Building Dynamic Post-Acute Partnerships to Reduce Readmissions

by Jared Landis and Harrison Brown

The average hospital discharges patients to more than 60 post-acute facilities and agencies with nearly 40% of patients discharged into post-acute care nationally. As a result of these realities, the secret is out: post-acute partnerships are an invaluable part of any hospital’s readmission reduction strategy.

In response, hospital and health system executives have been building preferred post-acute provider networks that better monitor patient care post-discharge. These networks prioritize transitions to high-quality post-acute providers and are dependent on the successful implementation of joint operating committees—regular meetings that review post-acute clinical performance data and address non-clinical issues impacting the patient transfer process.

Simply establishing mutual expectations can be an effective tool for driving initial performance. When parties agree to standards for service timeliness and information exchange, they can reduce readmissions significantly. Yet after establishing expectations for care, these relationships too often devolve into a single monthly meeting that is a mere review of post-acute quality metrics. Such an approach may maintain the quality of providers in a post-acute network, but it will not address the readmission challenges that result from a lack of alignment between multiple providers in the network.

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Inside and Outside the Hospital’s Walls: Telehealth Reinvents the Continuum of Care

by Brian Rosenfeld, MD

As health systems continue to move to new value-based models of care, understanding how to efficiently move patients from high to lower cost settings and increasing provider productivity is crucial. This includes reducing emergency department visits and hospital readmissions, and increasing the number of patients living and recovering in the comfort of their homes, while providing this care with the same or fewer caregivers. Because personnel already accounts for 56 percent of the $2.8 trillion spent on healthcare in the United States, and the industry is facing a significant shortage of clinicians, simply adding staff will not address the needs of this new model.

As the continuum of care moves beyond the hospital walls, many healthcare executives are struggling to find the right mix of technology, personnel and clinical programs to support these different environments. As a result, many health systems are leveraging telehealth to reinvent their approach to critical, acute and home care in order to meet their quality and cost needs.

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Editor’s Corner

Peter Grant, Jr., Editor, Readmissions News

Greetings readers of Readmissions News! After an extended absence, I am happy to announce that I have returned to reprise my role as Editor of this excellent publication. Its excellence is, of course, due to the top quality content of contributors who represent experts and stakeholders from across the Health System. It has been, and will continue to be, a privilege editing their work. Their insights into the vexing problem of hospital readmissions never cease to amaze me.

As a first order of business, I would like to extend my heartfelt gratitude to our outgoing Editor, Raymond Carter. Luckily for us all, we can still enjoy his excellent work. If you haven’t already, I would heartily recommend exploring several other publications offered by our parent organization, Health Policy Publishing, LLC: Accountable Care News and Medical Home News, both of which continue to be edited by Mr. Carter. There are many other valuable resources offered on all manner of topics. Please take a moment to visit our website and subscribe: www.HealthPolicyPublishing.com.

This issue we are pleased once again to feature an excellent assortment of viewpoints from across the healthcare industry. In our first article, Jared Landis and Harrison Brown of the Advisory Board Company delve deep into the necessity of incorporating post-acute partnerships into any hospital readmissions reduction strategy. From there, our next two articles are largely related to the expanding role technology can play in reducing readmissions. Dr. Brian Rosenfeld guides us through not only the promise Telehealth offers in reducing readmissions, but through concrete examples of how it is doing so in the real world today. Finally, Brian Barberic provides a comprehensive overview of the pioneering work of Dr. Shenyong Wang in developing predictive modeling technology that accurately predicts when Congestive Heart Failure patients will be readmitted.

In keeping with our focus on the impact of technology on readmissions, I had the opportunity to discuss related matters with Eric Heil, the Co-Founder, President and CEO of RightCare. A former NCAA Basketball player, since 2008 Heil has also been at Domain Associates, LLC, a life-science venture capital fund with over $2.4 billion under management, where in 2012 he became an Entrepreneur-In-Residence.

Eric Heil, MBA
Co-Founder, President and CEO
RIGHTCARE
Philadelphia, PA

“RightCare is,” according to Mr. Heil, “a medical technology company that is doing three things. It starts with risk assessment at admission for all patients, so for every patient entering the hospital we are generating a risk score and a set of factors and are ultimately identifying which care plan or level of post-acute care best matches that patient and their needs as well as prioritizing work-flow for patient managers.”

