Volume 2, Number 2 **February, 2013**

Readmissions NEWS

High Utilizer Pilot to Ambulatory ICU

By Chris Echterling, MD

WellSpan Health has successfully transitioned a virtual SuperUtilizer Pilot to a dedicated Ambulatory Intensive Care Unit model.

As stated in a 2011 Institute for Healthcare Improvement White Paper:

> *Individuals with multiple needs are perhaps least poised to navigate the complex and fragmented health care system, yet are often left to serve as the only link among their various professional care providers. For their part, health care providers may identify individuals' many social needs but recognize that the health care system does not have capacity to meet those needs, even when an individual's life circumstances deeply impact health outcomes. Care providers recognize the need for better coordinated care that leverages community resources to align social determinants of health (i.e., housing, healthy food, and safe neighborhoods), but payment structures in the health care system remain misaligned to deliver coordinated services and connect individuals with crucial supports.*

Craig C, Eby D, Whittington J. *Care Coordination Model: Better Care at Lower Cost for People with Multiple Health and Social Needs*. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2011. www.ihi.org/knowledge/Pages/IHIWhitePapers/IHICareCoordinationModelWhitePaper.asp

In This Issue

ACOs and Long-Term Care: It's All about Readmissions!

By Neville M. Bilimoria, Esq.

With last year's Supreme Court decision ratifying President Obama's Patient Protection and Affordable Care Act ("Affordable Care Act"), nursing homes are slowly turning toward a closer review of ACOs to see how they might fit in. Indeed, the failure of our long-term care clients to weigh options with ACOs could be detrimental to the future of their business.

Why? Because if nursing homes are left behind in the ACO process, nursing homes will see that they may also be left out of key referrals from hospitals participating in particular ACOs that could result in a redirecting of admissions to nursing homes that are part of that ACO, resulting lower admissions for the nursing homes that are not part of the ACO. Indeed, we have seen clients already feeling the drastic drop or redirection of admissions from hospitals to competitor nursing homes.

With all the recent health care reform activity, health care providers have been clamoring over each other in strategizing how to deal ACOs with the new in terms of structure, financial planning, and future viability. But what does all this ACO development mean for nursing homes?

continued on page 4

Readmissions News
February 2013, Volume 2, Issue 2
ISSN 2166-255X (Electronic)
ISSN 2166-2568 (Print)

Publisher - Clive Riddle, President, MCOL

Senior Editor - Raymond Carter

Readmissions News is published by Health Policy Publishing, LLC monthly with administration provided by MCOL.

Readmissions News
1101 Standiford Avenue, Suite C-3
Modesto, CA 95350
Tel: 209.577.4888 -- Fax: 209.577.3557
info@readmissionsnews.com
www.ReadmissionsNews.com

Editor's Corner

Raymond Carter, Senior Editor, *Readmissions News*

During the past year it has been our pleasure to feature a different member of the *Readmissions News* National Advisory Board each month. Now that everyone has been introduced, we plan to feature short op ed or "report from the field" kind of pieces on readmissions research, policy, or operational issues on this page.

We invite readers to submit ideas or finished pieces at any time. Have you tried something that worked well? Or perhaps something you thought would work well but didn't turn out quite the way you expected? Do you have a better way to structure a program of incentives and penalties in order to reduce unnecessary readmissions? Let us hear from you. This page is yours.

We begin with an op ed on readmissions numbers from Dr. Joanne Lynn.

Joanne Lynn, MD, MA, MS
Director, Center for Elder Care and Advanced Illness
Altarum Institute
Alexandria, VA

The Readmissions Numbers Game

When community coalitions apply for funding from the Community-Based Care Transitions program of the Centers for Medicare and Medicaid (CMS), they have to show that they will reduce hospital readmissions by 20% and will save money for Medicare. Funding recipients will be held to those two outcomes in evaluating the contract.

In general, CMS intends to evaluate these programs by applying the 20% reduction to the rate of rehospitalization: that is, rehospitalizations divided by live discharges. If a community's baseline rate in 2010 was 15%, then 20% of 15% is 3% and they'd have to reduce rehospitalizations to 12%.

If hospitalization itself remains stable, these are the same goals numerically.

However, much of what is done to reduce 30-day rehospitalization also reduces hospitalizations beyond 30 days, and sometimes even hospitalizations without antecedent hospitalizations. If patients learn more self-care, use more hospice, obtain more support in the community, and so forth, then the use of hospitalization outside of that 30-day window may decline as well. And it does not take a lot of decline in that rate to mimic the decline in 30-day rehospitalization, making it a challenge to change the rate of rehospitalization/hospitalization.

Suppose, for example, that a community had 10,000 hospitalizations and 1,500 30-day rehospitalizations in 2010. Suppose the CCTP work changed the rehospitalization number by a full 20% -- cutting it to 1,200 per year by 2014. But that good work also cut down on hospitalization by 10% -- yielding 9,000 for the denominator. Then 1200/9000 would be just a 13.3% rate, and the team would have missed the goal -- even though it had actually done a terrific job.

It is always risky to use a rate where the denominator is presumed to be stable but actually can respond to some of the same interventions as the numerator.

Using the N of 30-day rehospitalizations has its risks also -- a bad flu year or a decline in community-based support could push it up, as could an influx of patients that increases the denominator. It can also have spurious improvement if many patients are moved from FFS to managed care.

For now, it seems that the prudent thing to do is to convince CMS that they should keep the question open and make it legitimate for CCTP and providers to pursue the reduction in numbers only rather than the reduction in the rate.

Dr. Lynn may be reached at Joanne.Lynn@altarum.org.

