Readmission Strategies For a Health Plan

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What the Evidence Shows

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SPECIAL ARTICLE

Rehospitalizations among Patients in the Medicare Fee-for-Service Program

Stephen F. Jencks, M.D., M.P.H., Mark V. Williams, M.D., and Eric A. Coleman, M.D., M.P.H.

- **20% of Medicare beneficiaries discharged from a hospital were re-hospitalized within 30 days, and 34.0% were re-hospitalized within 90 days.**
- **For 50.2% of patients re-hospitalized within 30 days after a medical discharge to the community, there was no bill for a visit to a physician's office between the time of discharge and re-hospitalizations.**
- **The cost to Medicare of unplanned re-hospitalization in 2004 was $17.4 billion.**

N Engl J Med 2009;360:1418-28.

Coleman Model for Preventing Readmissions

Focuses on Four Conceptual Domains Referred to as "Pillars:"

1. Medication self-management
2. Use of a dynamic patient-centered record, the Personal Health Record
3. Timely primary care/specialty care follow up
4. Knowledge of red flags that indicate a worsening in their condition and how to respond

For more information about the model and its evidence base, and to access patient tools, performance measures, medication safety tools, etc., visit www.caretransitions.org

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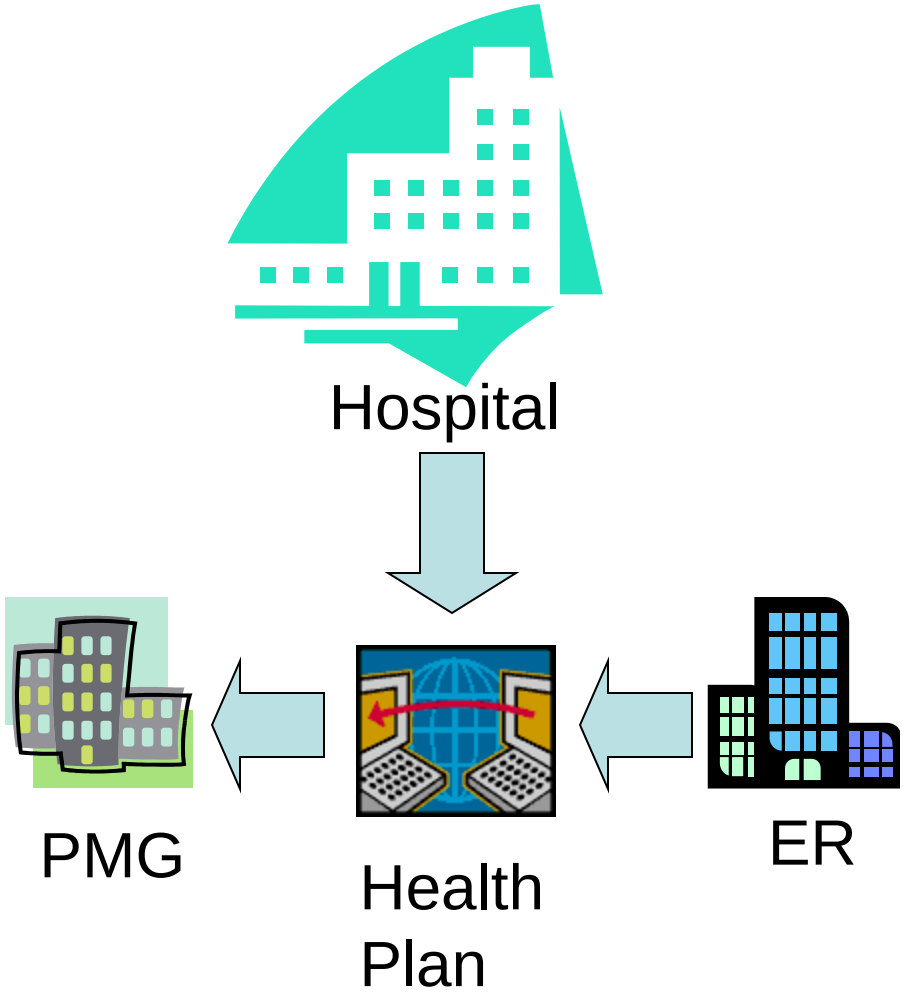
Why the payer has a unique role

