

Reducing Preventable Hospital Readmissions: A Multistakeholder Perspective

Shawn Nowicki, David Zembroski, Laurel Pickering, Jeremy Nobel



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 over 150 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, mid-sized, and small businesses by informing health care decisions, improving the health care delivery system, and controlling costs.

About the NEBGH Solutions & Innovations Center

Northeast Business Group on Health's Solutions and Innovations Center (SIC) identifies, investigates, and disseminates innovative ways to improve the quality and value of health care for the region's employers. Working with leaders in the fields of medicine, academia, and business, the Center conducts objective, structured research to make a difference in employee health care in the near term. The Center focuses on innovative approaches to improving care and delivery that are likely to make a significant impact on cost and quality, including new care delivery models, leading-edge provider payment models, and new benefit designs that maximize health improvement and encourage team-based care.

Contact information

To learn more about NEBGH's Solutions & Innovations Center and its projects, please visit: www.nebgh.org/sic.

NEBGH

Solutions & Innovations Center

61 Broadway

Suite 2705

New York, NY 10006

Phone: (212) 252-7440

Fax: (212) 252-7448



TABLE OF CONTENTS

Acknowledgements	4
Executive summary	5
Key recommendations and next steps	
Introduction	11
Section I: Background	12
Transitional care: A method for preventing unnecessary readmissions	
Section II: Policy & legislative action: Curbing preventable readmissions through payment reform	17
Affordable Care Act: Shifting financial incentives to reduce readmissions	
Partnership for patients	
Section III: Pay for value to reduce readmissions	19
Section IV: NEBGH Employer Survey: Readmissions are a top priority.....	21
Section V: Multistakeholder work groups address preventable readmission.....	22
Clinical process improvement work group	
• Reducing readmissions is complex and a sustainable business model is elusive	
• Collaboration and cooperation are integral to progress	
Measurement & analytics work group	
• Environment and revenue sources determine enthusiasm for readmission projects	
• Future directions: Strong collaboration to streamline and synergize efforts	
Sustainable business models work group	
• Making progress in value-based purchasing and collaborative efforts	
• System synchronization: Aligning stakeholder activity	
• Readmission reduction through gain-sharing	
Employee engagement work group	
• Integrating readmissions reduction into corporate health benefit business models	
• Building employee trust and awareness going forward	
Section VI: Recommendations & next steps.....	28
Appendix: Regional readmissions reduction efforts.....	31

ACKNOWLEDGEMENTS & LIST OF PARTICIPANTS

NEBGH gratefully acknowledges Boehringer Ingelheim and Merck for their unrestricted financial support of this publication and the related activities that contributed to its content and direction. We also recognize them as important stakeholders in the system-wide quest for safe, high-quality, and value-driven health care in New York, New Jersey, Connecticut, Massachusetts and, nationally.

In addition, we would like to express our gratitude to the stakeholder contributors — listed below — who made this project possible. Their enthusiastic and insightful participation and collaborative spirit were crucial to the success of this initiative.

We would also like to acknowledge Anne Meara of Montefiore CMO, the hospital system's care management company, and Spencer Vibbert and Sara Butterfield of IPRO, New York State's Medicare Quality Improvement Organization, for their expert review of this publication's manuscript. Their spirited contributions were invaluable.

The authors are solely responsible for the conduct of the research, analyses, and content of the manuscript. NEBGH also recognizes Louise Kertesz for her contributions to the editing of this publication as well as Rubin Meyer Communications for devising the report's formatting, graphic design, and layout.

David B. Bernard, MD

Chief Medical Officer
Continuum Health Partners

Kate Botley

Chief of Staff, Benefits
1199SEIU Benefit & Pension Funds

Mary Bradley

Director of Healthcare Planning
Pitney Bowes

Scott Breidbart, MD

Chief Medical Officer
Empire BlueCross BlueShield

MaryAnn Brown, RN

Senior Director, Clinical Improvement
VHA Empire – Metro

Sara Butterfield, RN, BSN, CPHQ, CCM

Senior Director, Health Care Quality
Improvement, Project Leader,
CMS Care Transitions Initiative
IPRO

Mark Callahan, MD

Chief Medical Officer,
FPA and Mount Sinai Network
Associate Dean for Clinical Excellence
Mount Sinai School of Medicine

Lawrence Casalino, MD, PhD

Livingston Farrand Associate
Professor of Public Health & Chief,
Division of Outcomes and
Effectiveness Research
Weill Cornell Medical College

Sanford Cohen, MD

VP, Clinical Affordability
UnitedHealthcare

Claudia Colgan

Vice President, Quality Initiatives
The Mount Sinai Hospital

Maria Costino

Director of Joint Quality Initiatives
Stellaris Health Network

Denise Davin

Senior Vice President & Chief
Human Resources Officer and
Labor Counsel
Visiting Nurse Service of New York

Dominic DePiano

Regional Vice President,
Network Management
Empire BlueCross BlueShield

Terry Golash, MD

Senior Medical Director
Aetna

Kathryn Haslanger, JD

Senior Vice President
Visiting Nurse Service of New York

Michael Johns, MPH

Senior Director
UNYHEALTH/VHA Empire – Metro

Marla Koroly, MD, FACP

Medical Director, Northern Westchester
Hospital & Chairman, Quality Council
Stellaris Health Network

Gilad Kuperman, MD, PhD

Executive Director
NYCLIX, Inc.

Jared Lewis

Manager, Compensation & Benefits
Curtiss-Wright Corp.

Sharon M. Lucian

Vice President & CFO
Stellaris Health Network

Coleen Lyons

Manager, Benefits
American Express

Michelle Martin

Director of Health & Welfare Benefits
CBS Corporation



Margaret Meagher

Director of Benefits
NYU Langone Medical Center

Anne Meara, RN, MBA

Associate Vice President,
Network Care Management
Montefiore CMO

Pranav C. Mehta, MD, MBA, FACHE

Vice President, Physician and Ambula-
tory Network Services
North Shore-LIJ Healthcare System

Ronald B. Menzin, MD

Tri-State Market Medical Executive
Cigna

Sarah Munson, MPH

Quality Program Manager
NYU Langone Medical Center

Alan Murray

Vice President
New York Market Lead,
Network Management
United Health Group

Ira S. Nash, MD

Chief Medical Officer & Senior Vice
President for Medical Affairs
Mount Sinai Medical Center

Pat Orchard, RN, FACHE

Director, Clinical Operations
Horizon Blue Cross Blue Shield
of New Jersey

Jennie Pao

Manager, Health Care Planning
Pitney Bowes

Lily Pazand, MPH

Contract Analyst, Payment Reform
NYU Langone Medical Center

Lisa Polk

Director, New York City Health
Benefits Program
City of New York, Office of Labor Relations

Martha J. Radford, MD

Chief Quality Officer
NYU Langone Medical Center

Barbara Schwartz

Director, Marketing
IPRO

Jason Shapiro, MD, FACEP

Associate Professor and Chief,
Division of Informatics
Department of Emergency Medicine
Mount Sinai School of Medicine and
Chair, NYCLIX Clinical Advisory and
Evaluation Committees

David J. Shulkin, MD

President
Morristown Memorial Hospital

Patricia Shute, RN

Senior Director,
Performance Improvement
VHA Empire – Metro

Christine Stegel, RN, MS, CPHQ

Senior Quality Improvement Specialist
IPRO

Anne Travisano, RN, BSN, MS-HCM

Senior Director, Care and
Case Management
Medical Review Unit and MLTC
EmblemHealth

Ralph Ullman

Director, Research & Analysis
1199SEIU Benefit & Pension Funds
Patrick Wormser
EmblemHealth

Patrick Wormser

Director, Downstate Contracting
EmblemHealth

EXECUTIVE SUMMARY

Preventable hospital readmissions are a threat to patient safety, a burden to employers, occur far too often, and contribute to the growth in national health care costs. Nationally, preventable readmissions cost an estimated \$25 billion per year and happen frequently in commercially-insured populations, although the problem is even more prevalent among those enrolled in public health insurance. Chronic conditions exacerbate the issue. Patients with diabetes and chronic obstructive pulmonary disease (COPD) are two pertinent readmission case studies. These patients are at greater risk for experiencing a preventable readmission than those without either condition. For instance, among the top 10 Diagnosis Related Groups, readmission rates are higher for diabetes patients than those without diabetes. Local and regional performance in reducing readmissions, moreover, is lamentable. New York, New Jersey, and Connecticut are three of the poorest-performing states.

Stakeholders in both the private and public sectors are mobilizing to address preventable readmissions. Federal health reform programs harness the levers of payment reform and community collaboration, aiming to not only reduce readmission rates, but also reengineer related clinical and administrative processes. Employers, health plans, and hospital systems, equally committed to improvement, are engaging in innovative efforts, as evidenced by their unique set of activities and sector-wide support for the public-private Partnership for Patients initiative. Indeed, the unnecessary expenditures that result from preventable readmissions, as well as the significant gaps in quality of care and care coordination that lead to these events, have attracted new and robust attention to the issue. In response, governments, employers, hospitals, and health plans have made preventable readmissions prime targets in their efforts to enhance health care value.

The current system of fee-for-service reimbursement discourages the adoption of strategies that have proven helpful in reducing preventable readmissions. There is widespread agreement that payment reform is critical to bending the health care cost curve and improving quality and value. Aligning providers' financial incentives with the goal of reducing readmissions is an essential component. The many approaches to achieving this include such arrangements as episode-based payments, comprehensive care payments/global payments, and shared savings programs/accountable care organizations. Leading organizations have begun testing these approaches and early results show promise.

This report details a recent investigation by Northeast Business Group on Health (NEBGH) into local and regional stakeholders' perspectives, insights, and concerns related to preventable readmissions. It presents a consensus reached by NEBGH core working groups on steps that can be taken to address this serious problem, one that is central to efforts to improve quality and reduce the costs of health care. A brief review of the literature detailing the extent of the preventable readmission problem is presented, followed by an overview of



At the heart of this report are findings from our interactive engagements with health systems, health plans, employers, and other stakeholders. These included workshop meetings, multistakeholder roundtables, surveys, and one-on-one interviews.

a number of models aimed at preventing these events while patients transition between care settings. Stakeholder perspectives, insights, and concerns related to preventable readmissions — collected in a number of multistakeholder working meetings — are presented next. Concluding the report is a set of recommendations for making further progress in the readmissions reduction arena. An appendix to the report profiles a number of local and regional efforts in New York and New Jersey — by health systems and health plans — aimed at reducing preventable readmissions.

