

Preventing patient rebounds



Value-based care organizations should focus on more than just readmissions

It is estimated that preventable readmissions for Medicare patients cost the federal health care trust fund about \$17.5 billion each year.¹

Medicare's average national hospital readmissions rate has remained steady over time at approximately 19%, with almost 4% of Medicare beneficiaries having two or more readmissions within 30 days.² A data study funded by the Agency for Healthcare Research and Quality found that commercial payers had an all-cause 30-day readmission rate that ranged from 10.1% to 11.9% based on age-band groupings—pediatrics, 11.3%; adult, age 18–44, 10.1%; and adult, age 45–64, 11.9%.³ According to an Optum analysis of 5.4 million commercial and 900,000 retired covered lives, the average commercial readmission cost is 37% higher than an average hospital admission.⁴ Considering the costs, it's no wonder that payers such as WellPoint, UnitedHealthcare, and Aetna have also introduced initiatives meant to slow readmission rates within their insured populations.^{5,6,7}

The evidence is clear: Readmissions increase health care costs and negatively impact quality outcomes. For organizations that utilize value-based care models, the readmissions issue becomes critically important. In 2014, some of Medicare's Pioneer ACOs will transition from a shared savings/shared losses model to a completely "population-based payment,"⁸ meaning they would bear the full brunt of the cost of an unnecessary readmission, not just a percentage. In addition, Medicare Shared Savings Program (MSSP) participants selecting the Track 2 risk model, which includes upside and downside risk, may see zero shared savings if they do not meet cost and quality goals. For provider organizations participating in commercial fee-for-value partnerships, they may already be fully responsible for readmission costs.

And readmissions aren't the only concern. Any sort of patient rebound is a negative outcome for organizations operating under a value-based payment model. For instance, when a discharged patient rebounds to a hospital emergency room within 30 days, it can also be a costly proposition. The same Optum study referenced above found that about 6% of all discharged patients were treated in an emergency room within 30 days of a hospital discharge, at an average cost of more than \$1,900.⁹ These are significant costs that may have been avoided. Value-based care organizations must put programs in place that would address every sort of preventable patient rebound, not just inpatient readmissions.

This paper will share the perspectives of Steward Health Care System of Boston, MA, and Hill Physicians Medical Group of San Ramon, CA, innovative provider organizations developing integrated care transitions programs that address the root causes of patient readmissions and ER rebounds.

"Success is about building integrated care delivery approaches with the patient at the center of our focus," said Patti Landrum, senior director of care coordination for Hill Physicians. "The relationships between accountable care partners forms the foundation that makes the difference."

A tectonic shift is happening in health care, where outcomes are the bottom line and where the system conforms to the patient, rather than the patient conforming to the system.

Examining readmissions—not just from a diagnosis perspective but on a social, system, provider and patient level—can help develop a comprehensive readmissions program. The care coordinators at Steward have found that social issues are as much a contributor to patient rebounds as medical issues are. “Sometimes things like Mrs. Jones not being able to get cat food can result in a readmission, because her inability to feed the cat is what’s driving her blood pressure up,” said Dominique Morgan-Solomon, Steward’s director of care management.

Understanding the Root Cause of “Rebounding”

Looking at the root causes of patient rebounds can provide a framework for programs to keep rebounding to a minimum. But finding the readmission root causes can be a complex undertaking.

“There are many contributing factors to readmissions that need to be accounted for in a root cause analysis,” Landrum said. “There are many questions to ask: What occurred during the patient’s hospital course? How was the patient managing his/her conditions in the period prior to hospitalization? Was the patient visiting primary care or specialty physicians regularly? Was the patient taking medications as prescribed?”

To validate their hypotheses around the causes of patient rebounding, Hill Physicians conducted a root-cause analysis roundtable with its ACO hospital partners for a specific population. The roundtable included hospital nurses, hospitalists, discharge planners and other care team members. Because individual readmissions were discussed, Hill Physicians and the hospital system were able to modify both inpatient and outpatient clinical and system processes to decrease avoidable readmissions.