RightCare’s software, D2S2, was developed by a multidisciplinary team of researchers at the NewCourtland Center for Transitions and Health at the University of Pennsylvania led by Kathryn Bowles, PhD, RN, FAAN. Dr. Bowles holds the Ralston House Endowed Term Chair in Gerontological Nursing. RightCare recently entered into a partnership with Houston Methodist, a leading hospital system. Houston Methodist is utilizing RightCare’s full technology suite to identify patients at high-risk for readmission among their mental health population at three of their busiest locations: Texas Medical Center, San Jacinto/Baytown and Willowbrook.

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Reducing Hospital Readmissions Using Predictive Modeling and Real Time IT Solutions

by Brian Barberic, BSBA

Using patient data to reduce hospital readmissions is not a new idea. However, there are new options available using cutting-edge technology to see how various patient parameters interact with each other to accurately predict which patients will be readmitted.

One company, ACOMSplus, in Akron, Ohio, has developed a Readmission Prevention System (RPS), which does just that. It utilizes a sophisticated data mining, decision-tree algorithm with over 65 different medical and non-medical patient parameters to determine which patients are at high risk of readmission.

"Did you know that individuals who receive hemodialysis have three times the chance of being readmitted within 30 days than those without? Or that individuals who do not have a pharmacy are 1.4 times more likely to be readmitted than those who do?" Dr. Wang said. "But it’s not simply about looking at a few parameters like these; it’s about looking at a multitude of parameters and how they interact to predict an outcome."

Under the Affordable Care Act, readmissions can penalize health systems financially. In 2014, over 2,200 hospitals across the US forfeited nearly $230 million in Medicare funding due to high rates of avoidable readmission.

Under the Affordable Care Act, these readmissions can penalize health systems financially. In 2014, over 2,200 hospitals across the US forfeited nearly $230 million in Medicare funding due to high rates of avoidable readmission. That number of penalized hospitals increased slightly from 2013. Reducing readmissions is a key concern for hospitals in 2014, and many are looking at new ways to reliably predict which patients will be readmitted.

But predicting readmissions alone will not solve the problem. Hospitals need to prevent readmission. That is why integrated software platform solutions, like the one offered by ACOMSplus and other companies in the field, are so powerful. They do not take the place of the skilled doctor, nurse or caregiver. Instead, the system continually feeds patient data into the dynamic algorithm until a patient is considered to be at high risk of readmission. At that time, the system recommends intervention strategies. It does not replace the human element, but it enhances it.

The ultimate goal is recommending the proper intervention strategy using a minimal amount of hospital resources. A hospital can greatly reduce readmissions by increasing staff and heavily monitoring every patient after discharge. Of course, that’s unrealistic, and expensive. Instead, hospitals need a system that can predict which patients will be readmitted, and use lean, Six-Sigma principles to recommend the proper intervention strategy, using minimal resources.

A large number of readmissions can be avoided without further medical procedures and tests. Simple and regular post discharge communication, along with vital monitoring and medication compliance verification, are crucial factors in reducing readmissions. The key is allocating the right resources to the right patients. If done correctly, the hospital should significantly reduce readmissions without adding staffing costs.

For ACOMplus, the results have been astounding. The core of ACOMplus’s system, the readmission predictive model, first developed using data from Lake Health System in the Greater Cleveland area, has yielded more than a 70 percent accuracy rating. This was done using only post-discharge billing information and matching it up with readmission data.

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“The beauty of the software we’ve developed,” Mr. Heil replied when asked if their software solutions were specific to mental health patient populations, “is that over a decade of research from the University of Pennsylvania, Dr. Bowles has developed a tool that is not disease specific in terms of its ability to effect a patient population positively. Houston Methodist is not looking for a disease specific tool, which is very difficult to scale, especially with patients with co-morbidities. We have a platform that screens everybody independent of disease.”

“For the industry at large,” said Mr. Heil, when asked about the broader future of technology in the effort to reduce readmissions, “it’s really about a sense of collaboration. There are multiple tools to send a patient home with, including Telehealth solutions, patient engagement solutions, medication adherence solutions and just making sure that the right patients are not only getting the right placement, but ultimately the right protocols and pathways specific to their individual need.”

Fortunately for our readers here at Readmissions News, many of the solutions described by Mr. Heil are explored in depth in this very issue. Thank you once again for subscribing. I look forward to continuing the fine work of Raymond Carter in providing our readers with the most cutting edge information regarding readmissions in the industry. Please don’t hesitate to contact me at pgrant@readmissionsnews.com.

