Volume 7, Number 5 May 2018

Readmissions NEWS

Home Health Care as a Vehicle for Reducing Avoidable Hospital Readmissions

by Excel Health Group

All healthcare providers, in recent years, have dealt with seismic shifts in the way they are paid for the care provided to patients. Especially if the Medicare program is involved. Pay for performance, in one form or another, has become a fact of life. The performance and quality initiatives that impact hospitals including the Hospital Readmissions Reduction Program (HRRP) have the potential to increase payment rates by as much as 3.5% or lower them by as much as 6%. For hospitals, most of which are already grappling with negative Medicare margins that could fall as low as -10% in 2018, the reimbursement swings can have a significant negative impact. To say the least, the financial balancing act has its challenges.

Readmissions The problems with hospital discharges have been extensively reported. We know that about 19% of Medicare patients discharged from an inpatient stay are readmitted at least once within 30 days. The cost of avoidable Medicare readmissions has been estimated at upwards of $17 Billion a year. Currently, performance under HRRP is measured by same cause readmissions for about 180 primary diagnosis codes that indicate COPD, Heart Failure, Pneumonia, Stroke, or Acute Myocardial Infarction, as well as surgical procedures for CABG and elective knee or hip replacement. In its 2018 report to Congress, MedPAC reiterated its suggestion that the policy be expanded to cover all conditions rather than only the handful that are now included, and that the penalty formula be “fixed” to equate the financial consequence for each excess readmission to an amount approximating its cost.

As more and more baby boomers join the ranks of Medicare beneficiaries, the readmission problem is destined to get bigger. When increasing numbers of elderly patients are hospitalized, the pressure on the efficiency of hospital discharge planning and follow up processes will most certainly mount.

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In This Issue

Understanding All-Payer Readmissions at North Carolina Acute Care Hospitals

by Trish Vandersea

Recently, the North Carolina Healthcare Association analyzed all-cause, all-payer readmissions data for 110 acute care hospitals in North Carolina. The purpose of the analysis was to better understand what challenges these hospitals face when addressing readmissions. The analysis included all adult, non-OB patients living in North Carolina discharged between January 1, 2016 and December 31, 2016.

Question 1: How do readmission rates compare by payer for NC hospitals?

The overall readmissions rate among the 110 hospitals in this analysis was 15.0%. Looking at rates by payer, the Medicaid readmission rate was highest (19.3%) followed by Medicare (16.5%).

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Readmissions News
May 2018, Volume 7, Issue 5
ISSN 2166-255X (Electronic)
ISSN 2166-2568 (Print)

Publisher - Clive Riddle, President, MCOL
Senior Editor – Peter Grant, Jr.

Readmissions News is published by Health Policy Publishing, LLC monthly with administration provided by MCOL.

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Editor's Corner

Greetings readers of *Readmissions News*! Thank you for subscribing to the newsletter. We are pleased to once again be bringing you dispatches from professionals in the field who deal with the issue of readmissions on a daily basis. As always, please don't hesitate to reach out to me personally should you have any questions, comments or concerns. We always welcome suggestions for new content as well.

Kind Regards,
Peter Grant
Editor, *Readmissions News*
peter@granteventmanagement.com

Home Health Care as a Vehicle for Reducing Avoidable Hospital Readmissions...*continued from page 1*

And with nearly a third of Medicare beneficiaries now enrolled in Medicare Advantage plans, CMS has been joined by a host of commercial insurers all intent on one thing – keeping discharged patients stable and protected from an expensive U turn back to the hospital. The commitment also involves holding hospitals accountable for their results.

A recent study done at the University of Pittsburgh and recently published in the *Journal of the American Geriatrics Society* suggested that improved discharge planning processes, particularly with better involvement and understanding of discharge plans by patients and their caregivers, would significantly reduce hospital readmission rates. Across 15 separate studies involving more than 4,300 patients, the conclusion was that more effective discharge planning would yield a 25% improvement in readmission rates. Clearly, one way to avoid readmissions is to have better informed patients and caregivers with access to care at home. But to achieve the aim, we must close the post-discharge home healthcare gap.

Fallout from the Home Health Adherence Gap

Excel Health (Excel), with access to over 1.2 billion annual Medicare fee-for-service claims housed in the CMS Chronic Conditions Warehouse, recently researched an interesting aspect of the hospital readmission problem – the number of patients who don't get anticipated post-discharge home health services and how the absence of planned follow up care affects overall readmission rates.

> "Between 2016 and 2017, approximately 1.3 Million inpatient discharges were coded for follow-up home healthcare... 40% did not receive the follow up care that was anticipated."

With a focus on hospital inpatient discharges, Excel found that, over a four-quarter period between 2016 and 2017, approximately 1.3 Million inpatient discharges were coded for follow-up home healthcare; meaning skilled intermittent nursing and/or therapy at home.

A half million of these patients – about 40% - did not receive the follow up care that was anticipated upon discharge. The 60% who did "adhere" to their discharge instructions had measurably lower 30-day readmission rates. Looking at 2017 alone, home health patients that adhered to their discharge instructions were approximately 35% less likely to be re-admitted.

Hospitals in the northeast, particularly NH, VT, and ME, along with DE and SC had the highest home health adherence rates while WY, TX, NM, MN and HI had the lowest.

