Hospitals Collaborate with SNFs, Home Care, Hospice, to Reduce Readmissions

BY ELAINE ZABLOCKI, STAFF WRITER, NATIONAL RESEARCH CORPORATION

On October 1, 2012, a substantial number of hospitals began receiving reduced payments from Medicare, due to high patient readmission rates within 30 days after discharge. About 2,200 hospitals, amounting to two-thirds of all hospitals serving Medicare patients, received a reduction on all Medicare reimbursements (ranging up to a maximum of 1 percent) throughout fiscal 2013.

These penalties are due to the Hospital Readmissions Reduction Program, part of the Affordable Care Act. They are based on high readmission rates for patients discharged for three conditions: chronic heart failure, heart attack, and pneumonia. (These readmissions may or may not be related to the previous hospitalization.) Data on each hospital’s readmission rate will soon be posted on CMS’s Hospital Compare Web site.¹

For hospitals that aren’t able to bring down readmission rates, penalties will increase to a maximum of 2 percent for fiscal 2014 and 3 percent for 2015. In addition, CMS is considering similar payment reductions based on high readmission rates after joint replacement, stenting, heart bypass, and stroke.

These reduced payments have drawn substantial criticism because they apply to such a large number of hospitals, and because they don’t take into account special circumstances, such as the socioeconomic level of the hospital’s patients or limitations in the primary care infrastructure. “While hospitals feel these new developments are somewhat unfair, at the same time they have all accepted that we are now in a new world where they will be held at least partly accountable for what happens after the patient leaves the hospital,” said Robert M. Wachter, M.D., associate chairman of the Dept. of Medicine at the University of California, San Francisco. “Bundled payments, accountable care organizations, and readmission penalties are ways of readjusting hospital incentives and altering what hospitals do at many levels.”

A significant number of hospitals, knowing that financial incentives for reduced readmissions were in the pipeline, have been working on innovative programs, using a wide variety of approaches to help patients heal without complications, and to systematically streamline transitions between various care settings. What have they learned? How much has been accomplished?

Major points are emerging from current initiatives:

- The reasons for readmissions aren’t what people generally assume.
- Clear communication during transitions is key.
- Hospitals and health systems are forming collaborations with nursing homes and home care agencies, including monthly council meetings to look at problem cases together and explore the story behind the story.
- Hospitals are developing innovative services to offer needed support to patients without necessarily readmitting them.
- Hospitals and health systems are revamping transfer forms and educational materials to support smooth transitions and consistency between different settings.
- Hospitalists in the post-acute setting play a valuable role in reducing readmissions.
- Hospital and health system boards need to develop a consistent strategy for post-acute care.

This special section explores these issues in more detail and presents case examples and ideas for hospital and health system boards to consider in their role in enabling smoother transitions along the care continuum.

Hospitalists Play a Valuable Role in Post-Acute Settings

When patients leave the hospital there is a striking contrast between the intense level of care they receive in the hospital and the more subdued level of care received in skilled nursing facilities. Physicians check on patients (also referred to as residents) in a nursing home, but they are only present intermittently. When a nursing-home patient develops problems, sending them back to the hospital is often the first response that comes to mind.

Now the use of hospitalists is growing dramatically. In addition to caring for hospitalized patients, they are equally effective in post-acute settings.² IPC The Hospitalist Company, Inc., based in North Hollywood, California, is a large, single-specialty group practice with over 1,200 full-time hospitalists nationwide and several hundred more part-time. Five years ago, the post-acute sector accounted for only 5 percent of IPC’s business; today it accounts for over 20 percent.

A significant number of hospitals have been working on innovative programs, using a wide variety of approaches, to systematically streamline transitions between care settings.

