

HOSPITAL

Reducing Hospital Readmissions through Stakeholder Collaboration

By Jeremy Nobel, MD, MPH; Nita Stella; Erika Flores Uribe, MPH;
Sadiqa Mahmood, BDS, MPH; Carlos Duarte, MD, MPH; Laurel Pickering, MPH

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REDUCING HOSPITAL READMISSIONS THROUGH STAKEHOLDER COLLABORATION

A SOLUTIONS CENTER PROJECT

EXECUTIVE SUMMARY

As CMS and others continue driving the hospital readmission reduction agenda forward, many stakeholders have stepped up to the plate to begin to implement solutions. Such efforts include hospital-based transition planning, post-acute care management, care coordination initiatives, data analytics and technology solutions. All of these initiatives require significant investment, and the challenge lies in determining whether they can reduce preventable readmissions in a sustainable, replicable way.

Northeast Business Group on Health (NEBGH) convened stakeholders in a series of work group sessions to discuss the opportunities and challenges in implementing readmission avoidance programs and the role that the various stakeholders—health plans, hospitals, suppliers, employers and patients—play in the success of these programs. This work, which included a review of existing models, points to an approach that focuses on fostering a mutually accountable environment where multiple quality and cost issues are addressed in a collaborative way, instead of simply penalizing health systems for any readmission. It was our finding that this approach could potentially leverage assets and resources from all stakeholders with less duplication of effort and a greater likelihood of success.

Currently, health plans and health systems typically pursue independent and unaligned readmission reduction activities, including independent data analysis and unilateral patient outreach and support. It is our view that if health plans and health systems -- encouraged by employers through performance payments -- pursued a more collaborative path in tackling readmission reduction and similar care coordination challenges, the financial and clinical benefits could be significant. In our opinion, pre-planned shared management activities would

improve the ability to identify patients at high risk for readmission, lead to more efficient use of clinical support resources, and deliver better success at engaging and activating patients.

For an integrated collaborative approach to be successful, a multi-stakeholder cooperative care model needs to be better defined. Developing that model brings the following requirements into focus, all of which need to be more fully assessed and developed:

- **Requirement One**
Collaboration in Clinical Outreach and Care: Stakeholders must leverage their respective analytic and clinical assets appropriately to best identify high-risk patients and support them through the transition of care process.
- **Requirement Two**
Business Sustainability: Financial models must allow all economically involved stakeholders to thrive.
- **Requirement Three**
Employee Engagement and Communication: Employees and their caregivers must be fully engaged by embracing new models for communication and activation.

Requirement One: Collaboration in Clinical Outreach and Care

Through the data they have access to, health plans and health systems each have a unique vantage point from which to view a patient and his clinical needs. Pooling the clinical and analytic assets of both would likely create a more complete picture, and enable both health systems and health plans to better leverage their skills and resources to identify patients at risk for readmission, and then coordinate care and actively monitor them more effectively. Clinical building blocks key to most effectively leverage this effort are: a) Risk Identification and

Measurement, b) Collaborative Care Clinical Model, and c) Outcome Measurement.

The consensus from HRRP participants was that sharing data between health plans and health systems can lead to a more robust and effective risk identification and outcome measurement methodology. Similarly, this shared data set will allow for more predictive measurement systems that could span multiple care settings and address measures often not tracked but critical for purchasers, such as return-to work and employee productivity. Data sharing will also aid in designing a cooperative care clinical model that includes strategies to promote effective patient engagement and activation, defines requirements for adherence to medical regimens, and leads to improved outcomes. There is no simple solution for reducing preventable admissions, but better identifying high-risk patients, developing a joint care-coordination model with appropriate resources, engaging patients, and measuring success are all essential components of a successful program.

Requirement Two: Business Sustainability, an Essential Underpinning of Collaboration

Achieving health plan and health system collaboration will require new processes, tools and possibly even personnel, introducing the need for an underlying economic model that ensures long-term sustainability.

Questions such as: “Who will pay?” “Are resources being best deployed?” “Do the incentives align to sustain improvement?” and importantly, “Is there really a return on investment?” all need to be addressed in a business sustainability discussion. A clear and shared vision for a definition of “success” among all collaborators will be required, as will defining performance-based contracts that incorporate some form of shared risk/reward.

Employers, as purchasers, can play a pivotal role in facilitating the business sustainability discussion and providing the basis for a new business model by encouraging health plan and health system discussions that embrace collaborative models, and associated contracts that reward success.

Requirement Three: Employee Communication and Outreach

Patients and their families play a central role in driving resource utilization and medical regimen adherence, yet are often overlooked as new models of care are being deployed. The successful execution of a coordinated care program involves engaging the patient and ensuring he is equipped with the right information and tools to be involved in readmission avoidance from the onset. Patients should be given appropriate resources to adhere to their medical regimens and deal with behavioral and social challenges that might otherwise lead to readmission. Importantly, the patient’s caregiver should be seen as a valuable resource that can help facilitate

appropriate care management and care coordination. Bottom line, employee engagement and communication are as much a part of readmission reduction as an effective care model, and a sustainable business model, and need to be part of a coordinated approach going forward.

Summary: Achieving a Shared Sense of Opportunity around Collaboration—and Moving Forward

Health systems and health plans are both working to reduce preventable readmissions but in different ways and typically, with separate and unaligned initiatives. Though many employers have yet to focus on readmission reduction, they are in an important position as purchasers to drive change. Employers can help set the readmission reduction agenda and facilitate dialogue around new business arrangements that enable health systems and health plans to work collaboratively in developing more effective and efficient approaches. While many readmission reduction efforts are currently underway in the marketplace, they typically lack the shared data analytics, integrated care models, robust employee outreach and communication, and economic sustainability features we believe are essential to success. It is timely to address those shortfalls now and determine whether current pilots can be amended to include them, or whether new pilots should be explored that incorporate those missing elements.



THE NEW OPPORTUNITY: HEALTH PLAN AND HEALTH SYSTEM COLLABORATION TO PREVENT AVOIDABLE READMISSIONS

CMS and other important health care stakeholders have highlighted the challenge of improving patient care transitions from hospital to home as a national health care imperative. According to CMS, approximately two-thirds of U.S. hospitals will receive penalties for excess hospital readmissions of up to 1% of their reimbursement for Medicare patients. In the private sector the impact is also significant. An earlier report from the Northeast Business Group on Health's (NEBGH) Hospital Readmission Reduction Project found that 8% of hospital stays in New York State in 2008 that were paid by private insurance resulted in readmissions, which accounted for 16.5% of total admissions. Payments for these readmissions cost private payers, including employers, \$568.9 million. While the importance of reducing preventable readmissions is widely recognized, the question is whether the current methods employed by Medicare and other insurance entities fully address the problem or provide a sustainable business solution. Our research—and existing successful models including the integrated systems of Geisinger and Kaiser Permanente and approaches to care coordination and transitions of care such as the Transitional Care Model (TCM)—point to an alternate method that, instead of simply penalizing health systems for avoidable admissions, focuses on fostering a mutually accountable environment where multiple quality and cost issues are addressed in a collaborative way, leveraging assets and resources from employers, health systems, health plans, and even employees to better ensure success. The opportunity exists for collaboration between health plans and health systems in care coordination to reduce risk for readmission, by taking advantage of the varied capabilities

of these very different types of organizations—health plans in their administrative role and health systems in their direct contact with the patient. In future phases of its Readmissions Reduction Project, NEBGH envisions a set of demonstrations to explore sustainable models of improved care coordination.

