Here Come the Boomers
By Matthew W. Tanzer

A perfect storm is brewing in the healthcare industry. And if the forecasters are right, our little ship is in for a tumultuous voyage. Even as hospitals and healthcare providers work to fend off growing penalties for high readmission rates, dark and foreboding clouds loom on the horizon. The generation that brought you Woodstock, Happy Days, and Disco Music now brings you the largest retirement population in history.

Modern medicine has made remarkable things possible. We’ve increased life expectancy, improved quality of life for the aging, and found new and innovative ways to provide for comfortable, happy, and healthy retirement. Of course, this is great news. But it isn’t all golfing and early bird specials.

A recent VentureBeat article by Alicia Torres warns that as the biggest generation trends toward retirement, the costs and consequences for our healthcare system could be staggering. Simultaneously, the battle to reduce readmissions even at their current rates remains a considerable undertaking for the industry.

Combining the two concerns is a tremendous recipe for sleepless nights and indigestion. Suffice it to say that even if we think the waters are rough now, we’re only at the outer edge of a sprawling storm system.

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Homeless Readmissions in Los Angeles – A Community Acts
By Henry Fader, Esq.

After years of planning and in response to the reality of cuts from Medicare due to excessive readmissions, more than 30 Southern California hospitals and health systems and other providers gathered on June 10, 2013 to kick off an initiative to reduce readmissions among the 50,000-person homeless population in that region. The Los Angeles Regional Hospital Symposium (Symposium) in which I was invited to participate, was the start of a dialogue among health care providers in that region to develop an action plan to better coordinate care and develop working relationships to better deal with the homeless patient population in the Los Angeles community.

One of the acute health care needs of the Los Angeles homeless population is exemplified by the spread of communicable diseases. Tuberculosis (TB) is dramatically spreading among homeless patients in Los Angeles and was described at the Symposium by the Acting Director of the Los Angeles Tuberculosis Control Program.

Efforts are underway to educate shelter operators on screening imperatives to remove patients identified with TB for treatment to avoid further infection of others. TB infection can certainly complicate the health care needs of the homeless population.

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It is widely recognized that hospital readmissions in the Medicare population are very, very expensive, and implementation of a variety of models to reduce those readmissions has been met with varying success. Of critical importance, and often lacking in these models, is the simple fact that food counts. Adequate calorie and nutrient intake is essential for health and well-being throughout the lifecycle, especially during illness. Maintaining adequate nutritional status becomes more important as chronic conditions such as diabetes, heart disease and renal insufficiency become realities.

The nutritional status of older Americans has been studied and shows some disturbing trends. A study by “Meals on Wheels of America” indicates that older Americans are at risk for food insecurity or hunger and these individuals are also at risk for malnutrition. Studies have shown that the incidence of malnutrition ranges up to 15% of community or home-bound seniors, up to 60% of elderly admitted to hospitals, and an astounding 85% of nursing home elderly.

The causes and types of malnourishment (primarily protein energy malnutrition - PEM) in the elderly population are varied and both physiological and psychological in nature. The phrase “anorexia of aging” has been used by many to describe the decreased food intake of old age. Compromised metabolism caused by underlying chronic disease, natural processes, and immobility contribute to poor nutrition among this population. The presence of PEM has been shown to be a risk factor for elderly admitted to the hospital and for subsequent readmission.

The consequences of poor nutritional status in hospital-bound seniors are that length of stay increases and the overall outcome of the patient is at risk. Various studies, using different definitions and measures for nutritional status, have shown that malnutrition may be prevalent upon admission. Further complicating the outcome is that the nutritional status of the elderly patient has been shown to decline over the course of hospitalization. The end result is that the patient leaves the hospital in a compromised state, leading to more complications, poorer outcomes, increased readmissions, and higher rate of post-discharge mortality.

Once discharged, nutritional stature is likely to continue to decline unless some type of intervention is applied. Complicating this is the fact that the healing process often times requires more calories and nutrients than healthy status. Malnourished patients discharged into the community without some type of nutritional support have been shown to have a higher readmission rates, a higher probability of entering long term care facilities, and higher mortality rate when compared to a well-fed cohort. These results hold true even when other measures of elderly health (depression, mental state, abilities) are considered in the analysis.

That post discharge nutritional interventions can work to reduce readmission has been shown in a recent CMS pilot program which provides free meals to elderly patients upon discharge. A group of seniors enrolled in the program received one month’s worth of meals. When provided only meals, readmission rates dropped by nearly 10 percent.