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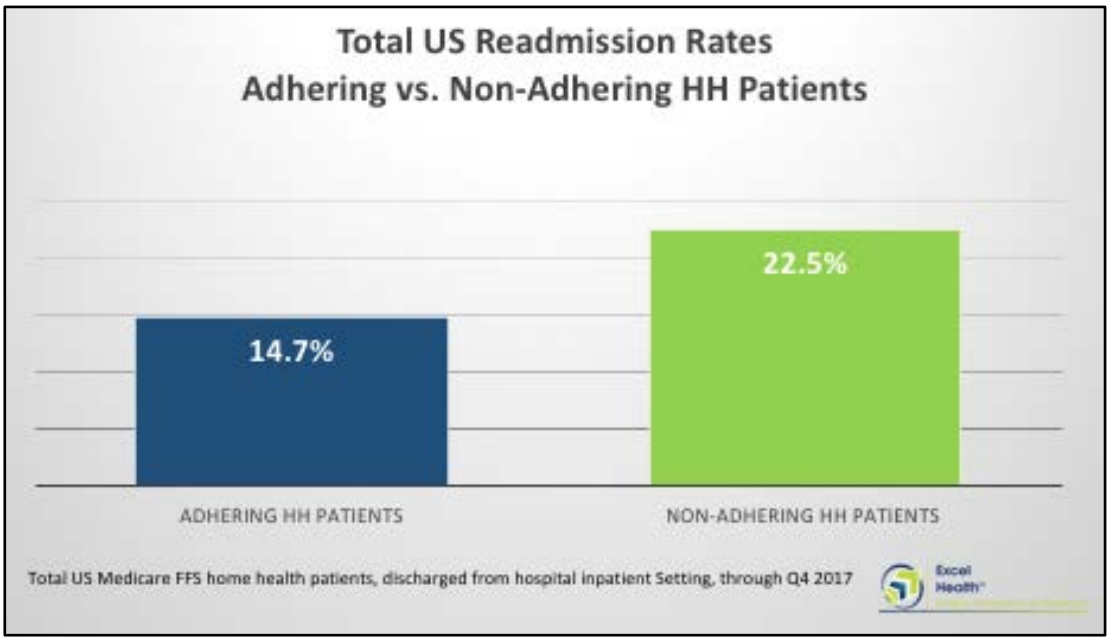
Home Health Care as a Vehicle for Reducing Avoidable Hospital Readmissions ...*continued from page 2*

Non-adhering patients represented a $2.5 Billion foregone revenue opportunity for home health providers. More to the point, the failure to get the needed home health care also ended up affecting the discharging hospitals' readmission calculations as the very diagnoses that make up the penalty group are also among the most prevalent conditions treated by Medicare-certified home health agencies. Medically fragile patients with COPD, Heart Failure, a history of Stroke, Acute Myocardial Infarction or Pneumonia are frequently treated by home health agencies well equipped to handle restorative and maintenance therapy as well as skilled teaching to expand the patient's understanding of the disease process, safety at home and need for medication compliance.



Characteristics of Adhering versus Non-Adhering Patients

- Younger Medicare patients with long-term disabilities are less likely to adhere to their discharge instructions for home health and significantly more likely to be readmitted within 30 days.

  Whereas 70% of the beneficiaries aged 75-85 received post-hospital home health services, only 60% of the beneficiaries under the age of 65 got care. Approximately 27% non-adhering under age 65 group were readmitted within 30 days; only 22% of the adhering patients were readmitted in the same time frame. In comparison, adhering patients between 65 and 74 were readmitted only 15% of the time. Older, adhering beneficiaries over the age of 75 were readmitted 17% of the time versus their non-adhering counterparts with a 24% readmission rate.

- Women are slightly more likely to adhere to discharge instructions for home health than men and less likely to be readmitted when they do. Non-adhering men and women have the same readmission rate of 24%.

- Patients being discharged following lower extremity joint replacement procedures have the highest post-discharge adherence rate of 82%. This bears out the strong relationships between orthopedic surgeons and specific home health providers with robust restorative therapy programs.

> "Patients being discharged following lower extremity joint replacement procedures have the highest post-discharge adherence rate of 82%."

On the other hand, only 67% of the cardiac patients discharged to home health actually received home health services and only 63% of patients hospitalized for respiratory events received home health following their discharge.

The adherence difference between patients with joint procedures versus those discharged following a cardiac or respiratory event, likely points to the overall involvement of the inpatient physician in specific discharge planning as one element of better adherence. To wit, the more involved the physician, the greater the likelihood of getting needed follow up care.

Stumbling Blocks to Adherence

There are several impediments to realization of the discharge plans involving home health services. Lack of communication, lack of understanding of the disease process and treatment medications, lack of awareness, involvement of primary care physicians in the process and caregivers' misunderstanding of the patient's care requirements all conspire to produce less than ideal adherence rates.

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Home Health Care as a Vehicle for Reducing Avoidable Hospital Readmissions ...*continued from page 3*

It is a fact that most patients who are discharged following a hospital stay are not at their best. Stays have gotten shorter and the natural by-product of more abbreviated hospital courses of treatment is that patients are usually weak and often overwhelmed by the array of instructions handed out as they return to their homes. Various studies have concluded that, as they are being discharged, only 37% of patients are able to articulate the reasons for their medications; only 14% understand the potential side effects of those medications and only 42% can confirm their diagnosis.

Caregivers can also be significantly stressed by events and the reality of taking care of a loved one with significant care requirements at home. Caregivers are can be reluctant to engage in a discussion of home health for a variety of reasons, including not wanting strangers in their homes or even a misunderstanding of home healthcare and what it can do to assist the patient and his/her caregivers.