Post-acute care includes a wide range of settings: skilled nursing facilities, post-acute rehabilitation, post-acute psychiatric facilities, custodial nursing care, assisted living, and inpatient hospice facilities. Today post-acute hospitalists are practicing in all those settings, according to Adam Singer, M.D., chairman and CEO of IPC. “Our post-acute hospitalists generally have internal medicine backgrounds and/or geriatric training,” he said. “We provide additional training so they understand key metrics for the post-acute facility, such as length of stay, readmission rate, and patient satisfaction. Our physicians are very good at managing individual patients clinically, and they also understand how to improve the general clinical quality within the facility.” Today IPC has over 200 post-acute hospitalists practicing in more than 1,000 post-acute facilities.

Although hospitalists do a great deal to improve care and reduce readmissions from post-acute settings, they face many practical challenges. Information flow between the

¹ See www.hospitalcompare.hhs.gov.

² See www.hospitalcompare.hhs.gov.
If possible, let the nursing home doctor know Fax needed medications to the pharmacy the day before discharge. Perform a review of five recently readmitted patients. Do not allow late-afternoon transfers. If you call the nurse, began their commitment to the seven principles. With them and presented these principles, they agreed to give the new approach a try. One factor that helped this change to occur at Stormont-Vail was that Sundbye had already been practicing for 10 years with colleagues who respected him. When he met with them and presented these principles, they agreed to give the new approach a try.

The standard hospital discharge form is designed as a succinct record of the care the patient received while hospitalized, but it is not designed as a road map for care the patient needs to receive after discharge. Privacy issues add another layer of complexity. “It is indeed a horrible problem,” commented Singer. “Nobody communicates well during the transition from the hospital to post-acute care. In fact, that’s what led us to build dedicated post-acute hospitalist practices; they connect to our acute-care practices through a single computer system. Since our doctors are all in the same medical group, they meet together every week, discuss their cases, and are able to hand off patients most effectively.”

Hospital and health system boards need to develop a consistent strategy for post-acute care.

Stormont-Vail HealthCare in Topeka, Kansas, independently discovered that post-acute hospitalists make an enormous difference in easing transitions when patients leave the hospital. It is an integrated delivery system that includes a 586-bed hospital plus 210 employed physicians in 28 locations throughout its service area. It started out with four hospitalists in 1999, and today it has 17. “Hospitalists admit 95 percent of our medical-surgical admissions,” said Kent Palmberg, M.D., senior vice president and chief medical officer.

One hospitalist, Kevin Sundbye, M.D., began noticing how many nursing home patients were quickly readmitted to the hospital. He looked closely at readmissions back to Stormont-Vail from nursing homes, and concluded that probably half of them were avoidable. “Two years ago he came to me and said, ‘I’ve been a hospitalist for 10 years; now I want to be an SNF-ist,’” recalled Palmberg.

Since then, Sundbye has been rounding on nursing home patients every day. He developed a set of seven guidelines or principles that he believes are key to minimizing readmissions from nursing homes:

- Fax needed medications to the pharmacy the day before discharge, so meds will be on hand when the patient arrives.
- Provide a written prescription for pain medications before the patient leaves the hospital.
- Have the doctor at the hospital contact the nursing home doctor who will be responsible for the patient. (Sundbye sees every patient dismissed within two days after their discharge to the nursing home.)
- If possible, let the nursing home doctor know ahead of time that the patient is being discharged. (Sundbye tries to come by the hospital to introduce himself to patients before they leave for the nursing home.)
- Do not allow late-afternoon transfers. If you can’t have the patient at the nursing home by 4 P.M., don’t send them.
- Anybody involved in the transfer process—doctor, nurse, social worker—can and should stop the discharge if they detect a problem.
- Use a checklist to confirm that everything is ready and going according to plan.

“It’s critically important to empower everyone to keep their eyes open and ensure that everything is going smoothly,” commented Palmberg. “After all, it’s no surprise that these patients are coming back from nursing homes, since the nursing homes are not incentivized to keep them. At the first sign of trouble, it’s so simple to send the patient back to the hospital.”

