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Readmissions NEWS

A Long-Term Care Facility Slashes Readmission Rates by Accessing Its Residents' Full Medical Records

Absolut Care had zero readmissions in Q1 2018, thanks in part to accessing their patient's complete records HealthlinkNY Health Information Exchange

by Staci Romeo

Reducing the number of preventable hospital readmissions within 30 days is one of the biggest goals in healthcare quality. It's also one of the hardest to reach.

So, it was quite an achievement when Absolut Care, a 160-bed rehabilitation and skilled nursing facility, had ***zero*** readmissions in the first quarter of 2018—especially since the facility had a 23% readmissions rate for the first half of 2017.

"A lot of good things have to happen to get to zero," explained Jim Shadduck, Administrator at Absolut Care in Endicott, New York. "You have to have the right systems in place, and residents to who can recover without returning to the hospital for care."

You also need to be able to access a patient's medical records quickly, and the most efficient way to do that is through data on the Health Information Exchange (HIE). In this case, Shadduck says his organization relied heavily on HealthlinkNY, the HIE that services his company's region.

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In This Issue

Patients as Partners in the Last Mile of Healthcare: Towards a Hospital Discharge Quality Guarantee

by Ben Rosner, MD, PhD

The last mile of healthcare, the vulnerable period of time up to 90 days post-discharge – when it is estimated that as many as 34% of Medicare beneficiaries are readmitted[1] – has long been a challenge for the U.S. healthcare system. If healthcare operated like any other industry, such a high "failure rate" might have prompted a "product recall" long ago. Certainly, however, healthcare is not a manufacturing assembly line. It is, at its core, about people. And associated with people comes great nuance and complexity.

But should healthcare not adopt best practices from other industries wherever possible? Should we not by now be on the road towards a post-discharge "quality guarantee," in which we have enough confidence in our discharge processes to stand behind such a "radical" assurance? Just as New York University received great publicity with its landmark announcement of free tuition for medical students,[2] so too will some future hospital or healthcare system when it is ready to disrupt healthcare with such a discharge guarantee.

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Editor's Corner

Greetings readers of *Readmissions News*! We are very pleased to be bringing you another excellent edition of the newsletter. Our contributors this month all have on-the-ground, hands on experience in readmissions relevant positions. Thank you again for subscribing and as always, please do not hesitate to get in touch with me personally should you have any wish to contribute or any questions.

Kind Regards,
Peter Grant
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The HIE is a secure network in which different provider organizations—such as hospitals, specialists, laboratories, and skilled nursing facilities, to name just a few—can look up and share medical encounter and diagnostic records.

"HealthlinkNY is a key part of us staying on top of everything," explained Donna Grover, Medical Records Director at Absolut Care. "We were able to access our patient's records so fast and catch things so fast, we had zero readmissions, which is almost unheard of."

Grover said that she and her nurse practitioner colleagues continually use HealthlinkNY to reduce preventable hospital readmissions. "There is not a day that goes by that I do not use HealthlinkNY," she said. "We get lab results faster in HealthlinkNY than we get from the labs themselves."

HealthlinkNY's records can be accessed at anytime, anywhere, by authorized users, as long as the resident has given written consent.

> *"HealthlinkNY records provide a baseline against which Absolut Care's clinical team can measure a resident's progress."*

In the second quarter of 2018, Absolut Care's readmission rate rose to a more realistic 8.2% due to the seriousness of some residents' medical condition. However, that rate is still far lower than the national average of 18.2%. And, because Absolut Care continues to have "the right systems in place," it is likely to keep its readmissions rate down. Last year, the facility contracted with a medical practice to have a physician and nurse practitioner on site two or three days a week. Additionally, Absolute Care assigned a resident care manager for each of its four units.

Promoting Continuity of Care

One of the biggest challenges in skilled nursing is figuring out what happened to the resident during his or her hospitalization. While a resident will return to the facility with discharge papers, a facility can enhance the continuity of care when it has access to hospital records. Grover pointed out that it is faster to access hospital records in HealthlinkNY than calling the hospital record department and waiting for a fax.

"HealthlinkNY records provide a baseline against which Absolut Care's clinical team can measure a resident's progress," she points out. After a resident returns from the hospital, Absolut Care will regularly test the resident's blood and conduct urine, stool, and wound cultures as necessary. HealthlinkNY allows Grover to spot trends over time. "A white blood cell count may be trending slowly up, from 7,000 to 8,000 to 9,000," she said. "Nine thousand is not critical, but it's telling you that something is going on there and it needs attention." Although laboratories will notify the facility if lab results are alarming, they won't pick up on more nuanced changes—changes that could indicate further care is necessary.

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Access to hospital records also improves the patient experience, which in turn might reduce readmission risk. For example, if the hospital recommends that a patient should have a follow-up visit to a specialist after discharge; Grover said she uses HealthlinkNY to find out which specialist had seen the resident in the hospital. "If the doctor did the consult in the hospital, that's who the resident should follow up with because residents are more comfortable seeing doctors they know," she explained. If the follow-up exam involves lab work or diagnostic imaging, Grover can find the results in HealthlinkNY and compare them to earlier test results.

