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Readmissions NEWS

A Care System for Effecting Reductions in Preventable Readmission Rates

By James L. Holly, MD

Southeast Texas Medical Associates, LLP (SETMA) has been actively working on reducing preventable readmissions for almost three years. We have employed multiple methods in this process.

The SETMA Methods

In a 2008 HIN reducing readmissions survey, thirteen methods (in bold-faced type below) were identified as being employed for the reducing of preventable readmissions to the hospital. The comments in parenthesis address some of the ways in which SEMTA is employing these methods. They were:

1. **Pre-admission Coaching.** This is the continuity of care piece whereby the patient understands the purpose and goal of inpatient care. The patient and family understand that except in accidents, this is typically a failure of effective outpatient care and the goal is to prevent the need for inpatient care in the future. The three-fold method of surviving the hospital is explained: eat, get up and get out! They know what to expect as to duration of inpatient care and transition to home.

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In This Issue

Medication Management and Hospital Readmissions

By Marie Smith, PharmD

The appropriate and safe use of medications is critical to avoid medication errors and prevent related hospitalizations. Today we have multiple studies that reveal the type and extent of hospital-related medication errors and issues:

- Unintended medication discrepancies at hospital admission range from 30%-70% (Cornish, *Arch Int Med*, 2005;165:424-9 and Gleason, *Amer J Health-Syst Pharm,* 2004; 61:1689-95)
- The average hospitalized patient is prone to at least one medication error per day (Institute of Medicine, *Preventing Medication Errors*, 2007)
- Poor communication at care transition or interfaces contributed to about 50% of all hospital-related medication errors and 20% of adverse drug events (ADEs). (Rozich, *Jt Comm J Qual Saf* , 2004; 30:5-14)

About 20% of patients discharged from hospitals have an adverse event, with 72% of them related to medications. (Forster, *Annals of Internal Medicine*, 2003; 138:161-7 and Forster, *Canadian Medical Association Journal*, 2004; 170:345-9)

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Editor's Corner

Raymond Carter, Senior Editor, *Readmissions News*

Erratum: The March issue incorrectly identified Henry C. Fader as Harry C. Fader. We regret the error. **Ed.**

I am pleased to announce that we have added a new *Readmissions News* National Advisory Board member – **Cary S. Sennett, MD, PhD, President of IMPAQ International.** He will be formally introduced later in the year. This month it is our pleasure to introduce Kathleen Drummy.

Kathleen Houston Drummy, Esq.
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Kathy Drummy is a Partner in the Los Angeles office of Davis Wright Tremaine, LLP. She has broad experience across the entire health sector, from hospitals and skilled nursing facilities to HMOs, physician organizations, and pharmaceutical and medical device companies.

Her extensive expertise encompasses regulatory, transactional and litigation aspects of health care law, including Medicare and Medicaid, programs, county mental health programs, facility and physician licensing, accreditation, certification, decertification and suspensions; federal and state anti-fraud/abuse and self-referral laws, compliance audits; and a broad range of financial and medical records issues.

She is a member of the California Bar Association and the American Health Lawyers Association. Among other honors, she was named "one of America's Leading Business Lawyers" by Chambers USA in 2007-2011 and one of the "Best Lawyers in America" in Health Care Law by Woodward/White in 2008-2011. Kathy was selected to "Southern California Super Lawyers," Law & Politics, 2005-2006, 2008-2012. She received her BA from UC Berkeley, and her MA and JD from UCLA. She may be reached at kathleendrummy@dwt.com.

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Reducing Costly Readmissions through Web-based, Post-discharge Follow-up Tools

By Theresa Edelstein, MPH, LNHA

The Centers for Medicare and Medicaid Services has estimated the cost of avoidable hospital readmissions at more than $17 billion a year. It's no surprise then that CMS has targeted readmissions as one area to realize significant Medicare savings. Beginning in fiscal year 2013, CMS will begin penalizing hospitals on readmissions for three conditions: heart failure, acute myocardial infarction and pneumonia. The list will grow even longer in 2015. The Congressional Budget Office projects that the savings could reach $7.1 billion over 10 years. And while that might be good news for the federal budget, it could be catastrophic for hospitals. Not surprisingly, providers aren't waiting until 2013 to rein in their unavoidable readmissions.

One of the solutions gaining ground is the implementation of follow-up communications with patients recently discharged from the hospital. These options can be as basic as a recorded automated phone call or as sophisticated as a nurse advocate calling the patient within 24 hours of discharge and going through a number of highly clinical questions tailored to the patient's specific illness and care setting.

Automated calling is cheap, but the call-back response tends to be low. The high-end options can be complex, expensive and require more training, staff and resources that hospitals may not have. There is a gap between the two, a middle ground with the need for a program that could work for everyone.