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First Look at Psychiatric Readmissions within the Medicare Inpatient Psychiatric Facility PPS

By Kathleen McCann, RN, PhD

As policymakers continue to focus on the broad issue of hospital readmissions, the National Association of Psychiatric Health Systems (NAPHS) recently commissioned The Moran Company to conduct the first study to analyze readmissions in a Medicare population being treated specifically for psychiatric diagnoses. The study looks at readmission patterns within inpatient psychiatric facilities (IPFs) paid under the Medicare IPF prospective payment system (IPF PPS).

Although the IPF PPS payment system is not currently subject to the Hospital Readmissions Reduction Program established for short-term, acute-care hospitals, NAPHS felt that it was important to get a better understanding of the characteristics of the Medicare population facing serious mental and addictive disorders and unique issues that may impact their readmission patterns. This information will be critical to future policy discussions, as well as to efforts to improve clinical practice.

Facilities paid under the IPF PPS treat the majority (some 64% in 2008) of all Medicare inpatient psychiatric admissions, according to the Medicare Payment Advisory Commission (MedPAC). Two types of facilities are included in the IPF PPS: 1) freestanding psychiatric IPFs (both governmental and nongovernmental) and 2) hospital-based (“distinct part”) psychiatric units in general hospitals (both governmental and nongovernmental). Together, these facilities deliver inpatient psychiatric hospital care to more than 300,000 Medicare beneficiaries each year.

Total Medicare Inpatient Psychiatric Admissions in 2008 = 693,000
(within two separate payment systems)


Yet until now, the only data on psychiatric readmissions has been drawn from the DRG payment system, which represents only 36% of all Medicare psychiatric admissions.

Psychiatric Patients Treated in IPFs Exhibit Characteristics that are Readmission Risk Factors. The new study, Medicare Psychiatric Patients & Readmissions in the Inpatient Psychiatric Facility Prospective Payment System, looks at 2010 Medicare fee-for-service claims data. The analysis found that the majority of Medicare beneficiaries treated in inpatient psychiatric facilities exhibit characteristics that the available literature associates as risk factors for hospital readmissions – including chronic psychiatric diagnoses, disability, and low income.

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Here Come the Boomers...continued

The Retirement Boom. Ten thousand baby boomers turn 65 every single day. According to the Organization for Economic Cooperation and Development, almost 87 million Americans will be past retirement age by the year 2050. The realities of Baby Boomer retirement include fixed incomes for many Americans, a strain on the Social Security system for all Americans, and a dramatic increase in the burden placed on our nurses, doctors, and hospitals. For a healthcare system already grappling to handle its current workload, disaster appears imminent.

The problem with Baby Boomers isn’t just that there are so many of them. Torres reports that while only 12% of the previous generation’s retirees suffered from diabetes, 16% of Boomers will require treatment for the condition. Likewise, where 29% of WWII generation retirees were classified as obese, 39% of Baby Boomers will bring this major health risk factor into retirement. In other words, in addition to representing a substantial portion of the population, Baby Boomers will also present a substantial increase in the number of high-risk patients entering into care. And as we all know by now, this also means a growing number of readmissions. If we don’t find a way to manage this risk and minimize its impact, we are churning toward catastrophe.

The Risk Boom. In spite of the grumbling over steep penalties and challenging deadlines associated with CMS’s Hospital Readmissions Reduction Program, the initiative has forced us to reexamine the way we do things. And it is most certainly for our own good. At our current trajectory, our future is one of shorthanded hospitals, overworked healthcare professionals, and diminishing treatment outcomes. But the very same pressures that are causing so many headaches for the hospital administrators of today may also be our best defense against a true healthcare crisis in the future.

Until recently, we’ve largely accepted the reality of readmissions. In a traditionally fee-for-service payment model, there has been limited incentive to invest in solutions that combat this troubling trend. But in doing so, we’ve allowed ourselves to fall prey to low standards when it comes to high-risk patients. Consequently, every day sees our hospitals wasting a tremendous amount of time and money on patients who shouldn’t have been hospitalized in the first place. This is a wastefulness that we simply can no longer afford, least of all as the retirement population comes to eclipse America’s workforce.

Managing high-risk patients more effectively from the start of hospitalization all the way through post-acute care is especially critical now. According to one source, roughly 60% of baby boomers have already been diagnosed with at least one chronic medical condition, with diabetes, heart disease, hypertension among the most common, all of which carry their own distinct treatment, check-up, prescription, and lifestyle demands. Managing these health risks will be a challenge compounded by the sheer scale of the endeavor.