Unnecessary and preventable hospital readmissions are a major problem in the U.S. health care system. These events are costly, occur far too frequently, and place vulnerable patients in dangerous situations. As patients move from one care setting to another, notably from the hospital setting to the ambulatory and both facility-based and ambulatory post-acute setting, they often experience gaps in the coordination, quality, and cost-effectiveness of the care they receive. These care deficiencies include clinical complications such as health care-associated infections, patient or caregiver confusion regarding the care process, medication mistakes, and unnecessary and inefficient resource use. Successful efforts to reduce hospital readmissions already deployed in the field all emphasize the need for care coordination between ambulatory and post-acute providers and hospital-based clinicians during the course of a transition as well as systematic and clear communication between clinicians, patients, and caregivers. Health plans also have the opportunity to play a more active role supporting providers in these care-transition activities.

Prior work done on this issue by NEBGH highlighted the opportunity to improve the effectiveness and efficiency of hospital readmission reduction programs by promoting active collaborations between health

plans, health systems, and employers. Frequently, health plans and health systems pursue independent and unaligned readmission reduction activities, including payment penalties based on proprietary data analysis and siloed care coordination and patient outreach. These independent efforts often result in inefficient duplication of effort and fragmentation of services as well as patient confusion. In addition, health plans have valuable information about readmissions that is often not

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shared with health systems, leading to narrow interventions. A large health system shared with NEBGH that they discovered their perceived readmission rates based on internal data were half the actual rates, upon analysis of claims data. Patients were being readmitted to neighboring hospitals, generating data known by the health plan but not necessarily shared with health systems. Similarly, the health system often has information on patients, gleaned from clinical interactions—including care preferences and nonadherence to medical regimen—that the health plan is not aware of. The health plan would need access to this information to establish a complete picture of readmission risk for any individual, as well as to launch effective and personalized outreach.

If health plans and health systems were to pursue a more collaborative path in tackling readmission reduction and similar care-coordination challenges, financial and clinical benefits would be realized, including an improved ability to identify high-risk patients, better coordinated care for patients,

and more efficiently used clinical resources. The employer's role is also critical, facilitating collaboration opportunities by encouraging health plans to introduce performance-based contracts that reward reducing preventable admissions and promoting patient engagement through employee education. Moreover, through benefit design, the employer can incentivize employees to more actively participate in risk-reducing care and education strategies.

To further explore the possibilities of enhanced collaboration among employers, health plans, and health systems, NEBGH performed an extensive literature review, interviewed experts in the field, and convened multistakeholder roundtables, with representation from health systems, health plans, employers, and other stakeholders. NEBGH discovered that to address readmission reduction effectively, a collaborative approach is an attractive and achievable option. Conceptually, a collaborative approach could enable sustainable change by integrating the analytic and care-coordination activities within a well-designed framework of business and clinical considerations.

However, for an integrated collaborative approach to be successful, the following requirements would need to be more fully explored and any challenges identified and addressed:

- **Requirement One**

Collaboration in Clinical Outreach and Care: stakeholders leveraging their analytic and clinical assets appropriately to best support the patient

- **Requirement Two**

Business Sustainability: financial models that allow economically involved stakeholders to thrive

- **Requirement Three**

Employee Engagement and Communication: fully enlisting employees and their caregivers through new models of communication, engagement, and activation.

REQUIREMENT ONE: COLLABORATION IN CLINICAL OUTREACH AND CARE

A collaborative clinical process and measurement approach to reducing preventable hospital readmissions is attractive for many reasons. Health plans and health systems bring different assets and capabilities to the challenge, yet these organizations often function independently of each other. When connected and coordinated, they complement each other to target and address readmission risks with information and outreach efforts, which, as independent activities, are often fragmented. A collaborative approach allows both the health plan and health system to improve quality of care, reduce costs, and provide an improved care experience to the patient.

Health Plans and Health Systems' Differing Clinical and Data Capabilities

Health plans, because of their administrative role, track and maintain an accurate record of services accessed by the patient. This administrative claim flow typically includes sufficient clinical information to identify site of service, type of service delivered, and some limited clinical information. Often coupled with claims-based analytics and an evidence-based rules engine that filters quality and severity of illness measures, this information can be predictive of the patient's underlying risk for readmission as well as provide knowledge about the presence and severity of conditions and comorbidities.

Health systems, since they are fundamentally in the business of providing care, also have the important role of direct contact with the patient. They can identify an extended range of underlying risks for readmission, including socioeconomic factors like poor health literacy or the lack of home support, that are known to drive up readmission rates. Moreover, patients

often have a high level of trust and confidence in their direct-care provider, which improves adherence to treatment guidelines as well as post-discharge self-care activities.

Coordination of Differing Clinical Capabilities

Because health plans and health systems review internal clinical information independently, they typically have an incomplete picture of the patient. Combining the varied clinical and analytic assets of both the health plan and health system offers a more complete picture. Through collaboration and appropriate clinical data sharing, both health systems and health plans can better leverage their skills and resources to identify patients at risk for readmission, coordinate care, and actively monitor them more effectively.

By working together rather than independently, both a health system and health plan can pool their assets to identify a more appropriate risk pool of patients, develop a stronger coordinated care plan with minimal duplication of resources, and achieve better outcomes of care. Achieving effective collaborative care models will require the development of three independent but synergistic capabilities, which can be considered as building blocks:

- **Building Block A**

Risk Identification and Stratification: Identifying and stratifying readmission risk for each patient

- **Building Block B**

A Coordinated Care Model: Designing and managing a collaboration-oriented clinical program

- **Building Block C**

Measurement: Assessing program process and outcomes

A variety of factors determine a patient's readmission risk, such as the underlying health of the patient, the complexity of the clinical issues dealt with during the hospitalization, and a broad spectrum of psychosocial issues (see sidebar). Currently there is no standardized approach used by health systems or health plans to identify patients at high risk for a readmission, which highlights an area that could be focused on productively.

Most health systems and health plans have ongoing activities aimed at using the data they can access to better understand and manage the populations they serve, including assessing readmission risk. Within health plans, the data used for the risk-stratification model include services billed for and providers visited, length of hospital stay, acuity of the disease, and comorbidities. Within health systems, the data

include information from laboratory testing, diagnostic images, medication prescriptions, and patient interviews. These risk-stratification models are rarely standardized or collaborative and as a consequence may under-assess or over-assess risk, handicapping various risk-management approaches.

To achieve a more robust and collaborative risk-identification methodology requires health systems and health plans to develop a shared risk-assessment tool or methodology that incorporates the data each has access to and combines those data-driven insights in a meaningful way. Inevitably, there will be some complexity in establishing risk scores for specific disease and patient populations, but the starting point can be based on a collectively-agreed-to set of data and data-collection opportunities rather than on independent scoring methodologies. There are risk analysis models in the industry, like those developed by Truven, 3M, Verisk Health, and Optum, that can be used

WHAT'S LIKELY TO INCREASE READMISSION RISK?