- **Data and access to information**
  - Real-time and claims ER data from various institutions
  - Admission data from various institutions (SNF, Rehab)
  - Radiology, Lab, Pharmacy, Benefits Data
- **Real-time capture of events**
  - Admissions captured based on need for authorization
  - Pharmacy and Radiology requests captured real-time
- **Case Management and Disease Management models**
  - Support the member between PCP visits
  - Help with access to information, appropriate care and services

How the payer can help with gaps in care

- **Identify gaps in care**
  - Use of claims history
  - Real-time medical management data
  - Use of pharmacy, ER & lab data
- **Support the member during those gaps in care**
  - Case Management
  - Disease Management
  - Nurse & MD support
  - PCP connection
- **Work with hospitals and providers (PCP/medical groups)**
  - Provide data/information on patients



Adapting the model: The unique role of health plan CM

Pre-admission Prevention:

- Complex & Focused Case Management
- Disease/Condition Management
- Pre-Surgical Counseling

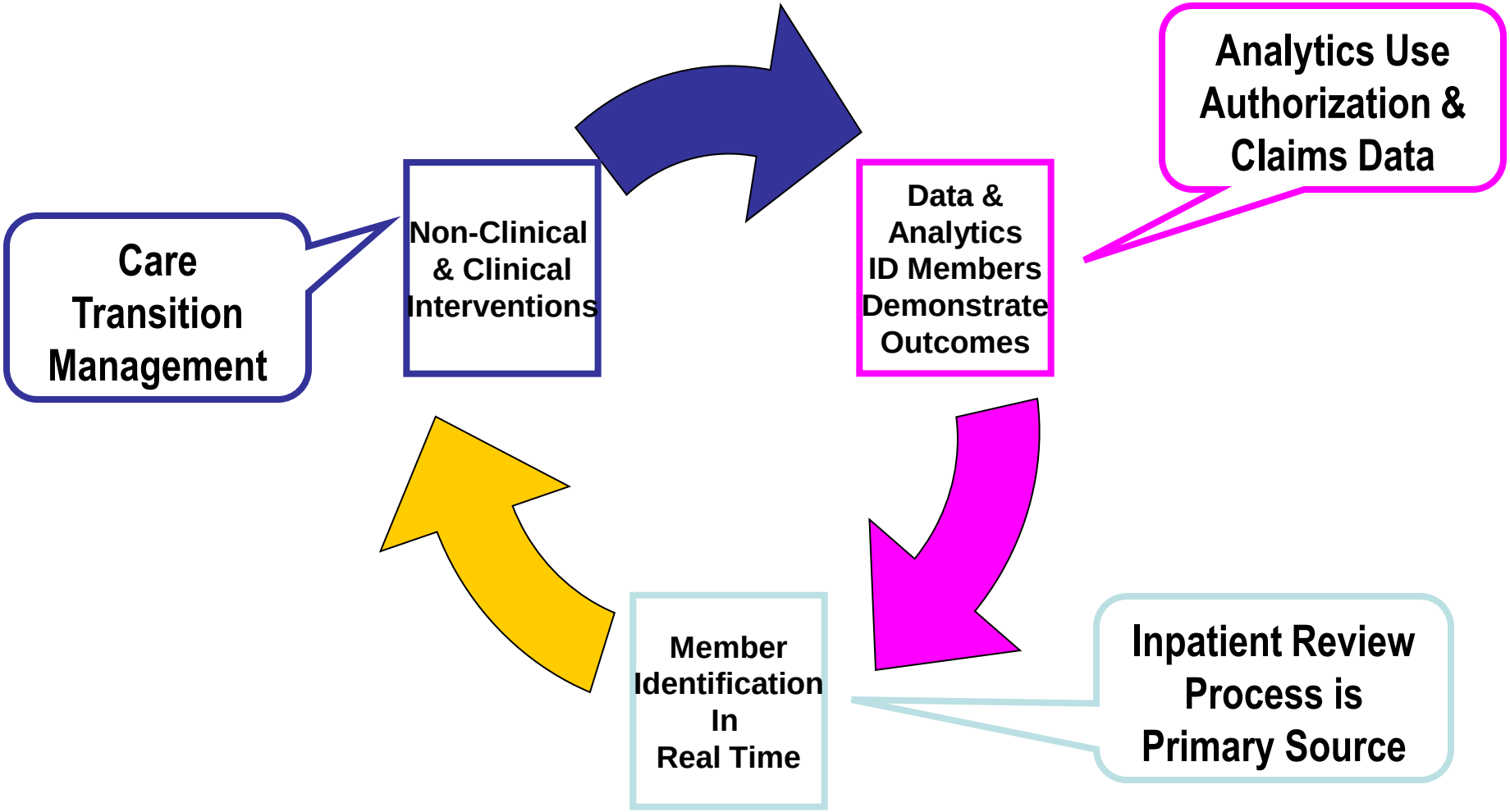
Post-admission Prevention

- Discharge Planning
- Care Transitions Management
- Patient-Centered Medical Homes

Hospital-focused interventions

- **Identification of members in the hospital who are experiencing their 3rd readmission or greater**
  - Discharge planning during the admission
  - Cross-functional rounding for inpatient members
  - Post-discharge calls
  - Engagement of the PCP by the plan post-discharge
- **Interview high-risk members by nurses before discharge**
- **E-Census/ER Census**
  - Real time census from hospitals and ERs that can be used internally or shared with PCPs or PMGs
- **Cross-Functional Rounding (UM/CM)**

Real-time data drives the model



Example of a trigger

Relative risk of re-hospitalization after 30 days associated with each variable

Variable	Hazard Ratio
0 Rehospitalizations in 12 Mo:	1