To augment root cause analyses, Hill and its ACO partners also sought the patient’s perspective. Hill’s hospital partners interviewed readmitted patients to learn patients’ thoughts about what caused them to return to the hospital, what they understood or didn’t understand about their discharge instructions, and what they might have done differently to achieve a different outcome.

These conversations helped Hill care coordinators galvanize what they learned from their internal analysis, and led them to search published studies on improving care and minimizing readmissions. By adopting practices such as appointment making, non-traditional home health visits, and other interventions, Hill Physicians was able to decrease its 30-day commercial readmission percentage by 20% in one year—from 5.4% to 4.3%.¹⁰

Clinical and non-clinical factors play equally important roles in whether a patient rebounds to the hospital. The clinical factors that lead to readmissions often fall under three headings:

- **Patients don’t follow-up with their physicians after they leave the hospital.** Multiple studies and continuity-of-care programs suggest that patients seen shortly after an inpatient discharge are less likely to be readmitted.¹¹
- **Patients don’t follow the right medication regimen or adhere to a harmful regimen.** Many patients, especially those taking multiple medications, get confused about what to take and when. They may also follow medication regimens that are based on a faulty medication reconciliation.
- **Patients are sicker with more care needs.** As hospital stays are getting shorter and patients are moved to lower levels of care, the patient experiences multiple transitions across the continuum—SNFs, long-term care, rehabilitation hospitals, nursing home and home—causing fragmented provider communication and limited continuity of care.

Non-clinical readmission causes offer significant challenges to integrated care transition programs. Often, non-clinical causes are the most difficult to address because they require a level of patient engagement and support that is not prevalent in the current health care system. Non-clinical reasons for readmissions can often be categorized as follows:

- Patients’ medical literacy is substandard.** While sharing discharge instructions for every patient is standard procedure, some patients don’t have the background to understand what they’re being told due to language barriers, medical context issues and cultural beliefs.

“Discharge instructions are almost always translated into the patient’s language, but it’s not necessarily translated from a cultural competency perspective,” said Steward’s Morgan-Solomon. “So patients are not always clear on what they need to do next.”
- Patients don’t have an adequate support structure.** Some patients rebound to hospitals or emergency departments because they don’t have the support of family or close friends to help them follow their post-discharge program.
- Information is not provided to care providers in a timely manner.** Siloed technology solutions and a lack of interoperability standards continue to make it hard to share the information across inpatient and outpatient settings.

Integrated Care Transitions (Continuity of Care)

Provider-based care transitions programs have addressed the above challenges and decreased patient 30-day readmissions and return-to-ER visits through the integration of discharge planning, post-discharge follow-up and care management interventions.

As noted by both Steward and Hill Physicians, it is the sum of the parts that create the optimal integrated care transition program with an emphasis on continuous improvements.

Improving the inpatient discharge process

The hospital discharge process—at its worst when done simply to indemnify the hospital—is at its best when it takes into account the specific needs of specific patients. The discharge process can be a stressful and hazardous venture for patients, especially patients with high-risk conditions. Developing a comprehensive planning process that incorporates and seamlessly integrates various discharge processes—using best clinical practices defined and agreed upon by the partners—can make a difference in the problem of inpatient readmissions and ER rebounds.

Discharge planning upon admission. Uncertainty about the clinical care plan, differences in patient expectations, communication difficulties, and challenges with securing outpatient resources often derail discharge planning that is done the day of or the day before discharge. The development of a thorough, organized, and comprehensive discharge initiated the day the patient is admitted makes a longer length of stay much less likely.

Primary care appointment setting. Hill Physicians works with hospital case managers to assess clinical risks for patients nearing discharge to see how quickly the patient needs to follow-up with the primary care physician. Hill and hospital coordinators work with the patient to find an appointment date and time that is convenient for the patient and then provide the patient an appointment reminder card that goes home in the

Root Cause of Patients’ Bounce-Back

CLINICAL

Outpatient Follow-up
Medication Regimen
Acuity of Patients

NON-CLINICAL

Patients’ Medical Literacy
Patients’ Support Structure
Sharing of Information

discharge packet. Hill also sends an auto-generated reminder letter to the patient's home. Patients receive a third reminder from the transition-of-care "Welcome Home" nurse. In the year since Hill has implemented the program, it increased the post-discharge primary care follow-up visit compliance rate from 35% to 75%, for patients keeping appointments on the date the appointment was scheduled.