- Prior history of frequent hospitalizations and emergency department visits
- Prolonged length of stay during a hospitalization
- Multiple chronic comorbidities
- Limited social support
- Elderly, disabled, and mentally or cognitively impaired patients
- Patients with low health literacy or English proficiency
- Patients from lower socioeconomic backgrounds
- History of poor medication compliance; polypharmacy
- No established primary care or medical home provider

**Table 1. Developing A Shared Data Platform:
Information Collaboration**

HEALTH PLANS	HEALTH SYSTEMS
<p>Utilization Data from Claims:</p> <ul style="list-style-type: none"> • Presence of conditions that increase readmission risk • Multiple comorbidities in any one patient • Behavioral health risk factors as available in claim data • Total cost of care per admission per member • All hospitalizations and length of stay • All emergency department utilization • Pharmacy data, including specific classes and volume of prescriptions; adherence to prescription data • Use of durable medical equipment (DME), such as wheelchairs • Utilization of long-term or transitional care in the past 	<p>Medical Record:</p> <ul style="list-style-type: none"> • History of previous conditions and comorbidities • Clinically detailed reason for admission and readmission • Lab values • Functional and cognitive status • Medication reconciliation • Psychosocial status and social support system • Health literacy status • Reliable patient contact information

as a base and extended in a collaborative way between the health system and the health plan. Risk-stratification models can be modified to incorporate both health plan and health system data but still require analytic resources and technologies from both entities to assemble and report findings effectively and link analytic insights into care-coordination workflow.

Table 1 illustrates general categories of information where health plans and health systems could collaborate in developing a shared data platform to identify patients at risk for a hospital readmission.



When care is poorly coordinated—with inaccurate/incomplete transmission of information, inadequate communication, and inappropriate follow-up care—patients who see multiple physicians and providers are at risk for medication errors, hospital readmissions, and avoidable emergency department visits. The effects of poorly coordinated care are particularly evident for people with chronic conditions and those with multiple illnesses, who often fail to successfully navigate a complex health care system. Preventable hospital readmissions are due in part to this lack of effective and personalized care coordination and represent an important area for improvement. The good news is that research has shown that improved coordination of care is achievable, and when implemented well, readmissions are reduced.

We assessed several models of care coordination and transitions of care. These models include the Care Transitions Intervention (CTI), Transitional Care Model (TCM), Better Outcomes for Older Adults

through Safe Transitions (BOOST), the Bridge Model, Guided Care, Geriatric Resources for Assessment and Care of Elders (GRACE), and Project RED (Re-Engineered Discharge). Many of these approaches have demonstrated improvement in reducing readmission rates, yet they have been developed from the perspective of the health system only, with no attention to opportunities for health plans and health systems to work jointly to reduce readmission risk. We are confident that the opportunity exists to build on these successful approaches to reduce readmissions, as health plans and health systems collaborate in care coordination by taking advantage of their varied capabilities.

In assessing existing models, we identified the key elements of successful care coordination and transition of care programs:

- a. **Agreement on standard protocols and procedures:** Joint committees to create a system-wide approach to risk stratification and care coordination.
- b. **Proactive collaborative care plan:** Shared process to enable appropriate follow-up, patient and family education, care coordination, and community support.
- c. **Timely care coordination before patient discharge:** Ability to identify patient needs pre-discharge, especially for high-risk, vulnerable cases, and trigger appropriate follow-up in the community setting.
- d. **Clear definition of roles and responsibilities:** As patients transition from one setting to the next, the roles of the various individuals should be clear, with minimal duplication of effort. The care map should include the responsibilities not only of the care providers but also the patient and caregivers.

- e. **Clear medication adherence program and follow-up:** One of the highest drivers for readmissions is medication mismanagement. Clear roles and responsibilities are described to ensure appropriate patient and family education and support around medication adherence (see sidebar).

We are confident that the opportunity exists to build on these successful approaches to reduce readmissions, as health plans and health systems collaborate in care coordination by taking advantage of their varied capabilities.

- f. **A multidisciplinary team focused on patient/caregiver education from admission to transition:** Leveraging the right individuals in a joint effort to educate and support the patient and family through all their various care-coordination needs.
- g. **Quality improvement process to track root causes of readmissions:** Continuous monitoring and data analytics to identify opportunities for improvement.
- h. **Continuous evaluation of the readmission reduction process:** As needs of the population change, the resources and protocols must be flexible to adjust to the requirements.

Employer-driven discussions can help motivate health plans and health systems to establish a coordinated clinical program that includes those critical elements. The discussions should also include how to support those key components financially. But even when organizations are motivated, it's not a simple task to collaboratively decide how best to deploy their analytic and clinical resources. While the overarching goal is minimizing redundancy and inefficiencies while striking a balance between the needs and preferences of often competing organizations, the most important consideration is what is right for the patient.

PREVENTING MEDICATION ERRORS

One of the most common problems in readmissions is patients' inability to manage their medication regimens—resulting in nonadherence or “medication misadventures.” This requires that first we understand the factors affecting adherence, e.g., knowledge deficit, financial constraints, pill burden, fear of/actual side effects. Then, we need to devise creative ways to help patients take their medication as directed, using targeted and personalized patient education, incentives, financial assistance programs, additional clinical resources such as pharmacists included in the discharge-support care team, and checklists and other quality management systems. This support would help ensure that patients understand and follow their often complex medication regimens.

Measurement is essential to any clinical program's success, including readmission reduction initiatives. Without accurately measuring key processes and outcomes, it's impossible to verify progress or identify opportunities for further improvement. To date, most measurement efforts related to readmissions have been created independently by health plans and health systems and reflect the processes those organizations typically engage in by themselves or via data feeds and sources easily accessible to them. Consequently, most health plan measurement approaches are claim based and track clinical events and costs from claims, while health systems, which have access to richer clinical data, can track and evaluate pertinent medical issues from that perspective. In a collaborative approach, the combined data sets will allow more robust analysis of process and outcomes.

With well-coordinated care, it is reasonable to expect that chronic illnesses will no longer be a major driver of potentially preventable readmissions.

Collaboration between health systems and health plans should aim at selecting important elements that need to be measured across the continuum of care. The measures used should follow national standards and benchmarks but also reflect metrics that can help evaluate the effectiveness of the new collaborative nature of the care programs. Such metrics or measure domains would include successful care

transitions between settings, timely and complete discharge by the right level of staff, consistent patient education throughout the care plan, and return on investment (ROI) for the resources deployed to support the patient and his or her caregiver. Most importantly, the measures used should be easily collected, shared, and consistent across multiple health systems and health plans. (See Appendix, Table 3, for sample measures.)

While the opportunities for a coordinated clinical program are compelling, there are significant barriers to establishing such a program. These include uncertainty about ROI for current initiatives, financial limitations to proactive resource deployment, limited consensus-building capability between entities unaccustomed to collaboration, lack of standard data collection, and many others. These barriers can best be addressed in a setting where joint business incentives and clinical goals come together within a business model that rewards success.

