prepared today to take on greater responsibility for managing patient care than they are the financial risk of managing care. Only 6 percent of the responding physicians feel they are extremely/very prepared to assume greater financial risk, according to the results of a recent survey commissioned by the Optum Institute.

Even so, by the end of this year, there could be at least 50 major health systems and physician groups managing full risk for at least 10 percent of their patient population—a lofty prediction, but one that is already moving toward fulfillment. Regardless of their motivations (e.g., cost reduction, market share, pilots with provider employee populations or payer-led efficiency programs) or reservations, there is no longer a question of whether providers will become more accountable. Now, the question is when and how to make the change.

Making the Change Amid Revenue Pressures

It’s clear that the ability to access and leverage the new core of HIT is a crucial capability if hospitals want to survive. But against this reality is a sobering picture of the revenue situation of many U.S. hospitals. Hospitals leak revenue, with the average health system collecting only a third of what they actually bill under the current fee-for-service system. On top of this, organizations will need to adjust to a fee-for-value payment system. Just meeting the basic requirements and maintaining status quo in this new environment will be challenging. As a result, over the next year hospitals will need to place an emphasis on closed-loop revenue cycle management, making it easier to adapt to new HIT systems and offer long-term improvements, rather than quick fixes that are not sustainable. They need to act sooner rather than later because adopting new core tools will require significant investment, and that won’t be possible if they don’t stop the bleed.

While adapting their models for the future and dealing with intense margin pressures, hospitals also must have an ICD-10 strategy. If hospitals aren’t prepared for ICD-10 and the increased specificity it demands in documentation, they risk losing significant revenue. According to many industry reports, less than 10 percent of health care providers are halfway to ICD-10 readiness. But with the introduction of up to 155,000 new reimbursement codes, ICD-10 could be a significant challenge for some hospitals. Ill-prepared hospitals face lost productivity, delays and denied claims. When coupled with undercoding, this could deliver a financial hit of as much as $850,000 for an average 250-bed hospital in the year following ICD-10 conversion, according to a recent analysis of publicly available information. Hospitals simply cannot afford these potential losses at a time when they must commit significant resources and make substantial investments in new delivery models.

Looking Back, Looking Ahead

The term “accountable care” arrived on the scene en masse in 2010; in 2011, we saw government regulations sorted out and the development of private partnerships around shared risk; 2012 will be remembered as the year the ACO translated into new models of care, with hospitals and large physician groups starting to manage risk and deliver care in a much more integrated fashion. As a result, HIT as we know it will transform. From a new breed of analytics that help measure quality outcomes, to secure networks enabling physicians to share patient information in a more integrated fashion, the new core has arrived.
OPEN CIRCUIT

In search of an effective, open exchange of information across the health system, stakeholders are uniting around interoperability.

By Janan Hanna
According to findings from an October 2011 survey by the Optum Institute for Sustainable Health/Harris Interactive, about half of physicians are already using some type of electronic medical record (EMR), with another third planning to implement similar systems in the next two or three years. It’s exciting and promising progress. But it will take something more to create long-term, sustained improvement of patient outcomes.

Hospitals and physicians are working hard to meet the requirements of the Centers for Medicare & Medicaid Services’ (CMS) Meaningful Use program, which was created by the American Recovery and Reinvestment Act of 2009. The program provides financial incentives to providers who prove meaningful use of an electronic health record (EHR), a medical record intended to reach beyond a single practice and aggregate broader data about a patient’s health. Meaningful Use requires that a provider be able to demonstrate their use of the technology in a way that can be measured. The program is rolled out in three stages. Proposed Stage 2 requirements were released in February 2012. Hospitals and physicians will need to meet the new Stage 2 requirements in order to qualify for incentive payments. The proposed rule also revises certain Stage 1 criteria, as well as criteria that apply regardless of stage. In 2015, the incentives become penalties in the form of reduced Medicare and Medicaid reimbursements for non-compliance.

Meaningful Use funding can help providers offset the cost of transitioning from paper to create useful electronic digitized medical records. “While the broad adoption of EMR technology should be celebrated, we cannot stop there,” says Dan Kinsella, senior vice president of accountable care solutions at OptumInsight. “In reality most patients are under the care of multiple physicians who are using various EMR products. Significant barriers exist in achieving our ultimate goal of having all relevant patient data available to an authorized caregiver in a secure and timely fashion.”