The Cost. If you were born between 1946 and 1964, you may remember when Neil Armstrong walked on the moon, there’s a good chance you saw the last episode of M.A.S.H. during its first broadcast and, I’m sorry to report, there’s a reasonable chance you suffer from some combination of high blood pressure, high cholesterol, and diabetes. Whether it’s because baby boomers are living longer than the generation before them or because of the generation’s lifestyle habits or because of some combination of the two, Baby Boomers are collectively less healthy than the World War II generation.

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The projected impact of these patterns on our economy is not insignificant. According to findings by the Centers for Disease Control and Prevention, reported on by ABC News, Americans spend an estimated $147 billion on obesity and $177 billion on diabetes. As Senator Everett Dirksen (R-IL) may or may not have said, “A billion here, a billion there, pretty soon, you’re talking about real money.” And on our current path, these are figures that will only grow more overwhelming with time.

When you start to consider these numbers in light of emergent evidence regarding hospital readmission rates, a connection becomes imminently clearer. According to Medicare data published in 2012, 18.5% of pneumonia patients, 19.7% of heart attack patients and 24.7% of heart failure patients were readmitted within 30 days of discharge. This represents a .1% decrease from the previous year for heart conditions and a .1% increase from the previous year for pneumonia. Recent news from CMS points to a modest reduction in readmissions when comparing data from November 2012 to a previous five year rolling average, however given the magnitude of the current problem (like the $17 billion spent annually on Medicare readmissions alone), the increasing size and scope of the readmissions penalties, and the impending explosion of the Medicare-eligible population, the trend is not reversing nearly fast enough.

To provide background on the regulatory and financial impact of readmission rates in Los Angeles, I was invited to address the community organizations attending the Symposium. I described how the new Medicare readmission rules were already impacting “safety-net hospitals.” Safety-net hospitals are seeing a dramatic loss of revenue due to the readmission penalties (from 1% to 3% of Medicare revenue in the next two years).
Homeless Readmissions in Los Angeles...continued

Additionally, appropriate discharge and patient satisfaction scores are included as part of Medicare’s Value-Based Purchasing (VBP) incentive payment system. Inadequate discharge planning will negatively impact any incentive payments to be received by these providers under VBP. The problem of discharging patients to overcrowded shelters or the streets is, however, a primary factor in the high readmission rates being experienced by many hospitals in Southern California. The Hospitals of Los Angeles region have witnessed a significant increase in the number of homeless patients who are discharged to these locations. The consequences of these high rates of readmission are significant in terms of patient care, hospital resources, and overall public health. Inadequate discharge planning will negatively impact any incentive payments to be received by these providers under VBP. The problem of discharging patients to overcrowded shelters or the streets is, however, a primary factor in the high readmission rates being experienced by many hospitals in Southern California. The Hospitals of Los Angeles region have witnessed a significant increase in the number of homeless patients who are discharged to these locations. The consequences of these high rates of readmission are significant in terms of patient care, hospital resources, and overall public health.

Safety-net hospitals are particularly vulnerable as they review readmission data for the coming years. The Healthcare Financial Management Association (HFMA) and other health care and hospital associations continue to press for changes to the readmission rules to include adjustments for low socio-economic status, which the HFMA has linked to poor post-discharge care and increased readmissions. The Symposium was intended to find clinical ways to influence those readmission penalties since it is unlikely that there will be a drastic change in readmission penalty policies in the coming years without a legislative fix. Such a change in definition would require the National Quality Forum (NQF) and CMS to accept socio-economic status as a determining factor in readmissions, perhaps an uphill battle as readmission disease categories are expanded by NQF and CMS.

These initiatives in Southern California in 2013 are in sharp contrast to the history of homeless patient discharges just a few years ago. From 2007 to 2011, the Los Angeles City Attorney sued a dozen or more hospitals in the Los Angeles region that served homeless patients through their emergency rooms. The accusations were multi-pronged, depending upon the facts and circumstances of the patients and the particular hospital. Generally, the allegations were that the hospitals charged were “dumping patients” by discharging them to shelters and the street without any way of establishing post-discharge care for patients in such environments. Aside from allegedly failing to abide by the discharge standards required under the Medicare and California Medicaid Conditions of Participation for hospitals, these patients frequently ended up back in the emergency room days later, perhaps at a different hospital. Due to the number of hospital emergency departments available to them in Los Angeles, these homeless patients were utilizing resources at an unprecedented rate. Since there was no coordination or ability to share data among providers, it also led to a duplication of tests and over-prescribing of drugs for these patients with multiple chronic conditions.