Teach-back process. Another notable inpatient discharge process, known as the *teach-back process*, helps providers know when patients understand their follow-up care needs. The discharging professional first educates the patient or the patient's caregiver about care and follow-up that needs to take place after discharge. Then the professional asks the patient or the caregiver to "teach back," or explain in his or her own words, what was just taught. After a few hours, the discharging professional returns and asks the patient or the patient's caregiver to again explain the care and follow-up that needs to occur after discharge. If the professional decides that the message was not absorbed, teaching and teach-back continues until the professional is confident that the patient or caregiver knows exactly what needs to happen post-discharge.

All these methods have been effective in the Steward system as well as in the hospitals that Hill Physicians members use. Both organizations continue to enhance aspects about their discharge programs as they work to reduce avoidable readmissions or ER visits.

At Steward, clinical social workers collaborate with nurses in the discharge process. Social workers focus on the assessment and coordination of patients once they return home, while the nurses ensure that clinical needs are met upon discharge. Hill Physicians concurrent review nurses focus less on utilization management—or length-of-stay management—and more on supporting hospital discharge planning processes. Hill's nurses work in the hospital with patients and discharge professionals on important items that can present barriers to a successful discharge, such as arranging needed specialist follow-up, facilitating referrals, authorizing post-discharge services, coordinating with home health agencies, or finding a bed in a skilled nursing facility.

Supporting post-discharge follow-up

The Institute for Healthcare Improvement suggests follow-up appointments should happen within two to five days, depending on the patient's risk level.¹² Oftentimes, however, physicians and their staff are not always aware that one of their patients has been hospitalized.

Steward's goal is to have its primary care physicians see discharged patients within three days of discharge, and they are working with their physicians to keep a portion of their calendars open for those quick turnaround post-discharge appointments. Steward holds physicians accountable for seeing discharged patients within that early timeframe. Another strategy that has been utilized by a large provider system in California is to reimburse primary care physicians a higher visit fee when they see patients post discharge within a certain timeframe. This incentivizes providers to hold time on their schedules to perform a comprehensive follow-up.¹³

Likewise, patients need to be reminded how important it is to keep their appointments. "Better Outcomes by Optimizing Safe Transitions"—better known as Project BOOST, a nationally recognized best practice program in care transitions—recommends a follow-up phone call within 72 hours in order to assess the patient's condition and adherence and to reinforce the need for follow-up.

Optum recently completed a pilot readmissions reduction project for a selected population within a 14-hospital system in the southwestern United States. In five of the system's hospitals, Optum nurses met with and assessed every admitted patient within the defined population prior to discharge. The nurses determined what medications the patient would be taking and found out what the patient's living conditions would be upon discharge, taking into account the kind of care the patient would need in the home. Once the patient was discharged, they made a follow-up call with the patient and made sure all appropriate prescriptions were filled and all the orders for in-home treatments were delivered. They reconciled medications between the discharging physician and primary care physician (PCP) and coordinated a follow-up appointment with the PCP. Optum's program resulted in a 30 percent reduction in readmissions for a commercially insured population.

Managing care transitions

In an episodic care environment, providers' responsibility for a patient ends when the patient walks out the door. But in a shared-risk environment, providers are working outside the walls of the hospital to ensure patients don't need to return. Steward and Hill Physicians are using innovative home-based models to improve care outreach.

Steward has taken a holistic approach to helping patients better manage various contributing factors in their lives so they can better manage their health. The system is using what they call "community health workers"—people who are trained to assess patients' home situations. These workers, under the direction of clinicians, see whether the patients are following the right medication regimen and determine whether they have adequate transportation to make it to their next physician appointment or screening. In addition, the community health workers see if there are social supports in place that will help the patient avoid future hospitalizations. If social supports aren't adequate, the worker teaches the patient how to leverage existing community resources.