Reducing Hospital Admissions: A Two-Pronged Approach

By Jasen Gundersen, MD, MBA, CPE, SFHM and Deborah Hinton

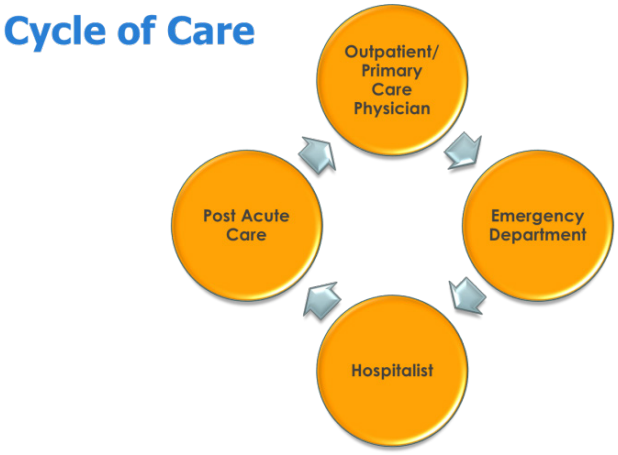
Hospital penalties and incentives in the Patient Protection and Affordable Care Act are having a dramatic impact on hospital processes and procedures. One area on which hospital executives are intensely focused is the law's provision for reducing Medicare payments for hospitals with high readmission rates.

Hospitals are in the midst of a readmissions crisis. The 30-day readmission rate for Medicare patients is 18 percent, accounting for about $15 billion in annual Medicare spending. Of all hospital readmissions, approximately three-quarters are potentially avoidable.

When addressing readmissions, it's critical that hospitals take a two-pronged approach –- focusing not only on internal processes and procedures, but also on involving other health care providers in the community in their effort to keep patients from returning to the hospital.

A Community Effort

Like many of the problems highlighted by provisions of the Affordable Care Act, a solution to the readmissions crisis cannot be achieved by one hospital department or even a single hospital on its own. Readmissions are a community challenge, requiring coordination among hospital departments as well as post-acute care providers.



In some cases, post-acute care providers like nursing homes may send patients back to the hospital for post-discharge care because they were not fully informed about the care the patient received at the inpatient facility or the post-discharge care instructions.

To circumvent such problems, consider implementing an educational programming for outside healthcare providers and agencies -- including home health agencies, nursing homes, and physician offices. These educational sessions discuss the critical importance of reducing unnecessary readmissions and how the hospital and outside providers can communicate and coordinate care for each patient. In many cases, outside agencies are not aware of the hospital's financial risks associated with readmissions and are open to increased collaboration –- especially when the hospital is a significant referral source.

The same type of effort is necessary internally within the hospital emergency department. With the understanding that unnecessary readmissions are harmful to the hospital's financial health, discuss the importance of exploring other options of care within the emergency department or in coordination with other care settings, when applicable, before the patient is admitted to the hospital. In some emergency departments, it helps to forge partnerships between the ER and home health agencies so patients can be referred directly from the ER. When appropriate, this process helps take the patient from an admission situation to receiving care at home.

Patient-Centered Focus

The other critical component of a readmissions reduction strategy is focusing on the care provided and interactions with patients during the *initial* hospital stay. TeamHealth has identified five core concepts that apply to each patient's admission that can help reduce the likelihood the individual will need to be readmitted for the same condition. These are recognition, communication, intervention, education, and reconciliation.

1. Recognition: It's critical for hospitals to recognize potential patient issues that could lead to a readmission. According to the Society of Hospital Medicine, the eight characteristics of high-risk patients are prior hospitalization, problem medications, depression, principal diagnosis, use of multiple medications, poor health literacy, poor patient support, and palliative care. Asking the right questions and reviewing patient information to identify these issues on the front end ensures physicians provide the proper treatment to help avoid readmissions.

Equally important is that physicians recognize and manage patient and family expectations –- both for treatment and post-discharge recovery. Physicians should also provide "downstream alerts" to other providers, both within and outside of the hospital, to whom they may be handing off the patient's care. The more information they have, the better care those individuals can provide.

2. Communication: At every level of patient care, communication is key. Poor communication may lead to misalignment of expectations and a lack of patient or family trust, contributing to potential readmissions.

continued on page 4

Reducing Hospital Admissions *…continued*

After providers fully understand a patient's diagnosis and treatment plan, the caregiving team must work to avoid communication breakdowns. That means relaying important information among providers and creating thorough documentation, including a detailed and complete discharge summary. Surprisingly, some 41 percent of inpatients are discharged with test results pending, and 25 percent of discharged patients required further work-up -- likely the result of poor communication.

Surprisingly, some 41 percent of inpatients are discharged with test results pending, and 25 percent of discharged patients required further work-up -- likely the result of poor communication.

Also beware communication breakdowns with patients and families. This means speaking to patients and families at the appropriate level for their healthcare literacy and, in many cases, identifying a single family spokesperson to whom the physician can provide updates and information to relay to other family members. And physicians who do not share the patient's native language should enlist the help of translators.

3. Intervention: Every point of contact with a patient is an opportunity to take appropriate action. Don't put off providing necessary care, and don't assume another care team member will handle a task.

4. Education: Hospital physicians can write prescriptions and prepare careful discharge plans, but when the patient leaves the hospital, the physician loses control. Perhaps the patient doesn't know there are resources available to help with medication expense, or perhaps his or her benefits don't cover home health care. Or the patient and family may not fully understand post-discharge instructions or dietary limitations.

Hospital physicians can write prescriptions and prepare careful discharge plans, but when the patient leaves the hospital, the physician loses control.