Building Dynamic Post-Acute Partnerships...continued from page 1

Rather, hospital, payer, and post-acute stakeholders must develop a dynamic partnership that drives performance improvement efforts to address market and patient challenges. Joint operating committees with dynamic partnerships build upon these meetings to implement shared programs and protocols that address more challenging drivers of readmissions, such as staff education, medication management, and patient care plan adherence.

To transform a static partnership into a truly strategic one—designed to reduce readmission rates—hospital leadership should seek to implement initiatives that:

- Leverage post-acute partner clinical expertise broadly
- Create specialized cross-continuum programs
- Build complementary, integrated care management capabilities

Leverage post-acute partner clinical expertise broadly

Because of the generally lower acuity nature of post-acute care, hospital leaders rarely recognize the unique expertise possessed by their post-acute partners. Yet post-acute providers consistently handle subsets of complex, challenging patients—notably within the geriatric population—and even partner with hospitals to help clinical staff develop the necessary expertise to best manage those individuals.

Select organizations acknowledge the unique competencies of post-acute clinicians, including Sparrow Health System—in Lansing, Michigan—where leadership recognized that clinicians within the system’s long-term acute hospital (LTACH) possessed advanced capabilities in specialty areas relevant to the LTACH’s core patient population. As such, the LTACH’s expert respiratory therapists staff units within the inpatient setting. Concurrently, the wound care team partners with the outpatient wound clinic to provide education on managing challenging patients, share and tailor care plans for the outpatient clinic’s needs, and support home and community-based providers caring for these patients.

And at Hebrew SeniorLife—a multi-service post-acute provider in Boston—executives recognize their organization has an advanced level of geriatric expertise to offer their partners. Hebrew SeniorLife has contracted its geriatric specialists to serve in the physician offices of the Dedham Medical Group, part of Atrius Health ACO. Similarly, they are engaged in conversations with a local hospital about the viability of co-developing a geriatric emergency department. Neither the physician space nor the emergency department are typically associated with post-acute partnerships but post-acute providers are increasingly extending their reach to both support acute episodes through multiple points of expertise as well as work to prevent them entirely.

Create specialized cross-continuum programs

All acute care hospitals have opportunities to build cross-continuum programs—typically defined by shared clinical leadership, cross-setting care pathways, and ongoing patient support—which supports key patient populations. These patient populations may align with more traditional hospital services lines, such as cardiovascular or orthopedic patients, or unique subsets such as chronic or behavioral health patients.

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HealthEast Care System, located in St. Paul, Minnesota, forged their partnership with Cerenity Senior Care around medically complex behavioral health patients. To support these challenging patients, leadership at both organizations identified three key problem areas and the collaborative solutions needed to ensure that Cerenity’s staff felt confident navigating their unique needs.

- **Problem - Protocols Around Patient Mental Capacity.** Skilled nursing staff were inexperienced in assessing capacity for patient decision-making and determining the appropriate decision-maker.
  - **Solution:** Hospital staff share ethical principles for substituted judgment and beneficence.

- **Problem - Clinical Training for Medication Management.** Mandated dose reductions in the skilled nursing environment raised concerns about the return of patient symptoms.
  - **Solution:** Hospital and SNF physicians discuss procedures for safely tapering medications.

- **Problem - Guidance for Addressing Population Needs.** Younger patient populations—such as traumatic brain injury patients—require activities atypical of average skilled nursing patient.
  - **Solution:** Hospital clinicians provide input on patient stimulation and socialization activities to complement clinical care enhancements.

Not only did HealthEast conduct rigorous training and help implement protocols upfront, but the system also hardwired continued physician involvement after the inpatient stay. Most notably, this occurred through the development of a physician support line making hospital physicians available over the phone for on-demand consults, as well as in-person access to those physicians at an outpatient clinic to avoid unnecessary readmissions.

**Build complementary, integrated care management capabilities**

Based on a 2012 survey of The Advisory Board Company’s members, 97% of hospitals and health systems report already investing in, or planning to invest in, additional care management staff—with more than 90% of members reporting the hiring of a health coach and/or a high-risk care manager.

![Image of interventionist care managers](image.png)

Given this imperative for additional care management staff, and the costs associated with those investments, post-acute partners already possessing the needed skills offer a cost-effective solution to this challenge. For example, instead of building its own care transition guide program, Greater Baltimore Medical Center partnered with Johns Hopkins Home Care Group to do so.