Another plus is that HealthlinkNY allows skilled nursing facilities to plan ahead. They receive alerts about a resident's change in status within the hospital, such as when a visit to the ER has resulted in an admission. This allows facilities to maintain an accurate census for billing purposes. The facility can sign up to receive alerts to so it knows when a resident will be discharged.

"Even if you call the hospital, they are not always as knowledgeable as HealthlinkNY is," Grover said.

Is the Patient Ready to Come Home?

Medicare has introduced a Skilled Nursing Facility Value-Base Purchasing Program that includes a hospital readmission measure. Facilities are eligible for an additional performance payment based on their score. So, skilled nursing facilities have an incentive to lower readmission rates. For Absolut Care, that means making sure a resident is fully ready to be discharged.

The facility uses the HIE to find out if the hospital has completed all tests before a patient is discharged. In one case, a nurse practitioner looked up a patient's record and saw one test was missing, a test that would determine if the patient was cleared to be discharged. The nurse practitioner contacted the hospital, and the test was immediately done. The results were fine, and the patient was discharged as planned. If that had not been the case, the resident's discharge would have been delayed, adding to the cost of their care.

Pulling Together Records from Many Providers

Residents of skilled nursing facilities typically are diagnosed with complex medical conditions. They receive care in many different locations besides hospitals, such as primary and specialty practices, dialysis centers, and diagnostic centers. Blood, stool, and urine samples may be sent to outside laboratories for analysis. Monitoring the resident's outpatient encounters and testing results after hospitalization plays a role in reducing readmission rates.

Residents, either because of age or illness, may have difficulty remembering their encounters. They may not be able to keep track of their medications, care instructions, or even their diagnoses. Family members may not be able to fill in the information gap either. Tracking down medical records from different sources consumes a large part of a facility's care manager's time.

"I have a list that's a mile long of what I use HealthlinkNY for," Grover said. "I log in while I'm in our morning meeting so I can answer questions about the residents. What were the results of the urine culture? Did the resident complete all the necessary testing in the hospital? Which patients received a flu shot at the doctor's office? Who received a pneumonia shot while in the hospital?"

> *"Even if you call the hospital, they are not always as knowledgeable as HealthlinkNY is."*

Grover added that with the flu season upon us, she depends on the HIE to see if the hospital gave patients a flu and/or pneumonia shot. "HealthlinkNY is an awesome resource to find out if patients received flu shots or Pneumovax® in the hospital," Grover says. "I see what they gave them, when they came them, and the lot number, which I enter into our system so there is no duplication."

Shadduck, the Administrator of Absolut Care, emphasized how valuable it is for a clinician to access a patient's complete medical history in one place, instead of having just a one-page snapshot taken from one moment in time. "It documents and educates you about what's going on with a patient, so you can determine something about their history," he said.

Absolut Care is one of many skilled nursing facilities connecting to HealthlinkNY and other HIEs. They understand that the more they know about their residents, the more prepared they are to prevent readmissions.

Staci Romeo, MBA, is Executive Director of HealthlinkNY, which operates the Health Information Exchange (HIE) in the Hudson Valley, Catskills, and Southern Tier of New York State, and connects to the Statewide Health Information Network of New York (SHIN-NY).

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But how can we get there? Offering a guarantee about hospital readmission may sound like a daunting if not impossible task. But the first step for health care systems on the path toward improvement is understanding the scope of the current problem. In our recent publication in the *Journal of Medical Internet Research* (JMIR),[3] we presented a study conducted with Anthem Blue Cross that evaluated a pragmatic solution to the question about whether patients can be engaged as active partners in post-discharge quality improvement by providing accurate and timely feedback about events such as hospital readmissions. And it turns out that the answer to our observational cohort study was a resounding "Yes." Below, we provide context to this finding, and offer up unique new tools that hospitals and healthcare systems might implement to understand the scope of the current problem, so that they can then develop targeted solutions to reduce potentially avoidable readmissions.

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Defining the Problem

In our August, 2017 *Readmissions News* article, "The Hidden Actors in Hospital Readmissions," we described two issues termed lag and leak. The former described the amount of time (sometimes up to a year) between when a readmission occurs and when the index institution may become aware of that readmission. The latter described the percentage of patients whose readmissions occur at institutions other than the index facility; a rate that has been reported to be as high as 45-65%[4,5] This degree of leakage implies that readmissions may be quite under-recognized and underreported. For hospitals seeking to improve under the Hospital Readmission Reduction Program (HRRP)[6], those operating under federal value based care models such as the Comprehensive Care for Joint Replacement (CJR)[7] model, those participating in the Bundled Payments for Care Improvement Advanced (BPCI-A)[8] model which begins in October, or for hospitals in contract with commercial payers operating value-based initiatives, readmissions matter not merely from a quality perspective, but from a fiscal one as well.