> "As they are being discharged, only 37% of patients are able to articulate the reasons for their medications."

Discharge planners who can be simultaneously involved in facilitating multiple patient discharges often compound the communication and information gaps that contribute to non-adherence and post-discharge problems that can lead to a readmission.

Timely Data Can Facilitate Process Improvement and Reduce Avoidable Readmissions

With access to all of the claims data for both Medicare Part A and Part B services, Excel Health helps industry partners understand and address readmission challenges and improvement opportunities. The data tells the story. Here are two real world examples, direct from the Excel Health Market Intelligence Portal:

- Hospital A is a teaching institution with 800 beds. In the three quarters ended September 30, 2017 approximately 3,000 patients were discharged with home health instructions. Only 53% of those patients received home health services; representing a five-percentage point deviation from the State adherence rate of 58%. With improved adherence, this hospital had the potential of lowering its 30-day readmissions by 109 patients annually.
- Hospital B is a 425-bed facility and part of a health system in the southwest. The home health adherence rate was 56% which trailed the County average by 8%. Non-adhering patients were 64% more likely to be readmitted. With improved home health adherence, the hospital could potentially readmit 27 fewer patients and lessen its penalty exposure.

The challenge is that until this point, the connection between adherence and re-admit rates has not been a focus. Furthermore, the ability to track re-admissions to other hospitals has eluded many hospital executives. Excel Health now tracks re-admit rates for adhering and non-adhering patients for every hospital in the country, regardless of the readmitting hospital. A complete understanding of performance metrics can only be gained through an investigation of relevant and timely data, and the key starting point for a solution that will help to better understand and significantly reduce avoidable readmissions. Closing the home health adherence gap will be a good start in the right direction. For more detailed hospital readmissions data and full post-acute performance and quality metrics, go to www.excelhealthgroup.com and request to speak to a sales consultant.

Personalized Medicine and Patient Engagement: Care Management and Self Management

by John G. Singer

We have effectively killed of the independent sphere. Nature was once a "separate and wild province" from human civilization, as Bill McKibben wrote in his famous 1989 call-to-arms, *The End of Nature*: It was "a world apart from man to which he adapted and under whose rules he was born and died."

McKibben's argument was this: the world as we used to know it and define it has morphed into something completely different, one global system where everything is connected to everything else in one complex, interactive whole. He called for a fundamental, philosophical shift in the way we relate to nature. A whole new taxonomy was needed to shape thinking, creativity, solutions.

"There's still something out there," he said, "but in the place of the old nature rears up a new 'nature' of our own devising" – a construct where "each cubic yard of air, each square foot of soil is stamped indelibly with our crude imprint, our X."

In predicting the structural shift Apple's Health Records will cause in population health management strategies and precision medicine efforts, Shez Partovi, chief digital officer and senior vice president of digital health at Dignity Health, frames things this way:

> *"When you think of personalized medicine, you can think about caring for yourself in two dimensions. There's care management, where a health system or physician or team is managing your care, and there's self management."*

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Personalized Medicine and Patient Engagement: Care Management and Self Management *...continued from page 4*

Said differently, “patient engagement” is an under-conceptualized view of how health happens. It implies someone in a clinical setting, reinforces the perception of disease, excludes the role of family and caregivers, and doesn’t integrate the social determinants of health as one experience.

Healthcare is really one 'nested market' – it is big business comprised of an ever-expanding zoo of market segments and micro-services, an endless parade of bright and shiny digital objects, all with data that demonstrate promise to improve our health and well being. The reproductive cycle of stuff is an additive process, rather than subtractive. The old media forms endure; the new are layered on top of the previous (for evidence: the fax machine is still the predominant means of communications by the lion's share of physicians).

Our world is not multi-channel. It is infinite channel.

There are islands of features everywhere. The challenge is pulling it all together in a way that a whole system is born and becomes focused on generative value.

Or to put it another way, competing on outcomes means solving for fragmentation and serving a ‘patient-to-consumer loop’ over a long period of time. This is about harnessing a wide-open space to make things out of ceaseless change, where the next growth curve is based on dissolving boundaries, harnessing flow and connecting the adjacent possible.

> “Recombination is really the only source of innovation. Economic growth occurs whenever people take resources and rearrange them in new ways."

Paul Romer, an economist at New York University who specializes in the theory of economic growth, says real sustainable economic growth does not come from new resources, but from existing resources that are rearranged to make them more valuable.

"Recombination is really the only source of innovation. Economic growth occurs whenever people take resources and rearrange them in new ways."

More succinctly, new growth comes from remixing pieces and parts into novel combinations. Technology is a commodity input to this story, more like electricity.

The bigger context, though, is the emerging market transition to outcomes-based competition. Essentially everyone in healthcare – payers, providers, pharmaceutical and medical device companies – is groping their way through the white space.

And if you buy into the logic that it's not just one thing that improves outcomes, but many things simultaneously and interactively, then advantage goes to those who are best at creating and managing unique systems of health engagement. The data that flows from this system, and then refined into specialized cognition, is the thing that generates new business value, supports population health and guarantees performance.

Data strategy becomes market strategy. You design for the analytics you want to capture.

> ““Digital” is not a stand-alone idea. It enables a new logic of value creation."

