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The Patient-centered Discharge —
How Hospitals Are Rethinking Transitional Care to Avoid 30-day Readmission Penalties

Contents

1 In Pursuit of Better Outcomes

1 The Maximum Penalty Is Now In Force

2 The Status Quo No Longer Works

2 The Better Way: Combine the Best Practices of Transitional Care Into a Single Program

3 PatientCare Connex™: Combining Best Practices to Lower Costs and Improve Outcomes

3 PatientCare Connex Resource Timeline

4 Inspiring Outcomes

In pursuit of better outcomes

A major metropolitan hospital discharges a heart failure patient to her home, knowing there's a one-in-four chance she will need to be readmitted within 30 days. A 130-bed community hospital discharges a heart attack patient to a skilled nursing facility for rehabilitation, realizing there's a one-in-five chance he will be back in his hospital bed within a month.

Both scenarios are not only traumatic for the patients, but also for the hospitals' bottom lines. The penalties for 30-day readmissions have never been higher—and the number of hospitals affected never greater.

But for these two hospitals, the likelihood that their patients will be readmitted is significantly lower now than both the national average and their own, historical performance. The key? Fundamentally rethinking how transitional care works from hospital to home or another healthcare facility—and discovering new, more effective best practices to manage the 30 days of care after discharge. The timing of this evolution couldn't be more critical.

The maximum penalty is now in force

In 2013, a key quality-improvement program of the Affordable Care Act was implemented: the Hospital Readmission Reduction Program, designed to penalize hospitals for patient readmissions within 30 days of discharge for certain conditions.

That year, the maximum penalty was 1% of reimbursements, triggered by readmissions for heart attack, heart failure and pneumonia. In 2014, the penalty increased to 2%, while the disease states remained the same.

In 2015, the penalties expanded in both the scope of the conditions affected and the size of the penalties themselves. The penalty has now reached the maximum allowed by statute: 3%. And the conditions triggering the penalty have expanded to include chronic obstructive pulmonary disorder (COPD) and total hip/knee replacement.

These penalties are comprehensive, reducing the total base reimbursement across all Medicare payments—not just those

A pervasive problem, now with the maximum penalty allowed by law

30-day Readmission Rates for:

HEART ATTACK **19.9%**

HEART FAILURE **24.5%**

PNEUMONIA **18.2%**

COPD **17-25%**

KNEE/HIP REPLACEMENT **5.5%**

For ALL Reimbursements:

3% PENALTY

While this is the maximum penalty set in statute, CMS can add new conditions that will trigger the penalty, beyond the five conditions already in place.

associated with the conditions triggering the penalty. And the penalties are far-reaching: in 2015, a record number of hospitals—more than 2,600—will be penalized by CMS.

As a result, readmissions are one of the hottest topics in healthcare today. Hospitals are forming 30-day readmissions reductions teams—and administrators and clinicians are coming together everywhere to seek an effective solution.

The status quo no longer works

The shift from traditional discharge planning to managing the full 30 days after discharge is daunting. While many hospitals seek to internally address the challenges of transitional care, others are looking outside their four walls for the answer.

But until now, third-party programs have fallen short by addressing only part of the problem. While these programs had favorable results within their narrow focus, they didn't offer a total solution that addressed all of the risks associated with the full 30 days following discharge.

The better way: combine the best practices of transitional care into a single program

A comprehensive, sustainable readmissions program requires six key best practices. When effectively combined and managed, they not only help lower readmission rates, but also improve patient satisfaction. The best practices that create this patient-centered solution include:

1. **Onsite, full-time management:** Given the depth of detail and attention the program requires, it needs a full-time manager onsite at the hospital. In effect, this professional functions as an extension of the hospital's staff to manage the program more effectively.
2. **Medication reconciliation:** A patient's medications often change at discharge, and 50% to 70% of hospital readmissions are a direct result of issues with adherence or errors. That's why it is essential for a patient to leave the hospital with the correct set of medication instructions, as well as the advice of a registered pharmacist to help ensure that they're taken as directed.
3. **After-hospital Care Plan:** The cornerstone of an effective 30-day readmissions program is a thorough patient discharge and medication management plan shared not only with the patient and caregivers, but also the primary care physician to improve communication and ensure continuity of care.
4. **Managing skilled nursing and LTC transitional care:** According to the American Health Care Association, 20% of Medicare-eligible patients are discharged to a skilled nursing or other long-term care facility before going home. Wherever the patient is, the 30-day discharge management program must monitor the transition of care to these facilities and the status of care while there. And that's critical, because a hospital can incur the same reimbursement penalty whether the patient is readmitted from home or a non-acute care facility.