No one solution is the answer, but better identifying high-risk patients, developing a joint care-coordination model with appropriate

resources, and measuring success are essential steps for establishing a successful coordinated care program.

Case Study: Sentinel Chronic Conditions—Diabetes, COPD, Acute Coronary Syndrome

In addition to considering these general opportunities for readmission reduction, we assessed a number of clinical conditions to identify areas

TARGETING THE LEADING CAUSE OF HOSPITAL READMISSIONS

Acute Coronary Syndrome and Heart Failure remain the leading cause of hospital readmissions, at 23.6% in 2011. Nearly one in four patients hospitalized with heart failure and one in five patients hospitalized with acute myocardial infarction (AMI) are readmitted within 30 days of discharge. Higher readmissions rates, associated with lower patient satisfaction, are estimated to cost Medicare more than \$17 billion per year in hospital payments. Various interventions have proven effective for reducing readmissions for these patients, including using a checklist that helps remind both patients and doctors about steps that can be taken to manage the condition:

- Medications and their appropriate dose
- Dietary and lifestyle change coaching
- Counseling and monitoring intervention (self-management)
- Follow-up instructions (patient education)
- Assigning a nurse as a clinical manager
- Coordination of transitional care in a safe and timely manner.

Many of these interventions have proven to decrease readmissions by 15% in three years.

that might offer specific opportunities. As a result, we found that various chronic conditions have management considerations that merit specific attention. The conditions that we explored include diabetes, chronic obstructive pulmonary disease (COPD),



heart failure, and acute coronary syndrome.

Chronic diseases such as diabetes, heart failure, and COPD play a large role in preventable hospital readmissions in New York State and the rest of the country.

Chronic conditions often require enhanced care management to avoid exacerbation during the vulnerable post-discharge period. These exacerbations can lead to preventable readmissions, representing a burden to the patient and family as well as excess cost.

THE CHALLENGE OF DIABETES

Diabetes is the second leading cause of all readmissions in New York state—at 21% at 90 days post discharge—and is associated with 15.2% of total state readmissions costs. Over 8% of the U.S. workforce suffers from this disease. Employers spend on average \$4,413 more per diabetic employee as compared to controls, with more than 30% of these costs attributable to work absences and diabetes-caused disability.

What's required is a standardized approach to identifying patients with a chronic condition early in their hospital stay and then executing effective protocols for appropriate medical management and patient engagement during the discharge period, followed by outpatient monitoring and support. Health systems and plans are working together to bridge this care gap by drawing on the unique capabilities of each.

Identifying patients early and executing standardized and effective clinical-care paths provides an opportunity to evaluate each patient to make sure they are receiving the right treatments related to their chronic illness. For diabetes, this includes assessing whether they are being adequately managed on oral medication or would benefit from the use of insulin, given only by injection. For patients with COPD, this means ensuring that they have



treatment for both the chronic aspect of the disease and also for acute flare-ups. For patients with acute coronary syndrome, it means verifying that the medications are up to date and conform to most recent clinical guidelines.

Educating patients during the pre-discharge period is essential, especially if there has been a change in medications that have been prescribed for outpatient use after the hospital stay. For diabetes, this could mean training patients in how to give themselves insulin shots and to recognize the symptoms of low and high blood sugar. COPD patients could be shown how to use an inhaler, which requires a bit of practice to master. Patients with acute coronary syndrome need to understand any new medications and be fully comfortable with how best to take them.

Providing outpatient monitoring and support once patients leave the hospital is also imperative, especially to ensure that medications are taken as prescribed. Failure to adhere to a medication regimen is a leading cause of preventable readmission. Patients with diabetes also need to know how to test their blood sugar at least daily and adjust medication levels accordingly. COPD patients must continue their medication and appropriate use of their inhalers, as well as avoid allergens and other pulmonary irritants. Patients with acute coronary syndrome need to adhere to their prescribed medication regimen and recognize the symptoms of a potential worsening of their condition as well as how to seek emergency care.

In some situations, the health plan can be responsible for these readmission

reduction activities, whereas in other cases it might make more sense for the health system to take the lead. A coordinated care model that avoids duplication of effort and measures the effectiveness of the program against established benchmarks is essential. With well-coordinated care, it is reasonable to expect that chronic illnesses will no longer be a major driver of potentially preventable readmissions.

COPD IS COSTLY—BUT PILOT PROGRAMS SHOW DECREASED READMISSIONS

COPD is the third leading cause of readmissions—with a 20.5% 30-day readmission rate. In fact, 40%–50% of COPD patients are readmitted to the hospital within a year of discharge. Each of these readmissions, on average, costs 18% more than a COPD index, or initial, admission. Employers also pay for these readmissions indirectly in reduced productivity, presenteeism—when employees are at work but not fully engaged—and absenteeism. Readmissions are more likely for some groups of patients, including those with multiple chronic conditions, previous substandard transitions into post-hospitalization care, or other risk factors, such as depression, cognitive impairment, or a history of readmissions and weak social support. However, promising data from several readmission reduction pilot programs have demonstrated a decrease in hospital readmission rates from 20% to 15% within two years.

REQUIREMENT TWO: BUSINESS SUSTAINABILITY, AN ESSENTIAL UNDERPINNING OF COLLABORATION

NEBGH research has concluded that effective, active collaboration in efforts to reduce readmissions is needed to integrate workflows that currently fail to address all aspects of the problem. Active health plan and health system collaboration will require new processes, tools, and possibly even personnel, introducing a need for an underlying economic model that ensures long-term sustainability. This section discusses the business sustainability challenge and identifies key areas of activity that merit further attention.

Bolstered by the success of a number of care transition and care-coordination demonstrations, CMS and the Patient Protection and Affordable Care Act (PPACA) launched payment reform initiatives aimed at controlling preventable readmissions, including the bundled payment ACE demonstration, which showed readmission reduction.

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But with two-thirds of U.S. hospitals being penalized for excess readmissions, it's clear that the solution to this intractable problem will require going beyond payment reform. Early pilot studies generally concluded that successful readmission reduction programs require incremental resources, such as dedicated care coordinators, social workers, and pharmacists, and in-home assessments for high-risk individuals. The studies also found that care-coordination support is required to assist in overcoming socioeconomic barriers to successful follow-up after discharge. Companies in a burgeoning new cottage industry are dedicated to support for discharge and care coordination. But with nonpayment for certain readmissions, these incremental services are not reimbursed, so for most institutions all these activities come

at a significant cost and diversion of financial resources.

To promote more effective readmission reduction for commercially insured lives, important business issues need to be resolved, such as: Who will pay, are resources being best deployed, do the incentives align to sustain improvement, and importantly, is there really a return on investment?