Stakeholder perspectives

At the heart of this report are findings from multiple interactive engagements with health systems, health plans, employers, and other stakeholders over the course of six months. These included workshop meetings, multistakeholder roundtables, surveys, and one-on-one interviews. Both hospitals and health plans describe various efforts aimed at reducing preventable readmissions. It was generally acknowledged, however, that these initiatives are occurring simultaneously but are not necessarily collaborative. Some obstacles to partnership that were identified included the historical adversarial nature of payer-provider relationships, as well as mutual skepticism about the other party's willingness and/or ability to impact readmissions. Despite these dynamics, it emerged that both stakeholder groups are engaged in the early stages of efforts aimed at finding common ground among competing interests.

Survey notes employer attitudes toward preventable readmissions

In an October 2011 survey of NEBGH employer-members, the majority of respondents noted that reducing preventable readmissions is a top priority and believe strongly that they should be actively engaged in efforts to reduce preventable readmissions. They recognize, however, that their employees do not share this priority, indicating the need for more robust employee engagement. A majority of employers also believe that value-based purchasing strategies, as well as innovative payment models, are vital to reducing preventable readmissions.

The survey findings reinforce the theme that emerged from other work conducted as part of this project: multistakeholder collaboration is essential to reducing preventable readmissions, a clinical scenario many stakeholders believe is ripe for improvement.

Multistakeholder work groups explore & define issues

Following a multistakeholder roundtable, four work stream groups — composed of representatives from health systems, health plans, employers, and other stakeholders — formed to further explore and define a set of issues related to preventable readmissions. Their concerns and findings are highlighted on the next page.

■ CLINICAL PROCESS IMPROVEMENT WORK GROUP

Hospitals and health plans are engaged in limitedly collaborative efforts – many of which are only just burgeoning – aimed at reducing preventable readmissions. Much of this activity, however, is not well-coordinated and may be duplicative. In spite of this, these efforts share a number of intervention components, including coordination of care; post-discharge phone calls to the patient; medication reconciliation; and a robust role for transitional nurses or other professionals such as social workers.

The consensus view is that collaboration among hospital systems, health plans, and health care purchasers should include more experiments in innovative payment and clinical process redesign. In addition, there also appears to be a significant opportunity to engage physicians in dialogue regarding the practices and conditions that lead to readmissions as well as best practices for preventing such events.

It is too early to identify the most effective, sustainable, and replicable elements of readmission interventions. What is clear now, however, is that patients most prone to being readmitted are those with comorbidities, including mental health and substance use; complex living circumstances; cognitive impairment; and weak social supports.

Staff education and transformation of care processes are critical but are potentially at odds with deeply embedded practice patterns, requiring significant organizational change.

■ MEASUREMENT & ANALYTICS WORK GROUP

Each health system and health plan is taking a unique approach to reducing readmissions, complicating efforts to standardize measurement protocols and procedures.

Common concerns, however, include the need for collaboration so that health plans provide hospitals, upon readmission, with detailed information on the patient's prior history and treatment. Many stakeholders also note that senior leadership at both health plans and hospitals is essential to initiating and sustaining efforts to reduce readmissions.

Further progress can be made by standardizing readmission definitions and measurement time frames to allow apples-to-apples comparisons between conditions and hospitals. Consideration also should be given to complementary quality measures — such as considering increases in length of stay and observation days when evaluating readmission decreases — that paint a more complete readmissions picture.

Large, urban, academic medical centers that rely heavily on public payer reimbursement have taken lead roles in tackling preventable readmissions, largely in response to policy changes under federal health reform and other initiatives driven by the federal Centers for Medicare & Medicaid Services (CMS). More robust and specific collaboration between hospitals primarily reliant on private payments and those largely reimbursed by public payers would help promote alignment and send stronger signals to the rest of the market.

Stakeholders see opportunity for collaboration between health systems and health plans in prompt and effective intervention for patients identified as being at high risk for readmission.

■ SUSTAINABLE BUSINESS MODELS WORK GROUP

Stakeholders note the urgent need to align economic incentives because reducing readmissions under current payment systems results in financial loss. Rewarding value creation is crucial; moving reimbursement toward value-based payment arrangements is a meaningful first step. Stakeholders collectively suggest that efforts aimed at reducing readmissions must be replicable, generalizable, and sustainable.

Including readmission reduction quality measures in payment contracts has not yet gained wide prevalence in the New York metro region. However, employers indicate significant interest in collaborating with health plans to create value-based contracts that hold hospitals and health systems more accountable for the care they provide to their employees and dependents. Health plans caution that including incentives to meet readmission reduction targets must be part of a broader performance-based contract arrangement. Health plans recognize the value of reducing readmissions but acknowledge the challenges related to capital investment, program execution, claims adjudication, and changing provider behavior.

Lags in systems synchronization, communication, and data sharing between hospital systems and health plans hinder progress. Full availability of real-time information would allow for more effective measurement as well as streamlined clinical processes. It would also contribute to efforts aimed at developing effective cost-sharing differentiations and network tiering arrangements in benefit designs, among other alignments.

Health plans and employers agree that gain-sharing should be explored as a reimbursement scheme to incentivize collaboration and reduce preventable readmissions. They identify case management and disease management services as having the most potential for possible gain-sharing arrangements.

■ EMPLOYEE ENGAGEMENT WORK GROUP

Although employers are working to engage their employees in their health care, a lack of trust, especially of health plans, undermines employee engagement aimed at reducing readmissions. Employees may resist being engaged yet at the same time welcome assistance and guidance if the source is credible and trusted. Building trust is key to effectively engaging employees to take more control of their health.

Employers should engage with employees before they become ill, provide tools to help them understand how their health plans work, and inform employees of changes in how their care will be administered. Employers must also be more proactive with health plans in requesting data on readmissions rates and other quality indicators.

Like other stakeholders, employers struggle to determine their return on investment on readmissions-focused outreach. Efforts are complicated by employers not having sufficient data from health plans regarding the details of their outreach efforts and the types of employees who have been targeted. Employers also experience coding and reimbursement problems with their health plan regarding whether outreach services are defined as a wellness/preventive benefit or a tactic specific to a readmissions reduction initiative, and thus whether to selectively target outreach efforts or to apply them broadly.

Key recommendations and next steps

LOOK BEYOND CLINICAL PROCESS IMPROVEMENT

Achieving reductions in preventable readmissions requires looking beyond clinical process improvement strategies to other important issues that are typically not addressed in the literature. Among these are to: obtain a deep understanding of how patients' sociopsychological characteristics and socioeconomic circumstances affect readmission patterns; create more effective and timely data linkages among stakeholders; formulate a tangible connection between employee engagement and clinical outcomes; and develop a sustainable economic model.

EXPLORE SPECIFIC OPPORTUNITIES FOR MULTISTAKEHOLDER COLLABORATION

Since most readmission reduction programs now operate in silos, future industry work should explore specific opportunities for multistakeholder collaboration, especially between hospital systems and health plans. A detailed investigation should be conducted into stakeholders' desired clinical, measurement, business model, and patient engagement components in order to create a replicable, generalizable, and sustainable model. Development of such a prototype — one that finds common ground among many competing interests and fosters a team-based orientation — could serve as a launching pad for future collaborative work.

With evidence showing that many readmissions can be prevented, momentum to curb readmissions is strong and strategies to prevent readmissions are being refined. Employers are eager to contribute and are considering increased employee engagement in activities to prevent readmissions. Health plans are investing in resources and infrastructure to address the problem in multiple locations and among diverse populations. Given the resource-intensive nature of readmission prevention initiatives, it was acknowledged generally that health plans and hospitals need to be working toward integrating models that avoid duplication and introduce both clinical and administrative efficiencies.

Early results from these efforts show great promise and provide encouragement to additional projects underway. The time appears ripe to harness stakeholder expertise to set and reach achievable goals in reducing readmissions. Ultimately, care will be better coordinated, clinical outcomes will improve, the burden on patients and caregivers will lessen, and health care cost growth will be impacted. These are outcomes all stakeholders can agree on.

INTRODUCTION

11

Unnecessary and potentially preventable hospital readmissions are costly and occur frequently, with employers bearing much of their direct and indirect costs. Patients are often readmitted following preventable clinical complications, patient or caregiver confusion regarding the care process, hospital-acquired conditions, medication errors, and lack of caregiver readiness to support a discharged patient in the home setting. Because of these significant gaps in the quality and coordination of care that lead to excessive expenditures, preventable readmissions have become prime targets in efforts to improve care and reduce costs, and employers have made addressing readmissions a top priority.

Nationally, nearly 20% of Medicare patients are readmitted to a hospital setting within 30 days of discharge.¹ Commercially-insured patients are readmitted at unacceptably high levels as well.² All together, these events cost an estimated \$25 billion per year, accounting for an ever-increasing segment of the nation's health care expenditures.³

Private sector stakeholders and policymakers — at both state and federal levels — have mobilized to tackle readmissions head-on, and the future appears promising. In the last five years, the industry has made efforts not only to reduce readmissions, but also to reengineer the clinical and administrative processes underlying the events that often trigger a readmission. Early results show progress. One study demonstrated that across all insured populations, improved intake procedures and reformulated, standardized discharge processes can reduce total readmissions by 12%.⁴ In the policy arena, the Patient Protection and Affordable Care Act (PPACA), the federal health reform package that was made law in 2010, includes multiple initiatives aimed at stemming preventable readmissions across the country.

We report here on a recent investigation by Northeast Business Group on Health into local and regional stakeholders' perspectives, insights, and concerns related to preventable hospital readmissions. We set out to investigate:

- **What are industry stakeholders doing to tackle preventable readmissions locally, regionally, and nationally?**
- **What kind of collaboration related to reducing preventable readmissions is most effective, and what is the opportunity for further and more robust partnership?**
- **What factors contribute to the success or hinder the progress of efforts to reduce readmissions?**
- **How do employers perceive the issue of preventable readmissions and are they ready to make it a major focus?**

Following a brief review of the data in the literature and a scan of initiatives to reduce readmissions, findings from our interactive engagements with health systems, health plans, employers, and other stakeholders over the course of six months are presented. These included workshop meetings, multistakeholder roundtables, surveys, and one-on-one interviews. Concluding the report are recommendations for making further progress in this arena regionally and nationally. Finally, an appendix to the report profiles a number of local and regional efforts — by health systems and health plans — aimed at reducing preventable readmissions.