The seven principles listed above embody a dramatic change from the usual way of doing things. One factor that helped this change to occur at Stormont-Vail was that Sundbye had already been practicing for 10 years with colleagues who respected him. When he met with them and presented these principles, they agreed to give the new approach a try.

The hospital’s service area includes 11 nursing homes in the area, and they vary in their commitment to the seven principles. Stormont-Vail is working most closely with four nursing homes that are particularly receptive to these new ways of organizing care. “The whole concept is, when your patient isn’t doing well, you don’t need to call 911. Call Dr. Sundbye and you can count on him to come by and see the patient,” Palmberg explained. “Don’t transfer a patient back to the hospital until he sees them first.”

Since the program’s inception, it has expanded to include two geriatric advanced practice nurses, and recently another half-time hospitalist with training in gerontology. “The first year Dr. Sundbye was doing this, he didn’t take a day of vacation,” Palmberg reflected. “We were lucky. He has a passion for this work.”

Cross-Continuum Teams: Successful Collaborations

Amy E. Boutwell, M.D., M.P.P., cofounded the STAAR (State Action on Avoidable Rehospitalizations) initiative of the Institute for Healthcare Improvement (IHI). STAAR was one of the first large-scale, multi-stakeholder efforts to reduce readmissions and was an early leader in encouraging the field to form state-level and local cross-setting partnerships to address the systems issues inherent in transitioning care across settings.

Boutwell, who now runs her own firm, Collaborative Healthcare Strategies, pinpointed five steps the STAAR initiative found to be especially effective:

- Know your data.
- Know your partners—with whom you share patients.
- Form operational alliances to share data and improve transition processes. Form a cross-continuum team.
- Perform a review of five recently readmitted patients, and bring that information to the first cross-continuum team meeting.
- Identify shared processes that span the transition from the hospital to other settings, and work together to improve those processes.

At present hospitals tend to analyze readmissions by diagnosis and service line. For example, they may look at heart failure readmissions, and then try to improve internal
discharge processes for high-risk heart failure patients. A much stronger approach would be to understand the facilities to where your patients are discharged. Which home health agencies, which SNFs [skilled nursing facilities], and in what volume?” said Boutwell. “Also, try to gather information on where your readmissions come from. At present most hospital databases don’t include this information. This quest for data leads very naturally into forming partnerships so hospitals can access the information they need in order to drive down readmission rates.”

Patients who are discharged to nursing homes are more likely to be readmitted than patients with the same diagnosis who are discharged home and don’t require home health services.

One tool the STAAR initiative developed was the concept of a cross-continuum team. “It was an experiment, and it has proven to be the single most highly rated and implemented recommendation that we made. That tells me hospitals find it is a helpful, practical initiative,” Boutwell said. “One advantage is, this is a broadly leveraged method. You form relationships and work together with several providers in your area. You can create a sense of urgency, a plan of action focused on specific measures, and that drives a broad transformation.” Typically the first tool Boutwell recommends for the cross-continuum team is a quick, practical, review of the last five patients who were readmitted. “This can be divided among the team members,” she said. “Briefly review the charts, but more importantly speak to the patient, the family caregiver, the post-acute provider. Elicit the story behind the story [emphasis added] of why this readmission occurred. Starting the team off with patient-centered stories helps to reduce finger-pointing and focus the team on the task at hand.”

The Affordable Care Act created a formal Community-based Care Transitions Program (CCTP) to test models for improving care transitions after hospitalization, and reducing readmissions for high-risk Medicare beneficiaries. In this program, community-based organizations use special services to manage Medicare patients’ transitions most effectively and improve their quality of care. CCTP is part of the Partnership for Patients, a nationwide public-private partnership that aims to reduce preventable hospital errors by 40 percent and reduce hospital readmissions by 20 percent. Currently 47 organizations have been enrolled in CCTP, and the program is budgeted at up to $500 million in total funding for 2011–2015. These organizations must implement interventions designed to reduce readmissions. Based on the interventions they are using, they will receive a special blended Medicare rate for each eligible patient discharge.