To fill that gap, the New Jersey Hospital Association (www.njha.com) in Princeton, N.J., began developing such a product to support its members' participation in a CMS demonstration project on gainsharing. This three-year pilot partners physicians and hospitals in an effort to reduce costs, increase efficiencies and maintain or improve quality of care. NJHA supplied the 12 participating hospitals with an Internet-based software application to help them follow up with patients discharged with congestive heart failure or stroke in order to improve care and prevent or reduce readmissions. This Web-based, post-discharge follow-up tool became Well On Track, (www.wellontrack.net) a product priced to fill the affordability gap that also is flexible, easy to use and most importantly, patient centric.

In its work with the 12 initial users, Well On Track fulfilled CMS' goal of providing better continuity of care, improving communication between the hospital and patient and promoting patient recoveries. According to the hospitals using Well On Track, some health crises were averted and patients' compliancy with discharge planning instructions and filling prescriptions increased.

"Well On Track provides the right questions to ask so we can monitor patient progress accurately. It's been an invaluable tool. With its reporting feature we are able to screen clinical issues as well as trends in patient populations that are vulnerable to readmission," stated Sharon Holden, RDCS, BSN, MPA, assistant vice president, cardiopulmonary, critical care and emergency services at Monmouth Medical Center.

Most hospitals in the pilot group, if they were doing follow up at all, were using a paper-based system, inviting errors due to loss of information, misfiling, using the wrong information and patients falling through the cracks.

How it Works

Well On Track was developed with input from clinicians to identify the most appropriate intervals for patient follow-up, as well as a list of focused questions designed to elicit helpful patient feedback. A nurse or a social worker calls the patient, or the facility where the patient has been discharged to, such as a rehabilitation hospital, skilled nursing facility or home health agency. A list of applicable questions appears on the computer screen that could include:

- How are you feeling?
- Have you scheduled a follow-up appointment with your doctor?
- Do you understand your discharge instructions?
- Do you have any questions about your medications?
- Are you taking your medications?
- Are you eating?
- Are you gaining or losing weight?
- Are you able to move around the house?
- Have you had to go back to the hospital or ED since you were discharged?

These are focused, simple, nonclinical questions that patients usually feel comfortable answering. The phone call gives patients an opportunity to ask questions they might have been embarrassed to mention during the discharge planning process or to express any confusion they might have about their discharge instructions.

Ideally, the same person calls the patient each time so there is a feeling of comfort and rapport, fostering the patient's compliance. But if there are different callers, Well On Track ensures that responses are entered into its database – giving the caller valuable information and saving the patient from repeatedly answering the same questions.

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Reducing Costly Readmissions*…continued*

According to Ann B. Townsend, RN, DrNP, APN, nurse practitioner, cardiology at Our Lady of Lourdes Medical Center, "Our patients reacted very favorably to our follow-up efforts with Well On Track. They told us they felt like we really cared about them. In many instances, we were able to clear any confusion they had about upcoming physician appointments and medications. By working with this tool, we were able to augment our discharge efforts and implement a Discharge Help Line so that our patients could call us with any questions related to their discharge."

Based on answers from the patient, Well On Track automatically prompts the caller with drop down answers when applicable, with each containing a text box for additional notes. If the patient has a more complex question, the caller has all the contact information for the patient's physician right on the computer and can call the physician to get an answer. Because there is one-to-one communication with the patient, the caller can pick up on subtle changes and decide if that patient needs to go to the ED, needs a home care visit or a physician to intervene. In fact, Well On Track even has a unique identifier function called Send Action Plan. If the caller suspects the patient is at serious risk, he or she presses this button and an e-mail is automatically sent to the hospital's Well On Track Action Team members letting them know that the patient is in trouble so they can act accordingly.

"Well On Track enables us to be very proactive in recognizing a concern which left unaddressed could lead to potential readmission within a short period of time," stated Sharon Hayo, nurse manager of the Ask a Nurse Call Center at Holy Name Medical Center.

The program is work flow-driven so everything the caller needs is right there on the computer screen. Every day a list comes up of patients who need to be contacted, why they were hospitalized and what kind of information needs to be gathered.

The system organizes calls into two, spaced intervals by disease category and can be modified to add a third interval along with customized questions and additional text boxes.
Other features include:

- Web-based ADT interface option for automated patient selection
- Downloadable reporting capability
- Color-coded tickler system
- Easy work queues with sort and clinical condition category filters
- Automatic follow-up notifications
- Best practice follow-up intervals for CMS core clinical conditions
- Secure Web-based application for easy implementation and usage
- Role-based user provisioning.

Based on reports and feedback from Well On Track, hospitals can determine whether or not their discharge instructions are clear, how many patients are filling and/or taking their medications and overall patient satisfaction. According to Pamela Abraham, MSN, RN, clinical nurse leader at Hunterdon Medical Center, "We are in a unique position to know patients and their families prior to their discharge so it makes follow-up with Well On Track a much more personal experience. We can intervene effectively if patients need assistance with discharge instructions, prescriptions and/or follow-up appointments with their physicians."

