

MANAGED HEALTHCARE EXECUTIVE®

www.managedhealthcareexecutive.com

Part of the  Modern Medicine
NETWORK

{ HEALTH MANAGEMENT }

Reduce readmissions by closing transitional gaps in care

Seniors are vulnerable to losing care momentum

BY MICHAEL T. MCCUE



Getty Images / DAU

On the surface, “care transitions” sounds like an area of responsibility limited to hospitals and clinicians, since those stakeholders deliver direct patient care. But insurers also have a role to play, otherwise that type of segmented thinking will likely lead to care breakdowns and hospital readmissions.

“This isn’t something that can be done just by physicians and hospitals,” says Mark D. Stewart, MPH, associate director of quality programs at the Washington, D.C.-based American College of Cardiology Foundation (ACC). “One of the very first ingredients in creating a good care transition plan is gaining the support of top ex-

ecutives, including those at payer organizations. In fact, if getting the buy-in of top non-clinical executives isn’t the single most important success factor, it’s close.”

When insurers and hospitals find ways to work together, the quality and cost improvements they achieve can be significant. For example, an initiative developed by Aetna and Mary Naylor, MD, a professor of gerontology and director of the New Courtland Center for Transitions and Health at the University of Pennsylvania Health System, combined case management and home care, coordinated by advanced practice nurses (APNs). In the program, an APN visited Aetna members in the hospital before discharge to ensure they knew what to expect once they got home.

“One critical success factor is that the nurses assist patients with all health factors, not just the episode that landed them in the hospital,” says Marcia Wade, MD, senior medical director for Aetna’s Medicare medical management team. “Together, we’ve been able to reduce readmissions by about 25% during the three-to-six-month post-discharge period. Health plans need to view hospital systems as key components in the continuum of patient care, not just as inpatient facilities.”

The need to tighten up gaps in the system will continue to be an area of emphasis due to demographic factors;

Michael T. McCue is a Virginia-based freelance writer.

BEST PRACTICES

Four opportunities for improving care transitions for seniors

1. HOSPITAL PREADMISSION.

This is an opportunity for diversion. For example, if a patient with congestive heart failure shows up in an emergency room due to wheezing, the situation might call for a home respiratory specialist rather than an admission.

2. INPATIENT STAY. Many seniors admitted to hospitals might not even need to be there. Patients admitted for infused drugs, for example, could be better served by a home-care specialist.

3. DISCHARGE. The clearest opportunity to manage transitions starts at the outpatient discharge process. There is an emphasis on reducing lengths of stay, but spending a little extra time to educate patients about what they need to do for proper follow-up care can dramatically reduce re-admissions. Education is especially important for seniors who take multiple prescription drugs.

4. POST-ACUTE. Communication among different types of providers is the hurdle here, leading to insufficient follow-up. Lack of communication puts even greater pressure on the patient's ability to follow care plans as they move between different providers.

Source: Univita Health

people over the age of 80 is the fastest-growing population segment in the United States, and they are also the most susceptible to falling through the cracks in the healthcare system. Equally important, today's seniors want to remain in their homes as long as possible.

"The defining question for healthcare right now is the aging population, and healthcare professionals aren't quite sure how to engage this group," says Hugh Lytle, co-founder, president and CEO

of Univita Health, a Scottsdale, Ariz.-based company that integrates clinical and non-clinical services to promote a home-centered approach to independent aging. "They have a lot of healthcare needs, but they are also passionate about staying independent and don't want to repeat their parents' aging experiences. From both a cost and quality-of-life perspective, we need to find ways to allow patients to stay in their homes rather than move into long-term institutions."

FROM THE HOSPITAL TO THE HOME

One of the most prominent care-transition projects currently under way is Hospital to Home (H2H), a joint initiative of the ACC and Institute for Healthcare Improvement. This national quality improvement initiative seeks to improve transitions from inpatient to outpatient status for individuals hospitalized with cardiovascular disease. Its goal is to reduce the 30-day, all-cause, risk-adjusted hospital readmission rates for patients discharged with heart failure or acute myocardial infarction by 20% by December 2012.

The potential rewards are significant. Currently, almost 20% of Medicare patients are readmitted to the hospital within 30 days of discharge, with heart failure listed as the most common reason for readmission. In 2004 alone, the total cost of these readmissions was \$17.4 billion.

The H2H initiative focuses on three main areas for improvement:

■ **Post-discharge medication management.** Patients must not only have access to the proper medications, they need to be properly educated on how to use them.

■ **Early follow-up.** Discharged patients should have a follow-up visit scheduled within a week of discharge, as well as the means of getting to that appointment.

■ **Symptom management.** Patients must recognize the signs and symptoms that require medical attention, as well

as the appropriate person to contact if those signs/symptoms appear.

As is always the case, no healthcare initiative—including provider-oriented ones such as H2H—can achieve much without the proper funding, and that's where health plan executives come in.

"The best thing we can do to encourage better care transitions is to reward the organizations that follow best practices," Stewart says. "It would help if health plans rewarded hospitals for their quality by paying more to those facilities that have lower readmission rates."

With budgets stretched so tight, the incentives wouldn't even necessarily have to be financial. For example, he is currently in discussions with health plans to incorporate participation in H2H into programs to recognize quality hospitals.

Aetna's Dr. Wade says that one of the challenges for insurers is to deliver the right amount of information to providers without overwhelming them. There's an opportunity to collaborate on the quality of care, which obviously helps with costs as well.

"Plans have a lot of information that physician groups can use to provide better care to their patients, and the trick is to get them as much information as they can use without 'spamming' them with too many data points," she says. "We're working with more than 30 of our provider groups around the country to strike that balance and develop a truly patient-centered medical home."

To improve those care transitions, healthcare stakeholders must continue to focus on eliminating what Lytle refers to as "the black hole" in the care continuum.

"We need to close the loop between hospitalists, primary care physicians, social workers and families," he says. "We advocate the use of a 'residentialist' who can coach patients and assist in the coordination of care. Depending on the situation, that residentialist might be a nurse, a nurse practitioner or a social worker." **MHE**