Other speakers at the Symposium provided strategies for the development of a regional plan on readmissions by the better use of technology to track patients and their care, the focus on medical homes for homeless patients, and better coordination of care provided to homeless patients. City of Los Angeles officials at the Symposium indicated that their data demonstrated a remarkable reduction in further inpatient admissions and ER visits when homeless patients were discharged from the hospital to recuperative care. In Los Angeles, they found a 62% reduction in the number of expected readmissions and a 68% reduction in inpatient hospital days for homeless patients. These statistics are in line with results in other cities that have recuperative or respite health facilities. As a result, representatives of the City of Los Angeles spoke of initiatives to make more respite care facilities available to homeless patients.

At the end of the Symposium, a five-person Steering Committee of lawyers, clinicians, and those who work with the homeless population was charged with continuing to find solutions to the homeless readmission problem. Some of the initiatives will include:

- establishing transfer agreements and protocols with psychiatric and substance abuse providers;
- providing for post-discharge recuperative care facilities, which has been successful in reducing readmissions in a number of urban settings;
- looking for ways to develop supportive housing for the homeless so that they can find permanent homes away from the street or shelters;
- using technology to provide for enhanced sharing of information among hospitals and other providers for more successful care coordination; and
- generally aligning all provider interests to avoid unnecessary readmissions.

As the Steering Committee progresses with its work, financial, clinical, and governance issues will require resolution. Many hospitals are throwing the kitchen sink at this problem, hoping something will stick. But with the Baby Boomer retirement crisis mounting, the truth is that the obstacles to reducing these readmission numbers have become greater in number and severity. Perhaps one of the reasons we are struggling so mightily with this issue is that we’re looking at it the wrong way. We’ve outgrown one-size-fits-all health strategy. Yet many hospitals still fail to differentiate high-risk patients, still overlook opportunities to individualize plans for care, and still neglect to utilize time spent with patients to better pinpoint and remedy risk factors. And the more we come to understand the needs of the Baby Boomer generation, the less rational these overlooked opportunities appear.
Here Come the Boomers...continued

**Boomer-centered Care.** While the Baby Boomer demographic can count a number of shared cultural experiences and more than a few sepia-toned memories, it still is a generation of diverse needs, distinctive health histories, unique personal circumstances, and individual health outlooks. This means that there isn’t a single fix that will work for everybody. With patient-centered care, the philosophy of individualizing a plan of action becomes essential to treatment. This is really the key to improving outcomes for aging Baby Boomers. Rather than thinking of this demographic as presenting one very large and overwhelming health problem, we must think of Baby Boomers as representing many smaller and more readily surmountable health issues.

In fact, this is an essential strand in the strategy for reducing readmissions. Every individual patient leaves the hospital with his or her own unique set of challenges. They may include complex medication instructions, transportation obstacles, or the lack of a personal support system. Language barriers, health literacy limitations, and cultural values may produce a disconnect between health behaviors and discharge instructions. Some patients may be contending with difficult lifestyle adjustments such as smoking cessation, the integration of exercise into an everyday routine, or the wholesale improvement of dietary habits.

Factors that focus on who the patient is, not what disease the patient has, should be used to ensure that the right patients are getting the right types of post-acute care interventions, which will lead to fewer readmissions and better outcomes. Even those in the industry that criticize the value or fairness of using readmission rates as a measure of healthcare quality recognize that by being forced to attend to the reduction of these rates, they are also being forced to reevaluate the way they do things. Since few experts would suggest that our healthcare system is either at its best or most efficient at this juncture, that reevaluation should yield positive change.

**The Technology Boom.** With the generational and demographic transition already well underway, the need to reduce readmissions has never been higher. Fortunately, neither have the incentives or the technological means with which to do so. Under the auspices of 2009's HITECH Act, the healthcare IT industry is booming (pun intended) with opportunity. Patients flow through hospitals so quickly, and the most impactful products have begun addressing readmissions challenges from the moment a patient enters the hospital, if not earlier.

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Q. "What are the hottest new apps and technologies that help providers prevent unnecessary hospital readmissions?"

"One of the interesting things we have seen are organizations that have created their own technology-based tools to support their efforts. For example, one organization created a home grown suite of iPad-based apps that uses discharge checklists and performs medication reconciliation and other practices that allow a clinician or other staff member to work directly with patients and families in their hospital rooms. Another example was a method to deal with homeless patients by using their cell phones (or a family member's, friend's) and preprogramming telephone numbers for various places like the PCP office, a case manager, the pharmacy, or laboratory. Seems simple, but they were able to demonstrate better care coordination and more adherence to scheduled follow-up visits and medication refills. Sometimes technology does not have to be sophisticated and complex to help."