In addition to this program, Medicare Quality Improvement Organizations are offering extensive technical assistance and support to cross-continuum teams. “They will help review data,” Boutwell said. “They offer access to CMS data that no individual hospital has. They will facilitate group meetings, conduct root-cause analyses, and do focus groups.”

New York Methodist Hospital (NYM) is one of the 47 organizations enrolled in the CCTP initiative. It is a large, urban 600-bed teaching hospital located in Park Slope, Brooklyn, with a high readmission rate in 2010. “In part that is related to our patient population and our city environment,” said Steven Silber, M.D., medical director for quality management and vice president of medical affairs. “There are language, psychosocial, and socioeconomic issues, transportation problems, apartment buildings with many flights of stairs.”

Patients who are discharged to nursing homes are 1.75 times more likely to be readmitted than patients with the same diagnosis who are discharged home and don’t require home health services, Silber noted. Because of this, NYM started out by working with five nursing homes that were high admitters, using the INTERACT (Interventions to Reduce Acute Care Transfers) model, in which a hospital and nursing homes work together as partners to try to prevent readmissions. “When we actually meet with the nursing homes, we asked them to describe the biggest problem they faced around transitions,” Silber said. “They said, ‘you send us so much documentation, we can’t make head or tails of it. We can’t figure out what the patient’s needs are.’” In response, NYM streamlined the communication tool it sends to nursing homes, cutting it down to essentials.

But developing a better discharge form is only the beginning, Silber said. “In this partnership we are putting together what we call transitional care personnel: nurses and case managers within both the hospital and the nursing home. Besides the paperwork there must be a person-to-person conversation; there are important considerations that just can’t be conveyed by a piece of paper. The most important aspect of this is for the person at the receiving end to understand what is actually going on with the patient.”

NYM has set up monthly face-to-face conferences with two of the nursing homes, and plans to expand to others. This regular communication process leads to important changes in habitual hospital processes. “I am an emergency medicine doctor by training,” Silber says. “When a nursing home patient shows up in the ER, that is almost always an automatic admission. But these days nursing homes are able to administer more therapies: antibiotics, IV fluids. Now, due to the transitional care discussions, we’re finding new ways to avoid knee-jerk admissions. For example, nursing homes send us patients so we can do a set of labs and find out what is going on, without necessarily admitting them. When a

---

3 For more information, see www.innovations.cms.gov/initiatives/Partnership-for-Patients/CCTP/partners.html.
4 For more information, see the QIO directory at www.qualitynet.org.
5 See http://interact2.net.
patient is anemic and needs a transfusion, in the past we used to admit them. Now we have a hospital infusion center, so we are able to send them there for needed treatment without readmitting them.”

In the first quarter of 2009, NYM’s 30-day readmission rate for heart failure patients who were discharged to nursing homes was 50 percent. The hospital began working on preventable readmissions, with a special focus on heart failure patients discharged to nursing homes. By the first quarter of 2012, its 30-day readmission rate for these patients was down to 13 percent.

MetroWest HomeCare & Hospice in Framingham, Massachusetts, is another CCTP participant. It is a home-care agency with an 80-year history, owned and operated by Vanguard Health System. It provides services to patients discharged from St. Vincent Hospital and MetroWest Medical Center, which are also part of the Vanguard system.

MetroWest was one of the original participants in the STAAR project, and the home-care agency has worked to develop new care delivery models. It is relying on transition care coaches as one of four core intervention strategies. That means the transition care coach sees the patient in the hospital, ideally twice, and spends a significant chunk of time educating the patient and building a coaching relationship. “Together with the patient they analyze and evaluate any potential gaps in care that may occur once that patient leaves the hospital,” said Jane Pike-Benton, executive vice president, Home Health & Care Transitions. “We target the pieces that we know by evidence-based research lead to readmissions, and we make sure that any gaps are filled.”