Payer/Provider Collaboration Provides Opportunities to Better Manage Costs—But a Sound Business Model Is Essential

The prevailing fee-for-service payment model for hospital-based care does not directly fund the costs associated with preventing avoidable hospital readmissions—a well-recognized challenge for both public and private purchasers of care. Yet payer/provider organizations such as Geisinger and Kaiser

Permanente have in fact demonstrated that through an integrated approach to managing readmission risk, readmissions can be reduced while also covering the incremental costs. To extend this success beyond the few fully integrated payer/provider models in the United States, health systems, health plans, and employers must

come to the table ready to engage in conversations around new contracts, new reimbursement and/or incentive models, new metrics, new resources, and clinical collaboration. Though these conversations may be difficult, they can help pave the way to a better business model that leverages the best of all organizations and offers the likelihood of substantially reduced aggregate costs.

The underlying question for all these discussions is how best to balance the new costs of addressing the readmission challenge with the expected downstream benefits of cost reduction. As they discussed elements of a sustainable business model (see chart), the NEBGH workgroups identified basic building blocks of a sustainable coordinated model for avoiding hospital readmissions:

- **Building Block A**
Establishing a clear and shared vision and definition of “success” among all collaborators
- **Building Block B**
Defining new performance-based contracts that incorporate some form of shared risk/reward
- **Building Block C**
Recognizing that “perfection is the enemy of the good”—Don’t wait. Start now, improve as you go.

Though perhaps not the only requirements for achieving business sustainability in hospital readmission reduction efforts, these essential design components were commonly thought to be essential for getting started, allowing for adjustments as programs begin to take shape.



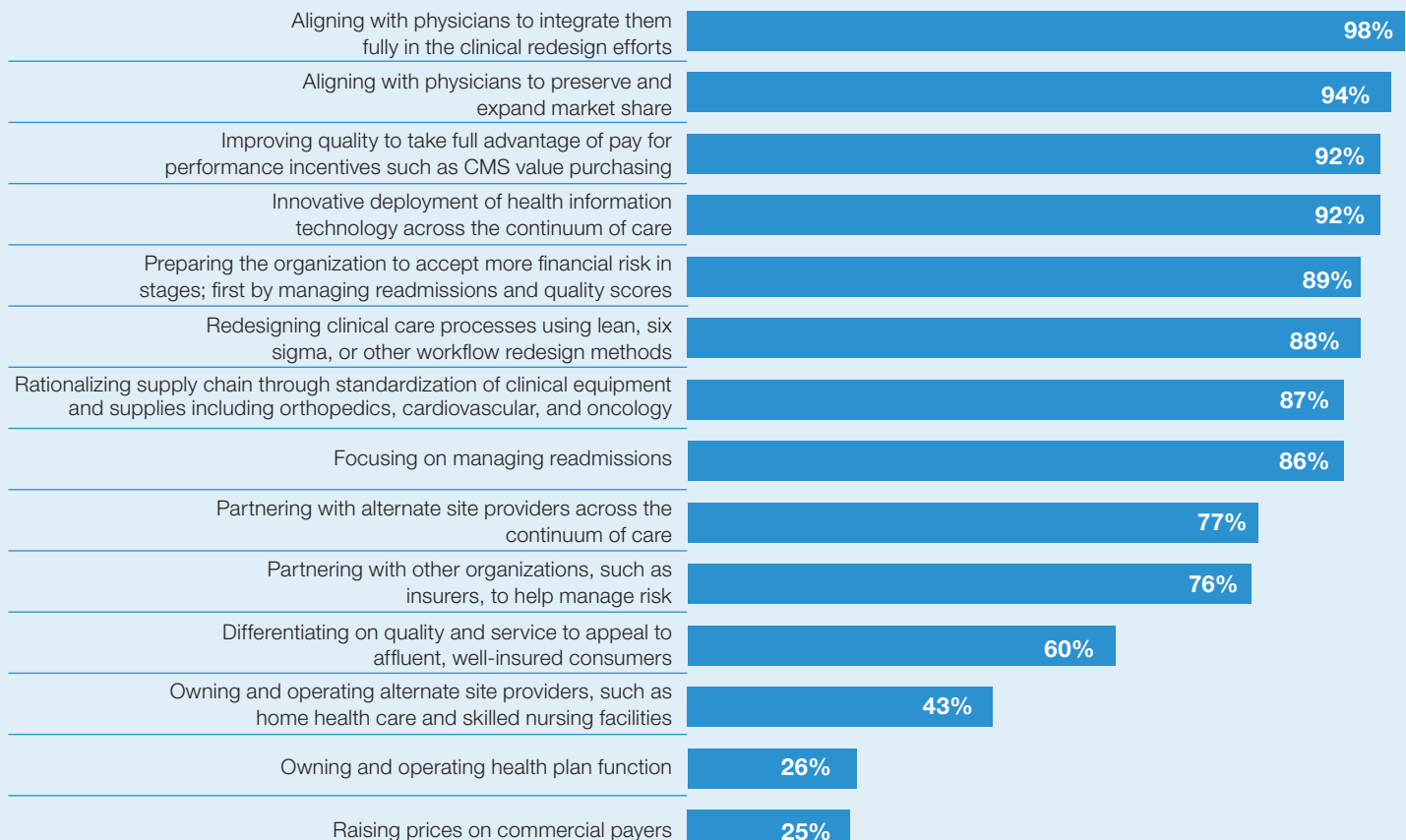
Historically, the health care system has not focused on true, care-directed collaboration between health systems and health plans. Consequently, it is not surprising that there is no shared vision to support such collaboration, nor an easy recipe for determining appropriate financial incentives to each stakeholder or for achieving the secure and timely sharing of longitudinal data required to guide and reward high-value care. But general market forces and experience with PPACA are spurring interest in establishing a collaborative approach to containing health care costs while also addressing system-wide quality and efficiency. Stakeholders increasingly recognize that a shared vision is essential to creating a sustainable business model that assures them that that the economic risks they are being asked to bear are reasonable.

How can we get to a shared vision? Achieving it requires the active participation of payers, providers, employers, and even employees, fostering an environment where people and institutions are motivated and energized to work together to achieve common goals. Employers in particular can play a pivotal role in facilitating that shared vision by encouraging health plan and health system discussions that rethink boundaries and imagine new collaborative models and new contract models that reward success. In a shared vision of a collaborative care model, stakeholders recognize that achieving optimal care rarely rests solely with any one entity. Instead, a shared vision mandates a broader look at integrated solutions, requiring employers, health systems, and health plans to embrace clinical process redesigns, success-based financial incentives, and other contract terms that deliver the best outcomes. In short, it compels all stakeholders to establish shared goals that:

- Go beyond just measuring avoidable hospital readmissions to identifying and quantifying the causes that lead to them
- Better engage and incentivize all stakeholders, including patients and caregivers, to be fully engaged in effective care processes
- Gather and share appropriate and timely data in a secure and cost-effective manner
- Agree on a long-term financial model that rewards success but also provides the necessary resources to achieve it.

All parties should feel enabled and empowered to proactively share information and participate in supporting the care needs of patients as they move through their transitions, and—just as importantly—feel confident that the economic model will adequately reward all involved.