However, due to lag and leak, hospitals rarely have timely insight into the true extent of readmission rates for patients discharged from their facilities. When a patient is readmitted within 90 days at an institution other than the index facility, it is the index institution under value based initiatives that bears financial risk. However, that institution may not become aware of the very readmission event until reconciliation with the payer occurs, which under various federal models may not happen until 6-12 months later. Where health care has failed is its inability to systematically implement quality control processes to detect every readmission as it occurs in near-real time. Just as it would be unacceptable for manufacturers not to monitor the quality of parts at each step in the their assembly lines, so too should it be incumbent upon the health care system to have an active feedback cycle post-discharge to learn where our failure points are so we can target where the improvements need to be made. Such temporally proximate feedback is critical for a learning health care system.

Potential Solutions

Few parties have more invested in a good outcome than the patient. And few patients view a hospital readmission as a good outcome. Some promising research has described technology-enabled means to detect hospital readmissions in real-time using smartphone-based geofencing.[9] This approach uses an app installed on a patient's phone at the time of discharge to detect when that patient subsequently enters and remains within the boundaries of any U.S. hospital for more than 4 hours (presumed to be an admission). While this technique demonstrated a fair degree of specificity and positive predictive value, logistical challenges remained to quantifying its sensitivity and negative predictive values.

However, simpler approaches may work just as well. In the JMIR study we conducted with Anthem Blue Cross, patients who had undergone orthopedic procedures were sent automated electronic surveys 90-days post-discharge asking them to self-report healthcare utilization (including readmissions and emergency room/urgent care visits) and complications. Patients' responses were compared against claims data to determine the degree of accuracy with which they self-reported. Not only was there a 76.8% survey completion rate – demonstrating that patients were very willing to complete these surveys and submit them to their providers – but patients were found to have a degree of accuracy characterized as "excellent" by the kappa statistic of 0.80 (with agreement of 0.99) on self-reporting readmissions. Moreover, it was demonstrated that those who did not respond, introduced no bias.

The Future

The findings of this study are both interesting and compelling because they provide new and simple tools with which hospitals might close the open post-discharge feedback loop and gain true insights into their actual readmission rates in a near-real time manner. For example, by simply surveying patients post-discharge, as is currently done for HCAHPS, it might be possible to pinpoint that a given facility's readmission rate is driven largely by a single service line, or even by a single procedure or diagnosis. Understanding the characteristics of the drivers for readmissions is the first, necessary step in implementing targeted quality assurance processes to mitigate such readmissions.

The healthcare sector may have much to teach and much to learn from our colleagues in other industries. But implementing a closed-loop feedback cycle in the post-discharge period to create a learning system is one whose time has come. Whoever in health care is the earliest to adopt these principles stands to gain tremendous benefits for its system, its community, and ultimately its patients. And perhaps the notion of a hospital discharge quality guarantee may not be so far-fetched after all.

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[6] https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html

[7] https://innovation.cms.gov/initiatives/cjr

[8] https://innovation.cms.gov/initiatives/bpci-advanced

[9] Nguyen KT, Olgin JE, Pletcher MJ, et al. Smartphone-based "Geofencing" to Ascertain Hospitalizations. *Circ. Cardiovasc. Qual. Outcomes*. 2017 Mar; 10(3): e003326.

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Kidney Disease Patients Can Benefit from Home Support

by Carmen A. Peralta, MD, MAS, Chief Medical Officer of Cricket Health

For individuals with chronic kidney disease (CKD), and especially those suffering from end-stage renal disease (ESRD), hospitalizations can be a frequent occurrence. Each new medication, life event, dietary change or even a simple cold can result in a patient quickly going from managing their disease to needing urgent care and multi-day hospitalization.

As a practicing nephrologist, professor and researcher, I've seen first-hand the struggles that patients with kidney disease face, including hours spent at outpatient dialysis clinics and frequent hospitalization. Patients with CKD and ESRD experienced rehospitalization at rates of 21.4 percent and 35.2 percent, as compared to only 15.4 percent for older Medicare beneficiaries without a diagnosis of kidney disease. ESRD patients, on average, are admitted twice a year, and more than one-third face rehospitalization within 30 days following discharge.

"Patients with CKD and ESRD experienced rehospitalization at rates of 21.4 percent and 35.2 percent, as compared to only 15.4 percent for older Medicare beneficiaries without a diagnosis of kidney disease."

The current healthcare system – which focuses more on reactive care after a catastrophic event results in kidney disease diagnosis and puts patients on a fast track to dialysis – is partially to blame for readmissions. I believe a new approach is necessary; one that empowers the patient with education, support and proactive care, and one that eliminates the silos that result in fragmented care, miscommunications and medical errors. Most importantly, the level of care and support should be personalized, and it should address specific health, social and functional needs for each patient.

Healthcare providers must focus on prevention of kidney disease, and screenings for individuals at highest risk, including those with diabetes or high blood pressure, or taking certain medications. A key to that is a multidisciplinary care team, comprised of a nephrologist, primary care physician and other medical professionals, who can educate patients, and their family/friends, and help them understand how best to manage their disease at home.

Home care is a critical component to proactively addressing kidney disease complications and key to preventing frequent rehospitalizations. One study published in the *Journal of the American Medical Association* noted that home care intervention for at-risk elderly patients demonstrated great potential in promoting several positive outcomes by reducing readmissions, lengthening the time between discharge and readmission, and decreasing the costs of providing healthcare.