Be sure discussions with family are tailored appropriately, taking into account any social and cultural considerations. Continuous education with the patient, family and other care providers allows physicians to feel confident they did everything they could to educate and empower the patient and family. The teach-back method can be very effective here. That is, once the physician explains the post-discharge instructions, have the patient or family member repeat the instructions back to the physician. This will help reveal the level of understanding about the patient's post-discharge care.

5. Reconciliation: Electronic Medical Records, while in many ways immensely helpful, have certain drawbacks. If one caregiver enters data or medication information incorrectly, that information will be considered correct by other providers who view the record until the error is corrected. To ensure optimal care, it's important to reconcile errors and confirm EMR records regularly.

Results

TeamHealth Hospital Medicine has been able to keep all-in readmission rates at the hospitals it works with at 11 percent or below. The national average is about 19 percent.

Watch the video at http://www.youtube.com/watch?v=g86p-iVHb7E&list=PL57F896F93102C91A&index=3 where Joseph P. Coyle, President of Southern Ocean Medical Center, shares how SOMC is "ahead of the game" in readmission rates.

Jasen Gundersen, MD, MBA, CPE, SFHM is President and Chief Medical Officer of TeamHealth Hospital Medicine and Deborah Hinton is Vice President of Client Services there. For additional information about TeamHealth's process and success in reducing readmission rates, contact Mike Miller at Mike_Miller@teamhealth.com or 800.818.1498.

ACOs and Long Term Care *…continued*

History of ACOs and Nursing Homes

On March 31, 2011 the Centers for Medicare and Medicaid Services ("CMS") and the Department of Health and Human Services ("DHHS") issued a proposed rule on the Medicare Shared Saving Programs for Accountable Care Organizations. That proposed rule actually stated that skilled nursing homes could not be designated as eligible participants in ACOs. So for many months, skilled nursing facility owners stood by the sidelines as hospitals drafted key physicians and groups to be part of the ACO model. Then, In October 2011, CMS issued its final regulation for ACOs but also significantly opened the door for long term care providers in the final rule by allowing nursing homes to participate in an ACO and to play an important role in ACO model development.

So all of a sudden in October, 2011, long term care providers who had ignored ACO development now learned that while they cannot form an ACO, they could participate in them and have substantial say in the ACO governance as a result. But, according to recent reports, long term care providers are still uncertain about what ACOs mean, the roll they should play in them, and how or if it would benefit them directly. A recent survey showed that many nursing facilities don't even know what ACOs are and even less nursing home professionals believe that it will benefit them.[1]

But with Medicaid nursing home rates having been held flat, or increasing minimally over the years, along with delayed payments, and with the percentage of private pay patients continuing to decrease and the news of Medicare rates being cut on October 1, 2011 by 11%, the nursing home business now faces a tipping point and along with it, the impetus for the thought that perhaps ACOs are worth looking into more seriously after all.

continued on page 5

ACOs and Long Term Care *…continued*

Furthermore, a recent study done by CMS on a pilot program for ACOs from 2005 to 2010 demonstrated that ACO participants had reaped millions of dollars in savings/profit as a result of their participation in the ACO pilot program.[2] According to that program, almost all of the participant ACOs achieved a substantial benefit, indicating to nursing home owners for the first time that perhaps there are merits to the ACO model that are worth being a part of, especially in light of recent cut backs.

Standing back, it is not hard to see how nursing homes should be considered an integral part of the ACO cost savings overall for patients. Indeed, one individual did mention early on the importance of nursing homes in the ACO game:

> *"It occurs to me that these separate entities need to start talking to each other. Because as hospitals theoretically switch from a sickness to a wellness model and coordinate care throughout the continuum, agency services providers will be in some way part of the hospital's ACO."* [3]

If ACOs must improve quality of care to avoid lengthy procedures and costly facility visits, it makes sense, then, that nursing homes are critical to the ACO model by being partners in ACOs to reduce lengthy stays and to avoid hospital readmissions.

If ACOs must improve quality of care to avoid lengthy procedures and costly facility visits, it makes sense, then, that nursing homes are critical to the ACO model by being partners in ACOs to reduce lengthy stays and to avoid hospital readmissions.

The Playing Field

With such a focus on quality of care and the shared savings program, it becomes apparent that most hospital CEOs would discuss or contemplate owning nursing homes, just as they have clamored own physician practices, in preparation for ACO development and rollout. However, the industry is not seeing the movement of hospitals toward nursing home ownership perhaps due to the fact that CEOs and physicians are so embroiled in focusing on themselves to be part of the best "ACO team" in order to take advantage of the shared savings through quality of care at the physician level.

That having been said, the importance of nursing homes is evident in the ACO model and the overall care management of the patient. For example, ACOs save money by providing beneficiaries the right care early on. If an ACO provides or improves access to primary care physicians to avoid emergency room visits or lengthy hospital stays, the ACO will make money over time through shared savings. Similarly, if nursing homes can provide quality care and avoid readmission to hospitals, this will save an ACO a considerable amount of money over time.

While most hospital CEOs have not focused on the nursing home component as much as physicians or home care, it is clear that hospitals and other participants in large ACOs would want to partner with providers who know how to manage key conditions and who can demonstrate a low readmission hospital rate. Furthermore, the long term care physicians, including medical directors, will be critical to the ACO model because they can control costs in the nursing home by following patients closely and preventing hospital admissions more readily than physicians outside the nursing home.

With such a focus on quality of care and the shared savings program, it becomes apparent that most hospital CEOs would discuss or contemplate owning nursing homes, just as they have clamored own physician practices, in preparation for ACO development and rollout.

However, ACOs may not be good news for all nursing homes. There will be strict competition in vying to become part of certain ACOs in a particular marketplace for each nursing home. Furthermore, if the nursing home next door can show a lower rate of hospital readmissions, then that next door facility may be better positioned to be part of an ACO and to receive those hospital admissions more frequently.