HEALTH SYSTEM: EXTREMELY/VERY IMPORTANT FACTORS IN DEVELOPING A LONG-RUN BUSINESS MODEL*



BUILDING BLOCK B

Performance-Based Contracts

Employers, as purchasers, have a unique opportunity to lean on health plans to put pressure on care-delivery systems through contractual arrangements that include expanded quality initiatives and aggressive shared-savings scenarios. Well-constructed contracts can cut through much of the confusion about who is responsible for managing unnecessary hospital readmissions by establishing clear accountabilities. This may involve new assignments of responsibility, modifications to existing network arrangements, and agreement on new metrics.

Since these efforts introduce new business models, focused effort will be required to support and educate organizations traditionally not accustomed to assuming financial contract risk, sharing data, or active partnering. Fortunately, almost all health care organizations are moving rapidly along a path where the ability to manage alternative contractual reimbursement and/or incentive models and deliver superior outcomes within these new business models is becoming the “new normal.”

New contractual models require purchasers, in discussions with health systems and providers, to agree on the type of savings and risk-based models best suited for both short and long term. Fortunately, a marketplace is developing where stakeholders can agree on mutual financial goals, designing contracts to include shared-savings or shared-risk models—and there is some early indication of success. Blue Cross

Blue Shield of Massachusetts, through their Alternative Quality Contracts (AQC), which included global provider payment and incentives based on quality and patient satisfaction, has demonstrated reductions in medical cost trend and reductions in hospital readmissions, compared to non-AQC contracts. The global payment model initiated a dialogue that encouraged various players to design and implement solutions with a shared goal of better care and lower cost. Appropriate financial rewards allowed parties with previously conflicting objectives to come together for mutual gain, and patients and purchasers also benefitted.

BUILDING BLOCK C

Immediacy: Don't Wait, Start Now

The full array of contract decisions and care-process improvements needed to reduce avoidable readmissions are complex and will require time to sort out. But why wait? Even while designing and implementing broad system changes and drafting new contracts, some simple collaboration approaches can be applied. Baby steps—that can be taken before a total solution is developed—include funding clinical personnel to serve as care coordinators to assist in post-hospitalization care coordination, establishing cross-function workgroups to define and quantify performance improvement opportunities and benefits, and identifying opportunities to reduce communication and data barriers between various facilities. Well-chosen, these incremental activities can deliver immediate value

NEW BUSINESS MODELS BECOMING THE NEW NORMAL

The health care landscape is fertile with new collaborative arrangements:

- Accountable Care Organizations
- CMS Star Ratings Program
- Patient-Centered Medical Home model
- The Leapfrog Group
- Bridges to Excellence
- Catalyst for Payment Reform
- BCBSMA Alternative Quality Contracts
- CMS Value-Based Purchasing pilots
- CMS Bundled Payments for Care Improvement initiative
- PROMETHEUS Payment
- Geisinger ProvenCare model

(See Appendix Table 2 for details about these business models.)

while providing a platform to evaluate success and leverage insights in future collaborative designs. Unless excessive, the costs for these interim solutions can likely be shared, with each stakeholder allocating either personnel or capital as more detailed contract models are developed, initiating an important and much-needed collaborative process to immediately generate momentum on quality improvement.



REQUIREMENT THREE: EMPLOYEE COMMUNICATION AND OUTREACH

Successful models of care transition that prevent rehospitalization clearly demonstrate that involving patients and their families is critical. Engaging and educating the patient ideally starts before admission, involves shared decision making, and extends well past discharge from the hospital. Patients play a central role in driving utilization and compliance and it is very important to consider how best to partner with and involve them.

It's essential to increase patients' and families'/caregivers' awareness of opportunities for patients to participate in their own care. Employers have a role to play in raising that awareness, by combining targeted employee education and outreach efforts with benefit designs that reward active participation in care programs.

In the Robert Wood Johnson Foundation Report on U.S. Hospital Readmissions, 32 interviews were conducted with patients about their experience with readmissions. In many of their stories, the common themes were not receiving information, rushed discharge processes, lack of follow-up care, and even patients treating the hospital system as their own primary care facility. What is clear is that a patient and family's perspective on what is "broken" is not always how the health system views what needs improvement. It's essential to increase patients' and families'/caregivers' awareness of opportunities for patients to participate in their own care. Employers have a role to play in raising that awareness, by combining targeted employee education and outreach efforts with benefit designs that reward active participation in care programs.

Increasing employee awareness and engagement

Employers and their partner health plans have long been challenged by

how to effectively communicate with employees about the need to engage in self-care programs. Despite outreach efforts and incentives, engagement and enrollment in the programs remain lackluster, and employees continue to evince a general mistrust of their health plan. In a collaborative effort between health plans and health systems, providers can communicate with the employee in a timely and trusted manner, increasing the likelihood of engagement.

Employees should be made aware of the importance of planning ahead. Through appropriate education and incentives, employees could be made increasingly

aware of centers of excellence and high-quality providers with a proven track record in avoiding readmissions. Networks could steer patients towards these high-performing facilities and providers.

Before going to the hospital for an elective admission, employees should be encouraged to educate themselves about what to expect and how best to prepare the home for their return after discharge. Needed care coordination, whether sophisticated clinical home care or just having someone assist with meals, should be anticipated and established well before admission.

Addressing the caregiver's needs

The caregiver is often a big influence on how well a patient does at home after a hospitalization. Sometimes a family member, often a friend or neighbor, these unpaid "care assistants" can ensure that care plans and medication regimens are carried out and that any problems are quickly identified and

communicated. Collaborating with and educating the caregiver may be just as important—or even in some cases more important—than informing the patient. The integrative approach involves understanding the challenges of being a caregiver, who may suffer as much confusion, lost productivity at work, and emotional distress as the patient. Therefore ideally, education, support, and benefits should address caregiver needs as well. Modifying programs already in the workplace to support employees—Employee Assistance Programs (EAPs)—would be an innovative way to help patients and caregivers alike. EAP-like post-hospitalization support programs could be developed and introduced to employees as a way to provide them and their caregivers support and guidance in care coordination after a hospital discharge. Additionally, expert resources dedicated to helping patients and caregivers could be made available telephonically or online to address care-coordination issues proactively and more efficiently.

KEYS TO SUCCESSFUL OUTREACH

Supporting employees to be more active in self-care and readmission reduction efforts often will not mean providing more clinical care but instead helping them resolve social issues and address financial or emotional needs. These are complex issues to address but if done effectively, everyone benefits. A good starting point is communicating with appropriate language so employees better understand what they can do to avoid returning to the hospital and how best to plan ahead for their elective stays. Another solution is to implement benefit designs that encourage engagement with post-hospital support programs perhaps tied to a reward or incentive program.

SUMMARY: ACHIEVING A SHARED SENSE OF URGENCY AROUND COLLABORATION—AND MOVING FORWARD

There is a new, heightened awareness of immediate opportunities to reduce hospital readmissions and the challenges involved. What lags is awareness of the need for improved coordination between health plans and health systems—a collaborative model that will allow the various stakeholders to move forward effectively to resolve these issues together. While health systems and health plans are sustaining the momentum toward coordination, they're each advancing at a different pace and often with different motivators.

While many readmission reduction efforts are underway in the marketplace, few, if any, have the shared data analytics, integrated care models, robust employee outreach and communication, and the economic sustainability features we describe in this report.