SECTION I: BACKGROUND

The costs and frequency of preventable readmissions have been well documented. A seminal 2009 study found that approximately 20% of Medicare patients discharged from hospitals are readmitted within 30 days, and 34% are readmitted within 90 days.⁵ The Medicare Payment Advisory Commission (MedPAC) contends that 76% of these readmissions are potentially preventable.⁶ Curbing these dangerous events could save \$15 billion in Medicare spending alone.⁷

Preventable readmissions are also burdensome to employer purchasers. Although patients with private insurance are less likely to experience a readmission than those with public health insurance, the cost of readmitting commercially insured patients is higher because of higher commercial payment rates.⁸ Eight percent of hospital stays in New York State in 2008 that were paid by private insurance resulted in a readmission, which accounted for 16.5% of total readmissions. Payments for these readmissions cost private payers, including employers, \$568.9 million, or 15.2% of the state's total readmissions costs.⁹

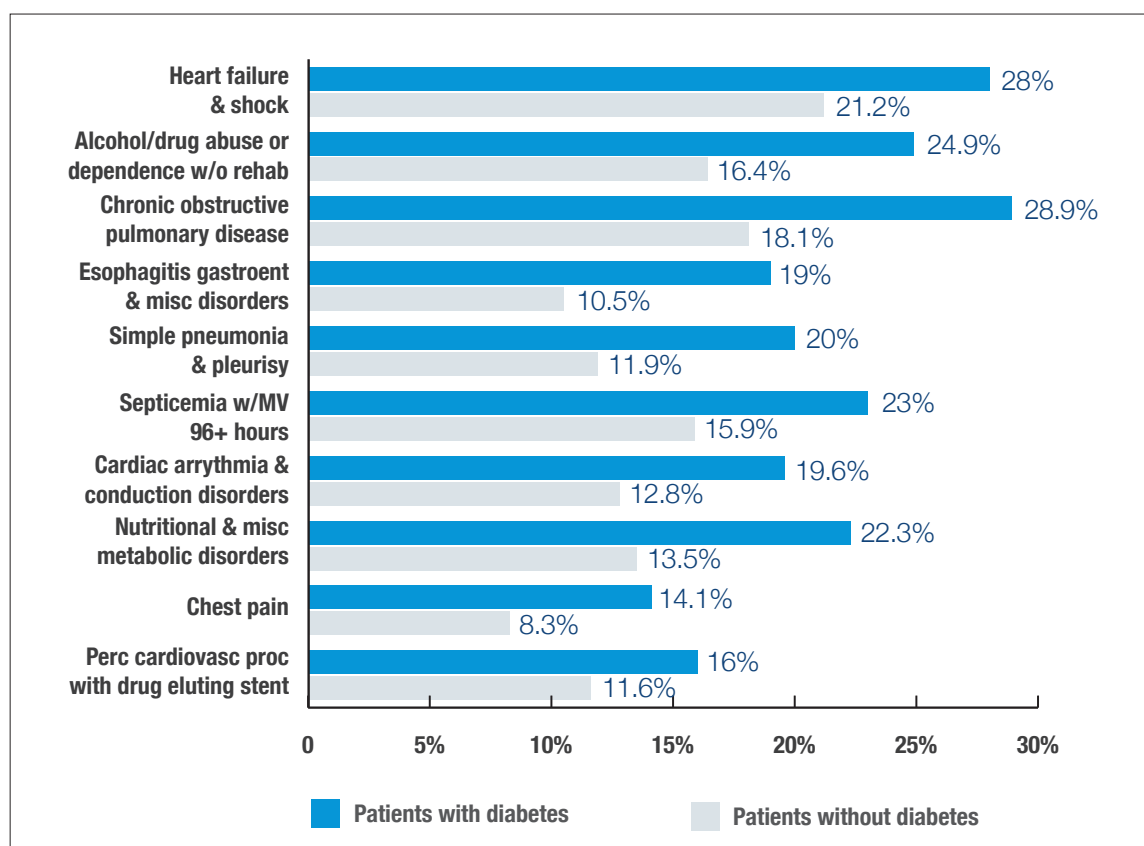
The three conditions associated with the highest rates of preventable readmissions — congestive heart failure, diabetes, and chronic obstructive pulmonary disease (COPD) — significantly affect the working population.^{10, 11, 12} COPD, for instance, is the third-leading cause of readmissions—with a 20.5% 30-day readmission rate. Even more troubling is that 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.¹³ Employers also pay for these readmissions indirectly in reduced productivity, presenteeism — when employees are at work but not fully engaged — and absenteeism.

Patients with chronic conditions are at higher risk for experiencing a preventable readmission than those without a chronic condition. Diabetics exemplify this. Among the top 10 Diagnosis Related Groups (DRGs), readmission rates are higher for diabetes patients than those without diabetes (Figure 1). After congestive heart failure, diabetes is the second most common diagnosis associated with unscheduled readmissions. Its 90-day readmission rate is 26.3%, of which 87.2% are unscheduled.¹⁴ New York's overall readmission rate closely mirrors the national rate; the 2009 rate for patients with diabetes was 25.6%, far higher than the 10.6% rate for non-diabetic patients.¹⁵ Older workers are especially vulnerable. Individuals aged 50–64 with diabetes as a primary or secondary diagnosis have a 20.16% chance of experiencing an unscheduled readmission.¹⁶ New York-specific data follows this national trend. Patients with diabetes are generally 2.4 times more likely to be readmitted for any reason than patients without diabetes.¹⁷ Perhaps not surprisingly, privately insured patients with diabetes have a somewhat lower risk for unscheduled readmission than patients with public health insurance (25.05% for Medicare beneficiaries and 27.03% for Medicaid beneficiaries), although the figure (15.54%) still affords much room for improvement.¹⁸



Patients with diabetes are generally 2.4 times more likely to be readmitted for any reason than patients without diabetes.

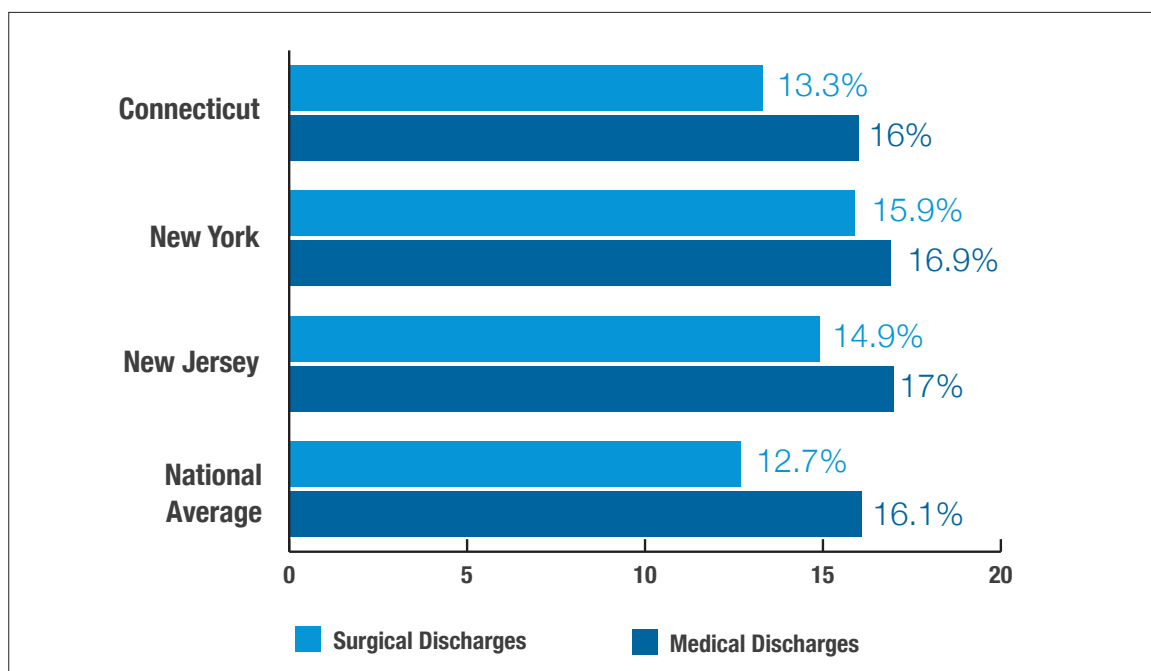
FIGURE 1: Readmission rates of the ten most commonly admitted diagnosis-related groups (DRGs), 2008



Source: SPARCS data, Dec. 1, 2007 - Dec. 31, 2008. Excludes rehabilitation, neonates, obstetrics, and transfers. Adapted from: Slide presentation from "Western New York Hospital Readmissions Summit." June 15, 2011.

The New York metro region's poor performance in readmission rates is particularly alarming. A 2009 state scorecard study by the Commonwealth Fund reported that New York, New Jersey, and Connecticut perform poorly when it comes to avoidable hospital use and costs. Among the 50 states, New York ranks last, New Jersey follows closely at 48th, and Connecticut comes in at 32nd.¹⁹ Among Medicare beneficiaries in 2009, New Jersey has the second-highest 30-day medical discharge readmissions rate in the country (following only West Virginia) at 17%, and New York follows closely with a rate of 16.9%. Connecticut performs marginally better, with a rate of 16%. The national average medical discharge readmissions rate is 16.1%.²⁰ For surgical discharges across all 50 states, New York scores worst, with a 30-day readmission rate of 15.9%, New Jersey ranks second-worst at 14.9%, and Connecticut ranks ninth-worst at 13.3%. The U.S. average rate for 30-day surgical discharge readmissions is 12.7% (Figure 2, next page).²¹

FIGURE 2: Surgical & medical discharge readmission rates in New York, New Jersey, & Connecticut, 2009



Other sources support these conclusions. A recent report commissioned by the New York State Health Foundation and conducted by Mathematica Policy Research found that across all payers, New York State's 30-day readmission rate in 2008 was 14.6%. These payments to hospitals amounted to \$3.7 billion and accounted for 16% of their total payments.²² However, hospitals vary widely in their readmission rates. Adjusted for case mix, 9% of hospitals account for over 50% of the state's readmission rate average.²³

The scenarios documented above clearly point to an opportunity for improvement, both nationally and regionally.



Patients often are at risk for readmission while in transition between sites of care, that is, when a patient is transferred from one care setting to another.