After discharge, the transition care coach checks in with the patient twice a week by phone for the next 30 days. The project makes sure patients have the resources they need to manage their own care, perhaps a medication planning box, or a scale for heart failure patients. MetroWest has developed a standardized teaching guide, so educational materials and processes are consistent throughout the hospital, home-care services, and additional settings.

Even though the MetroWest transition program has been very successful, generally speaking there is no reimbursement available for these services. “When we started doing this in November 2010, we just supported it out of our current budget in home care; it was a non-billable service,” Pike-Benton said. Participation in CCTP means that now MetroWest will receive reimbursement for interventions they currently have in place.

**Remarkable Ferment in Transition Planning**

In addition to the 47 organizations currently enrolled in the CCTP initiative, many others are working on independent initiatives to reduce preventable readmissions. There is a remarkable ferment underway in transition planning and coalition building. They are trying out a wide range of methods, and also developing their own innovative approaches. A significant number of hospitals have set up regular discussions with nursing homes, home-care agencies or both...and those that haven’t done it yet are quite likely to say they plan to do that as soon as their current transition-planning initiative is well underway.

Starting several months ago, Lake Health developed its own community transition program, combining ideas from Eric Coleman’s Care Transitions Model and Mary Naylor’s Transitional Care Model. Lake Health is an independent healthcare system in Lake County, Ohio, which includes two acute-care hospitals, home health services, an employed physician group, and multiple physician practice sites. Just over half of hospitalized patients are seen by hospitalists, and the remainder are managed by several independent practice groups.

“We formed a local coalition, and we’re looking together at specific readmissions. We learned that what people generally assume about the issues driving readmission is often mistaken,” said Joyce Taylor, R.N., M.B.A., chief quality officer and vice president of quality at Lake Health in Concord, Ohio. “Clinicians tend to go straight to the possible physiologic reasons for the return,” she recalls. “When a heart failure patient comes back, clinicians tend to say ‘oh, their condition worsened.’ But when our transitional care case manager interviews patients soon after they return to the hospital, she asks a few probing questions, and interesting facts emerge. A patient with heart failure reports they stopped weighing themselves—and the reason turns out to be ‘the scale at the nursing home is broken’ or ‘my glasses are

---

6 For more information about MetroWest’s Transitions in Care Collaborative, see www.innovations.cms.gov/Files/x/CCTP-CntrIAMAmetWest.pdf.

7 For more information on Eric Coleman’s Care Transitions Model, see www.caretransitions.org; for more information on Mary Naylor’s Transitional Care Model, see www.transitionalcare.info.
lost and I can’t see the numbers on the scale.” Probing interviews with readmitted patients turn out to be a fruitful tool suggesting new ways to limit preventable readmissions.

Lake Health currently has a pilot project underway with four skilled nursing facilities that frequently take its discharged patients, and have expressed interest in working with the hospital to improve care transitions. “It took us about six months just to get that pilot group organized,” Taylor said. “Several SNFs wanted partner with us, but only directly with us, one-on-one. We wanted meetings that included several SNFs working together. After we discussed the advantages of a community approach to care, with all of us working together to improve communication processes, four local SNFs agreed to try this approach with us.”

As organizations take increasing responsibility for managing patients across the full continuum of care, it becomes imperative to find lower-cost, more effective locations for delivering that care.

One of Lake Health’s first tasks is developing a new handoff communication tool, designed by its physicians. As the pilot group examined readmission issues, they found current hospital discharge forms had generic information, so SNFs were not getting the information they needed. “Accuracy of information at the handoff is crucial,” Taylor said. “For example, we might send a heart failure patient to the SNF, but fail to communicate that this patient needs tight control on fluid intake. Because the SNF wants to offer good patient care, they make sure that patient always has a full jug of water at their bedside, which could be problematic.”

On Lake Health’s discharge form, there wasn’t any place set aside for non-standard information. “Here’s one example of the unexpected problems that can lead to readmissions,” Taylor said. “We had a patient with an internal jugular line, and unfortunately we sent her off to the skilled nursing facility without mentioning that detail in advance. Well, they weren’t able to manage patients with that sort of line, so she came back to us right away.”