Though many employers have yet to fully engage on readmission reduction, they are in a critical position to promote a sense of urgency around these issues. Employers can help set the agenda and facilitate dialogue around new business arrangements that enable health systems and health plans to work collaboratively in developing aggressive solutions to improve the way care is delivered today. Employers can serve as the catalyst to enable action, even before new business arrangements and contract terms are fully worked out.

Pressure from public sector purchasers will increase the sense of urgency around the need to reduce preventable readmissions. Moreover, consumerism in health care will likely make patients and caregivers more aware of their choices and also give them a voice to express their dissatisfaction with the current status quo and demand more

support when they are discharged from the hospital.

Based on these findings from our latest explorations, NEBGH believes now is the time to begin a set of demonstration projects to explore sustainable models of improved care coordination. While many readmission reduction efforts are underway in the marketplace, few, if any, have the shared data analytics, integrated care models, robust employee outreach and communication, and the economic sustainability features we describe in this report.

Employers, as purchasers, are well positioned to promote improvement in readmission reduction, demanding better collaboration between health plans and

providers, with matching performance payments to all involved. The solution to avoidable hospital readmissions lies in harnessing the power of collaboration and in the ability of leaders in each of the stakeholder groups to drive the pace of readmission reduction even faster.



- **APPENDIX**
- **PROJECT PARTICIPANTS**
- **REFERENCES**

APPENDIX

Table 2. Business Models

Program	Description	Pros	Cons	Sample Programs
Pay for Performance and Quality Monitoring	Hospitals and providers can receive payment increases if they achieve or exceed performance targets for certain quality measures.	Multiple programs exist that can be extended to include the new readmission avoidance-based measures.	Resources are required to track and submit performance data. Looking at a single metric will not address the systemic issues; a group of measures will need to be considered.	<ul style="list-style-type: none"> • CMS STARS program • PCMH Model • Leapfrog • Bridges to Excellence
Value-Based Purchasing	Establishes pay-for-value payment incentive as part of contracting model.	Value-based contracting provides for greater price transparency.	Requires management and measurement of value and execution of new contracts.	<ul style="list-style-type: none"> • Catalyst for Payment Reform • BCBSMA AQC Contracts, • CMS Value-Based Purchasing pilots • Commercial pay-for-performance programs
Episode-Based Bundled Payments	Single payment to one entity for entire episode of care.	<p>Fosters collaboration between providers and institutions.</p> <p>Addresses issues for readmission across the entire care continuum and allows for flexibility in execution of care.</p>	<p>Need to develop strong strategic partnerships.</p> <p>Requires cooperation among multiple parties and significant modifications to existing contracting and business arrangements.</p>	<ul style="list-style-type: none"> • CMS Bundled Payments for Care Improvement Initiative • Acute Care Episode (ACE) Demonstration • ProvenCare
Shared Savings	An incentive to adjacent organizations to coordinate care and share in savings over benchmark.	Provides a more positive incentive for collaboration. Also affords flexibility in execution.	<p>Requires new business agreements between providers and hospital systems.</p> <p>New measurement models require calculation of appropriate benchmarks.</p>	<ul style="list-style-type: none"> • Accountable Care Organizations • Risk-Stratified Care Management
Capitation	A percentage of premium is passed on to a provider organization for members receiving care within the provider organization's network. The provider organization is responsible for administering all benefits and managing associated medical expense. Any savings generated are retained by the provider organization and any losses incurred are the responsibility of the provider organization.	This model aligns incentives for reducing medical expense by placing responsibility for both the total cost and quality of care with the provider organization.	Most provider organizations do not have the resources to invest in the infrastructure required to manage capitation arrangements and/or the risk tolerance to assume and manage capitation.	

APPENDIX

Table 3. Essential Measures

Health Plans

- Rates of all member admissions to facilities and ED visits
- Rate of readmission with valid risk adjustment
- Post-discharge complications resulting in readmission
- Time window for readmission
- Correlation between post-acute facility and readmission rates
- Medication adherence
- Cost of readmissions across networks over time (e.g., pre and post interventions)

Health Systems

Clinical Process Measures

1. Continual Optimization and Evaluation

- Medication reconciliation post discharge
- Presence of test result follow-up after discharge
- Timely follow-up with primary care physician and other providers
- Post-discharge calls/visits for high-risk patients
- Root cause analysis of readmission

2. Patient Risk/Perception Assessment

- Readmission assessment scores
- Percentage of patients who received post-discharge medication instructions
- Percentage of patients and caregivers given discharge instructions
- Satisfaction with discharge instructions
- Activation of community services
- Presence of PCP
- Patient Activation Measure
- Percentage of behavioral health patients, homeless patients, ESRD, HIV or other complex, high-risk populations

3. Organizational Structure and/or Systems

- Percentage of clinical staff utilizing accredited patient engagement and education techniques

Outcome Measures

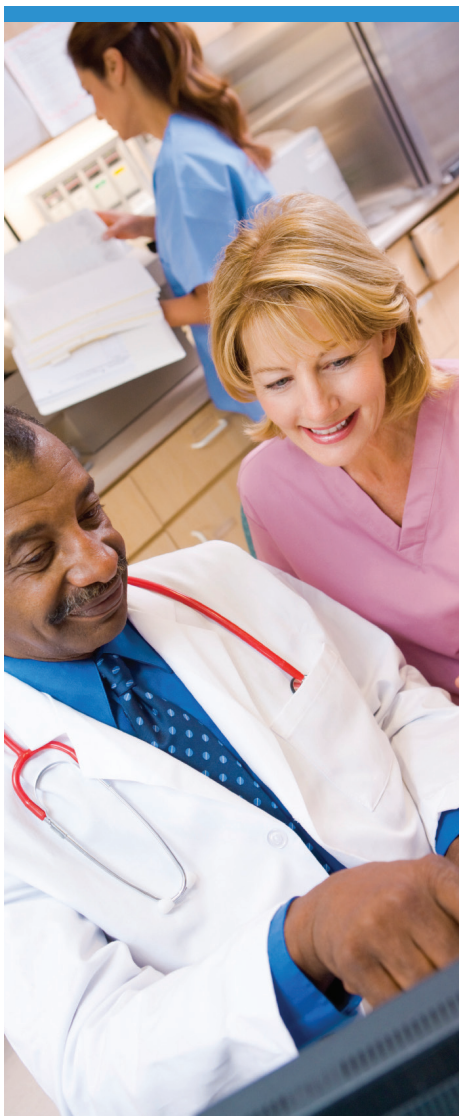
- Percentage of avoidable readmission, risk adjusted
- Detailed clinical resource utilization data
- Clinical data to determine disease burden and severity
- Cost of readmission to the health system
- Cost of dedicated care-coordination team

