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ALIGNING INITIATIVES WITH CONTINUUM OF CARE PARTNERS

REDUCING READMISSION RATES: SELECTING THE IDEAL POST-DISCHARGE PROVIDER FOR YOUR PATIENTS

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Reducing Readmission Rates:
Selecting the Ideal Post-Discharge Provider for Your Patients

In January 2013, the American College of Healthcare Executives released the results of their annual survey of top issues confronting hospitals in 2012 as reported by CEOs. Not surprisingly, financial concerns ranked number one with CEOs with the top three specific financial concerns identified as Medicaid reimbursement (83%), government funding cuts (81%), and Medicare reimbursement (72%). Patient safety and quality and healthcare reform implementation were ranked as the number two and three concerns, respectively.[1]

Because of studies such as the often cited 2009 study by Jencks, Williams & Coleman in The New England Journal of Medicine and the Patient Protection and Affordable Care Act (PPAACA), CEOs now have the benchmarks to which their healthcare organizations are being held accountable, which align with the top issues cited above.

The key benchmarks identified in the 2009 study were:

- 19.6% of Medicare beneficiaries who had been discharged from the hospital were rehospitalized within 30 days;
- 90% of the readmissions were estimated as unplanned;
- For approximately half of the patients who were rehospitalized within 30 days after a medical discharge, there was no bill for a visit to a physician's office between the time of discharge and rehospitalization; and
- The cost to Medicare for unplanned hospitalizations in 2004 was estimated at $17.4 billion.[2]

National hospital 30-day readmissions rates in 2010 for the three chronic illnesses typical of patients 65 years of age or older were:

- Heart attack: 19.23%[3]:
- Heart failure: 24.86%[4]:
- Pneumonia: 18.58%[5].

In summary, healthcare organizations must now meet a quantifiable readmission standard, mitigate unplanned readmissions, and act as a key coordinator in the continuum of care to avoid financial penalties.

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A review of the healthcare literature illustrates that many organizations are taking these benchmarks seriously and leaders are scrutinizing their organizations to see where improvements can be made. Many different types of formal and informal initiatives are being developed and implemented to avoid the financial penalties many organizations expect to receive. For example, Osei-Anto et al. (2010) and Lacker (2011) identified initiatives organizations are developing and implementing at each stage of care to reduce readmissions.[6,7] While outcomes struggle to be linked with processes (see for example Kociol et al., 20128) and analytic models continue to be refined (see for example Allaudeen et al., 20119 and Grunier et al, 201110), the accountability of health care organizations in terms of patient health and readmission and the threat of financial penalties continue to increase.

Improving Post-Discharge Transitions of Care

As now mandated by the PPACA, healthcare organizations' accountability for patient health does not end once the patient leaves the doors. The patient may have several "centers of care" such as the inpatient healthcare team, the outpatient healthcare team, the patient, and the informal caregiving team (e.g., family, friends) that exists in the home or community. With different systems involved, it is challenging for everyone to communicate efficiently and effectively about the patient's health.

As the patient transitions from one caregiver to another, important information and the opportunity to improve patient health in real-time is lost.

One suggested way to join these centers of care together and provide the best treatment for the patient is through technology. At its best, health technology puts the patient at the center of the treatment model, engages and coordinates care among all caregivers, and solves the problems most affecting the patient. HealthCall has been able to leverage technology in partnership with hospitals and other healthcare systems to provide solutions that improve patient health while providing a solid financial return on investment for our clients' organizations. These solutions have focused on encouraging self-care of health behaviors of patient post-discharge.

This use of technology to improve patient outcomes during transitions of care and post-discharge is recommended and supported in the research literature. For example, Escobedo, Kirtane, and Berman (2012-13) in the article in the Journal of American Society on Aging, identify health information technology as a potential solution to common problems that occur during transitions of care.[11] They list problems such as:

- Patients and caregivers not understanding medication or instructions;
- Patients not following up with a primary physician following the initial hospitalization; little or no coordination and integration between medical care and other support services; and
- Lack of information that impact patient self-care.

Using health technology post-discharge has the potential for reinforcement of discharge instructions and care plans, real-time data, consistent, planned check-in's and follow-ups,

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identification of patients at risk for readmission, and better patient-caregiver engagement. For example, Klersy et al. (2009) conducted a meta-analysis and reviewed the literature published between January 2000 and October 2008 on heart failure care as reported by usual care (in-person visit) or a remote patient monitoring program (RPM). Both randomized controlled trials and cohort studies showed that RPM was significantly associated with lower number of deaths and hospitalizations.[12]

Similar results were also reported by an independent study of 118 hospitalized patients with heart failure or chronic obstructive pulmonary disease randomly assigned to either HealthCall's Personal TouchTM Hospital-To-Home transitional care program or a traditional care program. The transitional care program included a home visit from a nurse, regular telephone consultants, weekly telehealth monitoring, and clinical process management through HealthCall LLC program. When compared to similar patients receiving traditional care, patients receiving the Personal TouchTM Hospital-To-Home transitional care program saw a significant reduction in 30 readmissions, 30 day readmissions of related diagnosis, and 90 day readmissions.