Under Lake Health’s pilot program, nursing homes will always receive discharged patients from the hospital between 9:00 and 10:00 a.m. “We are working with our physicians, and particularly with the hospitalist group, to write discharge orders a day or two ahead of time, to make sure everything is communicated well in advance,” Taylor said.

The nursing homes in the pilot project all have medical directors who happen to be Lake Health-affiliated physicians, so this significantly facilitates the communications process. “The SNF medical directors are generally leaders in patient care. They are active participants in quality committees or serve on operational planning committees,” Taylor said. “Since they are already so active in roles within our organization, they have a vantage point to fully understand the importance of smoothing out care transitions.”

UCSF Medical Center Forms Post-Acute Alliances

In recent years, UCSF Medical Center has formed special relationships with post-acute facilities such as hospice and SNFs. “We serve many cancer patients, and we’ve seen that our attempt to provide hospice services within the hospital high-rise setting isn’t ideal, from either a social standpoint or a patient satisfaction standpoint,” said Jay Harris, chief strategic planning officer. “About two years ago we worked with Zen Hospice to help them get off the ground; we guaranteed a certain level of revenue and patient transfers. Basically, we guarantee that at least a third of their facility is occupied; in exchange, they make a strong effort to take our patients. This has worked out very well. They solved a problem of ours, to the great benefit of our patients.”

UCSF also formed a special relationship with Kindred Healthcare, which has many SNFs in the Bay Area. The hospital has two dedicated chronic heart failure (CHF) discharge nurse coordinators, who do all the education for CHF patients, and act as a bridge at discharge to ensure patients are going to see their primary care physician. “We realized at one point that when we sent our patients to home care, or to an SNF, sometimes all that education got undone, because the hospital and SNF had different treatment practices,” said Adrienne Green, M.D., associate CMO. “In response, our specialized nurses offered in-service training at the SNFs and home-care agencies and have made themselves available for questions after discharge.”

In addition, UCSF has established quarterly meetings with Kindred leadership to review quality metrics and discuss what’s going well and what isn’t. “These sessions offer a great deal of information sharing and collaboration, strengthening the bonds between the two institutions,” Green said. “As a result of these conversations, Kindred realized they would do better with a care model relying on a hospitalist physician. Previously, when we sent a patient to an SNF, they could be picked up by one of many different physicians. Now one IPC hospitalist assumes their care. He sees our patients much more frequently than the prior physicians, and he knows how to reach us when needed. It has been a really effective collaboration.”

Hutchinson Community Pulmonary Program

In 2006, the Hutchinson Regional Medical Center in Kansas embarked on a program to reduce readmissions and improve care for chronic-obstructive pulmonary disease (COPD) patients. The system includes a 199-bed hospital, a home-health and hospice agency, a nursing home, a durable medical equipment company, and a freestanding outpatient mental health center. The COPD program includes a close collaboration with the Hutchinson Clinic, an independent multi-specialty physician group.

When the program started, Hutchinson’s COPD patients often experienced prolonged stays in the ICU and high ventilator usage. Care was episodic, and since pulmonary patients were admitted throughout the hospital it was difficult for physicians to standardize or streamline care.

The Community Pulmonary Program team developed evidence-based standardized order sets for ventilator management and weaning, multidisciplinary rounds in the ICU, a screening tool for referrals to the pulmonary nurse case manager, and multidisciplinary staff education on pulmonary care. They also standardized educational materials to be used by the hospital and by community providers.
The Community Pulmonary Program has significantly reduced the cost of providing COPD care. Since patients rarely need the ICU, hospital length of stay has decreased by 2.8 days, readmission rates have dropped by over 30 percent, and there has been a significant reduction in ED visits and EMS calls. In addition, patients on the program have increased survival times.