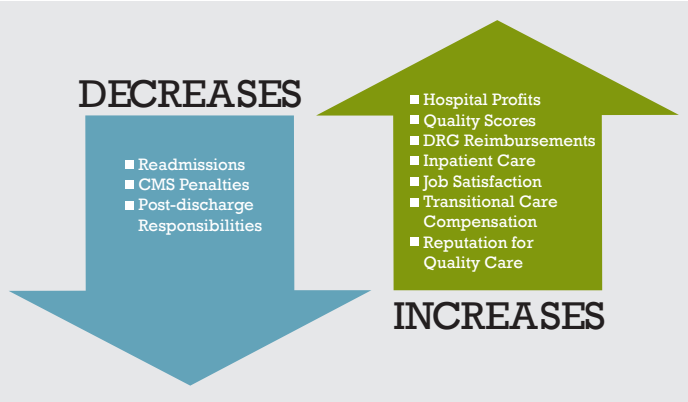
Discharged directly to home

Discharged to skilled nursing facility

5. **Maximizing transitional care payments to providers:** A best-practice 30-day readmissions program capitalizes on all available revenue opportunities, such as the transitional care payments available to primary care physicians (PCPs) who consult with their patients after discharge. Communication is the key, and when PCPs are made aware of new discharges, they can take advantage of transitional care codes CPT-99495 (about $163) and CPT-9496 (about $231).
6. **An extension of the hospital's brand:** Because patient satisfaction is essential in a pay-for-performance world, program services and staff must function as part of the hospital's care team. To patients and caregivers, there should be no difference between the program and the hospital itself. All they should see is quality, patient-centered care.

PatientCare Connex was created to combine these six best practices into a single, sustainable solution focused on patient-centered care and delivered by AmerisourceBergen, a global leader in pharmaceutical services.

PatientCare Connex: Combining best practices to lower costs and improve outcomes



The program manages all post-discharge responsibilities, whether from the hospital to home or another healthcare facility, such as skilled nursing or long-term care. Because the hospital spends less time and fewer resources on care coordination and managing multiple suppliers, it can redirect more attention elsewhere to improve patient care.

The comprehensive program includes three key components:

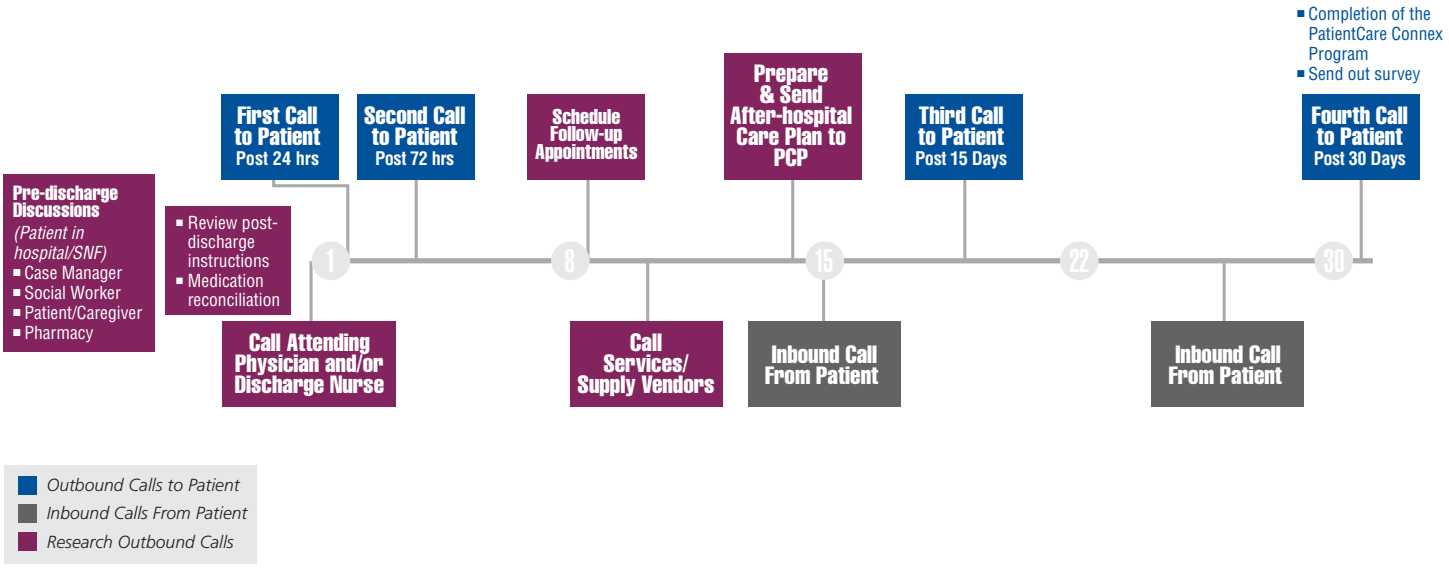
1. **Pre-discharge planning** led by an onsite navigator to ensure patients and their caregivers understand post-discharge instructions, including medications and how to administer them.
2. **After discharge,** the program includes a comprehensive 30-day system of phone calls from a registered pharmacist or registered nurse to ensure the patient is following the post-discharge plan as directed.
3. **Phone support for patients and caregivers** is offered throughout the program. So answers to care-related questions are always just a call away—an added measure of assurance during what can be a stressful and uncertain time for patients, families and other caregivers.