"Home visits after hospital discharge or during care transitions have significant potential to reduce rehospitalizations by educating patients about fluid management, reconciling medication, offering needed support and coaching, and even providing in-home alternatives to outpatient dialysis."

The approach outlined in the study is equally relevant for those with CKD and ESRD. Home visits after hospital discharge or during care transitions have significant potential to reduce rehospitalizations by educating patients about fluid management, reconciling medication, offering needed support and coaching, and even providing in-home alternatives to outpatient dialysis.

It's time for the industry to look beyond our existing approaches to healthcare, particularly with regard to treating those with kidney disease. By shifting away from reactive approaches, like dialysis, to a more conservative, proactive approach that arms patients and caregivers with information about their disease – including options for care at home – we may actually reduce rehospitalization, while improving the patient's quality of life.

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Thought Leaders' Corner

Q. How can the Hospital Readmissions Reduction Program (HRRP) be improved?

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.

To increase the impact of HRRP, primary care needs to be included more directly. Primary care should be rewarded for its part in reducing readmissions because primary care providers are the largest determinant to keeping patients from re-admitting in certain situations.

We often think of readmissions occurring because the hospital "did a bad job" and that patient didn't recover so she ended up back in the hospital. However, oftentimes, the reason a patient re-admits has nothing to do with the care delivered in the hospital and has everything to do with the transition out of the hospital. A common example is a discharged patient doesn't fully understand what she needs to do when she gets home or feels lonely, scared and no longer cared-for and ends up back in the ER a week later.

That patient would be much less likely to re-admit if a PCP office calls her the next day, brings her in for a visit with a familiar face, makes her feel cared for and helps internalize her plan to remain healthy at home.

That's exactly why CMS created a separate, smaller incentive program for PCPs to conduct "Transition of Care visits," but needs to go one step further and involve primary care more directly in HRRP, which has much higher stakes. Today, hospitals are rewarded or penalized in the hundreds of millions of dollars range for readmissions but primary care is not. Adapt HRRP to significantly share the responsibility and incentives with primary care and hospitals will see their readmissions drop.

Ben Kraus
Chief Executive Officer, Stellar Health

Penalties need to have teeth to be effective. Unfortunately, the Hospital Readmissions Reduction Program (HRRP) is toothless. While HRRP has raised awareness and education around this important issue, the relatively insignificant consequences have resulted in a lot of discussion from hospital and health system senior leadership, but little action. Although they may not admit it, C-level executives seem more than willing to sacrifice a small reduction in Medicare reimbursement in exchange for significant revenue generated from readmissions within 30 days.

Yet at these same healthcare organizations, case managers and hospitalists are demonstrably focused on choosing care programs that prevent readmissions, including partnering with high-quality home healthcare providers with documented experience at keeping patients out of the hospital. As a home healthcare organization, we have been impressed with the commitment by these clinicians and other healthcare professionals to pursue innovative high-touch, home-based care plans that help their patients avoid readmissions and stay in their home, even among patients with advanced stages of chronic conditions, such as chronic obstructive pulmonary disease (COPD).

While the penalty has had some positive effects, it is by no means a solution that inspires collaboration from all stakeholders to reduce the cost of healthcare, improve the patient experience and increase their quality of life. After all, we have yet to meet anyone who enjoys spending more time in a hospital. We would suggest that the reimbursement be capitated by patient for a 90-day period or increase the penalty percentage in addition to extending the readmission timeframe to 90 days.

Casey Hoyt
Chief Executive Officer, VieMed

Thought Leaders' Corner

The Hospital Readmissions Reduction Program (HRRP) has received a lot of attention this fall, with some hospitals being hit with penalties as high as 3% of FFS reimbursements, and this being the first year that CMS has grouped hospitals into peer groups based on their percentages of low-income patients. Since the start of the program in 2012, there have been over $1.9 billion in penalties to hospitals, and $528 million of that were in 2017 alone.[1] While evidence from value-based programs to date does support the use of financial incentives to motivate providers, on their own they're not sufficient to force meaningful change in the healthcare system. The underlying problems with preventable readmissions are lack of communication, disparate systems, and insufficient information-sharing. For HRRP or any other program of its kind to succeed, there also have to be incentives for providers to connect.

It's very common to see care management teams that aren't talking to PCPs, specialists, or other providers on a regular basis, simply because there's no efficient way for them to communicate and share information. This unfortunately results in patients being sent back to emergency rooms or being admitted for observation when they could have been treated at home or in an outpatient setting, preventing or preempting readmission to the hospital. There's no standard in healthcare that requires hospitals to share patient data—we have local and state HIEs, but there is no federal system tying everyone together. It's a system of disparate systems, so to speak, which creates a huge barrier to communication and hinders care managers' efforts to prevent readmissions.

This is not a new problem; providers have long been frustrated by the lack of available tools to track, manage and communicate about patient care. Fortunately, new technology is emerging to drive system integration and improve communication across the continuum. Hospitals can track their patients' movements in real time—and intervene in real time—before a patient is readmitted to the hospital. They can connect to post-acute providers' EHRs and see how their patients are faring post-discharge. They can also view aggregated data for their patient populations and assess how well their post-acute partners are performing when it comes to key metrics like length of stay or readmissions.