Transitional care: A method for preventing unnecessary readmissions

15

Patients often are at risk for readmission while in transition between sites of care, that is, when a patient is transferred from one care setting to another.²⁴ Examples of these transitions include hospital to home, rehabilitation facility to skilled nursing facility, and home care agency to hospital. Transitions from hospital to home have been associated with the highest number of emergency department (ED) visits and preventable readmissions.²⁵ These increase costs for employers because of excessive ED utilization and other avoidable care encounters. In addition to their high costs, readmissions reflect gaps in quality, which can lead to higher rates of presenteeism and absenteeism.

Ideally, transitional services promote continuity of care across multiple sites of care, avoid preventable poor outcomes, and ensure timely patient transfers.²⁶ Successful transitional services target highly vulnerable, chronically ill patients and emphasize patient and family caregiver education.²⁷

Industry efforts to reduce readmissions build on several successful models that follow practices proven to reduce readmissions. These practices include changing admission procedures, enhancing discharge processes, improving follow-up care, enhancing technology interventions, reforming provider payment, and expanding quality measurement.²⁸ Although initially focused on older patients, the application of these practices has evolved to include other segments of the population, as illustrated in the appendix to this report. Table 1 on the next page presents the key components of some of these models.

How the Tri-state region fares in reducing readmissions.

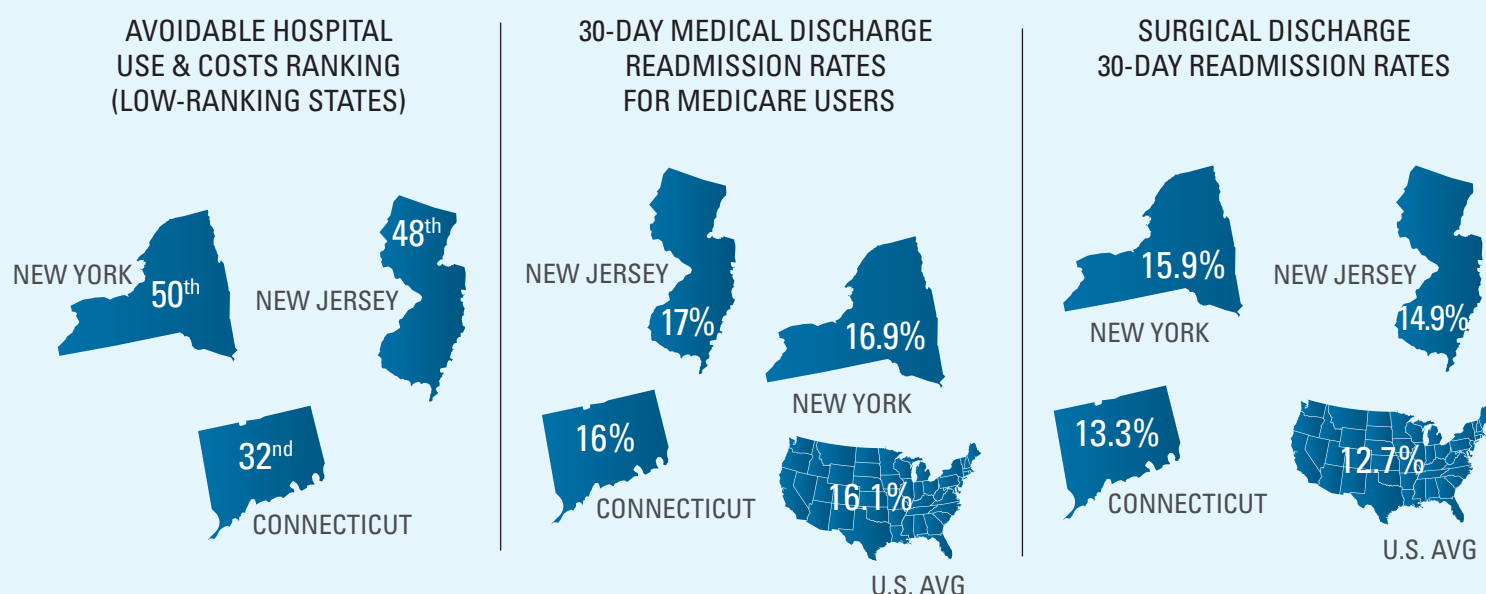


Table 1: Transitional Intervention Models for Reducing Preventable Readmissions

Model	Patient Population	INTERVENTION COMPONENTS			Core Care Components
		In-hospital Patient Advocate	Post-discharge Follow-up	Medication Reconciliation	
Transitional Care Model ("TCM," Naylor Model)	Aged 65+ with chronic conditions or surgery	Advanced practice nurse visits	Advanced practice nurse visits patient in home 1-3 days post-discharge, follow-up phone calls and comprehensive clinical management for 60-day period	Yes	Self-management skills, symptom identification, care coordination, patient-centered health record
Care Transitions Intervention (Coleman Model)	Aged 65+ with high-risk conditions	Coach makes at least one in-hospital visit to introduce Coleman model	1 nurse visit and 3 follow-up phone calls	Yes	Focus on chronic illness, risk screens, root cause analysis
Better Outcomes for Older Adults through Safe Transitions (BOOST)	Aged 65+	Clinical care team	Follow-up visit and 72-hour phone call post-discharge if patient is high risk	No	"Teach-back" education, use of family caregivers
Project RED (Re-Engineered Discharge)	All ages	Nurse discharge advocate	Pharmacist phone call 2-4 days post-discharge plan and problem solve	Yes	"Teach-back" education, pharmacist engagement

Adapted from Chollet, D., Barret, A., & Lake, T. *Reducing Hospital Readmissions in New York State: A Simulation Analysis of Alternative Payment Incentives*. Mathematica Policy Research. 2011; and Osei-Anto, A., Joshi, M., Audet, A.M., Berman, A., & Jencks, S. *Health Care Leader Action Guide to Reduce Avoidable Readmissions*. Health Research & Educational Trust. Chicago. January 2010.

SECTION II:

POLICY & LEGISLATIVE ACTION: CURBING PREVENTABLE READMISSIONS THROUGH PAYMENT REFORM

Payment reform is a top priority in the effort to transform the nation's health care system into one that rewards value and not volume, and quality instead of quantity. Policymakers have viewed payment reform as key to reducing preventable readmissions. Most recently, federal policymakers included several provisions in the ACA that will cut reimbursements to hospitals with high rates of readmissions. This attention to preventable readmissions is not new. In past years, other bodies that influence legislation and policy-making have noted the urgency of reducing preventable readmissions. The National Quality Forum (NQF), for instance, in July 2008 adopted two hospital performance measures tied to readmission rates; the Centers for Medicare & Medicaid Services (CMS) — the arm of the federal government that administers both public health insurance programs — expressed interest in incorporating readmission rates into a pre-ACA value-based hospital payment scheme;²⁹ and in setting an agenda for federal health reform, President Obama incorporated readmission reductions into a February 2009 proposal to pay for health reform.³⁰

Affordable Care Act: shifting financial incentives to reduce readmissions

The ACA created two programs intended to reduce preventable readmissions. Starting in October 2012 — the beginning of the 2013 federal fiscal year — the Hospital Readmissions Reduction Program (HRRP), under section 3024 of the ACA, will reduce hospitals' payments for "excess" readmissions attributed to three clinical conditions — heart failure, acute myocardial infarction (AMI, or heart attack), and pneumonia. Payments will be reduced 1% in 2012, 2% in 2013, and 3% in 2014. Beginning in 2015, the Secretary of Health & Human Services can expand the number of conditions scrutinized by the program to include COPD, coronary artery bypass grafts, percutaneous coronary angioplasties, and "other" vascular surgeries, among other conditions. Hospitals' readmission rates will be made available on the Hospital Compare website, a website managed by CMS that tracks and reports on a range of hospital performance measures.³¹ The Congressional Budget Office, the independent budget scorekeeper for government-based programs, estimates that the HRRP will save the Medicare program \$7.1 billion over the next seven years.

The second ACA program aimed at tackling preventable readmissions — and reducing overall Medicare costs — is the Community-Based Care Transitions Program (section 3026 of the ACA). This five-year, \$500 million initiative provides funding to community-based organizations located across the country charged with partnering with hospitals in reducing

readmission rates for high-risk Medicare beneficiaries. Patients 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 – associated with hospital readmissions will be targeted for inclusion. A number of care coordination and transition services can be delivered under this program. These include post-discharge follow-up to educate patients and their caregivers about responding to their health symptoms; providing self-management support; conducting medication reviews, counseling, and management support; and providing assistance to ensure effective and timely interactions between patients and primary care providers.

These ACA-based readmission reduction programs strike at the core of the readmissions problem. They seek to realign misaligned economic incentives that encourage readmissions and break down barriers to hospital collaboration with various community partners in an attempt to develop readmissions reduction models that are clinically effective and financially sustainable.

Partnership for Patients

Shortly following the passage of the ACA, the Obama Administration launched a public-private partnership aimed at aligning efforts to “help improve the quality, safety and affordability of health care for all Americans.” Among other goals, Partnership for Patients, a \$500 million patient safety initiative, seeks to reduce 30-day preventable hospital readmissions in 2013 by 20%, as compared to 2010 rates. This would equate to 1.6 million preventable readmissions and potential savings of \$35 billion. As of June 2012, more than 7,500 partners, including over 3,200 hospitals as well as physicians’ and nurses’ groups, consumer groups, and employers, have pledged their commitment to the Partnership for Patients.

SECTION III:

PAY FOR VALUE TO REDUCE READMISSIONS

19

The health care system must pay for what works. The current system of fee-for-service reimbursement does not pay for strategies that have proven helpful in reducing preventable readmissions, including the use of care transition coaches and nurse care managers, telemonitoring to identify patient problems before a readmission is necessary, and post-discharge phone calls by physicians. Instead, hospitals are paid based on the number of patients they admit/readmit. In this revenue arrangement, incentives are misaligned.

Hospitals and physicians must not be penalized for implementing and sustaining programs that reduce readmissions. Many have championed reconfiguring providers' financial incentives as an effective way to encourage practices that reduce preventable readmissions. Broad policies that hold promise include:³⁴

- Payers sharing with hospitals and physicians the net financial savings earned from reducing preventable readmissions
- Encouraging private payers to align their efforts with Medicare's policy of reducing payments if an acceptable readmission rate is not achieved
- Using alternative, innovative payment models, such as bundled payments, to cover an entire episode of care and consequently both fund and incentivize coordination of care
- Encouraging reimbursement for intervention investments, such as hiring readmission case managers

A number of specific payment reform approaches that seek to reduce preventable readmissions have been advanced.³⁵ Several of these innovative payment models are outlined in the box on the next page.