Again, the focus is on quality and any quality factors or indicators that can be shown to hospitals or ACOs would be beneficial to particular nursing homes in joining that ACO reaping the benefits.

Furthermore, the role of the medical director in the nursing home as a result of ACO development is amply evident. No longer can medical directors sit idly by and care for residents in the nursing home, but they also have to be actively communicating with ACOs and hospitals about the quality of care the nursing home provides.

Remember, hospitals and physicians outside the nursing home are not accustomed to quality of care issues for nursing homes or looking into them in any detail. But when it comes time for the ACO team draft, ACOs will surely want to focus on having nursing homes that can provide quality care and that do not have a history of being a poor performer. Therefore, poor performing facilities may have difficulty competing with better performing facilities in any ACO draft for nursing homes.

What Can Nursing Homes Do Now to Align Themselves With ACOs?

Up to the present date, ACO formation has been largely a numbers game. That is, hospitals and other ACO providers have focused on the quality of care provided by physicians when recruiting physicians to join an ACO. The same can be said for nursing homes and quality of care indicators. ACOs will look to hard statistics and hard data, preferably provided by the nursing homes' medical director, to show how meticulous the care is at the facility and to demonstrate to ACOs that the likelihood of hospital readmission from that nursing home would be less than at other facilities.

In addition to the importance of statistics in nursing home care quality, it will also be important for the nursing home to be able to adopt or utilize the current electronic medical record ("EMR") system of the hospital or the particular ACO involved.

continued on page 6

ACOs and Long Term Care *…continued*

Better accuracy and efficiency are possible through the use of EMRs and the most profitable ACOs will most likely require EMR compatibility with nursing home records. Therefore, it is best for nursing homes to see which ACO they wish to join before adopting an EMR on their own, otherwise they will only later find out that their EMR is incompatible with the ACO EMR they are looking to join.

Nursing homes with a poor survey history from CMS or State departments of Public Health will likely have to do more work to obtain ACO participation. In those instances it may be necessary to improve the physical plant of the nursing home while also touting the medical director to the ACO in an effort to show a focus on patient outcomes and quality of care. For obvious reasons, ACOs will be wary to enroll a nursing home poor performer, or worse, a nursing home embroiled in health care fraud and abuse compliance actions with the government. In the ACO would, one physician, one nursing home, or one hospital participant in the ACO that performs poorly could affect the bottom line by reducing the amount of the shared savings from the government.

In all, nursing homes have to put on a lot of makeup to look attractive to hospitals and ACOs they are looking to partner with. But their value to ACOs seems critical.

In all, nursing homes have to put on a lot of makeup to look attractive to hospitals and ACOs they are looking to partner with. But their value to ACOs seems critical. Failure to partner with an ACO for a nursing home could result in reduced admissions to the home and the loss of the seeming financial benefit offered by the shared savings through ACO implementation.

References

1. "Skilled Nursing Facilities Are Pessimistic, Skeptical, About the Benefits Of ACOs According To Survey By Patient Placement Systems," Online, August 16, 2011.
2. Jessica Zigmond, "Benchmarks Met in ACO Tryout," *Modern Healthcare*, August 15, 2011.
3. Anthony Cirillo, "A successful ACO must have a strong long-term care component," April 4 2011.

Neville M. Bilimoria is a partner in the Health Law Practice Group in the Chicago office of Duane Morris, LLP. He is also the chair of the Physician Services Group nationwide for Duane Morris, LLP. He can be reached at (312) 499-6758, or at nmbilimoria@duanemorris.com.

High Utilizer Pilot*…continued*

The Healthy York Network (HYN) in York PA, a regional healthcare charity program founded in 2003, is a collaboration of York, Gettysburg, Memorial, and Hanover Hospitals along with Family First Health, WellSpan Health Medical Group, and independent physicians. The care donated to the over 8,000 HYN patients by participating providers has grown from $11 million in 2006 to over $31 million in 2012. In June 2010, with the intent to be the best stewards of HYN finances, HYN began to analyze individual patient claims. As many other payers have found, HYN found that a small number of HYN patients were consuming a large amount of resources. Over 60 patients in particular stood out as having claims of over $50,000 in the previous year. Examination of many of these patient's medical records revealed patterns of care that were not in the patient's, the program's, or the community's best interest. These patterns included frequent use of the Emergency Department (ED) for non-urgent needs as well as frequent potentially preventable readmissions to the hospital.

As many other payers have found, HYN found that a small number of HYN patients were consuming a large amount of resources. Over 60 patients in particular stood out as having claims of over $50,000 in the previous year. … These patterns included frequent use of the Emergency Department (ED) for non-urgent needs as well as frequent potentially preventable readmissions to the hospital.

In the fall of 2010, HYN leadership participated in an Institute for Healthcare Improvement (IHI) collaborative learning community on "Managing Complex Populations" where successful models in the United Kingdom, Boston, and Oregon were highlighted. HYN proposed to WellSpan senior leadership the development of a pilot intervention and was given the approval to undertake a six-month pilot using a virtual team to attempt to intervene with a small number of WellSpan patients who were termed "SuperUtilizers".