Johns Hopkins Home Care Group provides transition guides as part of a contract with Greater Baltimore Medical Center. These guides work in the GBMC building and are, for all intents and purposes, GBMC staff. The transition guides support patients regardless of their post-discharge setting, and their role varies based on that setting. Patients discharged to the skilled nursing setting receive telephonic support focusing on a safe transition and the development of patient self-management skills. For patients transitioned home with home health support, the guides focus on a smooth transition that optimizes patient information exchange. In contrast, patients transitioned home without home health support receive home visits from the guides focused on patient coaching.

The program initially targeted CHF and COPD patients driving a 33% reduction in readmissions among those populations. As a result, both organizations are looking to expand the transitional guide program to support additional patient types.

**Identifying the Next Set of Collaborative Solutions**

The GBMC example serves as one of many potential solutions to building shared care management strategies across organizations—targeting specific disease states. While not always replicable for all patient disease categories, for higher-readmission, higher-volume categories—such as CHF and COPD—providers are well served to consider how specialized care management roles can further enhance their shared specialty programs.

Ultimately, these types of partnerships are dependent on understanding the specific care challenges and patient populations driving readmissions, while maintaining a collaborative dialogue that encourages dynamic performance improvement initiatives.

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The Critical Care: Lowering Mortality, Reducing Costs in the ICU

For many health systems, the first inpatient place to focus efforts on cost and quality benefits is the intensive care unit (ICU), since it can account for 50% of mortality and a third of hospital costs. Continuous monitoring of patients in the ICU is required, given that patient conditions can change rapidly and unexpectedly. While ICUs are staffed with capable care teams and intensivists are on-call, a dedicated team of specialists monitoring patients around the clock allows for more comprehensive care. By implementing an electronic ICU (eICU) telehealth program, hospitals can leverage the constant support of these focused teams during nights and weekends when intensivists are not at the bedside. The eICU care team has a full view of the patient’s medical records, monitoring data and sophisticated algorithms, to make the kind of proactive clinical decisions necessary to avoid complications. This results in improved patient outcomes and reduced costs for hospitals.

In a recent study published in *CHEST Journal’s Online First*, Craig M. Lilly, MD, Professor of Medicine, Anesthesiology and Surgery at the University of Massachusetts Medical School, examined the impact of an eICU program across 56 ICUs, 32 hospitals and 19 health systems, finding unadjusted and severity-adjusted reductions in both ICU and hospital mortality and length of stay. His study examined 118,990 critical care patients over a five-year period. Patients who received their ICU care from a hospital that utilized the eICU program were:

- 26% more likely to survive the ICU;
- Discharged from the ICU 20% faster;
- 16% more likely to survive hospitalization and be discharged;
- Discharged from the hospital 15% faster.

These results point to a significant opportunity for telehealth programs in the ICU to increase efficiency, reduce costs and improve outcomes among critical care patients.

Acute Care: Improving the Hospital Experience

As patient acuity in hospitals continues to increase, the acute care wards have become an area of increasing patient safety focus. Medical and surgical units can benefit from added monitoring and clinical attention, including bidirectional audio and video (AV) in patient rooms and wearable monitors. Institutions like Mercy, a St. Louis-based health system with 28 hospitals across four states, are implementing acute care telehealth programs to support their traditional care teams, hoping to achieve improved patient safety, with the attendant reductions in length of stay and ICU transfer, and increased patient and family satisfaction.

By adding features like automated early warning scoring to avoid cardio-pulmonary arrest and multi-screen AV viewing to avoid fall risk, these complications can be reduced. Providing recorded discharge instructions to a patient portal should also improve engagement in their own health after discharged. With this kind of enhanced monitoring incorporated across acute care settings, health systems can offer improved provider coordination and communication and help ensure best practices are met to provide quality care.

Post-Discharge: Bringing Healthcare to the Home

A major transition for health systems is moving care into the home, and it’s become an increasingly effective way of caring for patients, particularly those with multiple chronic diseases. By moving beyond episodic care and occasional physician office visits to monitoring daily symptoms, vital signs and medications, clinicians are able to get a better view into patient health and proactively make adjustments. Involving patients in their own care by teaching them to detect risk signs and promoting healthier living is critical to making these programs successful. Assessments of patient and family behavioral phenotypes enable clinicians to develop a tailored engagement, communication and adherence strategy. In combination, the elements of these programs reduce admissions and re-admissions by catching issues before they escalate and allowing any health concerns to be discussed via videoconference rather than requiring a trip to the doctor’s office or emergency department.