These limitations could impact patient care. For example, an elderly patient, arriving at a hospital emergency room from an assisted living center, may take medication that is listed at the assisted living center but is not noted at the hospital. He or she may be given medication that has counter-indications, or adverse effects, simply because the providers at one institution were not aware of the information given to providers at another institution.

“I think everyone knows intellectually that the more we can share information to benefit the patient, the better the outcome,” Kinsella says. “The result is increased safety and cost efficiency.”

Stakeholders are now seeking the creation of open information exchange capabilities that would allow all providers at various points of care to see relevant sections of a patient’s record—a concept known as “interoperability.” Perhaps in no other context is access to information more crucial than in health care, where errors resulting from a lack of information can cost lives.

**To Span the Silos**

Amid society’s high-tech information revolution, we have
come to take for granted certain benefits, such as Internet accessibility and the ability to exchange documents across platforms with sophisticated browsers and search engines. Unfortunately, such user-friendly applications and tools are not yet a reality for health care. This is due, in part, to the complex and fragmented nature of the health system, accompanying regulations and intense focus on data security and protecting patient privacy. Concerns aside, the industry is currently facing growing economic and regulatory pressures that make its IT infrastructure ripe for radical change.

“When Congress enacted the HITECH Act back in 2009, they made it very clear that they didn’t want to just be buying systems for physicians and hospitals,” says Joel White, executive director of Health IT Now, a coalition of health care providers, patient groups and payers that promote the use of technology. “Congress fully expected these systems to work together for a very definitive purpose.”

That purpose was not just to achieve interoperability for its own sake. “Rather, we’re interested in reaching the benefits that interoperability enables, which is the effective sharing of information among authorized and collaborating providers who are focused on a particular patient,” Kinsella says. “Interoperability has been the Holy Grail for health IT. It’s a little bit like the frog that jumps halfway to the wall. You make progress but you never quite get there.”

But privacy concerns, disagreements about how much information should be exchanged and other questions have kept interoperability from becoming a reality in recent years.

**To Meet the Challenge**

Closing the gap in the pursuit of interoperability will require 1) stakeholder agreement on standards, 2) “openness” of health IT systems and 3) alignment of economic incentives.

**Standards:** Health care is challenged with creating information systems that all speak the same language or translate data into information the systems can understand. This has long been a goal, yet federal standards and incentives are not in place to make this a reality. Health Level Seven (HL7) is an organization that works collaboratively to define standards for exchanging health information across systems. Specifically, HL7 defines standard transaction sets, along with the layout of the content included in each transaction. Systems integration involves the specification of trigger events, data bundles and delivery protocols among disparate systems. But HL7 on its own does not address the variability of content as it is captured and stored—even within standard formats, Kinsella says. For example, lab test names can vary substantially from one provider to another, even if they use the same EMR tools. Symantic interoperability looks at the challenge of standardizing content through code sets.

“I THINK EVERYONE KNOWS INTELLECTUALLY THAT THE MORE WE CAN SHARE INFORMATION TO BENEFIT THE PATIENT, THE BETTER THE OUTCOME.”

—Dan Kinsella, Senior Vice President, OptumInsight
At present, HL7 standards are widely used within a health system, a hospital or practice, says Mark Morsch, vice president of technology at OptumInsight, but they generally aren’t used across health care networks. It’s not mandatory for providers to use the standards or to exchange health care information. More recently, standards addressing how data is shared across health information exchanges (HIEs) are becoming a greater focus among early adopters of accountable care programs, Beacon Communities and state-level HIEs.

Open systems: Many systems aren’t open, but instead are blocked from sharing information with other systems. Today, physicians and staff within a small practice can share EHRs among themselves, but they can’t typically reach out to the local hospital to get lab results or to another practice for data on office visits without significant systems integration effort. Federal standards may not solve this issue. “Meaningful Use requires a consistent collection and exchange of certain information,” Morsch says, “but I don’t see any indication that it’s going to mandate adoption of full interoperability.” Instead, Morsch says, a solution will likely come about when there’s enough market pressure from those who don’t want to be locked into closed systems.

Economic incentives: Prior to the American Recovery and Reinvestment Act of 2009, there were too few incentives for health care organizations to want to work with interoperable systems and standardized data. In the absence of government intervention or heavy consolidation, there is a diverse and fragmented market of buyers for the myriad of today’s EMR offerings. “We have the market forces of a very fragmented buyer community—from single practice physicians for whom a $5,000 capital expenditure is something to be mulled over, to large health systems that are now trying to consolidate for economies of scale,” Kinsella says. “There’s not a universal business case to deploy true interoperability for everybody everywhere.”

