This is the American Association of Preferred Provider Organization’s Quick Brief, “Reducing Hospital Readmissions by Improving Care Transitions.” Every health care network and payer in this country needs to be concerned about rehospitalization. Up to 20% of patients discharged from the hospital are unexpectedly readmitted, often because of an inadequate handoff between health care providers and or lapses in medication regimens. Many readmissions are preventable, thus, the cost of the rebound admission is also preventable. Employers and other purchasers are scrutinizing these costs and the preventable morbidity for covered beneficiaries – and they want their health care delivery providers to take action.

PPOs have an important role in leveraging their contracting and purchasing power to reduce rehospitalizations (also called readmissions). The information and resources in this Quick Brief will help you understand the scope of the problem and start to develop a plan that meets the expectations of your customers – and the patients served by your organization.

The information herein is presented in bulleted format for easy review. Action steps for PPOs are also identified. For more details on preventing re-hospitalizations and improving care transitions, visit the web based resources linked to AAPPO’s website and listed at the end of this Quick Brief.

Scope of the Problem

Frequency and Cost of Readmissions

- One in five U.S. patients discharged from a hospital to their home experience an adverse event within three weeks of discharge. Of these 60% are medication related and avoidable; a third of discharged patients do not see a doctor within 30 days.
- Almost 20% of discharged Medicare fee for service beneficiaries are readmitted within 30 days; 34% readmitted within 90 days and 56% within one year.
- 30-day readmissions account for $15 billion of Medicare spending, of which $12 billion is thought to be preventable. The average payment for a potentially avoidable readmission is $7,200.

Why Readmissions Matter to PPOs

The policy landscape around readmissions is changing. Public payers are increasingly looking at readmissions as a cost and quality problem. Effective October 2012, CMS will rank hospitals based on 30 day readmission rates for heart attack, heart failure and pneumonia (expanded to seven conditions by 2015). CMS considers a hospitalization to be a readmission even if the patient is admitted to a different hospital or for a different condition. Poor performing hospitals will have payments reduced by an amount equal to the value of payments for excess readmissions. The federal Department of Health and Human Services has announced a major patient safety initiative, the Partnership for Patients, which includes a focus on reducing readmissions.

Most large commercial payers are taking action around readmissions as well. They are now commonly requiring metrics from hospitals showing the hospitals’ rate of readmission for high priority conditions. Major commercial payers including WellPoint and Aetna have announced payment initiatives to incentivize hospitals into reducing readmissions.
Strategies to Address Readmissions

Assessment: Why do Readmissions Occur?
Strategies to reduce readmissions must address multiple factors. Many key factors that increase risk for readmission are bulleted below. Underlying all these factors is the fee for service payment system, which creates no incentives for hospitals to reduce readmissions or tackle any of the underlying factors. That is now changing.

Member Related
• Caregiving gaps
• Financial or access barriers
• Patient gaps in understanding
• Patient inability to follow-through
• Deterioration of a clinical condition

Provider Related
• Access to coordinated primary care for discharged patients
• Quality of post-acute or long-term provider care
• Variation in hospital bed supply
• Availability of and access to other community based services
• Medic-legal concerns (impacting communication and coordination)
• Mis-aligned financial incentives

Care Related
• Hospital discharge planning gaps
• Transition support
• Medical errors and lack of medication reconciliation

A starting point for PPOs is to evaluate the scope of the problem and which factors underlie the bulk of readmissions – which patients are readmitted, and why? This analysis will help the hospital, PPO and payer to develop strategies to address them.

Interventions: Care Management and Payment Changes
Health plan and PPO interventions to reduce re-hospitalizations focus on two key levers: care management programs and payment realignment. These strategies are discussed in more detail here.

Care Management elements needed for effective transitions:

1.) Identification of high risk members and factors, that typically include:
   • Skilled nursing home residents
   • Disease states – some conditions such as pneumonia are associated with readmission
   • Prior admission, long stay admission
   • Patient barriers: limited family support or limited understanding
   • Poly-pharmacy

2.) Develop protocols to target highest risk (see Coleman Model)
   • Predictive modeling and pre-admission assessment
   • Trained care management staff
   • Support of members during care transitions
   • Discharge notification program and daily census process
   • Enhanced integration with social worker, behavioral health and pharmacy

3.) Implement care management strategies – focus on transition handoffs
   • Proactive discharge planning
   • Post discharge follow up – telephonic or in person
   • Medication reconciliation
   • Ensure clinical outpatient follow up appointments
   • Ensure home care needs met and devices are in place
   • Support a robust primary care infrastructure, including for seniors
   • Link to community resources to support care
   • Implement protocols for coordinating services of PPO/plans/hospital care managers
Payment Strategies
Fee-for-service (FFS) provider payments do not promote efficient, high quality care. FFS rewards volume and complexity regardless of quality and outcomes. FFS promotes system fragmentation and overutilization, and results in complex payment structures.

New models for hospital payment are being tested. The goals of these models are to reward high quality and to create incentives for better coordination and care management to result in better patient outcomes. Payment models may include:

- Fee-for-service with a pay for performance element (bonus, withhold, or rate adjustment)
- Fee for service with shared savings based on meeting performance targets
- Non-payment for adverse events
- Warranties for good patient outcomes
- Episode payment (pay an overall fee to care for a patient over a specified period)
- Global payment (pay an overall fee to care for a population over a specified period)
- Hybrid payment models

Performance measurement is an integral component of payment incentives. Health plans, federal payers and other private payers increasingly require hospitals to report on readmission metrics as a condition of participation. Bonus payments and other financial incentive systems listed above are based on either the hospital hitting certain agreed-upon performance targets, or making specified improvements in performance.