The pilot began in February 2011 and consisted of 12 patients. The care of each patient was coordinated by their already established primary care provider (PCP). Various interventions were used with the patients including:

1. Psychology consults and expedited access to psychological and psychiatric care
2. Home visits by PCPs and social workers
3. Physical and telephonic coordination meetings with other care providers including Home Health Nurses, Intensive Mental Health Case Managers and medical specialists including treating hospitalists and ED staff
4. Transportation assistance
5. Increased telephonic outreach and follow-up by primary care team and case management
6. Suggested initial orders and management approaches for ED and inpatient teams recorded in the inpatient electronic health record and available in all medical settings
7. Prepaid telephones and medications boxes

Monthly Community Care Coordination meetings provided PCPs the opportunity to collaborate with other pilot PCPs as well as other individuals who offered themselves and their areas of expertise as members of the PCP's "virtual team". Participants included Case Management, VNA, Rehabilitation Services, Behavioral Health, Chaplaincy, Hospitalists, Area Agency on Aging, County Human Services, and the York College Community Nursing Faculty.

continued on page 7

High Utilizer Pilot...*continued*

RESULTS FOR 12 PILOT PATIENTS

	# of Pre-Pilot Visits	# of Annualized Pilot Visits	Change in # of Visits	% Change
ED	99	72	27	- 27%
Inpatient	62	50.4	11.6	- 19%
Observation	25	16.8	8.2	- 33%
Total	186	139.2	46.8	- 25%
	Pre-Pilot Charges	Annualized Pilot Charges	Change in Charges	% Change
ED	$125,368	$119,906	$5,462	- 4%
Inpatient	$1,209,273	$881,201	$328,072	- 27%
Observation	$209,732	$107,102	$102,630	- 49%
Total	$1,544,373	$1,108,210	$436,163	- 28%

The PCP of SuperUtilizer patients related that they appreciated the increased support that the Community Care Coordination meetings and multi-disciplinary approach provided. The PCPs did not feel however that they would be able to take on any more patients in this context – since they already had their regular panels of patients to care for.

WellSpan supported the development of what it saw as the next evolution of intervention for High Utilizers – an Ambulatory Intensive Care Unit called "BRIDGES TO HEALTH". BRIDGES TO HEALTH patients are those whose needs have not been fully met by the traditional primary care, leading them to rely heavily on inpatient and Emergency Department services. The BRIDGES TO HEALTH clinical team includes a primary care physician, a social worker, and an RN and LPN.

The team, which assumes primary care for its patients, works in close contact and coordination with home health workers, hospitalists, behavioral health, and community services, and provides care through appointments and drop-in visits, as well as through home and telephonic contact. The team frequently accompanies its patients to specialist's appointments. The ultimate goal is to transition the patient to a more traditional primary care practice once a functional and sustainable care plan has been implemented.

The BRIDGES TO HEALTH team is also available for consultation with other primary care providers to assist them in managing patients with complex healthcare needs. Not only does BRIDGES TO HEALTH improve patient care, but it also enables WellSpan Health to manage the increased financial risk associated with certain patient populations effectively. Specifically, the project prepares WellSpan to have some of the capabilities necessary to function as an Accountable Care Organization. Foundational principles of BRIDGES TO HEALTH -- which has been termed a "Patient Centered Medical Home on steroids" -- include the commitment to constant learning and taking the time to truly determine patient goals and to build a care plan around them. The team views every admission and ED visit as a learning opportunity and tries to avoid "work arounds", instead bringing inadequacies of the system to those in a position to improve it, not only for BRIDGES TO HEALTH but for all patients.

BRIDGES TO HEALTH (BTH) currently has19 patients, the first enrolled in mid-September 2012. Results as of December 2012 for the 8 patients with at least 1 month experience with the program at that time show a dramatic decrease in utilization of inpatient and ED usage:

	BTH +n	BTH -n	BTH -(~n)	n*
Pt #1	$38,224	$15,391	$38,527	3
Pt #2	$32,821	$22,859	$23,077	4
Pt #3	$12,920	$16,121	$6,276	1
Pt #4	$2,715	$38,118	$16,949	1
Pt #5	$22,048	$32,715	$76,833	4
Pt #6	$13,895	$24,143	$20,896	3
Pt #7	$0	$0	$33,091	3
Pt #8	$0	$17,449	$26,027	3
Total	$122,623	$166,796	$241,675	

Aggregate pre-BTH $ Charge Average	$241,675	
Aggregate Total $ Charges since enrollment w/BTH	$122,623	
Estimated Charges Prevented	**$119,052**	**49%**

*n = the number of months the patient has been with BTH.
BTH+n = the amount of healthcare $ utilization after enrollment in the program.
BTH-n = the amount of healthcare $ utilization in an equivalent time frame just prior to enrollment in the program.
BTH-(~n) = the average amount of healthcare $ utilization for an equivalent time frame in the year prior to enrollment in the program. Since ED utilization tends to be variable in nature, BTH-(~n) is considered to be the more reliable baseline.

WellSpan believes that both its SuperUtilizer Pilot and now it's Ambulatory ICU model, BRIDGES TO HEALTH, have been successful, improving the quality of life for patients, decreasing inpatient and ED costs, and providing an important learning for the health system that will be critical in the new health care environment.

Chris Echterling, MD is Associate Medical Director for Quality and Innovation at WellSpan Medical Group and Medical Director for the WellSpan Bridges to Health and Healthy York Network initiatives. He may be reached at cechterling@wellspan.org.

Thought Leader's *C*orner

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. "CMS has recently endorsed the AMA's proposed two new codes for Transitional Care Management by physician and non-physician providers for moderate (99495) or high (99496) complexity of medical decision making. How important will these codes be? Have providers or payors begun to use them?"

"We see the TCM codes as a crucial signal from CMS. Where in the past CMS has strived to constrain fee for service reimbursement, this is a key signal that high quality care across the continuum will be rewarded. Developed upon the recommendation of the AAFP and the AMA, the new codes indicate that CMS has the ear of physicians and will emphasize care management, even within a fee for service environment. The impact of these changes is high, as much as a 7% uptick in reimbursement for the primary care physician, and we believe that this is only the first step in a broader care management strategy emphasized by CMS.