Outcomes-based competition is a strategic transformation. It is not a rigid creed. Rather, it is a spectrum of attitudes, techniques, and tools that promote collaboration, sharing, coordination and unique aggregations. This is a new frontier for design, and a particularly fertile space for innovation.

“Digital” is not a stand-alone idea. It enables a new logic of value creation. Its value is expressed in the ability to dissolve boundaries, create new identities, remove friction and re-configure entire business systems.

The map changes the landscape.

Or to put it another way, the transformational remit for today's health market leaders is the ability to creatively explore and conceptualize a new territory, assemble the intellectual viewpoint, and then design the new industry infrastructure – the nervous system – to own the space.

The objective is to write new rules by which others have to play. This is a race with machines, not against them. More like freestyle chess, where the partnership is between man and machine.

Winners are those who can move laterally the fastest, and think at a system level. Cue the entrance of Apple and Amazon…

Subscribers’ Corner

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Understanding All-Payer Readmissions at North Carolina Acute Care Hospitals ...*continued from page 1*

Question 2: Among NC hospitals, how often did high utilizers of a hospital readmit?

During the time period for this analysis, there were 22,509 patients across all 110 hospitals that were characterized as "high utilizers" – meaning patients with 4 or more inpatient discharges in one year. The readmissions rate among these patients was 44.4% (51,855 readmissions on 116,894 discharges). In addition, these readmissions made up 47.9% of total readmissions across all hospitals in this analysis.

Question 3: Among NC hospitals, what were some of the top diagnoses (by DRG) leading to readmission?

For this analysis, primary diagnoses leading to readmission were identified on the initial hospitalization - although the readmission itself could be for any reason. Among Medicare discharges, the top diagnoses (defined as those leading to the highest number of readmissions) were heart failure and sepsis. The table below lists the top diagnoses, as well as the associated readmission rates, for Medicare and Medicaid patients.

Question 4: Among NC hospitals, what was the readmissions rate for behavioral health patients?

For purposes of this analysis, behavioral health patients were identified using a standard definition developed by NCHA. This definition includes diagnoses for substance abuse, mental health, and developmental disorders. The readmissions rate for patients initially hospitalized with a primary diagnosis for behavioral health was 14.1% among all 110 acute care hospitals.

Further insight into readmissions among acute-care hospitals in North Carolina is provided in the following table:

Data: (Jan16 – Dec16)	Medicare	Medicaid	Other	Total
Discharges by Payer	408,617	78,685	236,396	723,698
% Total Discharges	56.5%	10.9%	32.7%	100.0%
Readmissions	67,314	15,198	25,833	108,345
% Total Readmissions	62.1%	14.0%	23.8%	100.0%
Readmissions Rate	16.5%	19.3%	10.9%	15.0%
Behavioral Health (BH) Readmissions Rate (BH Readmits/Total BH Discharges)	*	*	*	14.1% (7,630/54,058)
High Utilizers (HU) Readmissions Rate (HU Readmits/HU Discharges)	*	*	*	44.4% (51,855/116,894)
High Utilizers (HU) % Readmissions (HU Readmits/Total Readmits)	*	*	*	47.9% (51,855/108,345)
Top Primary Diagnoses Leading to Readmission (with associated Readmit Rates)	Heart Failure (22.9%) Sepsis (17.5%) COPD (18.7%) Renal Failure (19.1%) Pneumonia (16.9%) Cardiac Arrhythmia (16.5%)	Psychoses (15.4%) Sepsis (20.2%) Red Blood Cell Disorders (41.7%) Heart Failure (28.5%) Diabetes (27.4%) COPD (19.6)	*	Sepsis (16.7%) Heart Failure (22.3%) Psychoses (14.7%) COPD (17.2%) Renal Failure (18.6%) Pneumonia (15.6%)

*Data suppressed

As we continue to focus on the importance of improving readmissions in our state, NCHA has partnered with national expert, Dr. Amy Boutwell, Founder and President of Collaborative Healthcare Strategies to improve CMS 30-day pneumonia readmissions as part of a statewide Pneumonia Knockout Campaign in our state. Our pnuemonia goal for readmission improvement is to move NC from performing at national average in the Hospital Readmission Reduction Program to the upper 25% quartile by December 2019. Throughout 2018 Dr. Boutwell will be leading a webinar series to support and accelerate success in reducing pneumonia readmissions by applying the concepts of the ASPIRE Guide to Designing and Delivering Whole-Person Transitional Care, developed by Dr. Boutwell. This learning series will not only help hospitals better understand pneumonia readmission patterns but will also develop the infrastructure, care teams, processes, and partnerships needed to succeed in the value-based payment environment of the future. The ASPIRE Tool is aimed toward hospitals at all stages of readmission work and applies to teams working on Medicare, Medicaid, and all-payer target populations.

For questions or additional information about the Pneumonia Knockout Campaign, please contact: Trish Vandersea, Program Director, tvandersea@ncha.org. Regarding the readmissions data above, contact: Elizabeth Mizelle, Director of Measurement, emizelle@ncha.org, or Josh McGowan, Senior Healthcare Analyst, jmcgowan@ncha.org.

Thought Leaders' Corner

Q. What Patients Are Most at Risk of Being Readmitted?

Each month, *Readmissions News* asks a panel of industry experts to discuss a topic of interest to the hospital community. To suggest a topic, write to Editor@ReadmissionsNews.com.