**Sentara Establishes Coordination Council**

Early in 2012, Sentara Healthcare redesigned the way it oversees the continuum of care, changing “case management” to “care coordination.” In this redesign we moved utilization management from the hospital sites, including discharge facilitation, and centralized these functions at the resource management center,” said Teresa I. Gonzalvo, vice president for care coordination. “Seamless, patient-centered care coordination across the system is our vision.”

Sentara is a large health system serving southeastern Virginia and northeastern North Carolina. It includes 11 acute-care hospitals, seven nursing homes, three assisted living villages, home health, and 400 employed physicians, some of them specializing in elder care.

The push to improve collaboration presents an opportunity to empower customer-centric healthcare across the continuum.

Eight of Sentara’s hospitals have transitioned to the EPIC electronic medical record, facilitating communications with its nursing homes, since they are on the same system. It is now using an e-discharge packet that includes history and physical, medication list, progress notes, and a prospective plan for the transition to nursing home care. Centralizing the discharge referral process has allowed the care coordinators and social workers at the bedside to focus on the patient’s plan for the day as well as plan for the stay. Huddles and revitalized multidisciplinary rounds are components of Sentara’s multifaceted approach to transition management. Enhanced technology is the underlying infrastructure to improve efficiency and throughput. Follow-up appointments within four to seven days of transition from the acute care setting has been a critical strategy in reducing readmissions. Care coordinators at patients’ points of entry have been effective in reducing avoidable admissions, readmissions, as well as determining the appropriate level of care. Weekly system care coordination rounds, addressing patients with complex needs, readmissions, and social issues, among many others, are conducted with Sentara’s leadership teams, including vice presidents of medical affairs and directors of finance.

The nursing homes go under the collective title “Lifecare,” and Sentara has established “Lifecare liaisons” within its hospitals to facilitate communications with and transitions to its nursing homes. In addition, the system has just instituted a Long-Term Care Coordination Council, which meets monthly to look at opportunities for improvement in transition planning, quality and patient safety. “Our next phase will be to expand the council and involve the high-volume community-based nursing home providers who admit our patients,” Gonzalvo said. “We will work collaboratively to make a positive difference with our patients and the community. In addition to this, going forward our plan is to establish a care coordination practice council across the healthcare continuum, to include acute care, ambulatory, health plan, and home care and long-term care case managers.”

**The Business Case for Reduced Readmissions**

Many hospitals are experimenting with innovative programs to reduce readmissions and support patients after they leave the hospital. In the end, to what extent do these initiatives make sound business sense?

Stornmont-Vail now has one-and-a-half full-time physicians who are employed by the hospital but actually care for patients in nursing homes. “It’s close,” said Palmberg. “We are not actually collecting enough revenue from their visits to cover their salaries; there is a little shortfall.” To some extent the hospital looks at the program as “research and development”—it is just one aspect of finding better ways to care for people. “Actually, what is most significant for us is that we need beds because we are full most of the time,” added Palmberg. “From that viewpoint it certainly makes sense for us to do what we can to reduce readmissions from nursing homes.”

“Healthcare organizations are anticipating the industry’s evolution from fee-for-service to fee-for-value, from a hospital-centered acute care orientation to what might be recognized as an integrated system focused on population health management,” said Mark Dubow, M.S.PH., M.B.A., senior vice president at The Camden Group, a business advisory firm specializing in healthcare. “As organizations take increasing responsibility for managing patients across the full continuum of care, it becomes imperative to find lower-cost, more effective locations for delivering that care. From a strategic viewpoint, to the extent that an organization opts out of this process, they
risk that ultimately they will lose not only the post-acute patient, but also the acute patient.”

It’s difficult to estimate how many healthcare organizations are currently working to reduce readmissions through enhanced hospitalist and case management programs, as well as alignment of physicians with each other and other providers across the continuum of care, but Dubow offered an anecdotal report. “We work with over a thousand healthcare organizations, including academic medical centers, urban acute and tertiary facilities, rural facilities, critical access hospitals, physician organizations,” he says. “The vast majority of them are wrestling with exactly these issues.”

