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It pays to care at home

REDUCING READMISSIONS AND COSTS THROUGH AN INTEGRATED APPROACH TO POST-ACUTE CARE

Despite best efforts of many institutions and organizations, many patients who are discharged from acute care hospitals are readmitted. Readmissions reflect failings in all three "Triple Aim" dimensions: *poor patient experience, lower quality of care,* and *higher costs (waste)*. Reducing readmissions requires an integrated approach – one that involves transition coaching, coordination of services, close communication and coordination among stakeholders, and dedicated technology to integrate people and processes.

Health plans have partnered with provider organizations for years to collaboratively reduce avoidable hospitalizations and reduce readmissions. Many have learned that preventing readmissions is not easy. The Federal Medicare program has introduced an incentive program to reduce readmissions, yet of the 3,400 eligible hospitals in the most recent CMS Hospital Readmissions Reduction Program, only 799 (23%) reduced readmissions enough to avoid a penalty.[1]

Why do readmissions remain such a problem? One key driver is the lack of coordination of care after discharge and the fragmentation of our health delivery system. Once a patient is discharged to a Skilled Nursing Facility (SNF) for rehabilitation, or to home, the integration of services and support is often missing at a time when the patient is making a critical transition.

During this critical period, patients face coordination issues, potential challenges accessing their primary physician, conflicting plans of care, and medication-management issues. Data from the Medicare program indicates that the costs of post-acute care can vary by as much as 73%, largely due to factors like use of SNF and home care services, as well as readmission rates.[2] The current lack of post-discharge coordination and oversight leads to potentially-preventable readmissions, delivers poor outcomes, frustrates patients and increases cost.

CareCentrix has had a transition coaching program for commercial patients in place for several years, and our population of patients at increased risk reflects the key drivers of readmissions:

- More than 30% of patients were on 8 or more medications
- 69% had been prescribed a new medication at discharge
- Over 40% didn't understand the medication side-effects
- The majority had 3-4 services prescribed post-discharge
- Many had an incomplete understanding of their disease

There are other, factors that can increase readmission risk: some patients lack family and social support, and may also face transportation issues, difficulties with their home as a recuperative environment, and/or have difficulty communicating and comprehending the complexity of their condition.

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An Integrated Approach

Many factors can increase readmission risk, including medication problems, lack of access to follow up with primary care providers, caregiver issues, and transportation problems. Home-centered services play an increasingly important role in successful transitions because they can reduce costs and increase member satisfaction. But home services alone don't address the challenge of transitions. What's needed is an integrated approach.

An integrated approach to post-acute care is patient-focused and home-based, and can fill the gap between fragmented services. To be successful, an integrated approach identifies the best path for the patient's care, engages the highest-performing providers, intervenes for patients most at-risk for readmissions, and connects providers, patients, and caregivers through technology.

Identifying the best path for the patient's care after discharge

- **Costs are dependent on setting for care** – Hospitals sometimes discharge patients to high-cost settings even though the patient might be better served in their home setting. Discharge planners can use predictive models to determine the most appropriate site of post-acute care and length of stay. This is important because site of service is a major cost driver during post-acute transitions. Home health, the least costly alternative, represents 39% of all Medicare post-acute care episodes and comprises only 28% of payments. This table, from the Medicare Payment Advisory Commission, demonstrates how the choice of site of care influences post-acute costs[3]:

Condition	Average	Home Health	Skilled Nursing Facility	Inpatient Rehab Facility	Long Term Care Hospital
Stroke	$10,680	$2,478	$8,527	$18,923	$22,070
Hip and femur procedures for trauma	$10,392	$2,595	$8,761	$16,018	$22,738
Cardiac bypass with catherization	$5,230	$1,778	$5,737	$14,631	$24,526
Heart failure	$4,144	$1,611	$6,462	$14,698	$20,236

- **More acute settings may not be necessary for the patient to heal –** Recent studies show that 41% of patients who received care in a long term care hospital did not require this level of intervention – and could have safely and effectively healed in a different – and less costly – setting.[4]

Engaging the highest-performing providers

- **Network Evaluation** – Selecting the right partners for post-acute care can help identify institutions and agencies that provide high quality, efficient care. Data analysis of practice patterns can be used to choose preferred providers based on patient conditions and identification of post-acute services with the best results. A proven network lets care managers quickly select the most appropriate site of service and best provider among high-performing organizations. Post-acute networks can be developed for skilled nursing facilities, home health agencies, DME companies, and home infusion services.
- **Protocols** – Clinical protocols for specific conditions can streamline care coordination and keep the patient on the optimal path of care.

*Care coordination through a **single point of contact** is central to the integrated approach and helps to **reduce the burden** on patients.*