We've long known that poor transitions of care -- inadequate patient education about how to care for themselves, when to resume activities, how to comply with medications and follow up -- are key drivers of readmissions, but until today reimbursement was not aligned with action. However, many of our progressive members have already begun to invest in transitional care models and seen rewards as large as 30%+ reduction in readmission rates and 20% reduction in costs. We are committed to supporting our members as they look across the continuum of care, and we believe that it will not be long before commercial payors reward these investments as well."

Karoline Hilu, MD
Principal, Strategic Planning
The Advisory Board Company
Washington, DC

"The codes are an important step as 18 percent of hospitalized Medicare patients are readmitted within 30 days, which is a $15 billion annual and avoidable expense. Severely ill patients are often readmitted before returning to see their doctor in the office. The codes will encourage office-based physicians to be proactive in managing post-hospital care rather than waiting for patients to show up. They may do this by establishing relationships with hospitalists to inform them when their patients are hospitalized and discharged, and to bring them up to date about their hospital course, as well as their clinical and psychosocial needs. Use of the codes will likely encourage more patient education, better provider communication, improved care coordination, and increased access to the physician, especially in the important, early post-discharge period.

But most importantly, these codes represent a change in the health care reimbursement culture -- a move from pay-for-volume to pay-for-quality and value of care provided. The hope is that higher reimbursement for transitional care will lead to better care, happier patients, lower readmissions, and reduced costs. For physicians –- who are well aware of the time and effort required to discharge and arrange early follow-up for discharged patients effectively — this is finally an opportunity for them to be more adequately compensated for the difficult, but essential, work of managing post-hospital care."

Stephen E. Perkins, MD
Vice President, Medical Affairs
UPMC Health Plan
Pittsburgh, PA

Thought Leader's Corner

"Because SETMA is a Tier III NCQA Medical Home and certified by AAACH for Medical Home and Ambulatory Care, and because we have a robust transition of care and coordination of care program, this is very important. In the past 36 months, we have discharged over 13,000 patients from the hospital, and 98.7% of the time those patients have received their Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan –– previously called the 'discharge summary.' And 92% of the time, the patients receive a follow-up care-coaching call the day following discharge. In turn, if patients are judged a high risk for readmission, they are seen within two days and placed in a special 10-step program. If not, then they are seen within five days. So we have been doing the work envisioned by the Transitional Care Management payment program, and we are prepared to use these codes immediately. According to CMS, they were ready to receive these codes five weeks from January 1, 2013."

James L Holly, MD
CEO, SETMA, LLP
Adjunct Professor, Family and Community Medicine, School of Medicine, UT Health Science Center
Clinical Associate Professor, Department of Internal Medicine, Texas A&M Health Science Center College of Medicine
San Antonio, TX

"The Transitional Care Management codes are very important. For the first time we are acknowledging the importance of care coordination and transitions at the point of a patient leaving one provider/facility and moving to another. The need for follow through and support of patients and their family caregivers throughout this process is a key initiative to reducing avoidable hospital readmissions and improving the quality of the transition. The codes support physicians, physician assistants, and advanced practice registered nurses (APRNs) in providing transitional care management services and acknowledge the role of others on the collaborative team working with patients and their family caregivers. Practitioners do need additional support in understanding how the codes are applied to clinical practice, and as we move toward greater collaboration among all healthcare providers I believe these codes will need to be expanded to support other disciplines to the fullest extent of their practice. Aligning payment incentives for care coordination and transitions of care for the multidisciplinary team is a key principle for improving the quality of patient care and reducing miscommunication, not only between providers but between patients and their family caregivers as well."

Cheri Lattimer
Executive Director, Case Management Society of America (CMSA)
Director, National Transitions of Care Coalition (NTOCC)
Little Rock, AR

"I have received more questions from the field about these new codes than reports of using the codes. Based on my conversations with providers, I can report two concerns that may impact how quickly providers start using these codes. First, ambulatory providers might be happy -- eager in fact -- to reach out telephonically to patients after a hospitalization; however, the face-to-face visit requirement gives them pause, as they feel they cannot be sure the patient will come to the office. Thus, an initiated transitional care episode may well end up being non-billable. That feels like a risk. Second, there is confusion over which provider *should* vs. *can* provide this service. While I think it made decent sense to keep this open on the part of CMS, I am seeing that this requires some level of communication between the inpatient and outpatient providers and among the various primary specialties that might potentially feel responsible for executing a successful transition. I fear where there is uncertainty, there may not be uptake. These are very early days for this service, and I am hopeful we will see some best practices emerge by the end of the year."

Amy Boutwell, MD, MPP
Founder and President
Collaborative Healthcare Strategies
Lexington, MA

Subscribers' Corner

Subscribers can access an archive of current and past issues of *Readmissions News*, view added features, change account information, and more from the Subscriber web site at www.ReadmissionsNews.com.

Subscribers can also network and discuss readmissions issues with other health care professionals, review job opportunities, and more in the LinkedIn Readmissions News Group. To join, go to **http://www.linkedin.com/groups/Readmissions-News-4220113?home=&gid=4220113**

Thought Leader's Corner

"The new CMS billing codes are an important transitional step to moving from Pay for Volume to Pay for Value. These kinds of transition maneuvers will ease the conversion. Leveraging our ProvenHealth Navigator ® program we are beginning to bill for these services, but currently only one other commercial payer has a fee schedule, which limits their use. Obviously, the technical issues for appropriate billing need to be managed and documented and built into standard workflows so as not to impact the usual flow of care in the office adversely."