Another major lever employers bring to bear is their ability to contract with health plans and their provider networks. Generally, employers should be aware that a variety of tactics can be leveraged to promote high-value care. Many of these involve steering employees to high-quality providers and/or integrating cost-sharing incentives into employees' benefit designs. A sampling of these "quick tips" is in Table 2.



TABLE 2:

Contracting "Quick Tips"

1. Pursue contracting that promotes patient safety and quality care protocols and uses high-performance networks.
2. Send patients to designated centers of excellence.
3. Offer lower cost-sharing for employees who obtain care at high-performing hospitals and provider groups.
4. Adopt performance-based contracting and public reporting of physician-specific, patient risk-adjusted readmission outcomes.
5. Pay bonuses for physician participation in quality and safety initiatives.
6. Request documentation of providers following best practice guidelines.

Innovative payment models

Episode-based payments

Also referred to as “bundled payments,” this payment strategy bundles a lump-sum amount around a set of services related to a patient’s single illness or condition — coronary artery bypass surgery, for instance — including inpatient services and outpatient services.³⁶ Physicians take on the financial risk of providing care from the beginning of an episode to its end, including care following a readmission. A 2009 RAND report contends that offering a group of providers a single reimbursement strengthens their incentive to coordinate a patient’s care and can reduce national health spending by 5.4%.³⁷ Geisinger Health System’s ProvenCare program has popularized this method with its flat fee episode payment for all related care provided 90 days after receiving coronary artery bypass surgery, including complications and readmissions.³⁸ The Center for Medicare and Medicaid Innovation, newly established under the ACA, is set to launch a “Bundled Payments for Care Improvement” program in 2012 based on these principles. These “bundles” of reimbursement will include physicians’ services, care by a post-acute provider, and related readmissions.³⁹

Comprehensive care payments/global payments

This approach is a modified capitated payment scheme in which providers are paid a condition- and risk-adjusted payment over a given period of time (usually 1 year), regardless of how many hospitalizations or readmissions are needed.⁴⁰ Unlike traditional capitation arrangements, providers do not have the incentive to avoid treating sicker patients since payment rates are adjusted for patient severity. However, like traditional capitation arrangements, physicians are still incentivized to avoid unnecessary services and procedures. One prominent example of this approach is Blue Cross Blue Shield of Massachusetts’s Alternative Quality Contract (AQC). In the program’s first year, “AQC provider groups improved their hospital readmission rates more than non-AQC groups, a decrease equivalent to \$1.8 million in avoided readmission costs for the AQC groups.”⁴¹

Shared savings programs/accountable care organizations

Under gain-sharing programs such as the Medicare Shared Savings Program, hospitals and physicians determine the potential cost savings achievable for specific conditions while maintaining and improving quality of care. One prominent example is the Medicare Shared Savings Program, established by the ACA. As is the case in Medicare’s Physician Group Practice (PGP) Demonstration, providers are paid on a fee-for-service (FFS) basis and the accountable care organization (ACO) — the collection of entities jointly responsible for a patient’s care, including any readmissions — receives a bonus if patients receive care at below projected costs, assuming quality standards are maintained. The savings achieved are distributed as payouts to each participating physician.

SECTION IV:

21

NEBGH EMPLOYER SURVEY: READMISSIONS ARE A TOP PRIORITY

In an October 2011 survey of NEBGH employer members aimed at gauging their views on preventable readmissions, the majority (56%) noted that reducing preventable readmissions is a top priority and believed strongly that they should be actively engaged in efforts to reduce preventable readmissions. However, they recognize that their employees do not share this priority, highlighting the need for more robust employee engagement. Most employers (75%) acknowledge that employee education and engagement around preventable readmissions is essential to slowing the growth of health care costs. Moreover, almost all employer respondents (94%) believe their contracted health plans should take a lead role in educating employees about reducing their chances of being readmitted. Collaboration among stakeholders is integral to reducing readmissions. Yet employers indicate that they are unsure whether their health plans and their network providers are engaged in efforts to reduce preventable readmissions. The majority (68%) of employers report that their health plans do not provide them with data on their population's readmission rate(s), with a small segment unsure if their health plans are even capable of providing such information. Sixty-three percent of employers believe that value-based purchasing strategies, as well as innovative payment models, are vital to reducing preventable readmissions.

Of the employers tapped to participate in the survey, 16 responded. While perhaps lacking statistical validity, the responses nonetheless offer initial insights into employers' perspectives and concerns. These reinforce the theme that emerged from other work conducted as part of this project: that multistakeholder collaboration is essential to reducing preventable readmissions, an area many stakeholders believe is ripe for improvement.



Preventing readmissions:

Tips for getting safe and value-based hospital care the first time around

PREPARING FOR THE VISIT

1. Identify hospitals in your area that are high-performing relative to your procedure or condition.
2. Ask your nurses and doctors questions about what to expect before, during, and after the procedure.
3. Bring with you updated documentation of your current list of medications, allergies, medical history, and any advance directives.
4. Plan ahead for the day. Make sure someone is scheduled to pick you up from the hospital, and that you'll know where you're going following your procedure.

Adapted from: HealthGrades 2011 Healthcare Consumerism and Hospital Quality in America Report. Health Grades, Inc. 2011. Available at <http://www.healthgrades.com/business/img/HealthcareConsumerism-HospitalQualityReport2011.pdf>

BE ATTENTIVE WHILE IN THE HOSPITAL

1. Have an advocate — a friend or family member — with you whenever possible to ensure your care is safe and according to plan.
2. At each step of care, ask questions about what's happening and about each medication when it is being administered.
3. Avoid patient mix-ups by making sure hospital staff are asking for your name and checking your ID band before administering any procedure or medication.
4. Pay attention to staff hygiene. Ensure hands are washed or in a clean pair of disposable gloves before they touch you.
5. Make a follow-up appointment with your doctor before you leave the hospital.
6. Ask your doctors and nurses about your discharge process and procedures before they're initiated.

SECTION V: MULTISTAKEHOLDER WORK GROUPS ADDRESS PREVENTABLE READMISSIONS

Following a multistakeholder roundtable, four work stream groups formed to further explore and define a set of issues related to preventable readmissions. These multistakeholder groups — composed of representatives from health systems, health plans, employers, and other stakeholders — were segmented as follows:

- Clinical Process Improvement
- Measurement & Analytics
- Sustainable Business Models
- Employee Engagement

At these meetings, stakeholders shared their concerns, progress to date in various initiatives, lessons learned, tips for success, and future directions related to their efforts to reduce readmissions.

Clinical process improvement work group

Hospitals and health plans are engaged in limitedly collaborative efforts, which are occurring in parallel with each other, aimed at reducing preventable readmissions. While these projects vary in scope and future directions, they share a number of intervention components, which include coordination of care; post-discharge phone calls to the patient; medication reconciliation; and a robust role for transitional nurses or other professionals such as social workers. The urgency to design effective readmission reduction strategies is amplified by the ACA's Medicare Hospital VBP program and Hospital Readmission Reduction program, two initiatives that will, beginning in 2012, cut reimbursement to hospitals with high preventable readmission rates. Stakeholders suggest that the extent and vigor of a hospital's efforts to reduce readmissions generally correlate with its particular payer mix as well as its baseline deviation from national and regional readmission rates.

REDUCING READMISSIONS IS COMPLEX; A SUSTAINABLE BUSINESS MODEL IS ELUSIVE

Stakeholders suggest that it is too early to identify the most effective, sustainable, and replicable elements of readmission interventions. They note, however, that patients most prone to being readmitted are those with comorbidities, including mental health and substance use; complex living circumstances; cognitive impairment; and weak social supports. Success and progress depend largely on the extent and quality of targeted staff education on reducing readmissions as well as evaluating patients' readmission risk. Staff education and transformation of care processes, while viewed as critical, are labor- and cost-intensive, are potentially at odds with deeply embedded practice patterns, and require significant organizational change. Stakeholders expressed that many physicians still believe that frequent admissions of patients is the best form of care. There is also uncertainty among stakeholders about the number and types of conditions that should be targeted for readmission rate reductions as well as what target reduction rates should be. Different providers/hospitals have different

goals. Myriad factors go into setting these objectives and expectations, including varying baseline readmission rates, payer mix, and patient population demographics.

COLLABORATION & COOPERATION ARE INTEGRAL TO PROGRESS

Stakeholders strongly assert their desire — and the urgent need — for more robust collaboration across and within stakeholder groups. The consensus view is that collaboration among hospital systems, health plans, and purchasers should include more experiments in innovative payment and clinical process redesign. There also appeared to be a significant opportunity to engage physicians in dialogue regarding the practices and conditions that lead to readmissions as well as best practices for preventing such events. Stakeholders' efforts have been advanced by internal organizational research that seeks to understand and address the factors that trigger readmissions. Electronic medical records that include readmissions-related information embedded in patients' records have been important to many of these initiatives, but by no means are solutions in themselves. More specific suggestions from stakeholders for how health plans could augment hospital systems' efforts to reduce readmissions include: supplying patients' diagnoses, recent treatment actions, and other relevant information from their primary care providers electronically to the hospital upon admission; regularly reporting occurrence and rate-based data related to readmissions; and redeploying, or sharing, various resources — such as medication reconciliation services, follow-up appointment management, and post-discharge phone calls—all techniques already being used by health plans to help providers manage their patients' navigation of the health care system.

Measurement & analytics work group

Each health system and health plan is taking a unique approach to reducing readmissions to align with its revenue goals and meet the needs of its patient population. This variation complicates efforts to standardize measurement protocols and procedures across stakeholder groups. Nevertheless, work group members share common concerns.

Stakeholders suggest the need for more precise patient attribution. Hospitalized patients often transition between multiple care settings — hospitals, primary care physicians, and home care, for instance — during their course of treatment. When being readmitted, patients sometimes receive care from hospitals and physicians that didn't treat them during their initial, or "index," hospital admission. Systems that track and measure the quality and cost of care, and store this information, should be configured to report which provider supplied which medical or readmission reduction services at any given stage of treatment. Yet this is not always the case. Health plans, however, bring to bear the data analytics and systems to identify potentially at-risk patients and the ability to attribute readmissions to the discharging physician, hospital, or facility. Hospitals note that sharing of these resources is another opportunity for collaboration with health plans. Hospitals suggest that health plans could augment hospital efforts by providing them, upon readmission, detailed information on the patient's prior history and treatment related to the index admission. If this were to happen,



The consensus view is that collaboration among hospital systems, health plans, and purchasers should include more experiments in innovative payment and clinical process redesign.

hospitals could be better equipped to tailor patients' readmission reduction strategy rather than providing a one-size-fits-all solution that may or may not be the best fit for every patient.