NJHA is already in the process of enhancing Well On Track by adding more diseases such as pneumonia, acute myocardial infarction, diabetes and transient ischemia attacks, more options to customize call intervals, additional questions and modifying the program for use in accountable care organizations and medical homes.

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Care System*…continued*

2. **Use of Hospitalists.** SETMA is using hospitalists for particular populations of patients but more than hospitalists the hospital-care-team, made up of physicians, nurse practitioners, nurses, care coordinators and case managers are the structural ways of solving this problems Hospitalists improve the disease-management elements of inpatient care but without a support tem often reproduce the transition-of-care deficiencies of the non-hospitalists program.
3. **Inpatient Coaching.** Keeping the patient and family informed is critical to reducing readmissions. Diagnoses, testing results and prognosis are critical elements to this part of the coaching.
4. Expectations are made realistic, when possible, and the patient and family are prepared for the transition to the post-hospital care setting.)
5. **Improved Discharge Notes.** SETMA has changed the name of the "discharge summary," to "Hospital Care Summary and Post Hospital Plan of Care and Treatment Plan." While long, this name is functional. For 2009-2011, SETMA discharged 25,949 patients from the hospital; 99.1% of the time this transition of care document was presented to the patient at the time of discharge.
6. **Plan of Care/PHR.** In SETMA, the Plan of Care and Treatment Plan is the "baton" whereby responsibility for care is transferred from the provider to the patient.

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Care System*…continued*

7. **Care Transitions & Management**. For SETMA, Care Transitions begins on admission, includes the "Hospital Care Summary" document, the Post-Hospital Care Coaching, 12-30 minute telephone contact, and does not end until the patient sees their personal healthcare provider in the clinic, which is always within six days unless the patient is designated as a high potential for readmission where it is within three days.
8. **Community Partnerships.** Key partnerships for decreasing readmissions are hospice, home health, physical therapy, meals-on-wheels and local government agencies who are prepared to supplement the healthcare needs of the patient. For SETMA patients this includes The SETMA Foundation which can help with cost not covered by insurance.
9. **Care Transitions Coaching.** For SETMA, this is done at the time of discharge by the hospital care team, and subsequently by SETMA's Department of Care Coordination.
10. **Post-hospitalization Coaching.** SETMA's Care Coordination Department staff makes the hospital follow-up call the day after discharge and schedules other calls as needed..
11. **Telephone Monitoring Post-discharge.** SETMA is adding telemonitoring for targeted conditions such as CHF, Diabetes, etc.
12. **Medication Reconciliation.** Each inpatient event results in four episodes of medication reconciliation: at admission, at discharge, in the care coaching call and then at the follow-up visit. Because all of these are done in the same electronic database, they are additive in their value to the patient's safety.
13. **Case Management.** This is the new part of the healthcare team. In the past, case management was added on to the care of inpatients but seldom interacted with primary healthcare deliverers. Now they are an integral team and they bring skills and functions which are critical to our goal.
14. **Self-management Education.** If the patient is to be in charge of his/her care 8,760 hours a year, they need educational resources with self-paced learning tools. When a patient or caregiver has a question, the first resource is the secure-web portal for research by the patient or family; the second is a secure message to the provider through the web portal and the last is a face-to-face visit.

As can be seen, the thirteen methods of the HIN survey are not distinct methods in SETMA's judgment, but elements of one integrated method.

The Baton

"The Baton" is a pictorial representation of the patient's "plan of care and the treatment plan," which is the instrument through which responsibility for a patient's health care is transferred to the patient. Framed copies hang in all pubic places throughout SETMA's clinics. A poster copy hangs in every examination room. The poster declares:

Firmly in the providers hand
--The baton – the care and treatment plan
Must be confidently and securely grasped by the patient,
If change is to make a difference
8,760 hours a year.

The poster illustrates the following seven key principles:

1. That the healthcare-team relationship, which exists between the patient and the healthcare provider, is key to the success of the outcome of quality healthcare.
2. That the plan of care and treatment plan, the "baton," is the engine through which the knowledge and power of the healthcare team is transmitted and sustained.
3. That the means of transfer of the "baton" which has been developed by the healthcare team is a coordinated effort between the provider and the patient.
4. That typically the healthcare provider knows and understands the patient's healthcare plan of care and the treatment plan, but that without its transfer to the patient, the provider's knowledge is useless to the patient.
5. That the imperative for the plan – the "baton" – is that it be transferred from the provider to the patient, if change in the life of the patient is going to make a difference in the patient's health.
6. That this transfer requires that the patient "grasps" the "baton," i.e., that the patient accepts, receives, understands and comprehends the plan, and that the patient is equipped and empowered to carry out the plan successfully.
7. That the patient knows that of the 8,760 hours in the year, he/she will be responsible for "carrying the baton," longer and better than any other member of the healthcare team.