Banner Health, a Phoenix, AZ-based health system operating 24 acute-care hospitals and health care facilities in seven states, is currently piloting a telehealth program called Banner iCare Primary Care. Banner identified hundreds of heavy users of healthcare services – some suffering from six or more chronic disease conditions – and developed a new care team to care for this population in their homes. Banner implemented a proactive Intensive Ambulatory care model where intensivist PCPs, nurses and a broader care team – including social workers, pharmacists and health coaches – identify early stages of deterioration and prevent adverse events. By collecting objective and subjective data, Banner has created a support system for these patients, improving patient satisfaction with near-instant access to their caregivers and care that is patient focused.

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Thought Leaders’ Corner

Each month, Readmissions News asks a panel of industry experts to discuss a topic of interest to the hospital community. To suggest a topic, write to Editor@ReadmissionsNews.com.

Q. The Medicare Spending Per Beneficiary (MSPB) includes the total costs from 3 days prior to admission to 30 days after admission and includes all costs, including post-acute. What impact might inclusion of this metric in hospital payments under Value Based Purchasing have on hospital readmissions strategies?

“While one can reasonably critique some details of the MSPB measure, it is a boon for those who care about improving the quality and efficiency of post-acute and transitional care. The most obvious impact on readmission strategies is the double bonus for reducing readmissions within the existing Readmission Reduction Program conditions (e.g. CHF, AMI, PNA, COPD, and hip/knee arthroplasty). This additional incentive can put some programs over-the-hump into financial sustainability (especially if your hospital is beginning to lose interest in readmissions – either through having avoided the penalties already or being impossibly deep into the penalty box). Moreover, MSPB expands the scope to all-cause readmissions – incentivizing care improvement for all Medicare patients, regardless of condition. Lastly, the path to long-term sustainability for readmission programs lies in neither the penalties nor MSPB – but in full-risk programs (e.g. accountable care organizations, episode-based payments, etc). As a “quasi-bundle” built into the FFS payment system, MSPB widens the care improvement lens beyond readmissions alone and into additional areas - such as the efficiency of your post-acute provider partners. Somewhat paradoxically, this broader focus should prepare hospitals for ACO and bundled payment arrangements – leading to a more robust and sustainable future for readmission reduction programs.”

D. Clay Ackerly II, MD, MSc
Associate Medical Director, Population Health and Continuing Care, Partners HealthCare
Assistant Chief Medical Officer, Non-Acute Services,
Primary Care Physician - MGH Senior Health, Massachusetts General Hospital
Instructor in Medicine, Harvard Medical School
Innovation Advisor, Centers for Medicare & Medicaid Services
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“The Medicare Spending Per Beneficiary (MSPB) can help healthcare organizations understand the role readmissions play in episodes of care. Unfortunately, CMS does not specifically pull out the readmissions in the MSPB data set for hospitals. Hospitals must back into this information by using the data sets provided by CMS. Focusing on disease specific episodes will help hospitals to further explore the MSPB data sets. Once disease specific episodes are prioritized, analyzing the data for trends related to spending falls into place. The MSPB data sets provide drill down capability including the identification of the hospitals and acute rehabilitation facilities in a specific episode by using the CMS CCN number. Hospitals can use this information to understand utilization of post acute services and their potential effect on readmissions. This measure is included in VBP starting in FY2015, but also will be included in the Physician Value Modifier program.”

Jacqueline Matthews, MS, BSN
Senior Director, Quality Reporting and Reform
Cleveland Clinic
Cleveland, OH
“Over time, hospitals will spend more resources and energy understanding the performance and value of their post-acute care partners. The inclusion of the MSPB will accelerate this trend. For many hospitals, this will represent their first episode payment program that extends beyond the hospital walls. Where adequate supply and variation in cost and/or quality exist, post-acute care services will feel strong downward pressure as hospitals channel patients to preferred partners. For those markets where finding a rehab/SNF/LTAC bed is challenging, the impact will be on determining if an extra day or two in the hospital is better than shortening the Length of Stay (LOS) for high-risk patients. And if CMS wants this trend to accelerate even more, they will increase the amount of impact in the Value Based Payment program.”