Bruce Spurlock, MD
President and Chief Executive Officer
Convergence Health Consulting, Inc.
Roseville, CA

"At this point, I think using ANY app -- and by that I mean a cross-setting care plan and service delivery tracker -- IS the hottest new technology. I find the value proposition of doing this work with an Excel spreadsheet and manual data entry increasingly disconnected from the mandate to change the way we deploy services and coordinate across care settings in a meaningful way. Coordination across settings by definition requires the combined input of numerous actors, and redesigned effective care requires process (service delivery) and outcome measurement. Let's let the technology do the tracking for us as part of our transitional care workflow."

Amy Boutwell, MD, MPP
Founder and President
Collaborative Healthcare Strategies
Lexington, MA

"CareTrax offers a proven predictive readmissions suite to help providers predict which patients are most likely to return, and focus their resources to keep high-risk patients out of the hospital and avoid unplanned readmission. The InterMountain Risk Score for HF (IMRS-HF) has been validated with over 6,000 patients and has proven 90% accurate in identifying patients at high, medium, and low risk for readmission. CareTrax also delivers a tool to ensure patients comply with their physician orders after discharge. The CareTrax Patient Outreach Suite is a flexible virtual communications platform that lets providers contact the specific population they wish to reach, deliver any instructions (via IVR, SMS, email, live caller, or on-line), and collect information via incisive, user-defined questions. Data from all collection modes is centralized and organized to build a complete and accurate picture of readmission reduction progress, enabling providers to both convey information to the patient and obtain crucial information from the patient."

Conrad Lenckos
Business Development
CareTrax
Golf, IL
Thought Leaders’ Corner

“Apps are a dime a dozen these days. Building an app takes little more than wearing a plaid shirt with thick-rimmed glasses and snug hipster jeans while punching out a few lines of code. Building an app that really solves a problem is a different story. When the problem is as complex as preventing hospitalizations, the difficulty of creating truly valuable technology precludes the pipeline of new apps from ever getting very hot.

Nevertheless, an app can solve real problems for risk-bearing organizations if it is (1) evidence-based, (2) builds upon existing workflow rather than creating new workflow, and (3) generates data that is actionable. And provided that the technology achieves the prerequisite HIPAA compliance, then it has a shot at become a hot readmission reduction app.

Care at Hand (www.careathand.com) is a great example. This technology has demonstrated decreases in admissions of 56% and estimated savings of 11% PMPM. And these numbers are derived from the mechanism of preventing admissions: Care at Hand enables $10/hour lay caregivers to prevent $10,000 hospitalizations. By meeting the aforementioned criteria for a ‘hot app’ Care at Hand creates real value for patients and a positive ROI for ACOs and payers.”

Andrey Ostrovsky, MD
CEO and Co-Founder
Care at Hand
Boston, MA

“The simplest and most effective solution I have seen to date is Cullman Regional Medical Center's (CMRC) award-winning ‘Good to Go’ recorded hospital discharge instructions. The instructions are recorded using an iTouch and are available after to patients via the Web or a land line. The interventions resulted in a 15 percent decline in readmission rates for patients who received recorded discharge instructions and a 62 percent increase in HCAPS satisfaction scores. It's really one of those ‘why didn't we think of this’ kind of ideas.

Realizing the notes were being recorded enabled the patients to relax, allowing better comprehension and compliance. In terms of technology, there was a 40/60 split between Web site and phone access; with 30 percent of the instructions accessed more than once, and more than 40 percent retrieval of instructions when notifications were sent to patients and families. And internal analysis of the recorded discharge instructions helped CRMC to further refine its discharge process and identify patients in need of post-discharge support.”

Patricia Donovan
Managing Editor
Healthcare Intelligence Network
Sea Girt, NJ

Homeless Readmissions in Los Angeles...continued

Recognition of the special health care needs of the homeless has definitely sparked an interest in reducing readmissions in Los Angeles. Since these patients tend to utilize expensive acute care settings for their medical care, finding solutions will also benefit providers watching out for the high cost and frequency of care including the Medicare readmission rules. The same community-wide effort is possible elsewhere. Since each region has different resources and needs, it appears that the best solutions for this patient population rest with each community working together cooperatively as Los Angeles is attempting to do.