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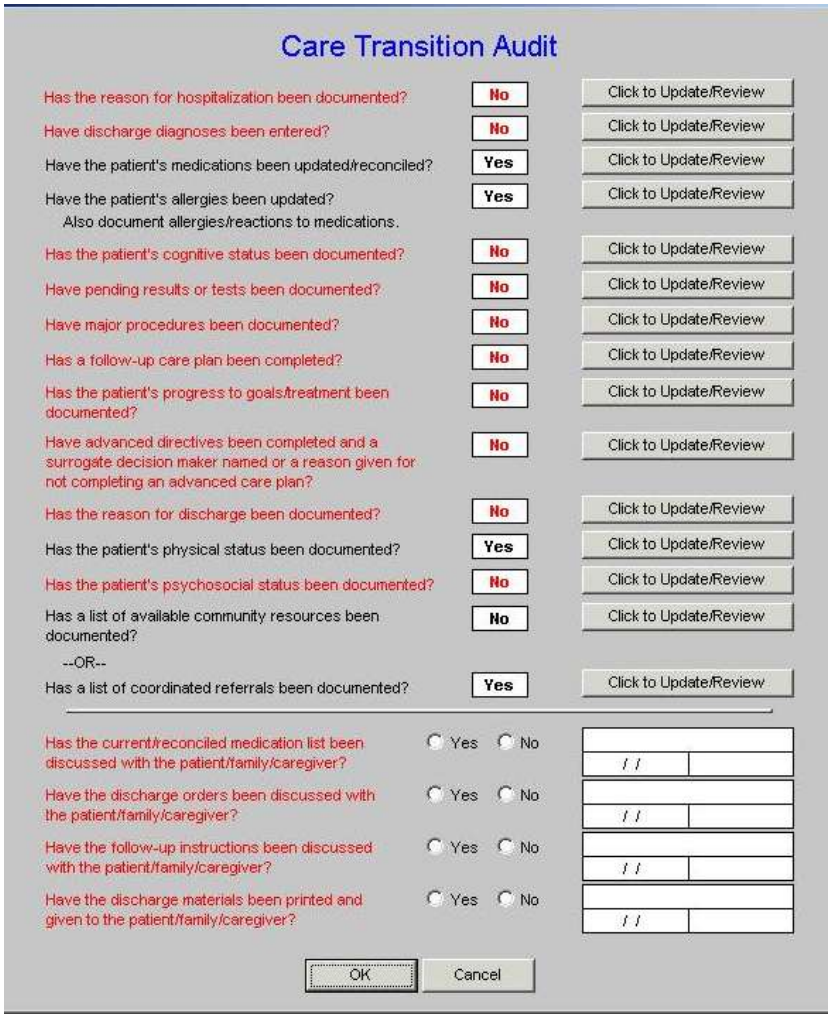
Care Systems*…continued*

8. It must be remembered that when a patient leaves the hospital, until they are seen in the office or home, the provider team member who is in charge of the patient's care is the patient or a family member. Therefore the baton must be successfully passed to the patient, if the coordination, integration, and continuity of care are to be maintained.

The Analytics

To successfully achieve and sustain reductions in readmissions, healthcare organizations must track, audit, and analyze the data.

Care Transition - in June, 2009 the AMA released the "PCPI Care Transitions measurement set". This transition audit is one of the tools used to "build" the "baton" and then to make sure that the complete "baton" has been transferred to the next team member.



Lessons to Date

What we have learned so far is:

- **The disease-management model-of-care will not solve this problem.** Healthcare providers can't see patients often enough, give them enough medications, or do enough procedures on them, to effectively reduce readmissions and/or to sustain any reductions which are achieved.
- **Care, even within the same organization or system, is still too fragmented to effectively achieve reductions in readmissions**. Team building and learning how to effectively use teams are key to this process. SETMA's current, active effort is to create a "team spirit and collaboration" between four SETMA departments which are working extraordinarily well individually but which are experiencing barriers to a full, integrated, team approach between departments.
- **Analytics will be an important part of discovering leverage points for the improving of readmission rates**. SETMA has deployed Business Intelligence analytics for that purpose. Because health deteriorates, and on an individual basis and on organizational level, methods must change to respond to that deterioration; it is imperative to continue to redesign the readmissions-reduction effort to keep pace with new realities.
- **There is no "silver bullet" for solving the problem of readmissions.** A multi-pronged effort will gradually improve readmission rates, until it is suddenly apparent that the system is working. Research will be required to determine the percentage contribution of each element to the success of the effort.

Readmissions rates will always be a challenge. They can be managed effectively with a system such as the one used at SETMA. More details on this system are available at **www.setma.com** under *Your Life Your Health* by accessing the icons entitled *Care Transitions* and *Care Coordination*.

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Medication Management…*continued*

"Gold-standard" Medication List. A critical element of preventing medication-related problems (MRPs) is the need for a comprehensive, accurate, and active medication list -- a "gold-standard" medication list -- that a health care professional can use to make accurate clinical decisions.

Three important aspects of constructing a "gold-standard" medication list are:

Comprehensiveness: includes all medications the patient uses including prescriptions, over-the-counter medications, herbal products, dietary or nutritional supplements, and physician samples; must include medications from all physicians (primary care and medical specialists) and all pharmacies including those obtained from community retail, mail-order, and Internet pharmacies.