Bruce Spurlock, MD  
Executive Director, Clinical Acceleration, Beacon  
Bay Area Patient Safety Collaborative  
President and Chief Executive Officer  
Convergence Health Consulting, Inc.  
Roseville, CA

“The inclusion of the MSPB measure in the Hospital Value Based Purchasing (VBP) Program, coupled with the expansion of the Hospital Readmissions Reduction Program (HRRP), creates additional incentives for hospitals to reduce avoidable readmissions but also magnifies the impact of the shortcomings of the measure and how it is applied. For the MSPB measure specifically, readmissions and post-acute care drive much of the performance variation. While hospitals are employing multiple strategies to reduce readmissions, the causes of readmissions remain complex.

MSPB accounts for 20 percent of a hospital's total score in FY 2015 and 25 percent in FY 2016, more than any other measure in VBP. MSPB adjusts for certain clinical factors, yet sociodemographic variables that are associated with readmissions are not accounted for in the measure. This affects performance for hospitals that treat sicker and more vulnerable patient populations. Another technical issue with MSPB is that performance for teaching hospitals, and large hospitals, tend to be tightly clustered around the national MSPB median. When this metric is translated into a score, artificial distinctions are created in this cluster between those hospitals who perform well enough to get credit for “achievement” and those hospitals who can only get credit from performance improvement.

Teaching hospitals are working diligently to understand how their patients navigate the health system after discharge and to improve their care coordination strategies. While hospitals have much room for improvement in reducing readmissions, flaws in the MSPB measure and score calculation must also be addressed.”

The AAMC represents all 141 accredited U.S. medical schools, nearly 400 major teaching hospitals and health systems, and nearly 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents 128,000 faculty members, 82,000 medical students, and 110,000 resident physicians who collectively deliver over one-fifth of all clinical care in the nation.

Mary Wheatley  
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Beth Deaconess Medical Center Reduces Readmissions

In 2012, Beth Deaconess Medical Center discovered it had one of the highest readmissions rates for Medicare patients in the United States. As a consequence it accrued over $1 million in Federal fines. As a result, they developed the Post-Acute Care Transitions (PACT) program.

Utilizing $5 million in Federal grants, the program is designed to track Medicare patients who are seen to be at high risk of readmissions. The program has thus far proved to be a success, responsible for a 25% reduction in readmissions since its introduction and a significant decrease in Federal fines.

Mayo Clinic Study Finds Mobile App Reduces Readmissions

A study by the Mayo Clinic, funded by the BIRD Foundation, has found that by incorporating a mobile phone app into cardiac rehabilitation, emergency room visits and readmissions can be reduced by up to 40%. Though the study has yet to be published, it was presented at the American College of Cardiology’s 63rd Annual Scientific Session held in Washington, DC.

The Mayo Clinic specifically designed the online and smartphone based program for patients recovering from stent placement for a heart attack. The study showed how patients who used the app were readmitted to the hospital at significantly lower rates than patients who did not.

Walgreens WellTransitions Program Reduces Hospital Readmissions

WellTransitions is a pharmacist-led, transition of care program designed by Walgreens to collaborate with hospital systems across the country to help patients better understand prescribed medications during their hospital stay and remain adherent to medication regimens upon returning home.

Walgreens…continued

According to internal company research presented at the 2014 American Pharmacists Association (APhA) conference in Orlando, patients who participated in Walgreens WellTransitions program were 46% less likely to experience an unplanned hospital readmission within 30 days of discharge.

Due to its success in promoting medication adherence and reducing hospital readmissions, the American Hospital Association has endorsed the program.

Boston University Study Finds Insurance Coverage Does Not Reduce Readmissions

A study conducted by the Boston University School of Medicine and published by the British Medical Journal found that providing previously uninsured patients with health insurance coverage does not reduce 30-day readmission rates.

The study went further to claim that health insurance does not reduce racial disparities in care. Racial minorities are at statistically higher risk of readmissions. The study compared patients from Massachusetts, which has 97% coverage, to patients from New York and New Jersey.

Cleveland Clinic: Simple Patient Cognition Test May Prevent Readmissions

A Cleveland Clinic study has found that a simple, three question cognition test offered to heart failure patients may in fact predict if they will die or be readmitted within thirty days of discharge. Their findings were presented at the American College of Cardiology’s 63rd Annual Scientific Session held in Washington, DC.