Many stakeholders note that senior leadership is essential to initiating and sustaining efforts to reduce readmissions. Changing market dynamics and payment structures are likely to generate new demand for a variety of resources, from upgraded health information technology to additional personnel. Support from the top has been a key ingredient in tackling the resource needs of readmissions reduction efforts.

The preferred time unit of measurement among most stakeholders is 30 days. However, some are tracking 60- and 90-day readmission rates. Progress in defining readmissions can be made by using common exclusion criteria and standardizing readmission definitions to allow apples-to-apples comparisons between conditions and hospitals. Consideration also should be given to complementary quality measures that paint a more complete readmissions picture. These might include considering increases in length of stay and observation days when evaluating readmission decreases as well as medication fill rates in conjunction with fluctuations in readmission rates.

ENVIRONMENT & REVENUE SOURCES DETERMINE ENTHUSIASM FOR READMISSION PROJECTS

Hospital systems approach projects to reduce readmissions with varying degrees of enthusiasm, often tied to the prevailing payment model. Those that rely on predominantly private payers are reluctant to take the lead in these efforts because excess costs to reduce readmissions are often not reimbursed for, and moreover, reducing readmissions reduces revenue. On the other hand, large, urban, academic medical centers that rely heavily on public payer reimbursement have taken lead roles in tackling preventable readmissions, largely in response to policy changes under the ACA and other CMS initiatives. Health plans suggest that readmissions are not a significant source of revenue since they usually involve nonsurgical medical complications that yield little revenue. In current efforts, hospitals and health plans differ in how they identify and target at-risk patient populations. More robust and specific collaboration between these two stakeholder groups would help promote alignment.

FUTURE DIRECTIONS: STRONG COLLABORATION TO STREAMLINE & SYNERGIZE EFFORTS

It seems clear that health systems can reduce readmission rates by improving existing discharge planning programs. Stakeholders see opportunity for collaboration between health systems and health plans in prompt and effective intervention for patients identified as being at high risk for readmission. Collaboration among hospitals and health plans could accelerate these efforts, enhance their cost-effectiveness, and reduce duplication of effort. Hospitals emphasize focusing on mental health comorbidities and social supports in addition to physical health indicators. Stakeholders also emphasize growing interest in participating in shared savings programs and expanding health information exchanges to augment these activities.



Support from the top has been a key ingredient in tackling the resource needs of readmissions reduction efforts.

Sustainable business models work group

25

To follow practices that benefit all stakeholders — and provide the best care to patients — hospitals face a dilemma. They are making crucial efforts to reduce readmissions in the context of conventional — predominantly fee-for-service financial models with unclear and unpredictable returns on investment. Many of the interventions that hospitals have adopted to reduce readmissions are only partially reimbursed, for example, hiring a nurse care manager to follow-up after hospitalization to review and reinforce education provided during hospitalization, monitor adherence to care plan, and address any acute issues that might lead to readmission. Stakeholders note the urgent need to align economic incentives because reducing readmissions under current payment schemes results in financial loss. Rewarding value creation is crucial; moving reimbursement toward value-based payment arrangements is a first step. Budgeting appropriately for readmissions reduction interventions is, although critical, still a work in progress. Determining how much is spent upfront on such interventions may be relatively straightforward; what's difficult is determining the return-on-investment of readmissions reduction efforts. These interventions likely decrease total care costs and reduce readmission rates, but stakeholders suggest that at this point the cost, especially when taking into account penalty avoidance, is obscure.

MAKING PROGRESS IN VALUE-BASED PURCHASING AND COLLABORATIVE EFFORTS

Including readmission reduction quality measures in payment contracts has not yet gained wide prevalence in the region. Most readmission reduction projects are pilot programs and few health plan contracts with employers include provisions related to reducing preventable readmissions. However, employers indicate significant interest in collaborating with health plans to create value-based contracts that hold hospitals and health systems more accountable for the care they provide to their employees and dependents.

Health plans indicate they are ready and willing to contract with hospital systems based on value and reaching performance goals but that most employers are still purchasing health care based on discounts and that performance targets are not incorporated into contracts. Plans contend that rapid progress in this arena could be made if employer purchasers gave a clear and robust signal that they are prepared to move to value-based contracting. However, health plans caution that a value-based payment model devoted strictly to reducing readmissions would not likely be effective. Instead they suggest that incentives to meet readmission reduction targets be part of a broader performance-based contract arrangement.

In the meantime, health plans indicate that their long-term strategy for reducing readmissions rests in part on providing coordinated care that includes patient-centered medical homes and case management, among other models.



Health plans suggest including incentives to meet readmission reduction targets as part of a broader performance-based contract arrangement.

Health plans recognize the value of reducing readmissions but acknowledge the challenges identified by health systems: capital investment requirements, program execution, claims adjudication, and changing provider behavior.

SYSTEM SYNCHRONIZATION: ALIGNING STAKEHOLDER ACTIVITY

Lags in system synchronization, communication, and data sharing between hospital systems and health plans hinder progress. Hospital systems often make improvements in systems and care processes, yet the results are often not recognized in health plans' data tracking systems until many months later. Thus, it is difficult for a hospital to evaluate the effectiveness of its efforts, especially since quality standards are constantly changing.

Hospitals and employers report they sometimes question the transparency and number of performance indicators and quality metrics supplied by health plans. Full availability of real-time information would allow comparisons of hospitals and physicians and provide data in order to develop effective cost-sharing differentiations and network tiering arrangements, among other alignments.

READMISSION REDUCTION THROUGH GAIN-SHARING

Health plans and employers agree that gain-sharing should be explored as a reimbursement scheme to incentivize collaboration and reduce preventable readmissions. Gain-sharing is viewed as a more favorable approach than direct financial penalties and other measures perceived as punitive. Employers and health plans see the most potential for gain-sharing in relation to case management and disease management services. Other avenues worth exploring include bundled payments involving both hospital and ambulatory services. Standardized readmission metrics, such as those proposed by the National Quality Forum, could serve as the basis for negotiations.

Employee engagement work group

Employers are working to engage their employees in their health care. Initiatives vary in their scope and objective. Some are multiyear efforts, and others are short-term and targeted at a narrow population or specific condition. Engagement techniques include 24/7 help lines, customized case management systems, the distribution of educational materials, and incentivizing the completion of health risk assessments. In some instances, employees are accustomed to regularly interacting with their health plan, and in others, employees view health plans with suspicion and distrust. A lack of trust, especially of health plans, undermines employee engagement activity aimed at reducing readmissions. Employees often resist being engaged yet at the same time welcome assistance and guidance if the source is credible and trusted. One example provided by employers is when health plans call employees with important follow-up information or assistance. Employees, suspicious of the health plan's motives, typically spurn the outreach. But, employees who are actually engaged (i.e., pick up the phone and delve into the issue with the health plan) indicate their appreciation for the service(s). Health plans suggest that early experience with post-

discharge phone calls, when they reach the employees, shows that they are receptive to and grateful for the targeted follow-up and would recommend the service to others in a similar situation.

INTEGRATING READMISSIONS REDUCTION INTO CORPORATE HEALTH BENEFIT BUSINESS MODELS

Like other stakeholders, employers struggle to determine their return-on-investment on readmissions-focused outreach. Such efforts are complicated by employers not having sufficient data from health plans regarding the details of their outreach efforts, the types of employees who have been targeted, and discrepant definitions of “participant” and “engagement” in their health plan contracts. What a health plan may classify as actual engagement an employer may consider inadequate. Simply making contact with an employee – through an outreach phone call, for instance—may constitute “engagement” by a health plan, but would fall short of what an employer would classify as effective engagement. Before considering the outreach as actual engagement, the employer might first require the employee to take specific actions prompted by the health plan outreach. Employers and health plans also differ on whether outreach services are defined as a wellness/preventive benefit or as a targeted readmission reduction tactic. This discrepancy sometimes leads to confusion over whether the health plan should selectively target certain outreach efforts (if they are part of a readmissions reduction strategy) or apply them broadly (if considered a general wellness/prevention benefit). Regardless of how employee outreach services are categorized, especially as more costs shift to the employee, transparency is needed in how health premiums will be adjusted based on treatment choices and readmission rates.

BUILDING EMPLOYEE TRUST AND AWARENESS GOING FORWARD

Building trust is essential to effectively engaging employees to take more control of their health. A suggested strategy is for employers to build on the trust generated by employee engagement techniques they have used before, such as staff testimonials about the benefits of transitional care services. While employers need to make employees aware of their relatively new readmission reduction programs, employers face communication challenges including language barriers and cultural issues. Employers must also anticipate that employees may access care at hospitals outside the employer’s provider network. To meet some of these challenges, employers should engage with employees before they become ill, provide tools to help them understand how their health plans work, and inform employees of changes in how their care will be administered. Employers must also be more proactive with health plans in requesting data on readmissions rates and other quality indicators. The more engaged employers become, the more their employees and their health plans are likely to become involved in readmission reduction efforts.



The more engaged employers become, the more their employees and their health plans are likely to become involved in readmission reduction efforts.

SECTION VI: RECOMMENDATIONS & NEXT STEPS

Groundbreaking efforts point the way

In these work stream groups, stakeholders shared their comprehensive, sophisticated efforts aimed at reducing preventable readmissions. From suburban community hospitals to large, urban academic medical centers, health systems have taken leadership roles in initiatives that not only reduce readmissions, but also reengineer the clinical care processes and structures that underlie them. Health plans' groundbreaking efforts hold equal promise. Their reach across geographies, strong provider relationships, and data analytic capabilities are a solid base upon which to build. Although their processes are constructed to meet the unique needs of their patient population and business objectives, health systems and health plans share the goals of improving patient outcomes and creating sustainable models from which other systems may draw inspiration or replicate.