Accuracy: includes the name, dose, frequency, route, and patient instructions for each medication; documents any discontinued (e.g., medications that caused an adverse reaction) or stopped medications (e.g., warfarin stopped prior to surgery).

Active Meds: includes those medications that the patient is actively taking and includes the date of the medication review; needs to be reviewed and documented at each time there is a care transition, and whenever a medication is added or discontinued, or a current medication dose is changed.

Without a 'gold-standard" medication list, health care professionals have inaccurate or insufficient information to make the best clinical decisions for prescribing, monitoring, and adjusting the patient's medications.

Medication Reconciliation. As defined in *Improving Care Transitions*: *Optimizing Medication Reconciliation* (APhA and ASHP 2012), medication reconciliation is the comprehensive evaluation of a patient's medication regimen by comparing a patient's existing medication orders to all of the medications that the patient has been taking. Medication reconciliation is done to avoid medication errors such as omissions, duplications, dosing errors, or drug interactions, as well as observe medication adherence patterns. This process should be done at every transition of care in which new medications are ordered or existing orders are rewritten or adjusted, or the patient has changed any non-prescription or self-care medications. Transitions of care includes (1) any change in a care setting such as entry/admission to or discharge from a hospital, ambulatory care setting, or long-term care facility, (2) a new level of care or change in location within a health-care setting, or (3) a change in care providers. It is important to note that medication reconciliation is not a simple task -- it is not merely comparing medication lists or compiling a medication list from a patient report.

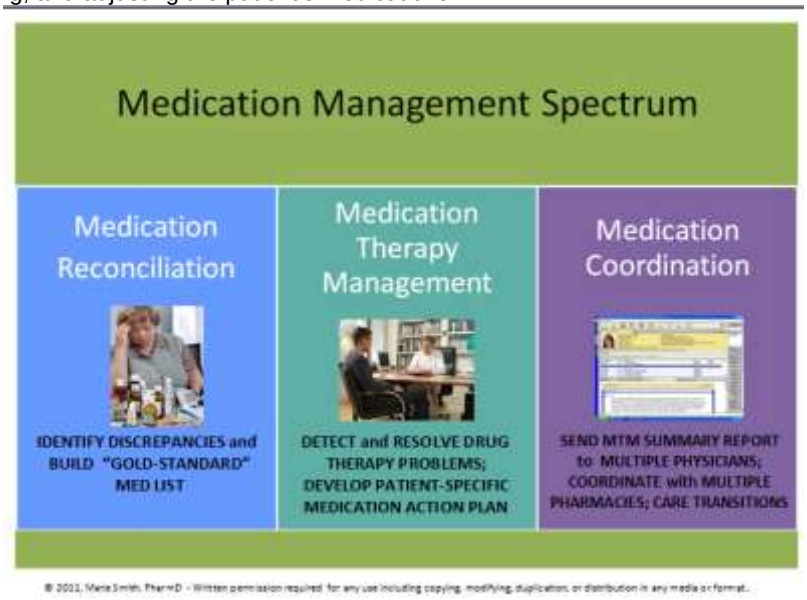

Figure 1. Medication Management Spectrum

Rather, it is the *first step in a comprehensive medication management process* to avoid/reduce medication errors, foster safe medication use, and encourage hospital-based and community-based practitioners to provide coordinated communications across the continuum of care. Medication reconciliation can be performed by pharmacists or other qualified professionals as long as a standardized and comprehensive approach is utilized to construct or update the "gold-standard" medication list.

It is crucial that each medication reconciliation should include the name and discipline of the person conducting the reconciliation, as well as the date of the reconciliation. The patient should be instructed to share only the most current and reconciled medication list with health care providers.

Medication Management. Medication management has been defined by the pharmacy profession as the processes in place for all the patient's medications (prescriptions, over-the-counter medications, herbal products, and dietary supplements) to be *reconciled, evaluated, monitored and coordinated* (across all prescribers, pharmacies, care transitions) in order to optimize evidence-based treatment goals for an individual patient (see Figure1). Once the patient's medication list is reconciled, the pharmacist performs a systematic approach to resolve any discrepancies or medication-related problems such as omissions, duplications, contraindications, drug interactions, adverse events, doses too low or high, adherence or health literacy issues, or any unclear and incomplete information. The pharmacist uses a standardized approach to:

- collect patient-specific medical and health information
- assess medication therapies to identify medication-related problems

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Medication Management…*continued*

- develop a prioritized list of medication-related problems
- create and implement a plan to resolve medication-related problems that is coordinated with the patient, caregivers/family, and all health care providers.

Pharmacists can improve patient care with medication management services and reduce the rate of hospitalizations. A systematic review of 12 randomized, controlled studies demonstrated that pharmacist collaborative care for medication management services were associated with significant reductions in the rate of all-cause hospitalizations and heart failure hospitalizations (Koshman SL, *Arch Intern Med.* Apr 14 2008;168:687-694.)