Originally designed to detect Alzheimer’s and Dementia, this so-called Mini-Cog Test has now been found to have utility in identifying potential heart failure readmissions. Dr. Eiran Gorodesky, MD, MPH, a Staff Cardiologist and the Director for the Center of Connected Care at the Cleveland Clinic, led the study.
Study Finds Readmission Rates for Prostate Removal Surgery Comparably Low

According to a Swedish study released by The Journal of Urology, readmission rates for prostate removal surgeries are low when compared to other procedures. This held true across all three of the dominant prostate removal methods: open, laparoscopic and robotic. This is good news as prostate removal surgery is one of the leading treatments for prostate cancer.

The study undertook a review of over 24,000 prostate cancer patients who had undergone radical prostatectomy and found that 90-day readmission rates held at about 10%, regardless of the technique used.

However, the results unsurprisingly varied with age. Patients aged 70 and older were found to be 17% more likely to be readmitted to the hospital after prostate removal surgery than those 60 and older.

Community EMS Pilot Testing Mobile Health Initiatives to Reduce Readmissions

An ambulance and consulting company based out of Southfield, Michigan, Community EMS, has begun the process of pilot testing a mobile health initiative using paramedics and telemedicine in an effort to assess the health of chronic disease patients who develop non-emergency health problems.

The pilot was designed to reduce expensive hospital readmissions and prevent unnecessary visits to emergency departments.

Besides reducing unnecessary hospital readmissions or admissions, the project has the potential to reduce ER utilization, which in turn could lower staffing costs.

Dr. Gregory Berger, executive medical director with Detroit Medical Center’s Michigan Pioneer ACO, said the Community EMS initiative is a promising method that can save money and improve quality.

Software Based Methods Identify More Preventable Readmissions Than Manual, According to Study

A study published in BMC Medical Informatics and Decision Making concluded that while automated, software based methods did in fact identify more potentially preventable readmissions than manual methods, "concordance between methods was not high enough to replace manual review with automated classification as the primary method of identifying preventable 30-day, all-cause readmission for quality improvement purposes."

The researchers who conducted the study went to 18 Kaiser Permanente Northern California hospitals where they manually reviewed 459 30-day, all cause readmissions and determined whether or not they were preventable using a manual, four-step review process. They then used 3M Potential Preventable Readmissions (PPR) software to review the very same cases.

Whereas the manual review found that 47% of the readmissions were potentially preventable, the automated process determined that 78% of the readmissions could have potentially been avoided.

Maryland and Kentucky Using Big Data, Analytics to Reduce Readmissions

State officials from Maryland and Kentucky took the stage at the State Healthcare IT Connect Summit held in Baltimore to discuss how they are helping to reduce emergency department use and hospital readmissions through the use of analytics and data sharing.

Mike Powell, Maryland’s Chief Innovation Officer, described how his state utilizes data the Chesapeake Regional Information System for our Patients (Maryland’s Health Information Exchange), to gather and share readmissions data among post-acute hospitals.

The Chief Medical Officer of the Kentucky Department of Medicaid, Joe Langfield, gave a detailed description of how the Kentucky Cabinet for Health and Family Services works with the State Health Information Exchange to issue readmissions alerts to hospitals and care-coordination teams.
Simple and regular post discharge communication, along with vital monitoring and medication compliance verification, are crucial factors in reducing readmissions. The key is allocating the right resources to the right patients…

For ACOMplus, the results have been astounding…

Siouxland Medical Education Foundation

Community Continuum of Care Develops Program to Reduce Readmissions in Nebraska Hospitals

Community Continuum of Care has developed a team-based approach to patient care that promotes and incentivizes coordination between Siouxland, Nebraska hospitals, clinics and care facilities that reportedly has reduced hospital readmission rates and improved patient care.

The program was formed in November 2010 after Leah Johnson, executive director of the Siouxland Medical Education Foundation and Family Medicine Center, told CEOs at Mercy and St. Luke’s about patients having to stay in the hospital through the weekend if they hadn’t been discharged by Friday afternoon to a long-term care or rehabilitation facility.

With help from Mercy and St. Luke’s, Johnson coordinated a meeting with long-term care facility administrators, social workers and case managers to discuss how to improve the hospitals’ length of stay and the transition to long-term care facilities. The meetings, now held bi-monthly and led by Johnson, are attended by 70-some physicians and agencies from Sioux City and outlying communities such as Le Mars and Orange City, Iowa, and Pender, Nebraska.