Look beyond just clinical process improvement strategies

ISSUES CENTRAL TO LONG-TERM SUCCESS

Creating successful, sustainable readmission reduction models requires a wide range of resources, strategies, and tested approaches. Many of these, most notably in the arena of clinical processes and analytics, have been described in the literature. Noticeably absent from the literature, however, are important administrative issues that this project highlighted. Among these is the need for:

- A deep understanding of how patients' sociopsychological characteristics affect readmission patterns
- More effective and timely data linkages among stakeholders
- A tangible connection between employee engagement and clinical outcomes
- The development of a sustainable economic model

These issues are central to ensuring the long-term success of activities that seek to reduce readmissions.



Successfully addressing readmissions must include a deep understanding of the complex clinical, social, economic, and cultural characteristics of patients and their caregivers.



Future industry work should explore specific opportunities for multistakeholder collaboration, especially between hospital systems and health plans.

Promote health plan & health system collaboration

BREAKING OUT OF SILOS

Achieving the objectives required for a successful readmissions reduction model is even more challenging when conducted in the absence of a proven business model. Impressive as they are programmatically, most readmission reduction programs operate in silos. Fragmentation and lack of coordination and collaboration across stakeholder groups are typical, which is unfortunate because health plan capabilities could augment health systems' efforts, and vice versa.

FINDING COMMON GROUND AMONG COMPETING INTERESTS

Future industry work in this arena should explore specific opportunities for multistakeholder collaboration, especially between hospital systems and health plans. A detailed investigation into stakeholders' desired clinical, measurement, business model, and patient engagement components for a replicable, generalizable, and sustainable model should be conducted. Development of such a prototype — one that finds common ground among many competing interests and fosters a team-based orientation — could serve as a launching pad for future collaborative work.

MYRIAD ACTIVITIES DEMONSTRATE COLLABORATION

This project has shined a light on many “on-the-ground” issues embedded in readmission reduction efforts. Each stakeholder interaction has demonstrated that collaboration — though rarely explored — is possible and achievable in myriad ways. Timely data sharing, patient monitoring and tracking, cooperative post-discharge coordination, formulation of common definitions and assumptions, creating streamlined health information exchange systems, development of standardized discharge procedures, and clearer discernment of stakeholder roles and expectations are examples of such collaborative activity.

THE TIME FOR COLLABORATION AND IMPROVEMENT IS RIPE

The future will need to blend the unique needs and goals of health systems, health plans, and employers to achieve system-wide readmission reduction ambitions. This exploration of regional initiatives and perspectives has set the stage. Robust and specific stakeholder cooperation is vital to accelerating progress. And clearly, the opportunity to do so is ripe.



This project highlighted important administrative issues that are absent from the literature. Among these are the need for a deep understanding of how patients' sociopsychological characteristics affect readmission patterns, more effective and timely data linkages among stakeholders, a tangible connection between employee engagement and clinical outcomes, and the development of a sustainable economic model.

APPENDIX:

REGIONAL READMISSIONS REDUCTION EFFORTS

EmblemHealth:

Transitions of Care & Point of Care

EmblemHealth's effort to reduce preventable readmissions is two-pronged and targets high-risk populations — members diagnosed with pneumonia, congestive heart failure, and those with comorbid conditions. Members enrolled in both public and commercial health plans are included. One initiative, referred to as *Transitions of Care*, was launched in late 2010 and leverages three distinct components:



1. For members undergoing elective procedures, pre-hospitalization services that include admissions procedures reviews, comprehensive discharge planning, and a post-discharge care needs assessment are provided;
2. Post-discharge phone calls that seek to assess unresolved questions and home care needs; and
3. Transitional nursing focused on the proper provision of home care, durable medical equipment, and case management for 30 days post-discharge.

Another initiative, *Point of Care*, is a pilot program that aims to provide comprehensive onsite discharge planning for patients in select outpatient medical clinics in Staten Island and Manhattan. These onsite teams of nurses, social workers, health navigators, and part-time pharmacists provide medication reconciliation services, medical and behavioral health assessments, and community resource referrals. EmblemHealth officials cite the onsite element as one that builds trust with members; catalyzes face-to-face interaction between the health plan, their members, and physicians; and facilitates more effective use of community-based resources. These efforts were launched in response to the urgent need to improve patient safety and quality, federal health reform, and opportunities to collaborate innovatively with other health industry stakeholders. Robust senior leadership and openness to collaboration on the part of partner stakeholders are cited as vital to success.

Empire BlueCross BlueShield

Spurred by organization-wide financial and clinical quality goals, Empire BlueCross BlueShield's (Empire) readmission reduction efforts are collaborative. Their layered approach harnesses the resources and expertise of its stakeholder partners across two separate initiatives. One is in the planning phase and, once implemented, will incorporate 12 hospitals in the New York metropolitan region reporting high preventable readmission rates. Identification of high-risk patients will augment provider provision of estimated discharge dates, comprehensive discharge plans, and post-discharge phone calls to members — made by Empire's transitions team—to assess needs and schedule follow-up appointments. The other initiative is a newly launched collaboration with the Visiting Nurse Service of New York (VNSNY) and White Plains Hospital, a member of the Stellaris Health Network. Once patients are discharged from White Plains Hospital, transitional nurses from VNSNY will provide self-



management, family engagement, and medication reconciliation services. In both instances, Empire is measuring 30-day readmission rates across all conditions, excluding maternity and pediatric cases. By risk stratifying patients according to their readmission risk and intensifying post-discharge phone calls, Empire is hopeful that these programs modernize previous standards of care, improve members' clinical outcomes, and drive down premiums.

Horizon Blue Cross Blue Shield of New Jersey



Horizon Blue Cross Blue Shield of New Jersey's (Horizon) enterprise-wide readmissions reduction effort aims to develop condition-specific readmission reduction strategies that further streamline clinical and process outcomes, enhance members' quality of life indicators, and mitigate cost increases. Spearheaded by the carrier's clinical operations team, this effort was launched in October 2011 as a response to employer demands for greater value, rising overall system costs, and federal health reform. The defining elements of the program include strengthening medication adherence, symptom identification, navigation of community services, and case management. Patients are actively engaged throughout their experience with the health system, as evidenced by Horizon's use of post-discharge phone calls as well as case management services for patients identified as being at high risk for a readmission. Collaboration among Horizon's utilization management, care management, medical management, and chronic care teams has proved integral to the project's initiation and maturation. Among their commercially-insured population, Horizon's readmission rate across their network hospitals for the eight months through August 2011 decreased from 9.0% to 6.9%. Horizon credits the success of their readmissions reduction activity to the local nature of the intervention; providing individualized care and planning; and establishing close partnerships with hospitals and providers.

Beth Israel Medical Center: *Project RED & Hospital at Home*



Beth Israel Medical Center's (Beth Israel) approach to reducing preventable readmissions is anchored in comprehensive care coordination, targets high-risk patients, and emphasizes post-discharge planning strategies. In 2010, this Manhattan-based hospital launched two readmissions reduction initiatives: Project RED and Hospital at Home. Project RED focuses on patients with congestive heart failure (CHF) and is a modified and intensive version of the transitions of care model by the same name. The project is currently in pilot testing at their Manhattan campus, but Beth Israel officials expect it will be implemented at their Brooklyn campus as well as at other hospitals throughout the Continuum Health Partners system. Hospital at Home seeks to reduce readmissions among high-risk individuals aged 65 and older through the use of preadmission home visits by social workers and nurses. These complement post-discharge patient engagement activities, which include follow-up phone calls. Prior to initiating these efforts, Beth Israel's 30-day readmission rate for CHF was 29.0%, and 20.0% for both pneumonia and myocardial infarction. In the period since, the hospital's all-cause readmissions rate has declined to 22%. The readmissions rate for patients in Hospital at Home is 10%. Beth Israel's all-cause readmission goal rate is 12%. Hospital staff buy-in, internal champions, care teams that incorporate dedicated discharge advocates, and partnership with external home care providers and community physicians are cited as elements central to success.

IPRO, New York's Medicare Quality Improvement Organization

Integrating Care for Populations and Community Initiative

IPRO's *Integrating Care for Populations and Community Initiative* is a statewide effort funded by the federal Centers for Medicare & Medicaid Services that seeks to organize local community partnerships around the common goal of reducing preventable Medicare readmissions to hospitals. The project emphasizes improving patient engagement in decision-making and streamlining information transfer across the continuum of care. Partners include hospitals, home health agencies, skilled nursing facilities and physicians — all of whom commit to reducing preventable readmissions via information sharing, goal-setting, use of evidence-based interventions, and collaborative root-cause analysis. Launched in August 2011 as part of the Quality Improvement Organizations' (QIOs') 10th Scope of Work, the three-year initiative targets high-risk patients diagnosed with congestive heart failure, pneumonia, chronic obstructive pulmonary disease, diabetes, acute myocardial infarction, and end-stage renal disease. Post-discharge patient engagement is based on the Coleman Care Transitions Intervention Model, the Naylor Transitional Care Model, and the United Hospital Fund's "Next Steps in Care" program. Components of the Project RED model, most notably the "teach back" technique and the emphasis on a cross-setting, multidisciplinary approach to care management, are also used. Best practices and lessons learned are disseminated through state and national forums called "Learning and Action Networks." IPRO cites robust engagement of clinical teams and commitment to performance measurement as key elements of success to date.



Montefiore

For Montefiore Medical Center, readmissions generally represent expenses rather than revenues, an effect contrary to that of most hospitals and health systems. This expansive integrated care system in the Bronx, N.Y., which operates largely under capitated and other value-based payment arrangements, was an early example of a working accountable care organization, and serves a population highly diverse in culture, ethnicity, race, and language. These factors, along with looming reimbursement changes associated with the Medicare Hospital Value-Based Purchasing program and other federal health reform provisions, were the impetus for creating a multipronged readmissions reduction program. One initiative, activated in 2008, provides high-risk patients with post-discharge phone calls for medication reconciliation, arranging follow-up appointments, and patient education about health conditions, symptom recognition, and physician-prescribed treatment plans. In addition, Montefiore has been an anchor hospital in the Bronx Collaborative, a multistakeholder readmission reduction project that involves three other hospitals and two payers. The chief aims of this program are to centralize patient information using electronic health records and provide patients transitional services for 60 days post-discharge. Central to Montefiore's efforts to combat preventable readmissions are: a focus on patient education, depression screenings as a standard of care, medication reconciliation, proper follow-up care, self management, and standardized assessments. Because of their unique patient base, Montefiore officials note their special attention to their patients' psychosocial and socioeconomic variables.