Medication management roles and processes need to be clearly defined and coordinated in acute care settings between pharmacists, nurses, hospitalists, medical consultants, and the patient's primary care physician. It is critical that a comprehensive and accurate medication list is compiled at admission and reviewed whenever the patient is transferred or discharged. Since the discharge process can be very fragmented and overwhelming for the patient, it is imperative that a written list of discharge medications is reviewed and understood by the patient. Careful attention must be paid to assure that any hospital formulary medication changes or intravenous medications are properly converted in the patient's discharge medication list. In addition, any discontinued or restarted medications should be clearly noted. The discharge medication list needs to be sent to the patient's primary care provider in advance of a follow-up appointment.

In the ambulatory care setting, there must be equal and careful attention to medication lists by primary care and specialist providers. The physician needs to be assured that any staff member with delegated responsibility for medication reconciliation is familiar with medication generic and brand names; knowledgeable about of common dosages, routes of administration, frequencies, usual quantities dispensed, and is diligent about medication list documentation. A proper analysis of medication-related policies and procedures in an office practice should reconfigure workflow processes to:

- allow for sufficient time to perform a comprehensive med list review at every patient encounter
- review patients' medication list for all medication renewals
- document patient calls about medication questions
- document pharmacist calls to clarify prescriptions
- handle medication prior authorizations in a timely manner
- provide feedback to office staff on accuracy issues in patient medication lists.

So patients and health care professionals in both hospital and ambulatory settings must share the responsibility for making sure that medication lists are complete, accurate, and communicated at every health care visit.

Common Medication Gaps and Challenges. Today there is an increased emphasis that a medication list be generated and given to a patient at every office visit, emergency department visit, and hospitalization. So it is imperative that a comprehensive medication reconciliation occurs at each point-of-care to ensure that the patient has only *one, current and updated medication list* to reduce any patient confusion and to assure that a provider is making clinical decisions on the most current and complete medication list.

Particular attention needs to paid to ask the patient if they have discontinued or temporarily stopped taking any medications -- either as a result of a physician's instructions or initiated by the patient due to unclear instructions, health belief or literacy issues, or adverse drug events. Many decisions regarding medication discontinuation are transmitted to a patient verbally and may not be reflected on the patient's written medication list.

Another challenge with medication lists involve discontinued medications that still have remaining refills or have been included in a pharmacy's auto-refill program. This is especially critical for patients who are admitted to hospitals with adverse drug events (ADE). The medication that caused the ADE will be discontinued yet the patient can still have remaining refills -- especially for chronic medications. The patient must understand that any remaining medication at home should be discontinued and properly disposed.

Also, the dispensing pharmacy needs to be informed so that remaining refills can be cancelled.

The updated medication list needs to be entered into the patient's medical chart, shared with any medical specialists, and given to the patient with instructions to share it anytime s/he has a medical appointment or visits the emergency department or is admitted to a hospital.

Role of Pharmacists. Pharmacists can apply their pharmacology, pharmaceutics, and pharmacokinetics knowledge to the reconciled medication list to *identify and resolve* MRPs. With their familiarity of drug products and medication distribution systems, pharmacists can also coordinate medication management recommendations with multiple prescribers and pharmacies. As a result of the pharmacist's medication management services, the patient will receive a personalized Medication Action Plan that includes a reconciled and updated medication list plus self-management goals. In addition, the patient's primary care provider (and specialists as needed) will receive a Medication Therapy Management Summary Report that includes any recommendations to optimize the patient's medication regimen. This collaborative and team-based care coordination approach will improve medication use and safety in primary care, and has the potential to minimize avoidable hospitalizations or readmissions.

Marie Smith, PharmD is the Palmer Professor and Assistant Dean, Practice and Public Policy Partnerships at the University of Connecticut School of Pharmacy in Storrs, CT. She can be reached at marie.smith@uconn.edu.

*T*hought 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. "*Are the CMS readmissions penalties on hospitals too harsh, too small to make a real difference, about right, or the wrong approach in the first place?"*

"Like Goldilocks and the Three Bears, it appears that CMS is striving to develop a lever that is 'just right'. One that increases attention on a problem that is frequent, costly and, at least in part, believed to be preventable. All sides of this question have been argued.

Some in the hospital community believe that the penalties are not only too harsh but that they may, in fact, be harmful especially for facilities that have patient populations with more complex social needs. Others argue that the amount of money a hospital might lose from the penalty is less than what they would lose from the reduction in revenue from the readmitted patients plus the cost of the interventions, thus begging the question: will hospitals make changes that will adversely impact their income, at least in the short term? Some question why, instead of penalties, CMS doesn't just start to pay for things that are believed to reduce readmissions, e.g., care transitions coaches, nurse care managers, telemonitoring, etc. Others suggest that giving warranties for certain procedures is a better approach.