In some cases, providers could have to spend many millions of dollars and a couple of years of work to implement integrated systems, says Ted Hoy, senior vice president of cloud services at OptumInsight. Hoy advocates for a “collaborative process” to bring all industry stakeholders together to create an open system. Providers must be encouraged to buy certified open platforms and recognize that they will save money in the future through reduced IT and health care costs.

To Join the Cloud
For Jordan Shlain, MD, founder of Current Health (a seven-physician practice in San Francisco) and Healthloop.com
and a member of OptumInsight’s Physician Advisory Board, it seems obvious that the industry should be heading in the direction of cloud computing. Cloud computing allows participants—wherever they are—to access software applications and information with little more than an Internet connection and a Web browser. The structure pulls providers out of a physical space and allows for open exchange in a virtual space. There’s no expensive IT infrastructure to buy or maintain, little or no capital investment, lower operating costs and improved data sharing among different organizations.

“The cloud is clearly where all this has to go because that’s where everything else is going—why would health care be different?” Shlain says. “People think health care should be different because they have a loyalty to the way it’s always been and they fear change. I welcome change. I’ll go toe-to-toe with anybody who says it isn’t going to work or this can’t work or shouldn’t work.”

To Move Forward
A reimbursement model where providers are paid for volume to bending the cost curve such as accountable care organizations and other Sustainable Health Communities create a new set of incentives for alignment, with a business case for more open sharing of information. Available tools such as interface engines and HIEs are being stretched to accommodate basic and advanced functions that enable better coordination of care. The knowledge that connected health records and open systems could help to curb duplication of services and reduce readmissions should drive a demand for a connected solution.

“Figuring out how to bring a universe of 5,000 hospitals, 750,000 physicians, a couple of thousand payers and the government all together on the same page is a pretty daunting task,” White admits. “But I think if the standards exist, the technology can support the standards. And I think if we have strong government leadership that supports solid federal standards that the private market can build on, we can get this done.”

PODCAST
Jordan Shlain, MD, says now is the time for cloud computing. Listen to the podcast at ignite.optuminsight.com/ShlainPodcast
Providers are taking a new look at care transitions as a way to fill gaps in care and prevent unnecessary readmissions.

**With health care costs on the rise,** health care stakeholders are honing in on readmissions and insufficient care planning before and after discharge as key vulnerabilities leading to increased costs. During care transitions, patients sometimes fall through the gaps in care—failing to fill prescriptions or misinterpreting instructions for self-care. As a result, they end up back in a hospital or at a physician practice.

Pramod K. Gaur, PhD, vice president of telehealth at OptumHealth, identifies three main factors that lead to readmissions: 1) The patient fails to fill or take medication or fails to take medication properly; 2) the patient fails to follow up with their primary care physician or specialist within one week after discharge from the hospital to discuss continuity of care; and 3) health and social aspects at home (such as a caregiver not understanding how to properly care for the patient) could lead to an exacerbation, and ultimately, a readmission.

Resulting readmissions are costly. According to research quoted in the Oct. 18, 2011, issue of *Annals of Internal Medicine*, nearly 1 in 5 Medicare patients discharged from the hospital is readmitted within 30 days. The Medicare Payment Advisory Commission (MedPAC) estimates that the Centers for Medicare and Medicaid Services (CMS) spends $15 billion a year on readmissions, or about $7,200 for each patient who is rehospitalized. And according to MedPAC, two-thirds of all readmissions are preventable.

"An effective feedback loop to accurately assess and reassess a patient’s readmission risk is necessary," says Miles Snowden, MD, chief medical officer of OptumInsight.

This is the new care agenda: To work together to improve care transitions, which ultimately reduces costly and unnecessary readmissions and improves the quality of care overall. Hospitals and other providers are proactively developing and adopting new care transitions strategies to change the way patients receive care from the day they check in through post-discharge.
The Financial Factor

Providers have an added push to develop and adopt new care transitions models, thanks to impending penalties from CMS. Beginning in October 2012, the CMS Hospital Readmissions Reduction Program will reduce Medicare reimbursements for hospitals with higher-than-average 30-day readmission rates for patients with heart failure, acute myocardial infarction and pneumonia, with additional penalties coming for other conditions in the next few years.

According to the CMS Office for the Actuary, reducing preventable readmissions could save the agency as much as $8.2 billion by 2019. For providers, implementing care transitions could also save them money in the long run through avoidance of penalties. “Because Medicare penalties will be so substantive, care transitions strategies will be worth the return on investment,” Snowden says. “We’ve found that for every dollar invested in care transitions, for hospitals facing penalties from CMS in 2013, a return of $7 to $9 in avoided readmission penalties is not uncommon.”