MONTFIORE





NYU Langone Medical Center

Boosting the dynamic quality improvement program at NYU Langone Medical Center is a multi-departmental, system-wide scheme to reduce preventable readmissions. Launched in 2008, this initiative aims to reduce NYULMC's all-cause, 30-day readmission rate from 8.0% in 2011 to 7.5% in 2012, with an ultimate goal of 6.0%. Prior to this effort, this Manhattan health system's index readmissions rate was 8.7%. NYULMC officials cite managed care contracting forces and lower pay-for-performance targets as primary factors prompting this work. Led initially by their chief quality officer, the effort has grown and now encompasses both clinical and nonclinical departments and personnel. All patients undergoing an elective hospital stay, regardless of payer type, are engaged preadmission with education about what to expect during their stay. Attending physicians schedule follow-up visits with patients prior to discharge. Post-discharge phone calls are made to all patients — 70% of which are reached — within two days. These serve to arrange for a patient caregiver and to assess patient needs. Shared savings and episode-based payment schemes are being considered to link payment to readmissions reductions. NYULMC officials note provider buy-in and cultural change as primary challenges to success. Support from executive-level officials, shared goals, timely and accessible data, and clinical champions are cited as foundational to progress and improvement.



Visiting Nurse Service of New York

Reducing preventable readmissions among high-risk homebound patients is a hallmark of Visiting Nurse Service of New York's (VNS) continuous quality improvement process. VNS officials perceive this effort as an opportunity to enhance quality of care, identify gaps in care, and align with emerging pay-for-performance and outcomes-based reimbursement schemes. Working in tandem with both public and private payers, VNS engages homebound patients who have a skilled need and are either generally at-risk of a readmission or have experienced congestive heart failure or diabetes. Selecting patients for this initiative varies by health system, but hospitals generally provide a pool of candidates from which VNS then verifies to ensure they qualify for home care. Comprised of field nurses, home health aides, social workers, and nurse practitioners, VNS care teams use an enhanced version of the United Hospital Fund's "Next Steps in Care" model to provide patient and family education about "red flag symptoms" to watch for and develop an action plan for when such symptoms may occur. Care teams also provide medication reconciliation, schedule physician follow-up appointments prior to discharge, and provide other relevant services such as depression screenings and referrals to behavioral health services. Unique to VNS's effort, given their workforce's wide geographic spread, is the dissemination of evaluative outcomes to cross-setting improvement teams and the monitoring of practice patterns.

REFERENCES

1. Jencks, S. F., Williams, M. V., & Coleman, E. A. (2009). Rehospitalizations among patients in the Medicare fee-for-service program. *The New England Journal of Medicine*, 360(14), 1418-1428.
2. Chollet D., Barrett, A., & Lake T. (2011). Reducing hospital readmissions in New York State: A simulation analysis of alternative payment incentives. *Mathematica Policy Research*. Retrieved March 8, 2012, from http://www.nyshealthfoundation.org/userfiles/NYSHF_Mathematica%20Final_v5.pdf
3. Health Research Institute, PricewaterhouseCoopers. (2008). The price of excess: Identifying waste in healthcare, 2008. Retrieved March 8, 2012, from <http://www.pwc.com/us/en/healthcare/publications/the-price-of-excess.jhtml>
4. NEHI. (2010). Preventing hospital readmissions: A \$25 billion opportunity. Compact action brief: A roadmap for increasing value in health care. Retrieved March 8, 2012, from <http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=53687>
5. Jencks, S. F., et al. Rehospitalizations among patients in the Medicare fee-for-service program.
6. Medicare Payment Advisory Commission. (2007). Report to Congress: Promoting greater efficiency in Medicare. Retrieved March 8, 2012, from http://www.medpac.gov/documents/Jun07_EntireReport.pdf
7. Medicare Payment Advisory Commission. Report to Congress: Promoting greater efficiency in Medicare.
8. Steiner, C., Barrett, M., & Hunter, K. (2010). Hospital readmissions and multiple emergency department visits, in selected states, 2006–2007 (HCUP Statistical Brief #90). Rockville, MD: Agency for Healthcare Research and Quality. Retrieved March 8, 2012, from <http://www.hcup-us.ahrq.gov/reports/statbriefs/sb90.pdf>
9. Chollet, D., et al. Reducing hospital readmissions in New York State.
10. Jencks, S. F., et al. Rehospitalizations among patients in the Medicare fee-for-service program.
11. Kim, H., Ross, J.S., Melkus, G.D., Zhao, Z., & Boockvar, K. (2010). Scheduled and unscheduled hospital readmissions among patients with diabetes. *American Journal of Managed Care*, 16(10), 760-767.
12. Discern Consulting. (2009). A re-engineered delivery model for transitions of care: Addressing evolving market trends. Retrieved March 8, 2012, from http://www.ihpm.org/pdf/COPD81752MHC_AllPatientCOPDTran_Readers1up_PDF.pdf
13. Elixhauser, A., Au, D.H., & Podulka, J. (2008). Readmissions for chronic obstructive pulmonary disease (HCUP Statistical Brief #121). Rockville, MD: Agency for Healthcare Research and Quality. Retrieved March 8, 2012, from <http://www.hcup-us.ahrq.gov/reports/statbriefs/sb121.pdf>

14. Kim, H., et al. Scheduled and unscheduled hospital readmissions among patients with diabetes.
15. Landor, N., Jones, A., & Mathis, A. (2011). Managing diabetes care: Moving an underlying chronic condition to the forefront. Albany, NY: Healthcare Association of New York. Retrieved March 8, 2012, from <http://www.nysdiabetescampaign.org/userfiles/Managing%20Diabetes%20Care%20White%20Paper%20-%20Dec2011.pdf>
16. Kim, H., et al. Scheduled and unscheduled hospital readmissions among patients with diabetes.
17. Landor, N., et al. Managing diabetes care.
18. Kim, H., et al. Scheduled and unscheduled hospital readmissions among patients with diabetes.
19. McCarthy, D., How, S.K.H., Schoen, C., Cantor, J., & Belloff, D. (2009). Aiming higher: Results from a state scorecard on health system performance. New York: The Commonwealth Fund. Retrieved March 8, 2012, from http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2009/Oct/1326_McCarthy_aiming_higher_state_scorecard_2009_full_report_FINAL_v2.pdf
20. Data from Dartmouth Atlas of Health Care. Retrieved January 10, 2012, from <http://www.dartmouthatlas.org/>
21. Goodman, D.C., Fisher, E.S., & Chang, C. (2011). After hospitalization: A Dartmouth Atlas report on post-acute care to Medicare beneficiaries. Lebanon, NH: The Dartmouth Institute for Health Policy & Clinical Practice. Retrieved March 8, 2012, from http://www.dartmouthatlas.org/downloads/reports/Post_discharge_events_092811.pdf
22. Chollet, D., et al. Reducing hospital readmissions in New York State.
23. Ibid.
24. Adapted from: National Transitions of Care Coalition. (2010). Improving transitions of care: Findings and considerations of the "Vision of the National Transitions of Care Coalition."
25. Arbaje, A. Measures to rate the quality of care transitions and impact re-admissions: Lessons from research. In: Presentations from the World Health Care Congress Leadership Summit on Hospital Readmission: Best practices for implementing transitions of care models. January 28-29, 2010. Washington, DC: World Congress. Retrieved December 21, 2011, from <http://www.worldcongress.com/>
26. Naylor, M.D., Aiken, L.H., Kurtzman, E.T., Olds, D.M., & Hirschman, K.B. (2011). The importance of transitional care in achieving health reform. *Health Affairs (Millwood)*, 30(4), 746-754.
27. Naylor, M.D., et al. The importance of transitional care in achieving health reform.

28. NEHI. (2011). Bend the curve: A health care leader's guide to high value health care. Retrieved March 8, 2012, from http://www.nehi.net/bendthecurve/sup/documents/Health_Care_Leaders_Guide.pdf
29. Jencks, S. F., et al. Rehospitalizations among patients in the Medicare fee-for-service program.
30. Connolly, C. (2009, February 26). Obama proposes \$634 billion fund for health care. Washington Post. Retrieved from <http://www.washingtonpost.com/wp-dyn/content/article/2009/02/25/AR2009022502587.html>
31. Available at <http://www.hospitalcompare.hhs.gov/>
32. Partnership for Patients. Retrieved March 8, 2012, from <http://www.healthcare.gov/compare/partnership-for-patients/about/index.html>
33. Partnership for Patients Pledgers. Retrieved March 8, 2012, from <http://partnership-pledge.healthcare.gov/>
34. NEHI. (2011). Bend the curve.
35. Miller, H.D. (2011). Successfully using payment reform to help reduce hospital readmissions. [PowerPoint slides]. Center for Healthcare Quality and Payment Reform. Retrieved March 8, 2012, from <http://www.chqpr.org/downloads/UsingPaymentReform-toReduceReadmissions.pdf>
36. Hussey, P.S., Sorbero, M.E., Mehrotra, A., Liu H., & Damberg, C.L. (2009). Episode-based performance measurement and payment: Making it a reality. *Health Affairs (Millwood)*. 28(5), 1406-1417.
37. Pham, H.H., O'Malley, A.S., Bach, P.B., Sainotz-Martinez, C., & Schrag, D. (2009). Primary care physicians' links to other physicians through Medicare patients: The scope of care coordination. *Annals of Internal Medicine*. 150(4), 236-242.
38. American Hospital Association Committee on Research. (2010). Bundled payment: AHA research synthesis report. Retrieved March 8, 2012, from www.hret.org/bundled/resources/BundledPayment.pdf
39. Center for Medicare & Medicaid Services. Fact sheet: Bundled payments for care improvement initiative. Retrieved March 8, 2012, from <http://innovations.cms.gov/documents/pdf/Fact-Sheet-Bundled-Payment-FINAL82311.pdf>
40. Miller, H.D. (2009). From volume to value: Better ways to pay for health, *Health Affairs (Millwood)* 28(5), 1418-1428.
41. Blue Cross Blue Shield of Massachusetts. (2011). The alternative quality contract: Year one results. White Paper. Retrieved March 8, 2012, from <http://www.bluecrossma.com/visitor/pdf/aqc-results-white-paper.pdf>



A Report on the NEBGH Hospital Readmissions Reduction Project:

An Initiative of Northeast Business Group on Health's Solutions & Innovations Center.

To learn more about NEBGH's Solutions & Innovations Center and its projects, please visit: www.nebgh.org/sic or call (212) 252-7440.

