



The NEBGH Hospital Readmission Reduction Project of 2011: Enhancing Purchaser and Consumer Value

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OVERVIEW & OPPORTUNITY

The Hospital Readmission Reduction Project of 2011 builds on NEBGH's previous efforts to advance value-based purchasing and improve the quality, safety and cost-effectiveness of health care in the region.

Spurred by the payment reform initiatives of the Centers for Medicare and Medicaid Services (CMS), in 2009 NEBGH brought together purchasers, providers and health plans to conduct a two-year study of hospital-based performance and transparency. The study concluded:

- ✓ Payment models must be aligned specific value-oriented outcomes to improve the quality and cost-effectiveness of care.
- ✓ Consumers cannot be passive. To improve the healthcare system, consumers must be fully informed and engaged.

The current project will delve deeper into transitions of care processes, business models and consumer engagement, and take the effort to reduce admissions and increase the quality and value of health care to the next level.

BACKGROUND AND RATIONALE

Patients in the U.S. healthcare system who move from one treatment setting to another – especially from hospital to ambulatory settings – experience significant gaps in the quality and cost-effectiveness of care. Patients and caregivers too often lack the information and tools needed to safely and successfully make this transition, resulting in several negative outcomes, including:

- Preventable clinical complications
- Patient or caregiver confusion and isolation from the care process
- Poor follow-up and inconsistent patient monitoring
- Medication errors, including sub-optimal use of medicines
- Unnecessary and inefficient use of resources

Recent studies of Medicare populations suggest a 30-day readmission rate of almost 20%, of which 60-70% is thought to be avoidable. Since commercially insured patients are subject to the same fragmented and poorly coordinated transition of care environment, significant cost and quality improvements are possible in that population as well.

On behalf of employer-purchasers, NEBGH supports Federal “Partnership for Patients” program to improve patient safety and deliver “value-oriented” care. To overcome challenges to high-value care, we believe it is critical to manage how patients flow through the health care system, and align payments to reward successful care management efforts. This involves many steps, including:

- Improving communication during transitions between providers, patients, caregivers, and facilities
- Enhancing health information technology
- Improving analytical tools
- Intensifying care management and care coordination
- Expanding the role of the non-physician care providers including pharmacists, care managers, health educators, patients, and family members
- Developing transitions of care-specific performance measurement and public reporting tools
- Implementing innovative payment systems that align incentives

With the launch of this project, NEBGH hopes to improve transitions of care by focusing on the reduction of preventable readmissions and emergency department visits within 30 days of discharge. Certain clinical conditions, such as COPD, diabetes, heart failure, and other cardiovascular disorders will receive particular attention because of their high cost, and the likelihood that a significant reduction in readmissions is achievable.

Success of this project will depend on collaboration between patients, purchasers, payors and providers. Clinical best practices must be identified and advanced. Metrics that reflect improvements in care must become the basis for payment incentives. And consumers must be informed and engaged.

PROJECT SCOPE AND ACTIVITIES

The project scope will include:

- A comprehensive review of current and planned regional readmission management activities including regional readmit rates, clinical “best practices,” innovative reimbursement models, and employee/consumer education and outreach models.

- A discussion of specific barriers to reducing preventable post-hospital discharge readmissions and ED use, including suggestions of how they may be effectively addressed.
- The identification of a framework for a readmission reduction program that could be the basis for a regional pilot demonstration.

The project activities will include:

- General discussions and follow-up with stakeholder group representatives to identify, quantify and explore of the hospital re-admission landscape
- The formation of four working sub-groups:
 - A. Clinical Practices:** Identify models for transitions of care-process improvement, including a review of local initiatives.
 - B. Measurement:** Evaluate and compare metrics used to assess efficacy of transitions of care-related activity, including both process and outcome measures.
 - C. Payment Models:** Review and discuss contractual options that link improved transitions of care to a range of financial considerations.
 - D. Employee Outreach:** Assess opportunity for employee education, use of benefit design incentives, and overall communication opportunities.
- The creation of discussion papers that will summarize the findings of the research.

TIME FRAME

Project will commence in July 2011, and conclude in December 2011. A specific activities roadmap and a milestone-driven timeline will be developed and distributed in September 2011.

SUMMARY

NEBGH believes that that there is an important opportunity to build on CMS' "Partnership for Patients" initiative in the commercial insurance sector and reduce preventable hospital readmissions in the Northeast.

Within the scope of the Hospital Readmission Reduction Project of 2011, NEBGH hopes to expand the knowledge base essential to reducing preventable hospital readmissions, and build a partnership and shared vision that can lead to follow-up projects in this critical aspect of care delivery.