Seeking to reduce readmissions and avoid penalties, providers across the country are experimenting with existing models for care transitions and developing and implementing models of their own. It may be too early to determine which model will be most effective for a localized health organization. Yet these strategies serve as examples of ways that providers can blaze their own trails to address gaps in care among specific populations.

Focusing on Seniors

Tucson Medical Center (TMC) in Tucson, Ariz., has a number of strategies to address care transitions as part of its affiliation with Arizona Connected Care (ACC), an accountable care organization (see Q&A, page 19). The hospital itself is focusing on care transitions to address gaps in care for older adults, a high-risk patient population that TMC addresses with a senior services program and a variety of activities.

To help prevent readmissions, TMC works closely with grassroots, community-based organizations outside of the hospital including the local aging network and other local initiatives. Through TMC’s senior services post-hospital support program, a TMC staff member follows up via phone with patients at risk for readmission “to make sure they’re able to make appointments, that they filled their medications and that they understand their discharge,” says L’Don Sawyer, TMC’s director of senior services. In addition, TMC has 75 skilled volunteers available at its wellness center, Healthy Living Connections, to provide health coaching and Medicare counseling, lead support groups and refer patients to other community resources.

Mylynn Tufte, vice president at OptumInsight and project lead for the Office of Care Coordination for TMC, says these
programs reflect TMC’s adoption of the Coleman Model (see sidebar), which urges patients to take more of a hands-on role in their own care. In doing so, TMC works with seniors to help them reduce their own risk for readmission.

Community-based services such as those offered by TMC are getting a new boost through incentives from the CMS Community-based Care Transitions Program (CCTP). As mandated by the Affordable Care Act, CCTP provides funding to test models for care transitions for high-risk Medicare beneficiaries. CCTP began accepting participants on a rolling basis in April 2011 and plans to continue reviewing applications through the beginning of 2012. The program has selected seven programs to test community-based care transitions models so far.

Monitors the Homebound
Bangor Beacon Community is a coalition of several hospitals in Maine. The coalition received a three-year federal grant from the Office of the National Coordinator for Health Information Technology to improve its care management, care collaboration and health records. In August 2011, Bangor Beacon began testing telehealth on high-risk, non-homebound patients to see if in-home diagnostic monitoring could help to reduce readmission rates, emergency room visits and improve outcomes.

As part of the study, participants take simple diagnostic tests, respond to specific disease-related questions and then transmit the data to a central monitoring center via a basic phone line connection, says Catherine Bruno, executive sponsor at Bangor Beacon and chief information officer for the Eastern Maine Healthcare Systems. A telehealth nurse in a central monitoring center receives daily vital signs such as blood pressure, blood sugar levels and weight, along with responses to disease-related questions to identify trends and adjust the patient’s plan of care to maintain the patient in the community.

“We review data daily with the primary care provider’s care managers, look at patients who are at risk for an emergency room visit or rehospitalization, and evaluate the patient’s understanding of their chronic disease. The telehealth nurse calls the patient to discuss the information and works with care managers to discuss improvement plans,” Bruno says. “Roughly 20 care managers collaborate and share best practices based on findings from the data.”

### Models for Post-Discharge Care

Following are four popular care transitions models being tested by hospitals across the United States.

**Care Transition Intervention:** Also known as the Coleman Model, this model uses a transitions coach to track patient progress via electronic health records and helps patients and families learn self-management skills. The coach also makes an in-home visit within 72 hours of discharge, actively works with patients on medication reconciliation, notes any potential complications and makes three follow-up phone calls to review patient progress.

**Transitional Care Model:** Also known as the Naylor Model, this program targets older adults ages 65 or older with two or more of the following risk factors: poor self-health ratings, multiple chronic conditions and/or history of recent hospitalizations. The model incorporates a transitional care nurse who visits patients in the hospital to conduct a risk assessment and develops a post-discharge plan of care. The nurse also visits the patient within 24 hours of discharge and facilitates communication between the patient and his/her physician, caregivers and home health professionals.

**Better Outcomes for Older Adults through Safe Transitions (BOOST):** This model targets high-risk patients (particularly older adults) during the hospital stay and includes a follow-up call or visit within 72 hours of discharge. The program uses hospital-based multidisciplinary teams who follow a well-defined set of processes and procedures, including a universal checklist and general assessment of preparedness, to determine whether patients and caregivers are ready to transition out of the hospital.