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2. Presentation by Dr. Peter Kerndt, M.D., M.PH., Acting Director, Tuberculosis Control Program, L.A. County Department of Public Health.
3. Hospital Readmissions Reduction Program, Section 3025 of the Affordable Care Act.
4. See Section 1886(0) of the Social Security Act.
7. Presentation by Volanda Vera, Senior Deputy for Health and Advocacy, Los Angeles County Second District, June 10, 2013.
8. The Steering Committee members are George Colman, Esq. (Chair); Michael Arnold; Marc Futernick, M.D., Paul Gregerson, M.D., M.B.A. and Carolyn Phillips, Esq.
Healthy Transitions Colorado – Bold Goals for 2015
Healthy Transitions Colorado (HTC), a new statewide collaborative initiative just launched this month, is focused on aligning and accelerating existing care transitions efforts, advancing shared goals, and promoting best practices across the state. HTC seeks to break down the silos of individual facilities and programs to foster true community care coordination across facilities, specialties, and practices with a focus on improving the health and lives of Coloradans.

Sponsored by the Center for Improving Value in Health Care, HTC’s ambitious Triple Aim goals to reach by July 2015 are to (1) prevent 8700 all-cause hospital readmissions within 30 days of discharge (Better Care); (2) increase patient days outside of the hospital to 34,800 (Better Health); and (3) save over $80 million in health care dollars (Lower Costs).

ICU Readmissions Not a Valid Measure of “Quality”
A new study led by Cerner and published in Critical Care Medicine evaluated ICU readmissions at Baystate Medical Center using APACHE IV to adjust for case-mix. Severity-adjusted mortality or length-of-stay did not correlate at all with readmission rates, implying that patient factors rather than hospital action accounted for much of the spread seen in ICU readmission rates.

Using data on 263,000 admissions across 105 ICUs using the APACHE Outcomes system, the team first confirmed that units with a higher readmission rate generally had higher patient mortality and length of stay. However, when the observed outcomes were compared with what was predicted by APACHE Outcomes, units with a high readmission rate performed much like the units with a low readmission rate.

Many NJ Readmissions Correlate with Income, Race
Healthcare Quality Strategies, Inc., the QIO for New Jersey, has released a new report and interactive map showing hospital readmission rates by county which shows a strong correlation between median county income and diversity and the readmissions rate. For example, Hunterdon County, with the highest median-household income and second-largest percentage of the population that is non-Hispanic white, had the lowest readmission rate at just under 17%. Hudson County had the highest rate at 24% and the state’s most diverse population.

New Studies on Diabetes and Readmissions
Two new studies on readmissions were presented at the recent American Diabetes Association (ADA) 73d Scientific Sessions last month in Chicago. In the first, patients at State University Medical Center in Columbus, Ohio who received diabetes education by dedicated nurse-educators had a risk adjusted readmission rate that was lower than for those who did not (11% vs. 16%).

The second study presented retrospective data on 202,496 Medicare Advantage Plan enrollees with type 2 diabetes who had been hospitalized between July 1, 2007 and August 30, 2011. Baseline characteristics that increased readmission risk included being older than 75 and having severe diabetes complications, while 30-day readmission was associated with complications specific to the elderly, including urinary incontinence, cognitive impairment, falls, and a diagnosis of cancer.

Readmissions Measures Removed from July Report
CMS recently announced that it will not report five readmission measures and one complication measure on Hospital Compare in July as previously planned, citing an issue related to categorization of hospitals as better, worse and no different than the national average. The affected readmissions measures are heart attack, heart failure, pneumonia, hip and knee replacement, and hospital-wide readmissions. CMS will recalculate the hospital categories for the six measures, deliver new hospital specific reports, and conduct a new 30-day preview period. The action does not affect points used as the basis for HRRP penalties.

Why the Poor Choose the Emergency Room
Researchers at the University of Pennsylvania’s Penn Center for Community Health Workers interviewed 40 poor patients about why they chose to get medical help from a hospital emergency room rather than a primary care doctor. The reasons cited were that hospitals had all of the testing and specialty services in one place, versus having to rely on a referral from a PCP; they had shorter wait times; were more convenient; and were less costly since uninsured patients could receive charity care. Even those on Medicaid, where visit costs were not an issue, preferred the hospital ER because they did not have to deal with specialty referral and additional lab test costs. The researchers caution that the findings disabuse the notion that poor patients are abusing the ER, since they are clearly making choices, and note that hospitals need to make outpatient services more accessible and more convenient lest the hospital emergency room continue to be a more attractive alternative than the primary care doctor.
Psychiatric Readmissions...continued

Eighty percent of psychiatric discharges from IPFs had a primary diagnosis of either schizophrenia or episodic mood disorders (including depression), both of which are considered chronic psychiatric conditions and potential risk factors for readmission. The majority of beneficiaries who were readmitted to IPFs were disabled and dually eligible for both Medicaid and Medicare. Beneficiaries who were readmitted to IPFs tended to be younger and more likely to be male.