Having worked in the field of patient safety and quality improvement for several decades, I can say that these penalties, although not perfect, provide the essential currency for improvement, which is *attention*. Since the day that they were announced many organizations moved from *thinking* about improving readmissions to *doing* it, and for that reason it is my opinion that the CMS penalty will be somewhat effective. A more effective strategy may be to fully align reimbursement with the needs of the patients and not the providers. Short of that, I see the positive effect that the fear of penalties has had on bringing this challenging work into the forefront and providing the will to do it."

Pat Teske
Implementation Officer
Cynosure Health
Roseville, CA

"Unplanned readmissions represent a pervasive, costly problem with care coordination; however, historically perverse financial incentives under fee for service medicine and competing hospital priorities sidelined the issue. Today, public reporting of readmission rates and the looming readmissions penalty program have forced the issue to the top of hospital quality agendas.

The readmission penalty itself is an imperfect strategy for incenting care delivery reform because it places all of the financial risk on the hospital, even though other providers and patients are integral to the equation. However, hospitals sit at the hub of acute care and are best positioned to catalyze care coordination across providers, sites of care, and time. No payer has created the perfect value-based purchasing strategy to date, but the rapid response by hospitals to reduce readmissions suggests that the penalty program has played a role in moving the dial on care coordination. "

Brian Contos
Executive Director, Research and Insights
The Advisory Board Company
Washington, DC

"Medicare's Value Based Purchasing program is a good attempt to improve overall quality of care. The ability to share in improvements is an important element of the program, which allows for a positive incentive rather than just denying payment for care not meeting some criteria. All Medicine programs should be set up in a similar manner."

Thomas Sokola
Chief Administrative Officer, Clinical Operations,
Geisinger Medical Center
Danville, PA

INDUSTRY NEWS

IHI Offering Seminar on Readmissions Issues

The Institute for Healthcare Improvement (IHI) is offering a two-day seminar entitled *Reducing Readmissions by Improving Transitions in Care*. Utilizing ideas that have been tested in the STate Action on Avoidable Rehospitalizations (STAAR) initiative and IHI's Transforming Care at the Bedside Learning and Innovation Community, the seminar is designed to assist teams in enhancing communications, supporting patients and families, eliminating waste, and improving workflow.

Intuitive Health and *AT&T* Collaborate to Reduce Readmissions

Intuitive Health is collaborating with AT&T to reduce readmissions and lower the cost of healthcare by implementing a home-based remote patient monitoring pilot program. The pilot is intended to engage patients and their family members in their own care while also involving healthcare providers and augmenting clinical information systems. Through this program patients can send information through a variety of personal health devices to clinicians who have software that collects the data and allows them to offer constructive advice back to their patients. Wireless connectivity is provided by AT&T.

Association of Rehabilitation Nurses (ARN) Offers Insights Into Reducing Readmissions

The Association of Rehabilitation Nurses (ARN), which represents more than 5,700 nursing experts across the healthcare industry, has provided an important resource for organizations looking to prevent patients in rehabilitation from returning to acute care hospitals. The information has been made available in the December 2011/January 2012 edition of their online newsletter, ARN Network.

The *Academy of Managed Care Pharmacy* Offers Advice to the *National Quality Forum* Regarding Readmissions

The Academy of Managed Care Pharmacy (AMCP) had recommended that the National Quality Forum (NQF) put an emphasis on adverse drug events and medication errors, since 60% occur during transitions of care. AMCP argues that in doing so readmissions rates would be significantly lowered. Contributing factors include patient misunderstanding of instructions, drug-drug interactions,

LCH Group Inc. Enters Into Joint Venture with *Baptist Health System* in Alabama to Reduce Readmissions

In an effort to reduce preventable hospital readmissions, the Louisiana home health provider LHC Group Inc. has entered into a joint venture with the Baptist Health System in Alabama. LHC will provide home care to patients recovering from the care they received at Baptist Hospitals. The move was made as a response to Federal mandates within the Affordable Care Act that penalize preventable readmissions.

American Health Care Association Unveils Goals to Reduce Readmissions

A new multi-year initiative has been unveiled by the American Health Care Association (AHCA) designed to lower readmissions, retain staff at skilled nursing facilities, and meet new quality goals. The four main planks of the program include:

1. Reducing the number of resident hospital readmissions within 30 days of a SNF stay by 15 percent by March 2015, or 26,000 fewer residents being re-hospitalized annually.
2. Reducing turnover among all nursing staff -- RNs, LVNs, CNAs -- by 15 percent by March 2015.
3. Reducing the off-label use of antipsychotics in nursing home residents by 15 percent by December 2012.
4. Increasing the number of consumers who would recommend their facility to others up to 90 percent by March 2015.

Recommendations for a Readmissions Reduction Program Offered by HFMA

In a letter to the Centers for Medicare and Medicaid Services (CMS), the Healthcare Financial Management Association (HFMA) has offered changes to the Hospital Readmissions Reduction Program. HFMA suggests that CMS provide hospitals with readmissions data, align financial incentives across the care continuum, and change how excessive readmissions are defined and calculated. If CMS fails to do this, HFMA argues that hospitals will be unfairly and excessively penalized.

drug-food interactions, and duplicative therapy.