Inspiring outcomes

Two pilot programs reveal how PatientCare Connex succeeds in the real world. With the first pilot, a 140-bed city hospital

PATIENTCARE CONNEX RESOURCE TIMELINE

PatientCare Connex is an end-to-end system that comprehensively manages patient care for the first 30 days after discharge: *the critical period when patients and hospitals are at risk for readmissions that can severely impact reimbursements—not to mention patient satisfaction. When adopted as a hospital-wide best practice, PatientCare Connex can solve post-discharge challenges not only for patients impacted by the 30-day readmission policy, but for ALL patients.*



had just paid a substantial 30-day readmissions penalty. Eager to minimize their readmissions going forward, the hospital tested PatientCare Connex with a group of heart failure patients discharged to their homes.

The result: the readmissions rate dropped from 29.8% to just 20%. "PatientCare Connex really took the pressure off of our staff," one hospital executive said. "Our people were relieved that the program handled all the coordination, communication and other details."

The second pilot was conducted by a 130-bed community hospital discharging patients to skilled nursing facilities (SNFs). Due to a shortage of resources, communications between the hospital and SNFs needed improvement. PatientCare Connex closed the gap, ensuring critical details such as medication information were promptly communicated to the SNFs.

As a result, readmissions fell from 27.3% to 17.7% during the pilot program. "We were just astonished with the undivided attention we received," a hospital executive said. "And so were our patients and their caregivers, who appreciated the level of education PatientCare Connex provides. With that depth of understanding, everyone becomes more vested in the patient's recovery."

Pilot Program #1

Discharging to Home

Challenge A major metropolitan hospital had readmissions above the national average for heart failure (29.8% vs. 24.5%).

Solution Create a PatientCare Connex pilot program for a select group of heart failure patients discharged to their homes.

Results Avoided readmission for 80% of pilot patients. The resulting 20% readmission rate was significantly below both the national average and the hospital's prior performance.

Pilot Program #2

Discharging to a Skilled Nursing Facility

Challenge A 130-bed community hospital had readmissions above the national average for patients discharged to a skilled nursing facility (27.3% vs. 23.5%).

Solution Create a PatientCare Connex pilot program for a select group of patients diagnosed with a heart attack and discharged for cardiac rehabilitation at skilled nursing facilities chosen by the patients and their caregivers.

Results Lowered the readmission rate of the pilot patients to 17.7%, well below both the national average and the hospital's prior performance.

About the author

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Creator of PatientCare Connex

As a registered pharmacist for more than 30 years, Ron Leopold has been a retail pharmacy owner, an executive at a global pharmaceutical company and an independent consultant to the pharmaceutical industry. "I've been a caregiver myself and know first-hand how frustrating it can be for patients and their families when there's no follow-up after leaving the hospital," he said. "This gap in patient-centered care is at the heart of the readmissions crisis we're all facing today, and my passion is to be part of the solution."