For purposes of the study, the overall rate of IPF readmission was defined as the number of psychiatric discharges from either a freestanding IPF or psychiatric unit that were readmissions during a calendar year divided by the total number of psychiatric discharges from a freestanding IPF or psychiatric unit during that calendar year.

When readmissions were examined at various timeframes, the study found 15% of all psychiatric discharges from IPFs were readmissions that occurred within 30 days. Only 5.4% of all psychiatric discharges from IPFs were readmissions that occurred within 7 days.

The average length of stay (of all admissions) for beneficiaries readmitted to IPFs was greater (at 15.3 days) than those who were not readmitted (at 12.8 days). This may be an indication, said the study, “that beneficiaries who tend to get readmitted may require higher levels of care and thus need to stay longer.”

Partial hospitalization has an impact on time to readmission, the study also found. Some patients received IPF services through a partial hospitalization program. Time to readmission for these Medicare beneficiaries was 130.8 days (vs. 59.3 days for those who did not participate in this program between admissions).

Implications of the study

Despite the occurrence of readmission risk factors in the majority of the IPF beneficiary population, 71% of beneficiaries with psychiatric discharges in calendar year 2010 (CY10) were not readmitted in CY10. This suggests, as The Moran Company study noted, “that a specific subgroup of patients is at risk for readmissions. Policy interventions to reduce readmissions in inpatient psychiatric settings may be most successful if they are targeted to this subgroup of high-risk patients.”

Since IPF readmissions appear to be in large part due to the characteristics of patients who are treated here, further study may be needed to focus in on clinical strategies that can be most effective in addressing the specific needs of Medicare beneficiaries cared for in inpatient psychiatric facilities.

Kathleen McCann, RN, PhD, is Director of Quality and Regulatory Affairs for the National Association of Psychiatric Health Systems in Washington, DC. She can be reached at Kathleen@naphs.org. The Moran Company study, Medicare Psychiatric Patients & Readmissions in the Inpatient Psychiatric Facility Prospective Payment System, is available at www.naphs.org (under Resources).
Here Come the Boomers…continued

The best innovations must also achieve interoperability with existing systems. Try asking a case manager, on top of their already crushing workload, to open up a new website, log in with a different user name and password, run some complicated process, log out, and get back to business whether connectivity and integration is important.

The more disruptive a solution is to clinician workflow, and the more burdensome the process is to implement, the worse the outcomes will be. Technology-driven solutions hold considerable promise going forward. And for a generation that itself oversaw an incredible range of innovations during its pre-retirement years, this is a fitting salvation.

The Baby Boomer generation is not just the largest generation. It is also among the most resourceful, optimistic, and pragmatic. And it has earned the right to a happy and healthy retirement. We need only to channel its contributions into a healthcare system that actually works.

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Nutrition and Readmission…continued

Discharge planning must be holistic, and should consider the nutritional requirements and even the availability of adequate food for the patient. Interventions as simple as providing a care package of frozen or ready to eat meals at discharge may go a long way to reducing readmissions in the elderly population.

Mom’s Meals, specializing in senior and patient care for over a dozen years, prepares, packages, and ships ready-to-heat and eat meals directly to a customer’s door anywhere in the United States, including meals for those with heart-healthy, gluten-free, veggie, low carb, renal, and diabetic diets. Dr. Sam Beattie can be reached at sam.beattie@purfoods.com.

Catching Up With …continued from page 12

Readmissions News: Switching gears a bit, you are an expert in predictive modeling. Is this going to be a “must have” capability for hospitals, health systems, and ACOs going forward as they try to identify patients at high risk of a hospital admission or readmission?

Ian Duncan: This is not “going to be” but already is. There are regular announcements of new entrants into the analytics and predictive modeling space serving hospitals, health systems, physician groups etc. My observation is that these provider entities are at a beginning stage in terms of their understanding of the power of predictive modeling and its use for patient identification and stratification. A lot of the modeling that I have seen is focused on identifying gaps in care (a worthwhile endeavor but not one that is going to contribute a significant financial return in the short run) and high-risk patients. For those of us who are veterans of the disease management industry, this type of modeling is a decade old at least. One lesson that we learned in disease management is that if you want to generate a return on the resources deployed in patient management, you need to be very targeted in terms of who you manage, and very efficient in terms of deploying your clinical resources. These are lessons that some of the newer entrants have yet to learn, in my opinion.