With the shift to value-based care, post-acute facilities are gaining increased importance to the healthcare system, especially as it relates to hospital readmission rates. No longer are post-acute facilities considered an "add-on" to a care treatment plan. They're a necessary piece of the puzzle.

That said, many facilities aren't equipped with the tools needed to track real-time visibility into a patient's full spectrum of care, and patients aren't provided the necessary information to make empowered healthcare decisions. This combination can lead to higher readmission rates and increased costs. While these rates have declined marginally over the past decade, the threat still looms, and patients often operate in the dark when it comes to care options.

While the rate and reasons vary, some patients are more susceptible to the likelihood of readmissions than others. These patients often:

- Lack education on the facilities available to them – such as quality rating, care services, or insurance – and make decisions about their care based on geographic location.
- Are unable to adhere to care instructions, whether they forgot, misplaced or misconceived them.
- Don't have the proper tools to understand their care options and what is best for their treatment plan, leading to an uneducated medical decision.
- Cannot be properly tracked by providers during and after their transition to post-acute care and are vulnerable to being lost in the system.

The good news? There are tools available today to alleviate stressors for both providers and patients seeking post-acute care that help prevent readmission.

For healthcare organizations and their providers, acute and post-acute care management tools can ease discharge planning for clinicians. These technologies provide heightened visibility into where patients are headed, how their treatment plan is going, and if their health is improving. For patients, these tools give them control over where they receive care by providing deeper insights into the types of facilities available to them, how they are ranked against other facilities and if the care they need is provided. Additionally, these solutions digitally share the information with family members to ensure everyone is on the same page regarding a loved ones' treatment plan.

With the right technology and tools in place, providers, ACOs, healthcare organizations, payers and their patients can be fully equipped to understand the entire spectrum of care, meet value-based care requirements and increase positive patient outcomes to reduce readmission.

Dr. Lissy Hu
CEO, CarePort Health
Boston, MA

In our research, we've found that readmissions risk is a function of both clinical severity, and a combination of healthcare engagement and socio-economic issues. While clearly a patient with multiple chronic conditions (such as COPD, diabetes, etc.) is at higher risk for readmissions than one without multiple chronic conditions, there are significant differences in readmissions risk within that clinically-complex cohort. For example, we've found that patients who are more engaged with their doctor, get their preventive screenings and are adherent with their medications are much lower risk for readmissions than their unengaged counterparts. Further, patients who have a caregiver, have the resources to take care of themselves (transportation, credit cards, etc.), and have higher health literacy are also lower risk for readmissions.

An effective approach to lower readmissions is to proactively target and manage these patients (preferably prior to an admission) to disrupt the admission/readmission cycle.

Saeed Aminzadeh
Chief Executive Officer, Decision Point Healthcare Solutions
Boston, MA

Thought Leaders' Corner

Patients most at risk of being readmitted to the hospital are those individuals who have multiple chronic conditions, such as hypertension, diabetes, or congestive heart failure. Our most complex patients often have behavior health issues in addition to these challenges. Risk of readmission further increases with barriers to better health such as a lack of an adequate support system, unstable housing, substance abuse problems or unmet nutritional needs.

At Community Care of North Carolina (CCNC), we have developed a proven method of identifying patients who are most likely to benefit from intensive care management intervention. We call it ImpactabilityTM. Compared with managing only the most high-cost patients, using an ImpactabilityTM approach yields two to three times the return on investment, making it a much more cost-effective strategy in reducing health care costs and improving patient outcomes.

CCNC developed its targeting strategy after decades of experience managing North Carolina's statewide Medicaid population. From claims data, hospital ADT data and clinical inputs, we develop an, "Impactability Score" that predicts the likely return on care management post-discharge intervention. Many patients, despite being very sick and high cost, are managing their conditions as well as can be expected, and additional resources are not likely to change their health trajectory. The Impactability Score identifies patients with utilization patterns unexplained by disease burden. This approach has proved to be far better at predicting impactability than any given diagnosis or event, disease profile, or overall costs of care. For nearly all impactable patients – some 88 percent – social determinants play a significant role in patient needs. These are the patients we can really help – not just the riskiest or most expensive.

For each impactable patient, CCNC develops an individualized care plan with his or her assigned care manager. By focusing on individual care plans, quality of care is improved while avoidable hospital admissions and readmissions are reduced. Compared to other targeting strategies, CCNC's impactability-based targeting better allocates scarce care management resources and returns a far better return on investment. What it means for patients is that we are able to significantly improve the trajectory of their health status, improving their health not just in the short term but for at least the next year.

Dr. Carlos Jackson
Chief Data and Analytics Officer, Community Care of North Carolina

There are many factors that go into risk of relapse and readmission. On the top of my list are a patients' motivation, insight and willingness to change. Patients need to have a strong motivation to enter treatment and obtain recovery. It needs to be personal and internal. When patients come to treatment to satisfy others and not for themselves their outcomes are usually not as strong. Patients need to have some insight into the severity of their problems and need to overcome the denial that often accompanies addiction. If they fail to develop insight and remain in denial they will often relapse. It is also important to not only identify what you need to change but also be willing to make those changes, otherwise you remain likely to relapse.

Additionally, length of sobriety and duration of treatment play a big role. Getting to 90 days of recovery likely cuts your risk of relapse in half. The higher intensity and longer duration of treatment, also both contribute to improved outcomes. So, the goal is to get the longest amount and the highest intensity of treatment you can afford and are able to engage.