PROJECT PARTICIPANTS

- **Gail Amato**
Strategic Account Executive
Boehringer-Ingelheim
- **Aliyah Ansari**
Administrative Manager
Memorial Sloan-Kettering Cancer Center
- **Ruth Antoniadis**
Executive Director
Labor Health Alliance
- **Gregory Barbero**
Regional Account Executive
NovoNordisk
- **Mark Bardi**
Senior Regional Account Director
AstraZeneca
- **Randy Blum**
Vice President, Network Lead
UnitedHealthcare
- **Mary Bradley**
Director of Healthcare Planning
Pitney Bowes
- **Scott Breidbart, MD**
Chief Medical Officer
Empire Blue Cross Blue Shield
- **Lili Brillstein**
Senior Director, Medicare & Retirement
UnitedHealthcare
- **Sara Butterfield, RN, BSN, CPHQ, CCM**
Senior Director, Health Care Quality Improvement, Project Leader, CMS Care Transitions Initiative
IPRO
- **Kathleen Byrne**
Senior Manager
Montefiore CMO
- **Mark Calderon, MD**
Vice President and Chief Medical Officer
Horizon Blue Cross Blue Shield of NJ
- **Donald E. Casey, Jr., MD, MPH, MBA, FACP, FAHA**
Chief Medical Officer, NYUPN Clinically Integrated Network
NYU Langone Medical Center
- **David Cobden, PhD, MPH, MSc**
National Clinical Account Director
AstraZeneca
- **Sanford Cohen, MD**
Chief Medical Officer, Northeast Region
UnitedHealthcare
- **Claudia Colgan**
Vice President, Quality Initiatives
Mount Sinai
- **Mary Ellen Connington, RN**
Senior Vice President of Managed Care
Visiting Nurse Service of New York
- **Jim Cummings**
Employer Account Executive
Boehringer-Ingelheim
- **Christine Cunningham, RN**
Senior Staff Nurse
NYU Langone Medical Center
- **Annette Cutrino**
Vice President of Strategy & Innovation
VillageCare
- **Denise Davin**
VSPV/CHRO and Labor Counsel
Visiting Nurse Service of New York
- **Svetlana DeBellis**
Director, Business Development and Managed Care
Mt. Sinai
- **Dominic DePiano**
Director, Network Management
Empire Blue Cross Blue Shield
- **Maria Dugandzic, PharmD**
Associate Director, Healthcare Quality & Outcomes
Boehringer-Ingelheim
- **Steve First**
Vice President, Global Benefits
Pfizer
- **Elizabeth Garofalo**
Associate Director, Managed Markets Marketing
Boehringer-Ingelheim
- **JoAnn Goetz**
Clinical Coordinator
Episcopal Church Medical Trust
- **Terry Golash, MD**
Senior Medical Director
Aetna
- **Ann Marie Gothard**
Director, Communications Strategy
EmblemHealth
- **Kathryn Haslanger**
CEO
JASA
- **Theresa Hayde**
Nurse Manager
NBCUniversal
- **Richard Heitner**
Director, Business Advisory Services & Managed Care
Atlantic Health
- **Michael Johns**
Senior Director, Business Development
VHA Empire – Metro / UNYHEALTH
- **Jill Kalman, MD**
Director, Cardiomyopathy Program
Mt. Sinai
- **Joanne Kramar, RN, MS**
Senior Clinical Account Director
Empire Blue Cross Blue Shield
- **Alan Landauer**
Senior Vice President
Landauer Metropolitan
- **Jared Lewis**
Senior Manager, Corporate Benefits
Curtiss-Wright
- **Coleen Lyons**
US Healthcare & Wellness, Manager
American Express
- **Michelle Martin**
Director, Health & Welfare Benefits
CBS Corporation
- **Margaret Meagher**
Director of Benefits
NYU Langone Medical Center
- **Anne Meara, RN, MBA**
Director, Care Management Solutions
Montefiore CMO
- **Ronald B. Menzin, MD**
Chief Medical Officer
Cigna
- **Tom Moore**
Senior Vice President
Healthix
- **Greg Mulford, MD**
Chief Medical Officer
Morristown Memorial Hospital/Atlantic Health System
- **Sarah Munson, MPH**
Director, Program Implementation
Network Integration
NYU Langone Medical Center
- **Alan Murray**
President
Northshore-LIJ CareConnect Insurance Company, Inc.
- **Doreen Nelkin-Warantz**
Executive Director
Mt. Sinai IPA
- **Eliza Ng, MD**
Senior Medical Director
EmblemHealth
- **Michael Norton**
Director, Managed Care
NovoNordisk
- **William O'Donnell**
Vice President, Contracting
Cigna
- **Pat Orchard**
Director, Clinical Operations for Health Affairs
Horizon Blue Cross Blue Shield of NJ

REFERENCES AND SELECTED READING

- **Jennie Pao**
Manager, Health Care Planning
Pitney Bowes
 - **Nicola Pitter**
Director, Business Development and
Managed Care
Mt. Sinai
 - **Lisa Polk**
Director, New York City Health
Benefits Program
City of New York, Office of Labor Relations
 - **Matthew Press, MD**
Senior Manager
Weill Cornell Medical College
 - **Martha Radford, MD**
Chief Quality Officer
NYU Langone Medical Center
 - **John Roefaro**
Director, Regional Hospital and
Ancillary Contracting
Horizon Blue Cross Blue Shield of NJ
 - **Angela Scott**
Provider Relations Director
1199SEIU Benefit & Pension Funds
 - **Shelley Sinclair**
Assistant Director, Health & Welfare
Ernst & Young
 - **Michael Sturmer**
Senior Director Clinical Operations
Cigna
 - **John Tesoro**
Assistant Vice President, Network Contracting
Aetna
 - **Anne Travisano**
Senior Director, Medical Management
EmblemHealth
 - **Ralph Ullman**
Director, Research & Analysis
1199SEIU Benefit & Pension Funds
 - **Michael Vecciarelli**
Regional Account Executive
NovoNordisk
 - **Fred Verde**
Managed Markets Director
AstraZeneca
 - **MaryJo Vetter**
Vice President, New Product Development
Visiting Nurse Service of New York
 - **Patrick Wormser**
Director, Downstate Contracting
EmblemHealth
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About the NEBGH Solutions Center

Northeast Business Group on Health (NEBGH) is well positioned to act as an information gatherer and knowledge disseminator at a general level, but more importantly, facilitate discussions, relationships, and knowledge-sharing about best practices, all of which need to be explored at the local level.

As one of the largest purchasers of health care services, employers play a major role in forcing the health care system to deliver value. To better participate in the creation of value in health care, NEBGH has launched the Solutions Center (SC) as a new opportunity to identify and evaluate effective solutions; investigate and disseminate innovative ways to improve the quality and value of health care for employees, retirees, and dependents; and implement these solutions.

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About NEBGH

Northeast Business Group on Health is a network of employers, providers, insurers, and other organizations working together to improve the quality and reduce the cost of health care in New York, New Jersey, Connecticut, and Massachusetts. A not-for-profit coalition comprised of nearly 200 members and over a million covered lives, NEBGH speaks with one voice for quality, accountability, and value in the region's health care system. NEBGH helps large, midsize, and small businesses by informing health care decisions, improving the health care delivery system, and controlling costs.

Northeast Business Group on Health
61 Broadway, Suite 2705
New York, NY 10006

Phone: 212-252-7440 x223

Fax: 212-252-7448

www.solutionscenter-nebgh.org

www.nebgh.org



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