Programs like HRRP have started to motivate hospitals to look beyond their four walls, but they need to go further. Now that the technology is being developed to connect providers and disparate systems, the incentive to connect is really the missing ingredient and what can take this and other CMS programs to the next level.

[1] https://www.aha.org/system/files/2018-01/fs-readmissions.pdf

Michael Ipekdjian, MBA-HM, BSN, RN
Director of Customer Success, CarePort Health

Are we measuring the right things?

Medicare and other payers seeking to improve care quality are tying financial incentives to hospital readmission rates. Hospitals with worse-than-expected readmission rates face significant implications both financially and in terms of organizational reputation. But are readmission rates an effective way to measuring quality? CCNC experience suggests the metric could at times be providing an incomplete or misleading picture of health system performance.

Could we be getting better care along with higher readmissions?

CCNC is focused on interventions that improve access to primary care, quality of chronic disease care, and coordination among care providers. We have found that this approach can indeed reduce the frequency of inpatient admissions in a well-managed population over time. However, it is reasonable to expect that individuals in such a system who do require hospitalization will have greater clinical complexity and/or more advanced illness. And so, paradoxically, despite doing all the "right things," we would expect that rate at which hospitalized patients in this population will require readmission within 30 days will in fact RISE over time.

Can we find evidence that this dynamic is actually occurring?

A CCNC study of North Carolina Medicaid patients using claims data from 2008 through 2012 considered this issue. The data showed opposing trends in overall admission rates and 30-day readmissions per discharge. This pattern has also been observed in other population-based care improvement initiatives, including 14 Quality Improvement Organization initiatives to improve care transitions for Medicare beneficiaries and the Medicare Physician Group Practice demonstration, Medicare's first pay-for-performance initiative.

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Thought Leaders' Corner

The pattern consistently noted in evaluations is weak or inverse associations between the 30-day readmission rate and other measures of health system quality performance, including initial hospital length of stay, inpatient days over an episode of care and Medicare's Hospital Compare process quality measures, and rates of patient mortality.

Can we improve on this approach to quality measurement?

To adjust for this dynamic, robust methods for risk adjustment must be incorporated into readmissions standards to allow not only for cross-sectional comparisons to other entities, but for longitudinal observations within a target population. Also, given that improved management of chronically ill-patients can in fact lead to a rise in a per-discharge readmission rate, perhaps a more important approach for quality advocates would be looking beyond that first 30 days post discharge to longer-term outcomes. Essentially, we have made the case that good transitional care reduces "admissions" not just readmissions, and so, better metrics would be risk adjusted inpatient admission rates, OR risk adjusted readmission rates PER beneficiary as opposed to per admission. In this way the measure would reflect an overall reduction in these types of negative events.

Carlos Jackson, PhD
Chief Data & Analytics Officer, Community Care of North Carolina

HRRP is valuable in getting providers more aligned with long-term outcomes. Conceptually, getting providers to have some sort of risk in long-term outcomes gets everyone more aligned with the same goal, which is the most positive outcome possible for the patient.

However, this program has a side-effect, too. Organizations, which previously have had no incentive to share patient data, are now actively doing so, or at least exploring the option. For example, a hospital may have no reason to want to automatically interface with a post-acute facility. With strict fee-for-service, the acute facility is not under any financial pressure to ensure a smooth transition, and ensure the patient's long-term needs are met.

Of course, physicians and the individual providers have always been focused on this. Doctors always want the best outcomes for their patients. But when the entire organization is now financially incentivized to that same goal, they have better tools to actually make that happen. Data tools to make sure the right post-acute or home-health agency is used, and real-time data for readmission rates of these facilities lets doctors and case managers make data-driven decisions about the best next step for their patients.

Perhaps this transformation was bound to happen, but the financial pressure that HRRP exerts is a key motivator and call-to-action to make provider organizations change the way they approach treatment once a patient leaves the facility.

As with many CMS programs, HRRP could benefit from simplification in the way things are calculated. Adding unnecessary complexity always means adding more expense, meaning, organizations have to pay for personnel or consultants to assess their readmissions risk and plan for any penalties. A simplification in the formula could also help reduce the administrative cost for facilities.

Additionally, the payment reduction cap may not be high enough to drive action for health systems. Some health systems may calculate that the cost of deploying new technology to reduce readmissions will be more expensive than any projected penalties. The more that the maximum penalty is increased, the more organizations will be motivated to change.

Additionally, it would be a good approach to incentive health systems that are overperforming and innovating in ways to reduce readmissions. Financial incentives to innovate means that health systems are not just working to avoid penalties; they are actively innovating to capture a share of extra incentive payments.

Overall, HRRP is a significant step toward value-based care, and helps to align health-system incentives with patient outcomes. Simplification and providing upside can help this program drive results even further.