Family support is another big factor. Patients who have strong family, friend and/or social support are much more likely to succeed. Addiction is isolating and it is imperative to build your army in early recovery. The lone soldier is often the one to relapse.

Addressing co-occurring psychological/mental health symptoms is also vital for preventing relapse. Patients often use alcohol and drugs to reward, cope and escape issues they're dealing with. Sometimes the drugs and alcohol are used continuously or unconsciously to self-medicate with depression, anxiety, PTSD and other psychiatric conditions. Therefore, it is essential to address these underlying conditions including trauma and grief, if we want to have good outcomes and reduce the risk of relapse.

Dr. Matthew Goldenberg, D.O.
New Vista Behavioral Health, Center for Professional Recovery

Thought Leaders' Corner

The highest risk group today is senior orphans for 30 day readmissions; the next highest group is adults with disabilities without adequate family support. The most frequent reason is often medication noncompliance or side effects of new medicines, as well as infections. Older adults with no one to help them at home after an illness can often get confused, fall, become dehydrated or malnourished with no one around to notice.

Unfortunately, too often seniors are sent to rehab facilities as an answer to prevent readmissions, but the underlying lack of support at home is not addressed well enough. Home therapy and HHC nurses can only stay as long as a skill is being provided, and many seniors are unable to afford 24 hr home health aids, who provide housekeeping and companionship. No one keeps patients out of hospitals and healthy better than RN Patient Advocates, who care for people as consultants longer term. They oversee care from a medical perspective and address small problems before they become larger ones, especially for medically complex clients that may be challenge for geriatric care managers without a clinical background.

Additionally, nurses can assess and assure medication compliance, and keep doctors well informed, and help with transition challenges, and provide valuable referrals that help support holistic patient care. Unfortunately, the word advocate makes many hospitals bristle until they understand what we do that benefits everyone. Emergency room physicians and hospital care managers tell us all the time, "That is the best idea ever…every patient needs their own advocate!"

Teri Dreher, RN, CCRN, iRNPA
Owner/CEO, NShore Patient Advocates

Industry News

Remaining National Readmission Prevention Collaborative Events in 2018

- **May 17: Dallas**
- **June 6: Houston**
- **June 7: Pittsburgh**
- **June 12: Charlotte**
- **June 13: Atlanta**
- **September 12: Baltimore**
- **September 13: St. Louis**
- **September 27: Northern California**
- **October 10: New York**
- **October 11: Chicago**

Visit www.NationalReadmissionPrevention.com for information.

Readmission Collaborative Names Winners of 4th Annual Healthcare Innovation Contest

NRPC recognizes those technologies and programs delivering true transformational care

LOS ANGELES, CALIF. (April 26, 2018) – The National Readmission Prevention Collaborative announced today its 2018 winners of its 4th Annual Healthcare Innovation and Transformation Contest. Multiple category winners were named at todays USC C-Suite Invitational Event in Los Angeles, and winners will be featured at various NRPC C-Suite events throughout the country for the remainder of 2018.

The category winners are as follows:

- **Quadruple Aim, Caretaker Satisfaction:** Wambi and Carepostcard, online nurse gratification & rewards
- **Environmental Transformation:** Burcheyes, Energy reducing TruWhite™ LED Disinfection & control system
- **Post-Acute Connectivity:** PatientPing
- **Population Health Advancement:** Cortex, High Risk Patient Management program (Cortexhc.com)
- **Healthcare Finance:** RIP Medical Debt
- **Home Based Care:** AMADA Senior Care DART Readmissions program

Each of these products and services was reviewed and evaluated by members of the NRPC Advisory Board and selected as winners in their respective categories.

"This contest has become one of the most enjoyable accomplishments in the five year history of the readmission collaborative," said Founder Dr. Josh Luke. "It's inspiring to see these products and services that are truly transforming how we deliver patient centered care."

For more information on the National Readmission Prevention Collaborative or 2018 award winners, please visit www.NationalReadmissionPrevention.com.

Industry News

THE AMERICAN JOURNAL OF MANAGED CARE

Community Factors Drive Hospital Readmissions in the Delta, Study in AJMC Finds

How much do community factors drive 30-day readmission rates, the yardstick that Medicare has used since 2013 to gauge whether patients with heart failure or a heart attack get adequate follow-up care?

In the Mississippi Delta, one of the country's poorest areas, community factors matter a lot—so much so that once they are accounted for, readmissions here were not much different from those in the rest of the country for heart failure and were about the same for pneumonia and heart attacks (acute myocardial infarction), according to a new study.

Authors from the College of Public Health at the University of Arkansas for Medical Sciences, led by Hsueh-Fen Chen, PhD, write that their resultshave important policy implications—rather than rate hospitals entirely based on their performance compared with national averages, hospitals should be judged in part against prior performance.

To conduct the study, they examined data from 2013-2016 for counties that fall under the Mississippi Delta Regional Authority, in parts of eight states: Alabama, Arkansas, Illinois, Kentucky, Louisiana, Mississippi, Missouri, and Tennessee. The researchers compared 30-day readmission ratios for hospitals in the Delta region, the remaining counties of the eight Delta states, and the rest of the nation.

They found that when they did not control for hospital and community factors, Delta region and state hospitals had higher readmission ratios for pneumonia, heart failure, and heart attacks. But when they controlled for hospital and community factors, the significant difference in readmission ratios for pneumonia and heart attack disappeared, and the difference for heart failure was much less pronounced.