**The Bridge Program:** This model targets older adults ages 60 and over who meet two of the following criteria: discharged with home health referral, lives alone, hospitalized in the past six months, caregiver assessed as stressed/overburdened and/or a high determination of need. The program incorporates social workers (or “bridge care coordinators”) who provide care coordination and information about community-based resources, set up transitional care services, and call patients twice (within two days of discharge and again at 30 days post-discharge) to track patient progress.
By not only using telehealth strategies in the home, but also measuring the results, Bangor Beacon hopes to incorporate feedback from the study to better manage patients and reduce readmissions.

**Adopting Telehealth**

Stony Brook University Hospital in Long Island, N.Y., is also testing telehealth efforts as a way to reduce readmissions. Before it became popular to discuss post-discharge strategies, Stony Brook had been tracking their patients 30 days after discharge to assess risk of readmission. But a discovery in 2009 caused them to reassess their processes: Stony Brook’s study of their own data from 2006 to 2009 revealed that its 30-day readmission rate for heart failure, pneumonia and heart attack was above the national average.

In December 2011, Stony Brook launched a six-month pilot program to closely monitor 200 patients with congestive heart failure. The program begins the day the patient is admitted, says Gaur, who consulted with Stony Brook on their telehealth efforts. A nurse at the hospital serves as the patient’s onsite health adviser who assesses the patient’s risk factors and then tailors a 30-day post discharge care plan. Often the same nurse provides continuity of care and serves as the patient’s offsite health adviser after discharge.

Using a “high-tech/high-touch” approach, the patient is closely monitored throughout the length of the 30-day plan. The high-tech portion incorporates remote diagnostic testing and patient monitoring via live webcam contact with clinicians. The high-touch portion promises coordination and regular communication among patients, caregivers, clinicians and pharmacists as well as Stony Brook’s affiliated skilled nursing facilities and home care agencies. The decision on whether to use high-tech, high-touch or both depends on the specific needs of the patient, Gaur says. The point is to focus on the individual patient to better understand his/her needs and risks and avoid readmission.

**Care transitions models are used to maintain contact with the patient to ensure they will be able to manage their own care from home.**

**Coming Full Circle**

Regardless of which care transitions model a health care organization adopts, it is important to maintain a continuity of care from the moment a patient walks into a hospital through post-discharge. “You start the first step of a successful care transition at the very beginning of hospitalization,” Snowden says.

Snowden recommends using a screening tool or risk assessment to help determine the patient’s risk for readmission where practical—before that patient even receives care. Information gathered from the assessment can then be used to determine the appropriate care transitions model that should be used. Care transitions models are then used to maintain contact with the patient to ensure they will be able to manage their own care from home.

It will be important, too, for providers to evaluate the success of their efforts. In Snowden’s experience evaluating institutions in the Southwest that have deployed care transitions program, the results are compelling. “Among those patients post-discharge where an institution deploys care transitions programs, the rate of readmits for targeted adult medical conditions is less than half of the readmission rate of hospitals (even in the same system) where care transitions programs were not incorporated,” he says. “There’s definitely something there worth keeping and developing.”
As patients transition between care settings—whether from hospital to home, inpatient to outpatient, or otherwise—there are often gaps in care. Health care organizations across the country are working to improve these transitions and reduce preventable readmissions.

Arizona Connected Care (ACC) is an accountable care organization that includes Tucson Medical Center (TMC), New Pueblo Medicine, Saguaro Physicians and other community providers. ACC will implement three care management strategies to assist a patient’s transition to home: on-call nurse lines, transitions coaching and the Hospital-to-Home initiative. Ignite recently spoke to Judy Rich, president and CEO of TMC, to discuss the strategy behind these initiatives.

**IGNITE: WHY IS IT SO IMPORTANT TO CAREFULLY MANAGE CARE TRANSITIONS?**

**Rich:** We know that transitions and hand-offs are where a patient’s care plan can get off track, particularly as they transition from hospital to home. For example, we can be convinced that the patient understood our instructions and find out later that they didn’t understand because they were so nervous that they didn’t hear us, or they didn’t have a family member with them. The strategies we are implementing are designed to support the patients as they transition from the hospital care team back to their primary care physician.