The emphasis on home assessments is part of a metamorphosis that is occurring within Steward, where they see themselves as a service-oriented, patient-centric organization that provides quality care.

"It is important to recognize when your clinical staff doesn't reflect the patient population. To address this, we provide cultural competency training for our physicians, nurses, pharmacists, and nurse practitioners in an effort to increase their knowledge of the cultural attitudes and behaviors of their various patients," Morgan-Solomon said. "For example, we can help a clinician understand that in the Latino culture, the importance of a colorectal screening is not something they talk about. With cultural competency training, our clinicians are better prepared to communicate with all of their patients."

Hill Physicians is also placing a greater emphasis on reaching the patient at home. One pilot project with a partner hospital system involves home health visits for patients at high risk for readmission at a specific hospital. Rather than providing the traditional home health services, Hill has partnered with its home health agencies to implement a one-time visit with a specific focus on interventions that will help prevent readmissions. Those interventions include reinforcing discharge instructions and the importance of PCP follow-up; validating that the patient is getting any ordered post-discharge therapies; and performing a thorough in-home medication reconciliation.

INTEGRATED CARE TRANSITIONS

INPATIENT DISCHARGE PLANNING

- Early Discharge Planning
- Comprehensive Care Plans
- Teach Patients/Caregivers

POST-DISCHARGE FOLLOW-UP

- Outpatient Follow-up
- Resource Allocation
- Sharing Information

CARE MANAGEMENT

- Program Referral
- Continual Support
- Alternative Care Access

Hill Physicians also implemented a program where chronically ill patients—who have a higher potential for readmissions and ER visits—are managed by a home-visiting physician. The program carefully selects patients based on risk assessment. The home physician works in conjunction with the primary care physician to manage the patient in the home, communicating frequently with both the PCP and the care manager.

In addition to better managing care transitions to the home, both Hill Physicians and Steward are making concerted efforts to manage transitions to skilled nursing facilities (SNF). The cost to Medicare for SNF-related 30-day hospital readmissions comprised approximately 20% of the total cost of all Medicare readmissions.¹⁴

Many of the best practices that address care transitions to the home—root-cause analysis, discharge planning, post-discharge follow-up—can be applied to patients admitted to SNFs. But there are SNF-targeted approaches that value-based organizations should develop to create strong relationships with SNFs.

One approach is to perform an analysis of the SNFs with which they would like to more closely align. Such an analysis can include measuring clinical performance, inquiring into the quality of the SNF's relationships with physicians, and gauging the SNF's desire to improve care.

Another best practice, one implemented by Hill Physicians, is utilizing home-visiting physicians to perform rounds in selected SNFs for high-risk patients. Such a practice can encourage an appropriate level of physician oversight and management.

A best practice that can help all organizations involved in care transitions is to share patient data—electronically, if possible. Sharing data across all care providers, from hospitals and SNFs to physicians and home health agencies, can be accomplished through the use of public or private health information exchanges.

Measuring Care Transition Success

For accountable care organizations and other providers working under fee-for-value arrangements, the costs associated with inpatient and emergency department rebounds are too great to leave unmanaged. Managing and reducing patient rebounds starts with data.

Putting all the relevant information into a dashboard allows leadership and care management teams to quickly review outcomes that can help organizations take immediate action. The dashboard should illustrate performance on an aggregate level and then segment the information on key factors that include market, payer, product, facility, and diagnosis segments.

Anomalies found in rebound rates can lead to better understanding of how to treat that particular population or patient. “We started out by looking at high-level aggregate data to identify areas we wanted to focus on, and then we drilled into the patient-level clinical data. We review the data to identify those areas that we feel we can impact,” Landrum said.

What metrics do organizations need to manage a comprehensive rebound prevention program besides the overall 30-day readmission and 30-day ER return rates?