Factors linked to higher readmission ratios for pneumonia and heart failure were whether a patient was treated in a major teaching hospital, which tend to take the sickest patients, and the percentage of the community that is African American. Curiously, high poverty was associated with lower readmissions for heart attacks, but the researchers noted that mortality rates for this condition are very high if patients cannot access treatment in a timely manner.

In recent months, researchers from Harvard have found that HRRP has disproportionately penalized hospitals that serve minorities, and a group of cardiologists published a blockbuster finding that although 30-day readmissions are dropping, deaths from heart failure appear to be rising.

The authors of the Mississippi Delta study called for revisions to the HRRP, such as including improvement from past performance in penalty calculations and adding community characteristics in risk adjustment models.

Community Factors Drive Hospital Readmissions...*continued*

"This would likely reduce the unintended consequences of HRRP that may, with reductions in Medicare reimbursement, threaten the healthcare delivery system in the Mississippi Delta region and other similarly underserved areas," they wrote.

In fact, CMS has recently updated the program in response to such criticism. In 2018, CMS has updated performance criteria to base a hospital's penalties relative to other hospitals that are treating a similar share of Medicare patients who are also eligible for Medicaid, starting with fiscal year 2019.

Clarify

Clarify Health and North Carolina Healthcare Association Partner to Reduce Pneumonia Mortality and Readmissions

Clarify Health Solutions, Inc., a pioneer in machine learning-enabled care optimization today announced the North Carolina Healthcare Association (NCHA) has deployed Clarify's advanced analytics platform, Care Prism, to aid its statewide initiative to significantly reduce pneumonia (PNE) mortality and readmissions.

In 2017, NCHA rolled out the Pneumonia Knockout Campaign with the two-year goal to save 1,000 lives and over $8.8 million. The healthcare association had extensive inpatient data but needed a partner to provide hospitals and physicians with actionable insights into what happens after patients leave or are discharged.

The selection of Clarify Health was based on the company's extensive data set linking clinical claims and determinants of health insights on over 100 million individuals. NCHA was impressed by Clarify's ability to identify root causes of variation and uncover specific improvement opportunities that could be rapidly scaled across all facilities within weeks.

"This partnership has allowed us to look beyond the hospital and examine care transition patterns specific to our high-risk pneumonia patients," said Karen Southard, RN, NCHA's vice president of Quality and Clinical Performance Improvement. "The additional information has been very helpful to us and our members in developing targeted care coordination interventions to improve outcomes."

Clarify Health has taken a hands-on, true partnership approach with the NCHA. The Clarify Clinical Transformation team has trained NCHA hospital analysts to generate actionable insights. They also travel to NCHA meetings to connect with member hospital leadership, engaging them with their own nationally case-mix adjusted data.

Industry News

Clarify Health and North Carolina Healthcare...*continued*

"We are excited to announce that we are partnering with NCHA on this life saving campaign," said Jean Drouin, MD, CEO and founder of Clarify Health. "The power of the Clarify platform will enhance the care patients receive, lower costs, and ultimately improve health outcomes statewide. The precision with which we are able to deliver case-mix adjusted insights to clinicians gives doctors data they trust and the ability to make sustainable change."

The NCHA now serves rich information to over 90 hospitals engaged in the Pneumonia Knockout initiative at a fraction of the time previously required to generate insights. Beyond the analytics, the Clarify platform is inspiring real change. Leaders from NCHA member hospitals are using this information to help care teams identify at-risk patients and intervene earlier, thereby reducing the risk of costly readmission or death. For more information on the partnership between NCHA and Clarify, consult this case study.

medicfp
Prevention, not Recovery

MedicFP and LifeAssist Technologies Announce Joint Venture to Improve Health and Care Coordination, Reduce Readmissions, Prevent Fraud and Increase Patient Safety

MedicFP, a South Florida-based biometric company dedicated to providing innovative software solutions to revolutionize patient care, and LifeAssist Technologies (LifeAssist), a San Francisco, California-based leader in caregiving solutions for professional care providers, families and seniors, today announced that the companies have entered into a joint venture, which integrates two of their leading technology-based solutions. Under the terms of the agreement, MedicFP will provide VerifyID®, its facial biometric identification solutions, and LifeAssist will provide Circura™, its SaaS enterprise care coordination platform, to the partnership. Together, both parties aim to create a safer environment for highly vulnerable patient populations and caregivers, as well as to provide tools to engage caregivers in collaborative care for long-term chronic populations and facilitate the integration of medical-related data originating in the home into electronic medical records.

"We are excited to establish a joint venture with LifeAssist, and are excited through the synergies of our combined solutions to address three key areas: reduce waste, prevent fraud and, most important, coordinate the care and wellness of the home health patient within the walls of their home, in part due to the growing needs of Electronic Visit Verification (EVV) as per the 21st Century Cures Act," said MedicFP Chairman, President, and CEO, Ruben J. King-Shaw, Jr. "LifeAssist's expertise in utilizing technology to drive coordinated, patient-centric communication, integrated with our facial biometric identification capabilities, allows us to collectively improve patient safety and protect vulnerable patient populations from healthcare fraud and system abuse."