Many of the people working on reduced readmissions see this as a way to lift healthcare processes to a new level. “Our current healthcare system is upside down, focused financially and politically on acute care institutions,” said Amanda Twiss, president of Garnet Advisors, a healthcare consulting company with decades of experience analyzing data from all healthcare segments. “Because we spend so much time focused on acute care, we lose sight of broader population-based measures to promote health and reduce the incidence of sudden, very costly acute events. Now, with ACOs and other care models, the economic drivers are shifting towards keeping patients healthy and out of the hospital. This will happen partly through patient engagement and helping individuals maintain their own health, but also by ensuring that the healthcare ecosystem as a whole is designed to care for patients in the least costly, most appropriate setting.”

“In my view working to reduce readmissions is much more than an isolated hospital-based quality improvement project,” Boutwell said. “It is a highly strategic opportunity for hospitals and healthcare systems to convene collaborations and develop working relationships across the entire spectrum of providers in their service area. While we start with readmissions, these collaborative relationships focused on improving quality will lead to benefits in many other areas, supporting the overall health of the community.”

Who Should Focus on Post-Acute Care?
Caring for patients across the full continuum of care will be an issue for all healthcare organizations in coming years. However, for certain hospitals and health system, it should be a top priority now.

Mark Dubow, M.S.P.H., M.B.A., offered a useful analytic framework to highlight four circumstances in which organizations should establish a post-acute care strategic plan:

1. **Hospitals or health systems that already own multiple post-acute entities**: “Going forward they face a strategic and economic need to determine the most appropriate allocation of resources among the existing facilities. Many of these facilities are older and need enhancements to the physical plant, information technology, or staff. In some instances it may be effective to consolidate multiple single modality care sites to a more comprehensive organization. Ultimately, the system must develop a strategy to guide where to allocate scarce resources.”

2. **Organizations that are proactive in clinical integration, which may include hospitals, health systems, and physician organizations**: “Organizations that are pursuing service-line bundled payment arrangements, or developing an accountable care organization, have already made a commitment to managing care across the continuum. One of the first four models of bundled payment arrangements required risk management in both acute and post-acute arenas. As new bundled payment models unfold in the coming year, the episodes of care will be defined as including post-acute care management.”

3. **Organizations that maintain or are developing strong clinical service lines which include a post-acute component**: “For example, in stroke programs, neurology programs, orthopedics, oncology, and to an extent, cardiac care, post-acute services are an inherent component of the care delivery continuum. Many patients dealing with these conditions will be chronically ill and require ongoing treatment, so post-acute care needs to be seamlessly integrated into the service line.”

4. **Organizations that are already moving from a hospital-centered orientation to a system-of-care focus**: “Some organizations have already reached a point in their strategic planning process where they are looking at the next steps towards population health management, and post-acute care has already become an integral part of their strategic planning.”

Dubow concluded, “If you are a board member, and one of those four circumstances is consistent with the issues on your plate, then you should be asking your CEO, and through your COO, asking your management team, ‘what is our strategy on post-acute care?’”

With hospital reimbursement now impacted by what happens with patients after discharge to post-acute care, it makes sense that many are choosing to focus on ways to promote better care coordination. And with indications that post-acute providers may soon be held accountable for readmission rates much the same way that hospitals are today, this push to improve collaboration presents an opportunity to empower customer-centric healthcare across the continuum.

“Any cost savings realized through strategic improvement programs that promote better care coordination across the continuum may end up as a footnote in the chapter that can be written about the evolution of customer-centric healthcare,” said Susan L. Henricks, president and COO of National Research Corporation. “Improvements in care transitions, communication and outreach, collaboration, and patient and resident experiences connect to the original objective of healthcare: positive outcomes. Extending the concept of patient-centered care to incorporate all care settings and stakeholders is the way forward in healthcare. After all, reducing costs and rehospitalizations should come about through the collaborative pursuit of better outcomes.”