INDUSTRY NEWS

IHI Offering Seminar on Readmissions Issues

The Institute for Healthcare Improvement (IHI) is offering a two-day seminar entitled *Reducing Readmissions by Improving Transitions in Care*. Utilizing ideas that have been tested in the STate Action on Avoidable Rehospitalizations (STAAR) initiative and IHI's Transforming Care at the Bedside Learning and Innovation Community, the seminar is designed to assist teams in enhancing communications, supporting patients and families, eliminating waste, and improving workflow.

Intuitive Health and *AT&T* Collaborate to Reduce Readmissions

Intuitive Health is collaborating with AT&T to reduce readmissions and lower the cost of healthcare by implementing a home-based remote patient monitoring pilot program. The pilot is intended to engage patients and their family members in their own care while also involving healthcare providers and augmenting clinical information systems. Through this program patients can send information through a variety of personal health devices to clinicians who have software that collects the data and allows them to offer constructive advice back to their patients. Wireless connectivity is provided by AT&T.

Association of Rehabilitation Nurses (ARN) Offers Insights Into Reducing Readmissions

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Catching Up With …

Amy Boutwell, MD, MPP is the founder of Collaborative Healthcare Strategies, helping providers and communities respond to the health care delivery improvement vision outlined in the Affordable Care Act and the Triple Aim. She is also co-founder of the STAAR (State Action on Avoidable Rehospitalizations) initiative of the Institute for Healthcare Improvement (IHI), now engaging more than 150 hospitals in four States. She talks about STAAR, incentives and penalties, community approaches, Medicaid readmissions, and herself.

Amy Boutwell, MD, MPP

- Founder, Collaborative Healthcare Strategies, Lexington, MA (2011-Present)
- Practicing general internist, Massachusetts General Hospital and Newton-Wellesley Hospital
- Instructor in Medicine, Harvard Medical School
- Formerly Co-principal Investigator, STAAR Initiative and Director of Health Policy Strategy, IHI, Boston, MA
- Robert F. Kennedy Award for Excellence in Public Service, Harvard Kennedy School of Government, 2002
- BA from Stanford, MD from Brown University School of Medicine, MPP from Harvard Kennedy School of Government

Readmissions News: *You were the co-founder of the State Action on Avoidable Rehospitalizations (STAAR) initiative when you were at the Institute for Healthcare Improvement (IHI). How has that initiative grown and evolved over the years?*
Amy Boutwell:

Readmissions News*: This month's Thought Leader questions deals with the strength and appropriateness of readmissions penalties as a way of enhancing hospital performance in reducing unnecessary readmissions. How do you come out on that question?*
Amy Boutwell: To effectively prevent avoidable readmissions, I think we need approaches that are patient-centered and community-based. Related to that, I would highlight two major challenges to hospitals, aside from the payment issue. One is how to develop partnerships with other organizations and providers in the local community to ensure that the patient would get the care and assistance needed after discharge. It is not easy to forge that kind of relationship with external organizations. Another challenge is how to provide adequate education and training to the patient and family/caregiver so that they would learn manage their conditions on a daily basis once they leave the hospital.

Readmissions News: *Apart from the relative merits of penalties vs. incentives in changing organizational behavior, is the readmissions focus too hospital-centric and not enough on the need for a wide variety of players --nursing homes, home health agencies, VNA, area agencies on aging, etc. – to work collaboratively?*
Amy Boutwell: We could regard preventable readmissions as one special category of preventable admissions. So in that sense, there is no either or. They all need our attention.

Readmissions News: *The great majority of attention in the readmissions area to date has been with Medicare, but you're now working on readmissions issues in Medicaid. How are these issues similar or different?*
Amy Boutwell: Measures are created for serving particular purposes. Therefore, one size is not likely to fit all purposes. Conceptually, readmissions can be viewed as a quality indicator as well as a measure of utilization. The specifications can be very different. We have to keep that in mind when developing standardized measures. Also, the pattern of readmissions and potential underlying factors could vary substantially by the type of clinical conditions. And lastly, how should the measure differ as we focus on different levels – individual, hospital, or community? There is still a lot we need to work on.

Readmissions News: *Finally, tell us something about yourself that few people would know.*
Amy Boutwell: I'm a senior research scientist at the Agency for Healthcare Research and Quality (AHRQ) where I work with the Healthcare Cost and Utilization Project (HCUP) and the AHRQ Quality Indicators (QIs). I also conduct research using HCUP data and QIs on a variety of topics such as readmissions, potentially preventable hospitalizations, hospital governance and quality of care, and relationship of organizational and market characteristics with hospital cost-quality performance. In addition, I'm leading several projects to develop toolkits for improving hospital quality and patient safety and for reducing Medicaid readmissions.