Inside and Outside the Hospital’s Walls…continued from page 6

Across the Continuum: Managing Populations with Telehealth

The growth of the aging population and chronic disease, coupled with the rising cost of care, requires a tectonic shift in how health systems think about and deliver patient care. Coordinated telehealth programs allow health systems to implement the right care teams, technologies and services to improve the health of patients across the continuum – from the ICU to acute care to the home.

Supported by success stories from leading health systems as well as published research, this approach to care is quickly becoming a reality and is a critical step toward enabling cost-effective population health.

Dr. Brian Rosenfeld is VP and Chief Medical Officer for Telehealth at Philips Healthcare. He can be reached at brian.rosenfeld@philips.com.

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ACOMSplus is now testing the live transfer of data in a large Akron, Ohio health system, which will further improve the accuracy of the predictive model. They are currently looking for more pilot-test partners across the country to test their predictive model and the Readmission Prevention System.

If hospitals can accurately predict seven out of ten patients who are at high risk of readmission and intervene, hospital readmission rates will drop dramatically. As the accuracy of predictive models increases, alongside the correct use of intervention strategies, the readmission rates will continue to fall without an increase in staffing.

Whether hospitals look to predictive models, like the one offered by ACOMSplus, or to other readmission prevention solutions, there is no denying it will continue to be a focus for hospital executives over the coming months.

About ACOMSplus

ACOMSplus, based in Akron, OH, develops Readmission Prevention Systems (RPSs) for hospitals and Accountable Care Organizations, using predictive modeling. They combine expertise in process and system engineering with cutting-edge information technology.

Their real-time, cross-platform operations execution system proactively identifies patients at high risk of hospital readmission, customizes intervention strategies, and manages and tracks the execution of interventions for patients.

ACOMSplus also integrates various health data systems into one customized, user-focused interface, including integrating multiple EMRs and EHRs, and currently provides field resource management for the Home Health industry.

Brian Barberic, BSBA, VP of Marketing at ACOMplus, can be reached at brian.barberic@acomsplus.com for more information. Learn more about ACOMSplus on the web at www.acomsplus.com.
Readmissions News: **How do readmissions for heart failure differ between hospitals?**

Dr. Karen Joynt: We know from prior research that readmission rates for heart failure differ between hospitals for a number of reasons, some of which are related to the patients at the hospital, some to the resources and care delivered at the hospital itself, and some to the community in which the hospital is located. For example, hospitals that take care of sicker patients tend to have higher readmission rates, and hospitals that take care of a higher proportion of poor or minority patients tend to have higher readmission rates. These don’t tend to be characteristics that hospitals can (or should) change – we want hospitals to provide care to sick and disadvantaged patients.

On the other hand, there is research that shows that hospitals that have more nurses per patient day and hospitals that have more resources have lower readmission rates, so there may be things that hospitals can do to reduce readmissions, including investing in nursing staff and care coordinators.

Finally, we know that hospitals located in poorer neighborhoods, and hospitals located in areas with higher levels of inequality, have higher readmission rates. This suggests that the community matters in preventing readmissions as well, and that perhaps community efforts to provide better support when patients leave the hospital could be helpful in reducing readmissions.

Readmissions News: **What causes racial and ethnic disparities in readmissions?**

Dr. Karen Joynt: Unfortunately, we don’t really know. Certainly a large part of it is about poverty and access to health care rather than race per se. If patients don’t have access to high-quality primary care services when they leave the hospital, either due to a lack of insurance or simply a lack of physicians and other health care providers, they may not be able to receive the outpatient care they need. If patients can’t afford their medications, they are less likely to be receiving optimal outpatient management. This is an area in which further research could potentially help us figure out how to reduce disparities in care.

Readmissions News: **What are the differences between high- and low-volume, urban and rural hospitals as it relates to readmissions?**

Dr. Karen Joynt: The data here are a little more complicated. For heart failure in particular, mortality rates and readmission rates tend to be inversely related, so hospitals with lower mortality rates tend to have higher readmission rates. High-volume hospitals and urban hospitals are more likely to have lower mortality rates but higher readmission rates for heart failure. However, it is important to remember that these are just patterns – any individual hospital may not “fit” the pattern.

Readmissions News: **Finally, tell us something about yourself that few people would know.**

Dr. Karen Joynt: Well, plenty of people know this, but I’m a huge sports fan. I play in basketball, softball, and tennis leagues, and am trying to learn how to play golf (though the Boston weather makes that difficult right now). I am a willing spectator for just about any sport as well, especially if it involves teams from Michigan.