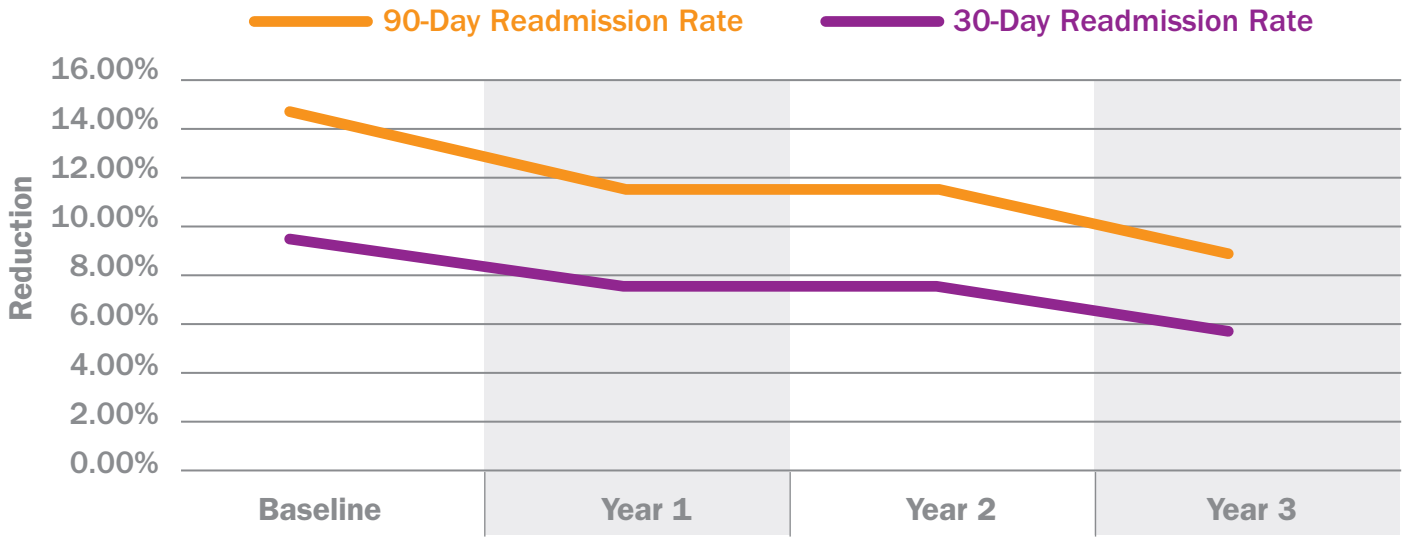
Identifying patients most at-risk for readmission and support interventions as needed

- **Transition –** Patients more at-risk for readmission may be discharged through the standard authorization/discharge process, but with a managed hand-off that includes a discharge plan overseen and implemented by a post-acute management team. The care management team collaborates with the patient, family caregivers, home health nurses, and primary care and specialist providers.
- **Remote Patient Monitoring** – In some many instances, high-risk patients can benefit from remote monitoring technology. These technologies identify changes in clinical condition and allow for earlier interventions and prevention of readmissions emergency room visits.

Connecting patients, providers, and caregivers through technology

- **Care Coordination** – For patients, it's easy to be overwhelmed by the sheer logistics of providers, clinical services, Durable Medical Equipment (DME) deliveries, case managers, and medication schedules. Care coordination through a single point of contact is central to the integrated approach and helps to reduce the burden on patients.

- **Care Management** – Care managers from home health agencies, provider organizations, or health plans can assess the patient and identify gaps in care, measure patient understanding, identify supports, and ensure quality. These gaps are addressed through the creation and implementation of an individualized care plan.
- **Connecting Technology** – Integration requires an actionable plan, a connected team, and timely interventions. New technology platforms hold the promise of connecting care managers, post-acute care providers, patients and families. The technology platform, in addition to augmenting communication, can support risk modeling and stratification, provide real-time service authorizations, recommend preferred sites of care, track plans of care, and validate delivery of services. The technology platform ultimately allows the home to become the hub for post-acute care.



Significant Results

Although truly integrated post-acute care programs are still being built, experience with existing pieces of these systems demonstrates great promise. For example, CareCentrix implemented a 90-day transition coaching program for a major health plan in the southern United States.

Over a three-year period, 30-day readmission rates were reduced from 9.6% to 5.8% – a 38 percent reduction. 90-day readmission rates were reduced from 14.5% to 8.8%. The health plan saved over $50 million in that period.

Patient experience was excellent; 95 percent of patients surveyed said they would recommend the program to a friend.

The Impact of Transition Coaching – A Personal Story

In a recent case, a female, living alone, age 61, suffered multiple fractures and injuries from a motor scooter crash. She also had pre-existing chronic conditions.

After medical treatment, the patient was transferred to a rehabilitation center to receive ongoing therapy. Prior to discharge, the patient was contacted by a transitions coach to discuss her needs and coach the patient on how to manager her transition.

The transitions coach helped the patient arrange home nursing, occupational therapy and physical therapy, as well as DME delivery of a wheel chair. Her coach also suggested massage therapy for pain management and aqua therapy at the YMCA to facilitate healing.

When the patient arrived home, she found life at home to be more difficult than she anticipated. "I couldn't maneuver around my little house – the wheelchair didn't maneuver well. I couldn't cook for myself," she explained. "It was a tough transition."

Amid the physical and emotional ups and downs, her care coach provided critical positive reinforcement and ongoing support. "I don't think I could have recovered as well as I did without that help," the patient explained. "In some ways having that support saved my life."

The patient completed outpatient rehabilitation and returned to work on a part-time basis. Her coach taught her to pace herself at work to prevent injury. Most importantly, the patient felt fortunate to be able to feel like her old self again and work toward her goal of a complete recovery.

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Integration gets everyone working together

Successful transitions reduce readmissions by integrating services, including care management, the use of data analytics for patient stratification and site of care selection, high performing networks of post-acute care providers, transitions coaching, a single-point-of-contact care management team, and a technology platform that connects the patient and caregiver and providers to each other. In this way, the people, processes, and technology can work together to help patients heal in a supportive, cost-effective home-based setting.

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1. http://www.modernhealthcare.com/article/20150803/NEWS/150809981

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3. Carter et al, Issues related to risk adjusting payments for bundled services. MedPac, October 8, 2010.

4. Dobson, DaVanzo, and Associates, Clinically Appropriate and Cost Effective Placement, Alliance for Home Health Quality and Innovation, 2012; Health Care Advisory Board interviews and analysis.