Joshua Douglas
Chief Technology Officer, Bridge Connector

Industry News

ConcertoHealth Achieves Double-Digit Improvements in Hospital Admissions and Readmissions for Washington's Highest Risk Patient Population

ConcertoHealth, the leading full-risk provider of specialized primary care and supporting clinical services for vulnerable, frail and elderly patients, announced that it has achieved a 29 percent reduction in hospital admissions and a 12 percent drop in readmissionsi in the state of Washington. The health services organization has also reduced overall emergency department (ED) readmission rates by 6 percentii, year-over-year, for Washington's most fragile patient population.

ConcertoHealth provides field-based care teams and "wraparound" support services to Washington state Medicare Advantage health plans. Rather than replace or compete with the health plans' primary care providers (PCPs), ConcertoHealth supports their performance with an array of clinical resources, including social workers, care managers, pharmacists, clinicians and nurses, to care for patients when they are most in need, in any care setting.

"Knowing that patients with complex medical needs can easily slip through the health care system is exactly why we developed our Primary Care Support Platform," said ConcertoHealth Chief Care Transformation Officer Christopher Dodd, M.D., M.S. "Our care model enables ConcertoHealth to stand shoulder-to-shoulder with primary care providers as partners in caring for Washington's most complex patients, many of whom are dual eligible for Medicare and Medicaid."

In addition to improved health outcomes for patients, the ConcertoHealth Primary Care Support Platform has also achieved 19 percent savings in medical costs nationally for its health plan partners.iii

Improving the Health of Washington's Most Vulnerable Residents One Patient at a Time

More than 52 percent of patients under ConcertoHealth care are diagnosed with three or more chronic medical conditions. The company reports the following disease prevalence rates among patients in Washington:

- 83 percent have a behavioral health diagnosis,
- 71 percent are diagnosed with cardiovascular disease,
- 51 percent have been diagnosed with congestive heart failure (CHF), and
- 41 percent are diabetic.

As patients' health care needs become more complex, ConcertoHealth relies on field-based interdisciplinary care teams to help health plans' PCPs manage their patients' myriad needs, identifying avoidable hospital admissions and readmissions. To facilitate effective collaboration with PCPs, ConcertoHealth utilizes a proprietary population health analytics platform, Patient3D, which provides PCPs with a 360-degree view of each patient's status and care needs.

Discharge Strategies to Prevent Asthma ...continued

ConcertoHealth deploys an ED intervention program, in which its medical directors closely monitor potentially avoidable hospital admissions. For each potential hospital admission intervention, ConcertoHealth medical directors partner with ED clinicians to determine the most appropriate care plan and setting.

The program has proven effective in reducing the percentage of would-be hospital admissions, by diverting patients to more appropriate care settings such as a skilled nursing facility.

One example is a 48-year-old patient from Kent, Washington, who visited the ED more than 91 times in 2016. At the time of ConcertoHealth's first encounter with him, the patient's primary medical issue was a set of nonhealing wounds from a 2015 surgery. In addition, he has an extensive history of issues with pain medication.

The patient has developmental disabilities, anemia and lives with his father, who was struggling with his own health issues. Since the patient engaged with ConcertoHealth in April 2017, the field-based care team established:

- regular home-based wound care and biweekly visits with key members of the care team, including a PCP, a pharmacist, and a registered primary care nurse,
- a pain-management plan, including a medication adherence agreement,
- communication and collaboration with the patient's family caregivers,
- case coordination with Department of Social and Health Services caseworkers to ensure patient care and safety, and
- a behavioral health services treatment plan to initiate a substance abuse assessment, as well as counseling for opioid dependency.

Since engaging with the ConcertoHealth care team, the patient's health has improved, with decreased ED utilization in 2017 and no ED visits or inpatient admissions in 2018.

Incentivizing Healthy Habits: Florida Hospital Partners with Digital Health Startup Wellth to Reduce Readmissions

One of the greatest challenges in keeping patients healthy and reducing costly hospital readmissions is ensuring they take their medication and follow doctors' orders.

Florida Hospital has partnered with New York-based Wellth to use the power of incentives to help keep patients on track — and out of the hospital.

Industry News

Incentivizing Healthy Habits: Florida Hospital *...continued*

Patients discharged from Florida Hospital DeLand with one of four common conditions – congestive heart failure, chronic obstructive pulmonary disease (COPD), heart attack and pneumonia – will be offered an opportunity to enroll in Wellth's app for free. Once home, patients start with $50 in an account in their name, which they can receive after using the app for 30 days. All they need to do to receive the $50 is log into the Wellth app daily and confirm they've taken their medication as prescribed. To further help patients stay on track, the app sends reminders and prompts patients to access the app. Each day a patient does not use the Wellth app to track their medications, they can lose up to $2 from the $50 balance.

Academic research, as well as Wellth's own results in other patient populations, showed that patients responded better when motivated by a desire to not lose money, rather than the promise of earning potential funds.

New York-based Wellth focuses on the field of behavioral economics — the study of human behavior using psychological insights to explain economic decision-making. The goal is to use these learnings to help patients with chronic disease change their behaviors and improve their health.