Thomas R. Graf, MD
Chief Medical Officer, Population Health and Longitudinal Care Service Lines
Geisinger Health System
Danville, PA

"The new codes are important because it is just about the first recognition that providing a service to improve transitions (and improve both the patient experience and improve communication) is a billable service. Up until now billing could be done only for specific interventions or examinations. The value of managing a transition or event has now been confirmed."

Martin S. Kohn, MD, MS, FACEP, CPE, FACPE
Chief Medical Scientist, Care Delivery Systems
IBM Research
Hawthorne, NY

INDUSTRY NEWS

BMC Seeks Patient Readmissions Stories

Researchers at Boston Medical Center (BMC) are still collecting stories about readmission experiences. They hope these will help them develop a patient-centered tool to evaluate reasons why people come back to the hospital. To add to the data they are collecting at BMC, they would like to hear any readmission stories that readers of *Readmissions News* have about their patients, family members, or themselves. Click this link to submit a story, or contact bu.anthro@gmail.com.

New Transitional Care Centers Established

Minnesota-based Allina Health, Benedictine Health System, and Presbyterian Homes & Services are creating a new type of transitional center that will provide post-acute care patients with a clinically advanced yet soothing environment in which to transition from hospital to home. Focused on hospitality, wellness and service delivered in a resort, spa-like environment, the centers will specialize in customized, high-quality, technologically advanced rehabilitation and recovery programs for patients. The goal is to create a class of branded centers that would be available to franchise operators.

RWJF Care About Your Care Initiative

The Robert Wood Johnson Foundation (RWJF) has launched a *Care About Your Care* initiative to help patients and families better manage their transitions of care. Among several initiatives, the Foundation has recently posted a series of patient-friendly checklists and tools to help ensure the tight questions are asked at the time of a transition and the right information is retained.

Hospital Readmission, Death Rates Not Linked

A new study in the *Journal of the American Medical Association* found no link between a hospital's 30-day risk-adjusted Medicare readmission rate and its 30-day risk-adjusted death rate. Some hospitals had claimed that their low mortality rates were tied to their readmitting sicker patients to ensure proper treatment, but a research team led by Yale University's Harlan Krumholz, MD found no connection between 30-day all-cause mortality rates and 30-day readmissions rates. The team studied Medicare FFS beneficiaries discharged with AMI, heart failure, or pneumonia between July 1, 2005, and June 30, 2008 and found only a weak association for heart failure and none for the other two. Some large hospitals with high heart failure readmission rates but low mortality have suggested the association is not as weak as the Krumholz study implies.

INDUSTRY NEWS

JAMA®
The Journal of the American Medical Association

Variation on Pediatric Readmissions

Pediatrician and researcher Jay G. Berry, MD, MPH from Boston Children's Hospital and colleagues published a study recently in the *Journal of the American Medical Association* on the prevalence of pediatric readmissions and the magnitude of variation in pediatric readmission rates across hospitals. The study team looked at 568,845 admissions at 72 children's hospitals between July 1, 2009, and June 30, 2010, examining unplanned 30-day readmissions following admission for any diagnosis and for the 10 admission diagnoses with the highest readmission prevalence. The 30-day unadjusted readmission rate for all children was 6.5%, but adjusted rates were 28.6% greater in hospitals with high vs. low readmission rates.

Robert Wood Johnson Foundation

The Revolving Door of U.S. Readmissions

This is the title of new, much-cited study from the Robert Wood Johnson Foundation that shows that hospitals and their community allies made little progress from 2008 to 2010 at reducing hospital readmissions for elderly patients. The key finding: patients were not significantly less likely to be readmitted in 2010 than in 2008. Further, new Medicare data from the *Dartmouth Atlas Project* shows that patients' chances of being readmitted largely depend on where they live and the hospitals where they receive care. The report includes highlights from interviews with 32 patients who experienced a recent readmission and an interactive map of Dartmouth Atlas Project data on the percent of patients readmitted within 30 days of discharge in 2010 by region.

Catching Up With… Cary Sennett, MD, PhD…*continued from page 12*

Those other explanations may include some that are purely technical; for example, "readmission rate," in the study that you mention, was defined differently than in our paper (and in Jencks'). In the study you mention, individuals with multiple admissions were excluded from consideration (after the first readmission). As the authors note, "This is a big difference from two previous studies." It is: it significantly discounts the effect that MA plans may have on that group of patients (like those with frequent readmissions for severe heart failure) who are the most challenging to manage—the group of patients that MA plans are most likely to target, and the group of patients for whom efforts to manage the transition from hospital to ambulatory care is most likely to benefit.

So I'm not ready to accept the argument that the effect we saw is all related to beneficiary selection. What we can't say from our study—and I think the next most interesting question—is: how much of the effect is related to MA plan programs directed toward improving care transitions and coordination of care (a "care management effect"), and how much is related to MA plan efforts to identify and select hospitals that have lower rates of readmission (a "network management effect"). This, too, "deserves further study…"

Readmissions News: *We hear a lot about "big data" these days. Is this going to help us predict more accurately which patients (or even which health plan members) may be at most risk of an unplanned readmission?*
Cary Sennett: I think it's generally true that, all other things held equal, more data allows the development of more powerful models. But it's not clear to me that "big data" is the key to advancing our models; to me, I think it's far more important that we have (and soon will have more) "better data."

By "better data" I mean data that more completely and more accurately describe the factors and forces that are related to (hence have predictive value in models for) readmission. These include the richer clinical datasets that are emerging from electronic medical records which -- if harvested and used in near-real time to evaluate patients -- may open a much more robust window on readiness for discharge. They also include more complete information about admissions that may be "planned." Finally, I've already commented on how the need for a better understanding of patient-level factors -- socioeconomic status, educational attainment, family structure -- may be important to understanding a patient's risk for readmission. Acquiring and using these data is likely, I think, to significantly enhance predictive power; the challenges to doing so may be more political than technical.