1 Rehospitalizations in 12 Mo:	1.378
2 Rehospitalizations iIn 12 Mo:	1.752
≥3 Rehospitalizations in 12 Mo:	2.504
ESRD	1.4
LOS > 2X DRG	1.266
Age (55-89)	1-1.18

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Patient-focused interventions

- **Identification through real-time census or risk stratification:**
  - Live outreach to members within 24-48 hrs of ER visit
  - Member education on PCP and urgent care
  - Post-discharge calls
- **Member messaging on gaps in care**
  - Claims-based algorithm to identify members and providers in gaps in care
- **24-hour NurseLine/24-hour physician line**
- **Case Management/Disease Management**
- **Community Resource Centers**
  - Community-based centers help in member and provider outreach
  - Help with transportation and access

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Provider-focused interventions

- **Linking the member with their PCP**
  - Post-discharge calls
  - Community Resource Centers
- **Messaging and engaging the provider**
  - Case manager and medical director calls to PCP
  - Mailings to providers on gaps in care
- **ACOs and Provider Groups**
  - Provide data on members and gaps in care
  - Provide real-time ER and census data

Opportunity to coordinate with PMGs

- **Sharing of data real-time**
  - Admissions, ER, pharmacy, discharge planning
- **Post-discharge follow-up**
  - PCP appointments
  - Specialty referrals
- **Risk stratification and gaps in care**
  - Share risk-stratified data to show high-risk members
  - Identify gaps in care and share with PMG/PCP
- **Aligned incentives**

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Next steps for payers

- Improve real time data sharing with PMGs and PCPs
- New ways of engaging the members through real-time monitoring, telemedicine, and home-based interventions
- Increase the quality and access or clinical data captured
- Incentivize providers and hospitals to help reduce re-hospitalizations

Questions