Track overall 30-day readmission and 30-day ER return rate by payer and by product:

A standard starting measurement is tracking the readmission rate for all patients. Medicare's readmission penalties certainly make it an important segment. But with commercial payers likely to follow CMS's lead,¹⁵ tracking all payer readmissions will put hospitals ahead of the game. For commercial populations, track not only fee-for-value contracts, but also traditional PPO, HMO and fee-for-service contracts.

Track 30-day readmission and 30-day ER return rate by diagnosis: Another layer of granularity, which is supported by the Medicare Hospital Readmissions Reduction Program, is to track rebounding by diagnosis. Doing so can help organizations find overarching issues with the care of certain types of conditions. For example, Steward looked at congestive heart failure (CHF) discharges and recognized that most CHF patients with heart failure were readmitted if they weren't seen within nine days. According to Morgan-Solomon, further investigation showed that patients' dosage of diuretics needed to be adjusted by a clinician between five and nine days after discharge.

Track 30-day readmission and 30-day ER return rate by timeframe: After defining a baseline of patients who have rebounded, cross-referencing patients by the timeframe within which they are readmitted can help care managers determine the reasons behind the rebounding. Consider tracking the following timeframes: one-to-seven days, seven-to-15 days, 15-to-30 days, 31-to-60 days and 61-to-90 days.

Track 30-day readmission and 30-day ER return rate by discharge place of service: Evaluating where readmissions and ER returns are coming from provides insights into the programs that the organization will want to target. If there are a significant number of readmissions coming from SNFs then the organization will want to create defined methods to improve processes and communication.

Track 30-day readmission and 30-day ER return rate by length of stay: It's also important to look at the number of days the rebounding patient stays in the facility. A one-day length of stay likely means the previous discharge was simply too early. Longer-stay readmissions could be caused by a hospital-acquired infection or other complicating factors.

Track 30-day readmission and 30-day ER return rate by service type: Not all admissions are equal. The same is true of patient rebounds. Surgical readmissions result from a different combination of factors than medical readmissions. For example, surgical readmissions due to hospital-acquired infections could suggest issues with surgical protocols, while medical readmissions could highlight those chronically ill patients are not being managed properly. And ER returns that don't result in an inpatient admission likely occurred for different reasons than ER returns that resulted in a full-fledged re-hospitalization.

Track 30-day readmission and 30-day ER return rate by physician: Another layer of granularity is to track the rebounding rates by physician to determine if there are issues with follow-up. If individual physicians are outliers, the organization can perform a root-cause analysis to help the physician improve outcomes.

Track post-follow-up visit rate: Assessing if patients are following-up with the provider within a defined timeframe allows the organization to monitor and enhance processes to ensure patient adherence. Evaluate follow-up visit information by time after discharge to follow-up—zero-to-five days, six-to-10 days, 11-to-15 days, etc.—and correlate the information to readmission and return ER visit rates.

While data can point to problems, it is only a starting point for finding solutions. These above measurements help organizations guide their root-cause analysis activities for readmissions. Only when root causes are known should organizations develop and implement programmatic interventions.

Conclusion: Success Hinges on Patient Focus and Partner Relationships

Limiting readmissions is part of a global strategy to improve care coordination at Hill Physicians Medical Group and Steward Health Care System. These and other cutting-edge health care organizations are dedicating significant resources to improve care and drive down costs, and their efforts are justified by the results. It's all part of a tectonic shift that is happening in health care, where outcomes are the bottom line and where the system conforms to the patient, rather than the patient conforming to the system.

"Hospitals and health systems have to think of ourselves in more of a service capacity," said Steward's Dominique Morgan-Solomon. "There are so many other business models that are meeting the consumers of health care where they are. The point is consumers getting what they want, right when they want it."

No one wants a long hospital stay, much less two hospital stays within weeks or months of the other. Preventing readmissions takes a high-touch approach with patients, but it also requires a high-touch approach between coordinating organizations.

"It's not that any of the interventions around readmission prevention are a great mystery," Landrum said. "The challenge is creating an integrated structure across partnering organizations that can enable us to take advantage of information exchange and coordinated processes."

Preventing readmissions takes a high-touch approach with patients, but it also requires a high-touch approach between coordinating organizations.

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