"There's a phenomenon known as the 'intent-behavior gap,'" said Wellth CEO Matt Loper. "We intend not to have the dessert. But then the dessert cart rolls by and you do the opposite."

"Patients often intend to take their pills every day, but doing so is not instantly motivating and the behavior often does not happen," Loper added.

As a result, roughly one in five patients nationwide end up back in the hospital within 30 days after a heart attack. This is not only bad for the patients, but it drives up costs for the health-care system as a whole.

"We see the Wellth app as an innovative way to make it easier for our patients with these conditions get and stay healthy, while also driving down the total cost of care," said Craig Lindsey, Chief Nursing Officer at Florida Hospital DeLand. "We're committed to a promise of wholeness, and that means caring for our patients not just while they're in the hospital, but at every stage of life and health. We're proud to partner Wellth to make health care more connected, affordable and exceptional."

Loper said patient response to the app has been positive.

"Patients enjoy that interaction because it's a fun interaction that forms a habit," Loper said. "We hear, 'We had a lot of fun taking that picture every day.' It makes patients more invested in the recovery process."

VISITING NURSE SERVICE & HOSPICE OF SUFFOLK, INC.

Visiting Nurse Service & Hospice of Suffolk Partners with HRS to Improve Patient Outcomes

Visiting Nurse Service & Hospice of Suffolk (VNSHS) has recently launched a telehealth program with Health Recovery Solutions (HRS). VNSHS partnered with HRS in September 2018 in order to enhance care for patients with heart failure, COPD, hypertension, pneumonia, and diabetes. Through their telehealth program, VNSHS hopes to improve patient outcomes, limit disease exacerbations, and reduce the risk of hospitalization for their patients.

Patients placed on the telehealth program at VNSHS are provided with 4G tablets pre-loaded with the HRS software. The tablets are paired with disease specific Bluetooth biometric devices that allow patients to capture their blood pressure, weight, heart rate, and more.

This information automatically transmits to the patient's tablet and is electronically delivered to patient's nurse, allowing clinical staff to quickly address any abnormalities or changes in medical status.

VNSHS decided to partner with HRS because of the extensive features that allow them to meet their needs and goals. The clinical team is particularly excited about the software's patient communication capabilities. Clinicians can keep in touch with patients through the tablet's text, call, and video chat features. Additionally, the clinicians at VNSHS plan to use HRS telehealth for wound imaging to facilitate remote assessment of wounds to ensure proper healing.

The HRS software allows VNSHS to take active steps to identify high risk patients and subsequently prevent avoidable hospital readmissions and emergency department visits. Diana Gallo, RN, Director of Operations at VNSHS, states, "Being able to partner with patients and their caregivers is critical to patient-centered care planning, and the HRS Telehealth platform will be an important tool to meet that goal."

Jarrett Bauer, CEO of HRS, adds, "We are thrilled to have been chosen as the telehealth provider for Visiting Nurse Service & Hospice of Suffolk. The clinicians at VNSHS are driven to improve healthcare and they are dedicated to the wellbeing of the patients they serve. We are excited to play a role in their progress and success."

Industry News

MCG Health Offers Certified Integration with Industry-Leading Care Management Application

MCG Health, part of the Hearst Health network and a leading provider of informed care strategies, and Pegasystems Inc., the software company empowering customer engagement at the world's leading enterprises, have completed certification (1) of their joint care solution. This solution integrates MCG's Chronic Care content via Informed by MCG for Disease Management directly into Pega Care Management™, providing care teams clinical guidance within their existing workflow. In addition to a streamlined workflow, the application features enhancements designed to improve patient experiences.

Care teams tasked with improving population health outcomes while maintaining regulatory compliance now have access to tools that allow them to efficiently build, document, and share evidence-based assessments and care plans. MCG's Chronic Care content helps care teams evaluate patient needs, identify relevant goals, develop individualized care plans, and support self-care for patients with chronic diseases or complex care needs. Also included are patient-facing handouts (available in English and Spanish) to educate patients and promote self-care.

Pega Care Management cost-effectively delivers a unique combination of care management best practices, real-time connected data and analytics, personalized care planning, and streamlined delivery of appropriate services for optimal patient outcomes. This enables care teams to remain connected and coordinated for consistent care across the patient journey. New omnichannel capabilities within Pega Care Management allow care teams to communicate seamlessly with their customers on any channel, including chat, web, mobile, and more. This update is part of Pega Infinity™—Pega's next generation digital transformation software suite that unifies customer engagement and digital process automation (DPA).

Integrating MCG care guidelines directly within the Pega Care Management workflow gives care teams the ability to quickly and easily assess patient needs against evidence-based standards and tailor care plans to ensure each patient receives effective and personalized care. Annotations and citations linked throughout the application provide insights into the evidence behind different elements of the care plan. Simplifying the creation of individualized care plans increases staff efficiency while evidence-based care coordination helps close care gaps and reduce readmissions.

"To achieve optimal patient outcomes, the healthcare industry needs access to the latest research and care guidelines while also creating seamless customer experiences on any channel," said Susan Taylor, vice president and industry market leader, healthcare and life sciences, Pegasystems. "Our recent enhancements to Pega Care Management enable members to receive relevant, critical communications on their channel of choice, while giving caregivers the tools to provide exceptional care."