**IGNITE: ACC WILL BE USING ON-CALL NURSE LINES TO SUPPORT ACO PHYSICIAN PRACTICES AND ALLOW PATIENTS TO GET IN TOUCH WITH NURSES FROM HOME. HOW DOES THIS HELP AVOID READMISSIONS?**

**Rich:** The most important part of the nurse call is that it’s immediate and it’s available. An 80-year-old woman with shortness of breath at 1 a.m. will now have access to on-call nurses who can help make a decision about whether she needs to be seen right away. The secondary benefit is that the call will be personal; it’s not going to feel to the patient like they’re calling random people off the street.

[Podcast: Read a Q&A on care transitions with Pramod Gaur, vice president of OptumInsight, at ignite.optuminsight.com/GaurQA]
There have to be **people with names and faces who connect with the patient, who visit them at home, who see them before they leave the doctor’s office.**

patient like it’s somebody far away who is very remote and disconnected. The on-call nurse will have access electronically to the patient’s record. Our expectations are that the nurse call system will show the patient that the nurse knows them.

**IGNITE: THE ACC TRANSITIONS COACH WILL BE A REGISTERED NURSE WHO WILL MEET WITH PATIENTS WITHIN 24 HOURS OF DISCHARGE AND FOLLOW UP WITH AT-HOME VISITS. WHAT’S DRIVING THIS STRATEGY?**

**Rich:** The transitions coach program is based on the Eric Coleman Care Transitions Intervention interdisciplinary model for care transition. The patient is visited in the hospital to start to define the goals for the whole relationship. Then there is a home visit that happens within three days of discharge with a lot of explanation about medications. A really important part of this transitions coach program is to identify potential complications and follow up to ensure that those issues are managed effectively.

**IGNITE: THE NATIONWIDE HOSPITAL-TO-HOME (H2H) INITIATIVE WAS INTRODUCED AT TMC TO REDUCE CARDIOVASCULAR-RELATED HOSPITAL READMISSIONS. HOW DOES THIS WORK?**

**Rich:** The H2H initiative empowers patients to care for themselves after leaving the hospital. It really gets to the heart of the issue: Our H2H nurse told me that her job is to love her patients no matter how challenging. One by one, she teaches them how to take better care of their health. It’s a very personal, self-management program that says, ‘your life can be better if you’ll do these things, and you have a nurse that can help you do that.’ We also have dieticians, therapists, pharmacists and other educators that we can call upon to be a part of all of this. We have been doing this for a year at TMC and we’ve seen our congestive heart failure readmission rate drop from 22 percent to 9 percent. Diabetes, COPD, Alzheimer’s and Parkinson’s are future opportunities for this program.

**IGNITE: HOW DO YOU MAKE PATIENTS AWARE OF AVAILABLE CARE TRANSITION SERVICES?**

**Rich:** We have to spend more time on discharge than we ever have before. During that time, we reinforce what we’ve told the patient throughout their hospitalization. We give the patient clear instructions on how to call a phone number to reach somebody 24/7. It really comes down to education, and then of course we have to make sure it works as we have designed it. Whether the nurse responding is sitting in Tucson or another city, we’re counting on that relationship to be just as effective and just as personal as if the person were sitting right beside them.

**IGNITE: HOW CAN OTHER STAKEHOLDERS SUCH AS PHARMACIES OR PAYERS BE INVOLVED IN CARE TRANSITIONS?**

**Rich:** Right now there’s really no coordination of the pharmacies and the doctor’s office and the hospital and the home health agency, but we are building a system that will bring them together and make them a very active partner in managing the patient.

**IGNITE: DOES THE SOLUTION FOR COORDINATED CARE TRANSITIONS ALSO LIE SOMEWHERE IN TECHNOLOGY?**

**Rich:** We believe that the opportunity to reduce health care costs is only going to be possible by leveraging technology. We stand in the gap between technology and the patient, always looking at how we can do things differently. We’ve had a major shift here at TMC in the last two years with an electronic medical record, and we’ve seen the exciting possibilities that come from that. We feel sometimes like we’ve leveraged about 10 percent of the whole capability of that system.

However, I’m a nurse, and I would never tell you that technology is the sole answer because care transitions still have to have a very high-touch solution. There still have to be people with names and faces who connect with the patient, who visit them at home, who see them before they leave the doctor’s office or before they leave the hospital. It’s a nice combination of both.
About Optum
Optum is a leading information and technology-enabled health services business dedicated to helping make the health system work better for everyone. Optum comprises three companies – OptumHealth, OptumInsight and OptumRx – representing over 35,000 employees worldwide who collaborate to deliver integrated, intelligent solutions that work to modernize the health system and improve overall population health.

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