MedicFP and LifeAssist Technologies...*continued*

"The partnership draws on the strengths of both companies to address a growing concern across healthcare: medical identity theft and the mounting rates of Medicare and Medicaid abuse. VerifyID combines healthcare data with biometric facial identification to certify that the correct patient is receiving the correct care at the correct time and place. Circura enables all relevant caregivers—professional, family and others—to effectively coordinate care by communicating and sharing data in a secure, HIPAA compliant, permission-based SaaS platform. By integrating the two technologies, MedicFP and LifeAssist will be able to ensure that the identity of an individual claiming to be a healthcare provider has been cross-checked and verified prior to the provision of care.

The United States Government Accountability Office (GAO), a nonpartisan agency that investigates federal spending and performance, estimates that about 10% of Medicaid and Medicare expenditures are attributed to fraud, waste, and abuse. That equates to approximately $120 billion annually, more than the total federal budget for science, energy, and the environment. The partnership between MedicFP and LifeAssist will also work to prevent such fraudulent reimbursement claims, which can result in the disruption of care and jeopardize the health of patients.

"Our mission is simple: to create coordinated, caregiving solutions that empower older adults and support their caregivers," said Val Ornoy, CEO of LifeAssist. "Seniors today face an increased risk of identity theft, which can lead to abuse from private care providers, false claims for Medicare & Medicaid reimbursement, and other fraudulent activity. That's why we are thrilled to integrate our technology with MedicFP's identity verification solutions. Together, we have the opportunity to protect seniors, bring peace of mind to their loved ones, and help to ensure that patients are receiving the healthcare they need and deserve." The joint venture reflects MedicFP's continuous commitment to patient safety and accuracy, and LifeAssist's vision of empowering older adults to live healthy, independent and joyful lives, while supporting the needs of their caregivers and care providers.

PharmaPoint

PharmaPoint Announces Grand Opening of New Outpatient Pharmacy at "The Hospital of Silicon Valley"

Clarify Health Solutions, Inc., a pioneer in machine learning-PharmaPoint is proud to announce today's grand opening of El Camino Hospital Outpatient Pharmacy. The nonprofit, community hospital and healthcare organization will also utilize XchangePoint for its bedside delivery of discharge medication program. "We are thrilled to partner with El Camino Hospital to provide outpatient pharmacy services to their patients," said Mike Plaia, CEO of PharmaPoint. "The addition of a pharmacist as an integral member of a patient's care team drives medication optimization for those at-risk in the acute, post-acute and ambulatory care settings."

Catching Up With …

Joseph Alpert, MSCPM, RHIT
Dean for Health Sciences, Collin College
McKinney, TX,

Readmissions News: What role does patient engagement play in terms of reducing preventable readmissions?

Mr. Alpert: Integrating patients into the care experience and offering clear and concise recovery instructions are important patient engagement strategies that can help healthcare organizations reduce unplanned hospital readmissions. Reducing preventable hospital readmissions is a key indicator of quality healthcare. Currently, CMS enacts the Hospital Readmission Reduction Program, which is a value-based care model that drives payment penalties when hospitals exceed a benchmark hospital readmission rate. Hospital readmissions, regardless of when they occur, can be extremely costly for hospitals and healthcare payers. In theory, delivering patient-centered and coordinated healthcare during the discharge process reduces the likelihood of hospital readmissions.

In addition to incorporating the patient as a partner in care and providing written instructions for follow-up self-care, separate research has indicated many strategies for reducing hospital readmissions. For example, incorporating family members as a part of the care team can reduce hospital readmission by up to 25 percent. Additionally, offering convenient opportunities for patients to engage with follow-up providers – such as through mHealth technology or telehealth – can be helpful in ensuring patients are adhering to self-care management plans.

Readmissions News: What role can a patient's family play in preventing readmissions?

Mr. Alpert: The vast majority of families like to have something to do and they like to participate in patient care. They're often the most motivated member of the care team. We've found that families not only want to promote healing, but patients benefit from someone who knows their preferences, and the result is, the rate of readmissions is reduced after patients are discharged from the hospital. Family engagement programs are usually effective because they equip relatives with the skills and knowledge necessary for keeping a patient healthy while recovering at home. When a patient can consult with a clinician about proper at-home care before hospital discharge, it is more likely that the patient will see optimal outcomes.

Readmissions News: How will technologies like artificial intelligence play a role in promoting patient engagement and have companies involved in these efforts achieved a high level of market penetration?

Mr. Alpert: Patients in a hospital are naturally filled with anxiety, fear and loneliness. Often, being hospitalized is a life changing event. It is really the worst time to try to educate someone about their health, but it is also the best time because caregivers have a captive audience.

Today, conventional interactive patient engagement systems integrate a library of condition-specific educational videos with smart TVs, Internet-based software platforms, interactive applications and mobile devices. TeleHealth Services is the largest provider of these interactive patient engagement systems to hospitals with more than 430 systems installed. But I knew something was still missing. Too many hospitals (8 out of 10) are still using paper handouts for education at discharge with little thought given to patient and family health literacy, education levels, or cultural and language barriers.

With hundreds of millions of dollars invested in electronic medical records (EMRs), the healthcare industry has focused on data-driven solutions but is still seeking new methods to engage patients with meaningful digital strategies that improve outcomes. Conventional patient engagement systems have typically focused on displaying information at the hospital bedside, but that alone is not authentic patient engagement. Displaying information on patient televisions can be like Bloomberg TV for healthcare. I believe that the inability to truly connect with the patient is why no company has fully penetrated the market.

Readmissions News: Lastly, tell us something about yourself that few would know.

Mr. Alpert: I enjoy mountain climbing and try to spend as much time with my family out in the natural world as I can.