While executives have influence over technology initiatives in their own organizations, once patients leave their system, executives are forced to rely on the technology platforms of post-discharge providers, which may or may not exist to the satisfaction and quality desired. Without data and cooperation from a post-discharge provider, hospitals are often left in the dark as to the treatment and condition of the patient for which they are still financially responsible.

Identifying the Ideal Post-Discharge Provider

Who is responsible for the patient after discharge? Primary care and outpatient physicians, nurses, social workers, family caregivers, and other professional health care providers are oftenidentified as centers of care once the patient has left the hospital. It is challenging for everyone to share information about the patient efficiently and effectively so other caregivers

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can respond in real-time in the best interest of the patient. However, someone who regularly sees the patient post-discharge needs to take charge in coordinating this post-charge continuum of care and communication.

The best post-discharge provider should be able to:

- Understand and appreciate the association between patient's post-discharge health and vulnerability to readmission and the red flags associated with each;
- Have regular scheduled contact with the patient through standardized, yet personable interactions;
- Consistently implement best practices regarding outpatient monitoring, e.g., scheduled assessments, engagement of patient in self-monitoring and reporting, care plan management;
- Understand how formal monitoring with objective measures decreases readmission rates and increases experience of care measures;
- Track and link important research-informed outcomes with processes;
- Document and report on demand both a core set of key signs, symptoms, and outcomes and any custom benchmarks desired by healthcare providers; and
- Easily communicate these outcomes to other health providers through a shared technology-based platform, which protects patient confidentiality and complies with all Health Insurance Portability and Accountability Act (HIPPA).

One type of post-discharge provider who is uniquely positioned to be an effective partner in a hospital's efforts to reduce readmission rates is the home medical equipment provider (HME). The HME provider is in a pivotal position to be in regular scheduled contact with the discharged patient. These regular contacts allow the HME provider to implement and follow-up on suggested post-discharge strategies such as promoting patient self-management, tracking key signs and symptoms, adherence to care plan, and encouraging communication between the patient and other health care providers. Often, collaborating with an HME means little or no additional investment for the healthcare organization in terms of monitoring platforms.

Typical customers of the HME providers include those often vulnerable to readmissions such as patients who have suffered a heart attack, heart failure, or pneumonia/COPD, which are also on the most healthcare organizations' list of critical patient populations to manage. Unlike inpatient teams, the HME provider is not limited to only concentrating on patients that appear to be high-risk but is able to monitor and provide feedback on all the patients for which it provides services. Patients who appear to be low risk but may not be are less likely to slip through the cracks.

The ideal HME provider is motivated to collaborate with the hospital for the following reasons:

- They want to take advantage of the trend of increased medical equipment use driven by patients with chronic illness who are taking over more of their self-care and spending more time at home;

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- They complement other healthcare providers by focusing on coaching the patient and empowering patient self-care;
- They are also being scrutinized by government attention to cutting Medicare costs;
- They need to differentiate themselves from their competitors by providing services that are alignment with hospital initiatives such as trackable metrics that are helpful in reducing readmissions;
- They can increase the profitability of their operations through effective marketing, efficient operations, and satisfied customers, which can all be better attained through outcome-informed care; and
- They have a cloud-based technology platform that allows hospitals to access metrics that matter (e.g., readmission rates, processes of care and experiences of care) and provides seamless coordination of patient care.

Assessing the Fit of an HME Provider

Once the inpatient healthcare team decides a patient requires an HME provider for transition to home care, the discharge team should be selective in choosing an HME provider, as not all providers are created equal.

With the PPACA now in motion, an HME provider wanting to receive a patient referral from a healthcare provider should be held to high standards. Assessing their desire and ability to work in conjunction with a hospital to reduce readmission rates has never been more important in avoiding financial penalties. The ideal HME provider will acknowledge its responsibility and use a proven form of trackable methods. Forming the right partnerships with HMEs that use an outcome-based patient monitoring system is going to produce the most desirable outcomes for the hospital and the patient in terms of reduced readmissions and patient satisfaction levels.