"Informed by MCG for Disease Management makes MCG's Chronic Care content readily available within the software healthcare professionals already use so they can avoid workflow disruption and proactively manage patient health to deliver appropriate, cost-effective care," said Jon Shreve, president and CEO of MCG Health.

Catching Up With Matt Miller ...continued from page 12

Consider the possibilities if a physician had access to social and behavioral information alongside lab tests, imaging results, and other background information about the patient. Not only could the doctor see that his 50-year old female patient's glucose is high, creatine and hemoglobin are slightly off, he could also evaluate the impact of her adherence to taking prescription medicine, stress level and the fact that she lives in an urban food desert and doesn't have access to regular care.

These types of solutions are already coming to fruition, in a variety of forms and functionality. Consider the offering developed by Proteus Digital Health, which combines ingestible sensors, a small wearable sensor patch and mobile application to monitor patient health patterns and medication adherence behaviors. The objective information collected by the Proteus system enables doctors to initiate, adjust or eliminate medication and measure treatment effectiveness, saving patients and payers money while optimizing care and amplifying outcomes.

Johns Hopkins University School of Medicine was also recently awarded a grant to continue research of the emocha mHealth app, which tracks medication details and care management for individuals with tuberculosis, a diagnosis where strict medication adherence is essential for positive outcomes. The app connects patients and providers for Directly Observed Therapy (DOT), in which patients record themselves taking prescribed medication. The video is uploaded to a telehealth portal, where providers can confirm the medication was taken correctly and collaborate with patients on care management. Early results show that emocha app boosted medication adherence rates by 94 percent and saved almost $1,400 per patient in treatment costs.

Using multiple data points to triangulate a patient's condition enables physicians to deliver healthcare with a more holistic perspective. Understanding the gravitational force SDOH has on health outcomes, physicians not only can address the symptoms of disease, but can also respond to variables known to cause and/or exacerbate illness. With these types of insights, they can make more informed decisions around diagnosis, treatment and the continuum of care.

Catching Up With ...

Matt Miller PhD

Vice President of BehavioralSscience
StayWell

Readmissions News: What impact are advances in technology having on the healthcare individuals receive?

Dr. Miller: Advances in technology are having a significant impact on the healthcare individuals receive. Patient DNA is used to personalize treatments with precision medicine. Artificial intelligence (AI) and machine learning is speeding diagnosis and helping providers determine the best courses of action. And the Internet of Things (IoT) is enabling a wide range of remote clinical applications – from medication adherence to monitoring vital functions including glucose, heart rate and blood pressure to configuring and gathering real-time data from medical devices such as pacemakers and defibrillators.

While these technologies are powerful on their own, the combination of these various patient-specific data streams can produce an exponential impact on improving patient outcomes when merged with behavioral and environmental insights. Integration of this diverse data, through electronic health records (EHRs) and other critical healthcare systems, will play an important role in creating an ecosystem that enables providers and patients to get the information they need, when they need it. In turn, this integration of data will support the larger goals of improving population health.

Readmissions News: Can you provide some concrete examples?

Dr. Miller: Modern healthcare is well positioned to reap the rewards of recent advances in technology. Silicon and graphene at the chip level and microelectromechanical systems (MEMS) in semiconductors are in devices used every day for diagnoses and treatment, such as CT scanners, X-ray machines, magnetic imaging, ultrasound, and for monitoring blood pressure, glucose levels and other vital statistics. These components play critical roles in sensing, data processing and controlling machines used to monitor and treat patients. Add data science – AI and machine learning – to the mix, and the industry can begin to explore new frontiers in healthcare by expanding our ability to detect and interpret patterns.

We are beginning to see this convergence of new technologies emerge in targeted use cases. Computer vision and convolutional neural networks are helping radiologists identify malignant tumors, minimizing the pain, inconvenience and cost of biopsies. Pharmacogenomics and precision medicine are enabling researchers to identify first-line medications for patients based on their genomes and develop therapeutics based on the unique characteristics of the individual and his or her disease.

These applications are just the beginning of innovations that will redefine healthcare in the 21st century. But there may be a simpler example of how today's data capture technology can make an equally significant impact in improving population health. This approach involves integrating behavioral, environmental and social data directly into physician's workflows, so health care professionals can have a more robust understanding of a patient's risk factors and take proactive steps to help patients remain, or become more, healthy.

Readmissions News: Why do the social determinants of health matter?

Dr. Miller: Social determinants of health (SDOH) are macro-level factors responsible for influencing health risks and health outcomes. SDOH include economic stability, neighborhood and physical environment, level of education, access to healthy food and quality healthcare, available support systems, and stress. These factors contribute to an individual's life expectancy, mortality, healthcare expenditures, health status and functional limitations, according to the Henry J. Kaiser Family Foundation.

Research demonstrates the enormous influence of behavior and SDOH on patient outcomes. Clinical interventions impact only 10 to 20 percent of a person's health outcomes, while socioeconomic and environmental factors determine 80 to 90 percent, according to The National Academy of Medicine.