Readmissions News: *Finally, tell us something about yourself that few people would know.*
Cary Sennett: There probably aren't five people alive who know the title of my PhD dissertation—which (so now you know) is: Why Hospital Admissions Have Declined. My doctoral work was an attempt to understand why Medicare admissions declined after the implementation of DRGs (which, as every economist of my day knows, created an incentive, at the margin, for hospitals to admit). So the question was of real interest to me, both as an economist and as a physician.

I approached the question as much as a physician as an economist, and looked at two conditions -- cataract and diabetes mellitus -- for which admissions had fallen most markedly in the interval following the implementation of DRGs. What I found is that declines in cataract admissions followed the introduction of a new type of intraocular lens, which permitted cataract surgery to take place safely in outpatient centers. And I found that admissions for diabetes fell inversely with the number of home blood glucose monitoring strips that were sold -- that a technology that permitted home monitoring of blood glucose appeared to significantly reduce the need to admit patients for control of diabetes and its complications.

I came away from this with a new respect for medical technology -- and humbled by the potential to mistake the obvious for the important. I don't mean to suggest that DRGs were not important, but the changes that we observed following their introduction could not be explained simply as the result of the so-obvious economic incentives.

Catching Up With …

Cary Sennett, MD, PhD is the President of IMPAQ International, a research, evaluation, and technical assistance firm collaborating with governments and the private sector to enhance policies and programs that improve the lives of millions across the globe. He has more than 20 years of experience working to improve the quality and value of health care in the United States, building infrastructure to support a high performing health care system. He talks about U.S readmission rates vs. the rest of the world, getting the metrics right, Medicare Advantage vs. FFS, "big data", and himself.

Cary Sennett, MD, PhD

- President of IMPAQ International
- Fellow in the Economic Studies Program at the Brookings Institution, and Managing Director for Health Care Finance Reform at the Engelberg Center for Health Care Reform
- Chief Medical Officer, MedAssurant (now Inovalon)
- Executive Vice President of the National Committee for Quality Assurance (NCQA)
- MD degree Yale University; PhD from the Sloan School at MIT; residency training in Internal Medicine at the Brigham and Women's Hospital in Boston

Readmissions News: *Your current role as head of IMPAQ International obviously gives you a global perspective. When it comes to readmissions problems and readmissions strategies, how does the U.S. stack up against the rest of the industrialized world?*

Cary Sennett: There is surprisingly little published comparing rates of readmission in the United States to other industrialized countries. That may, in fact, mean something: what evidence there is suggests that hospital readmission is much more of a problem in the US than it is elsewhere.

The reasons for this may be complex. A paper in JAMA last year showed that 30-day readmission rates for patients hospitalized for STEMI were significantly higher in the United States (14.5%) than in 16 other countries (average 9.3%). There was an intriguing inverse relationship between readmission rate and LOS -- suggesting that part of the explanation may be that patients with STEMI may be discharged in the U.S. sooner than is optimal. This is one of those observations that I think "deserves further study;" there are so many differences in the way health care systems are organized and operate in the United States and these other countries that it would be pretty risky to try to draw that conclusion. There may be more value in learning from the variation we see across hospitals in the United States, and from innovations (like CMS's Partnerships for Patients and Community-Based Care Transition Program -- some of which we at IMPAQ are evaluating) than in trying to apply what we learn from international studies.

Readmissions News: *You have long been a metrics guy and more importantly someone who cares about getting a quality measurement right so it measures what it is supposed to. What are we not getting right with the current 30-day readmission metric? What construct would effectively measure the quality of the hospital's performance?*

Cary Sennett: I HAVE long been a metrics guy, and we ALL care about getting it right. On the other hand, I firmly believe the old saw: Let not the perfect be the enemy of the good.

The measures that CMS is using now aren't perfect, but they are thoughtful and may be just about as good as we can get, given the limitations of claims data. My outstanding concern has to do with patient characteristics other than the clinical risk that current metrics consider pretty well. We know that patients vary with respect to behaviors, many of which (like follow up with a primary care physician) are critical to averting readmission, but patient-level factors that predict non-compliant behaviors are neither adequately understood nor adequately incorporated into risk adjustment models.

We need to understand those factors, but it's less clear that we want to adjust for them. If the policy goal is for hospitals to optimize discharge planning/transitions in care around the unique needs, capabilities, and barriers that the populations that they serve face, we may want to encourage, reward, and recognize hospitals that respond to this challenge rather than "adjusting them away."

Readmissions News: *When you were at MedAssurant (now Inovalon), you and Jeff Lemieux at AHIP looked at readmissions statistics for Medicare Advantage plan members vs. Medicare FFS beneficiaries, with positive results among the former cohort. At least one new study suggests the opposite may be true because of self-selection issues. With all the emphasis on transitions of care and care coordination, wouldn't a Medicare Advantage plan likely have a better chance of preventing an unnecessary readmission?*

Cary Sennett: The work that Jeff and I (with several others at MedAssurant/Inovalon and AHIP) did was simply one study in a growing (and complex) literature that suggests that readmission rates are lower in Medicare Advantage (MA) plans than in fee-for-service (FFS) Medicare. While it may be true that enrollees in MA plans are, on average, somewhat healthier than FFS beneficiaries, I think we need to look for other explanations, given the magnitude of the differences we saw (MA readmission rates in our study averaged 14.5% across MA plans, compared to the 19.6% reported by Steve Jencks using a comparable readmission metric).

continued on page 11