Collaborating with an HME that takes on a leadership role is a necessity for successful outcomes. They must operate in a manner that brings value to the situation. HME providers are the patient's eyes and ears after discharge. They can assist the patient with education about their condition, evaluate the at-home environment, make necessary suggestions, and have the potential to remediate issues that may otherwise result in patient readmission if left unnoticed.

Developing a strategic partnership with an HME means working with those who take on a leadership role, are proactive in their efforts to communicate in a quantifiable and trackable manner, and are willing to develop a plan designed to prevent and solve problems that might be largely unknown. While everyone can make claims of good customer service, not all HME providers can show they help hospitals take better care of patients and reduce readmission rates

Use the quick checklist below to evaluate your next HME provider or contact us if you would like to know the HME service providers in your area.

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Quick Checklist
Five Things to Look for in an HME Provider

- ☐ **Outcomes Tracking and Reporting**. The ability to collect, summarize, and report outcomes specific to patient continuity of care and goals of the hospital such as readmissions, wellbeing, adherence to care plan, and return on investment. Reports that are easy to access and read, highlighted with trends and benchmarks.
- ☐ **Accountability**. Data-informed processes that are accountable to the patient-provider relationship, patient self-management, and patient satisfaction. Understanding of key disciplines including assessment, building relationships and rapport with patients, patient self-monitoring and reporting, and care processes.
- ☐ **Leadership**. Proactive in communicating to the health care team and collaboratively addressing challenges that arise in coordination of care. Ability to customize processes and outcomes as need for individual preferences of healthcare organizations.
- ☐ **Value**. Brings value to the partnership such as reduction in readmission rates, increases in patient satisfaction and participation, and effective communication with hospital staff and can document return on investment.
- ☐ **Proven Results**. Has documentation to show how their services have generated positive results for other hospitals and patients.

Contact

HealthCall, LLC
9800 Connecticut Drive
Crown Point, IN 46307
219-476-3459
866-944-5433
Info@healthcall.com
www.healthcall.com

References

[1] http://www.ache.org/Pubs/Releases/2013/Top-Issues-Confronting-Hospitals-2012.cfm . Retrieved 03/23/13. Survey was sent to 1,202 community hospital CEOs who are ACHE members of whom 39% responded.

[2] Jencks, SF, Williams MV, Coleman, EA. (2009). Rehospitalizations among patients in the Medicare Fee-for-Service Program. *The New England Journal of Medicine*, 360, 1418-1428.

[3] http://healthindicators.gov/Indicators/Hospital-30-day-readmission-for-heart-attack-patients-percent_346/Profile/Data. Retrieved 03/23/2013.

[4] http://healthindicators.gov/Indicators/Hospital-30-day-readmission-for-heart-failure-patients-percent_347/Profile/Data. Retrieved 03/23/2013.

[5] http://healthindicators.gov/Indicators/Hospital-30-day-readmission-for-pneumonia-patients-percent_348/Profile/Data. Retrieved 03/23/2013.

[6] Osie-Anto A, Joshi M, Audet AM, Berman A, Jencks S. Health care leader action guide to reduce avoidable readmissions. *Health Research & Educational Trust*, Chicago, IL. January 2010.

[7] Lacker, C. (November 2011). Decreasing 30-day readmission rates. *Safety Monitor: Pennsylvania Patient Safety Reporting System*, 111(11), 65-69.

[8] Kociol, RD, Peterson ED, Hammill, BG, Flynn KE, Heidenreich PA, Pina IL, Lytle, BL, Albert NM, Curtis, LH, Fonarow, GC, Hernandez AF. (2012). National survey of hospital strategies to reduce heart failure readmissions: Findings from the Get With the Guidelines-Heart Failure Registry. *Circulation: Heart Failure*, 5, 680-687.

[9] Allaudeen N, Schnipper JL, Orav EJ, Wachter RM, Vidyarthi AR. (2011). Inability of providers to predict unplanned readmissions. *Journal of General Internal Medicine*, 26 (7), 771-776.

[10] Gruneir A, Dhalla IA, van Walraven C, Fischer HD, Camacho X, Rochon PA, Anderson GM. (2011). Unplanned readmissions after hospital discharge among patients identified as being at high risk for readmission using a validated predictive algorithm. *Open Medicine*, 5(2), E104-E111.

[11] Escobedo M, Kirtane J, Berman A. (2012-13). Health information technology: A path to improved care transitions and proactive patient care. *Journal of American Society of Aging*, 36(4), 56-62.

[12] Klersy C, De Silvestri A, Gabutti G, Regoli F, Auricchoi A. (2009) A meta-analysis of remote monitoring of heart failure patients. *Journal of the American College of Cardiology*, 54(18), 1683-1694.

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