How ACOs Can Prevent Avoidable Hospital Admissions

By Matt Adamson

Patients are grateful for the care they receive in the hospital, but they are always eager to return home. They certainly do not want to be readmitted days or weeks after discharge -- yet that's exactly what happens millions of times a year. As part of the Affordable Care Act (ACA), hospitals are now highly incented to reduce these high-cost readmissions, most of which are preventable.

Prevention begins with a thoughtful, comprehensive hospital discharge process that includes medication reconciliation, extremely clear discharge instructions, and strong encouragement to schedule follow-up visits with the patient’s primary care physician.

It also requires better care coordination in the ambulatory care setting -- a problem in the fee-for-service environment, where reimbursement for coordination is often lacking. In the medical-home model where some of those dollars are available, the primary care physician can better manage post-discharge patient care transitions. Still, without robust technology to ensure physicians are notified of discharges and to help them synchronize with hospitals and other members of the medical home program, the onus for coordination too often falls on the patient and his/her family.

Achieving a sweeping reduction in readmissions requires a new level of care coordination, one that involves disease management, early identification of patients at high risk of readmission, and a focus on medication adherence. Essentially, we're talking about a 180-degree shift in how the healthcare delivery system is run, and accountable care organizations (ACO) will be at the forefront of that change.

Just the Facts. The term “hospital readmission” began to make headlines in 2012 when the ACA put in place a system of Medicare penalties for hospitals with readmission rates higher than the national average. But, even then, the topic wasn’t exactly new. In fact, hospital readmissions have resulted in $25 billion a year of wasted spending, according to PriceWaterhouseCoopers.1

A hospital readmission is defined as a hospital stay following an original admission and discharge, within a certain timeframe. A readmission can occur at either the same hospital or a different one, and can involve planned or unplanned surgical or medical treatments. According to the Centers for Medicare and Medicaid Services (CMS), there were 1.9 million Medicare readmissions in 2010, at an estimated cost of $17.5 billion.2

Studies show that about one-fifth of Medicare beneficiaries discharged from a hospital were re-hospitalized within 30 days, and more than one-third were re-hospitalized within 90 days.3 Beginning in the last quarter of 2012, more than 2,000 hospitals began to see reduced Medicare payments because of readmissions above risk-adjusted national averages for patients admitted with heart failure, myocardial infarction and pneumonia.3

ACOs are uniquely positioned to improve care coordination to resolve these issues and dramatically lower readmission rates. The powerful combination of incentivized collaboration between hospital and primary care physician, sophisticated disease management practices, and new technologies that support a focus on preventive care and value is the key to preventing avoidable readmissions.

Keys to Success. We see three main areas of focus for ACOs as they work to create sustainable connectivity among physicians, hospitals, caregivers, and patients.

1. Implement rigorous disease management for high-risk populations. Our current fee-for-service reimbursement system, in which higher volumes equate to higher reimbursement, is problematic when it comes to treating high-risk populations. The ACO model, with appropriate incentives for quality, service, safety and cost, is a significant step forward, allowing providers to focus on quality outcomes rather than quantity of encounters.
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Along with this reimbursement shift, we need a comprehensive set of disease management programs. These programs should be (a) designed using the latest evidence, (b) disease-specific, and (c) focused on keeping selected individuals with specific co-morbidities as healthy as possible. The National Quality Forum, the Institute for Healthcare Improvement, and the Agency for Healthcare Research and Quality have all demonstrated that applying evidence-based approaches to commonly occurring conditions as part of a rigorous disease management program reduces the cost and optimizes the quality of care.4

Patients managed in this manner are generally more educated about their condition and have an established relationship with a health coach or care coordinator, so they are better prepared to be successful in the event they are admitted to the hospital for treatment. This can greatly reduce the risk of readmission.

2. Use technology to improve care coordination. The first role for technology in care coordination is notification. Providers must be informed when certain patients make a significant move through the healthcare system. To prevent becoming overwhelmed with data, providers need technology that lets them easily identify which patients are top/medium/low priority, and set thresholds for multiple types of notifications using evidence-based analytics.

Once notified of an admission, the care coordinator must have evidence-based protocols available to quickly assess the patient and create a custom care plan. This step should include a series of questions asked during the admission that provides data to help determine the likelihood of a readmission.

For example, a readmission score developed at Brigham and Women’s Hospital is being used successfully to determine the level of engagement post discharge. This process can be effective when content is wrapped in workflow-oriented technology that allows users to track tasks and next steps. The effectiveness compounds if the care coordinator already has a care plan established with the patient that is specific to his/her condition. Tools designed to manage care coordination and care transitions provide a key starting point for both readmission prevention and enabling a value-based healthcare delivery model.

3. Focus on medication adherence. A hospital stay can be confusing for patients and family members. Disorientation from being away from home and confusion caused by pain medication are common, making it difficult to understand complicated discharge instructions—especially medication additions and subtractions. The disconnected nature of our healthcare system can also lead to confusion about medication lists, with providers sometimes relying on patient information about current medications.

To address this issue, the care manager must have the following:

- Tools that integrate with the physician EHR and other systems to ensure an up-to-date medication list at admission
- Ability to create a comprehensive discharge plan, including a medication list and other instructions that can be adjusted based on patient needs
- Systems that can analyze the updated list and alert the clinician to any potential drug-drug or poly-pharmacy issues
- Data and tools that can inform the clinician about the historic level of patient adherence so that more rigorous controls and monitoring can be put into place as needed
- Access to pharmacists for in-depth education and medication review for patients who need it
- Inclusion of the medication list in any chronic disease management care plan or program

Conclusion. The CMS penalties already in place are making an impact. CMS reports the percentage of readmissions were half a percent lower in 2012 than 2011, representing 70,000 fewer readmissions. Just as important, hospitals like Penn State Milton S. Hershey Medical Center are earning news coverage about escaping Medicare fines because of low readmission rates. The hospital credits both its collaboration with nursing homes and home care agencies, and its use of care coordinators to keep patients as healthy as possible.

We expect ACOs to develop systems to identify gaps in care and problems with medication adherence, adding the necessary rigor to the disease management process. This 360-degree view of patient information that spans the full continuum of care, regardless of where the patient is seen, will enable a greater focus on care transitions and the value-based model necessary to improve care while lowering costs. Nationally, we are a long way from achieving that goal, but important steps are being taken each day by forward-thinking ACOs to make it a reality.

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