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

Ian Duncan: This isn’t exactly a secret but it seems to surprise some; in addition to my work as head of clinical research at Walgreens, I am also a professor of actuarial statistics at the University of California, Santa Barbara. I teach and mentor actuarial students and help them to get started in their careers. We have a very successful program in healthcare predictive modeling at the University and are helping to fulfill the extensive demand from interested employers for healthcare analysts and predictive modelers.

References:
4. Ibid.
Catching Up With …

Ian Duncan, FSA, FIA, FCIA, MAAA is Vice President, Clinical Research and Reporting at the Walgreen Company, responsible for Walgreens clinical outcomes, research and publications, client analytics and reporting, and actuarial functions. He is also an Adjunct Professor of Actuarial Statistics at the University of California Santa Barbara, and an Adjunct Research Professor in the Department of Healthcare Administration at Georgetown University. He talks about the WellTransitions® initiative, its retail clinic network, pharmacist supply, use of predictive modeling, and himself.

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• Founder of Solucia Consulting, a healthcare analytics and consulting company (now retired)
• Author of approximately 40 peer-reviewed papers, and several books and book chapters
• Board member, Commonwealth of Massachusetts Health Insurance Connector Authority, the Society of Actuaries and the Healthcare Informatics advisory board of Bryan University, Tempe AZ
• Post-graduate degree in economics, Balliol College, Oxford; fellow of the Society of Actuaries (US), the Institute of Actuaries (London), and the Canadian Institute of Actuaries.

Readmissions News: Walgreens has recently become an active player in the hospital readmissions space with the introduction of your WellTransitions® model. What is the company’s vision here and where are you on the path?

Ian Duncan: WellTransitions® is a program for preventing hospital readmissions and managing adherence. Preventable hospital readmissions have escalated exponentially over the years, costing the U.S. healthcare system approximately $25 billion annually. Many of these readmissions are linked to a failure of medication adherence, which is a symptom of inefficiencies around transitional care and follow-through for discharged patients. Health systems will face future penalties for any readmissions deemed preventable -- an important provision of the Affordable Care Act.

Walgreens WellTransitions® is a collaborative transitional care program under which pharmacist-led interventions provide ongoing follow-up and patient support during and after discharge from the hospital. This helps to achieve the goals of reducing hospital re-admissions and increasing adherence to medication regimes, two important criteria outlined under the CMS Medicare shared savings initiative. WellTransitions®, launched by Walgreens April 2012, utilizes features such as real-time patient readmission information and root cause analysis as part of a multi-step process that spans the discharge period and helps patients’ transition from hospital to home. The program has already contributed to helping hospitals achieve the CMS “triple aim” of greater patient satisfaction, better health outcomes and lower costs.

WellTransitions® aims to manage the patient both in the hospital and post-discharge. Once the patient is discharged, the pharmacist advises prescriptions, establishing an accurate start to medication therapy and encouraging adherence. The pharmacist provides education follow-up, usually 48-72 hours post-discharge, conducts a clinical therapy review approximately 10 days post-discharge, and follows up at day 25 post-discharge. The program has demonstrated early success at reducing admissions and increasing patient satisfaction (HCAHPS scores). Walgreens is providing WellTransitions to over a dozen hospitals currently, with plans to expand this program nationwide.

Readmissions News: Because of the shortage of primary care physicians, urgent care centers and retail clinics are growing at a fairly rapid pace, some part of hospital systems but many stand-alone entities or part of their own national chain. How large is the network of current retail clinics at Walgreens pharmacies and how fast do you expect these arrangements to grow?

Ian Duncan: A Walgreens affiliate currently manages 374 retail health clinics nationwide, and there are plans to expand these clinics aggressively over the next few years. The country will need the primary care services we help provide, if the projected 30 million newly-insured start requiring primary care. We made a significant move at the beginning of this year into hospitals currently, with plans to expand this program nationwide.

Readmissions News: Speaking of personnel shortages, with the increasing emphasis on medication management in population health, disease management, and readmissions, is the supply of pharmacists and/or pharmacy techs also an issue?

Ian Duncan: There has been a noticeable increase in the number of pharmacy programs developed recently. There are approximately 275,000 licensed pharmacists in the U.S.-- more than there are practicing primary care physicians, incidentally. Walgreens employs over 75,000 clinical professionals, nearly 28,000 of whom are pharmacists, in over 8,500 locations throughout the country, and we are a key component of access to care. Two- thirds of Americans live within three miles of a Walgreens community pharmacy. While we do not anticipate a shortage of pharmacists, the number and complexity of new therapies grows exponentially, for example among specialty pharmaceuticals which often require special handling, infusion and patient care, so we expect that the demand for pharmacists will continue to be high.

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