<table>
<thead>
<tr>
<th>Common Measures for Assessing Effective Transitions and Preventable Readmissions</th>
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<tbody>
<tr>
<td>30 day readmission</td>
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<tr>
<td>Medication reconciliation</td>
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<td>Transition record after discharge</td>
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<td>Transition record audited for specific transition elements</td>
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<td>Pending test result follow up after discharge</td>
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Payment innovations are typically a negotiated arrangement between payers and the health care providers and systems. Organizations that have implemented incentive programs to reduce readmissions report that critical elements are identifying the scope of the problem, agreeing upon metrics for measuring changes, rewarding improvements, and developing collaborative interventions. All of these models are being tested by both public and private payers. Ultimately, performance based payments may supersede the hospital FFS payment model.

For more details on payment reforms see: Center for Health Care Quality and Payment Reform
Many health plans and hospitals have developed initiatives to reduce readmissions. The lessons learned from these programs can be instructive to other PPOs engaging with hospitals to reduce readmissions and increase value. Key lessons include:

- Hospital readmissions are an important cost driver that impact commercial, Medicare and Medicaid populations.
- There are opportunities for cost and quality improvement in reducing unplanned hospital readmissions.
- Broadly defined, efforts to reduce readmissions can be categorized as care management and payment approaches.
- Preventing rehospitalizations can be a labor intensive process. Some plans focus on areas of largest opportunity, where impact can be measured.
- Health plans and networks have the data needed to quantify the opportunity for cost savings to their customers by using claims and care management data.
- Timely data is key to developing effective interventions. E-Census and E-discharge notification can help to improve real time notification that supports intervention.
- There are variations in metrics used to assess rehospitalization. Partners must be clear on definitions, measures, conditions, and time frames.
- Initiatives driven by the hospitals themselves are essential for implementing evidence-based care practices and well-coordinated transition programs.
- Hospital payments must reward reductions in readmissions and penalize failure to act.
- Availability of a community-based primary care infrastructure is essential. Many plans have determined that to make primary care available, they need to invest in development of medical homes.
- Care management is often the approach needed to ensure effective transitions from acute care to primary care.

### Lessons Learned

PPO plans and networks cannot sit out the issue of reducing rehospitalization. Regardless of the PPO’s business model, PPO leaders have a role to play in controlling these unnecessary costs. PPOs can use contract leverage, clinical expertise, and payments to drive hospital activities. They may also offer care management solutions that support improved transitions and reduced rehospitalizations.

Steps for PPOs include:

1. Help your customers understand the scope of the problem by analyzing readmissions by payer, hospital, or employer.
2. Position your organization for leadership on the topic of preventing readmissions and their associated costs e.g. become a consultant to your clients.
3. Review contracts with network hospitals and other providers to determine leverage.
4. Consider leveraging available opportunities in hospital payments to reduce readmissions; for example, the PPO may be able to require measures, improvements, or programs, and may be able to implement financial incentives.
5. Adopt a hospital payment model and care management approach consistent with evidence on what works to reduce readmissions and the PPO’s contract with the hospital.
6. Develop care management protocols focusing on transitions and that wrap around hospital and facility programs.
7. Define terms precisely for reporting and contracting expectations.
8. Talk about these steps you are taking to bring value to your network offering.

There is an extensive array of information, case studies, and educational opportunities available to support PPO plans and networks in developing a program to reduce readmissions in participating hospital providers. Good luck moving forward!
Resources for Next Steps

Center for Health Care Quality and Payment Reform
http://www.chqpr.org/

Congressional Research Service. Medicare Hospital Readmissions: Issues, Policy Options and PPACA

National Transitions of Care Coalition
http://www.ntocc.org/Toolbox/default.aspx

Partnership for Patients. Roadmap to Better Care Transitions and Fewer Readmissions
http://www.healthcare.gov/compare/partnership-for-patients/safety/transitions.html

State Action on Avoidable Readmissions (STAAR)
http://www.ihi.org/offerings/Initiatives/STAAR/Pages/default.aspx

The Care Transitions Program (explains the Coleman model and approaches to implementing it)
http://www.caretransitions.org/

Selected References

Peer Reviewed Articles


Reports, Briefs and Resource Guides

A Re-engineered Delivery Model for Transitions of Care: Addressing Evolving Market Trends
www.ihp.org/pdf/COPD81752MHC_AllPatientCOPDTran_Readers1up_PDF.pdf

AHRQ Medication Reconciliation Toolkit
www.ahrq.gov/qual/match/match.pdf

AHRQ Patient Safety Organization Resources
www.pso.ahrq.gov/readin/readin.htm

From Volume to Value: Transforming Health Care Payment and Delivery Systems to Improve Quality and Reduce Costs. A Primer on Healthcare Payment Reform
www.nrhi.org/downloads/NRHI-PaymentReformPrimer.pdf

Health Care Leader Action Guide to Reduce Avoidable Readmissions


Transitions of Care Compendium – National Transitions of Care Coalition
www.ntocc.org/Toolbox/

AAPPO thanks Boehringer Ingelheim for sponsorship of this initiative