Preventing Unnecessary Readmissions

Measuring Care Coordination Across the Continuum

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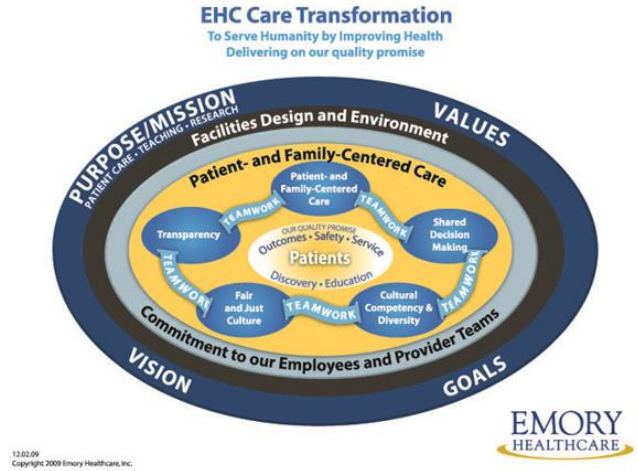
Readmissions (target pic)

- **Alliance for Home Health Quality and Innovation** (AHHQI) finds that hospital readmissions more than double the cost of providing care to a patient, and those readmissions become more likely when a patient suffers a chronic condition.
- 2009 Public Reporting of Hospital Readmission rates on the CMS Hospital Compare website
- Section 3025 of the Affordable Care Act added section 1886(q) to the Social Security Act establishing the Hospital Readmissions Reduction Program, which requires CMS to reduce payments to IPPS hospitals with excess readmissions, effective for discharges beginning on October 1, 2012.



Care Coordination

EMORY HEALTHCARE

Value

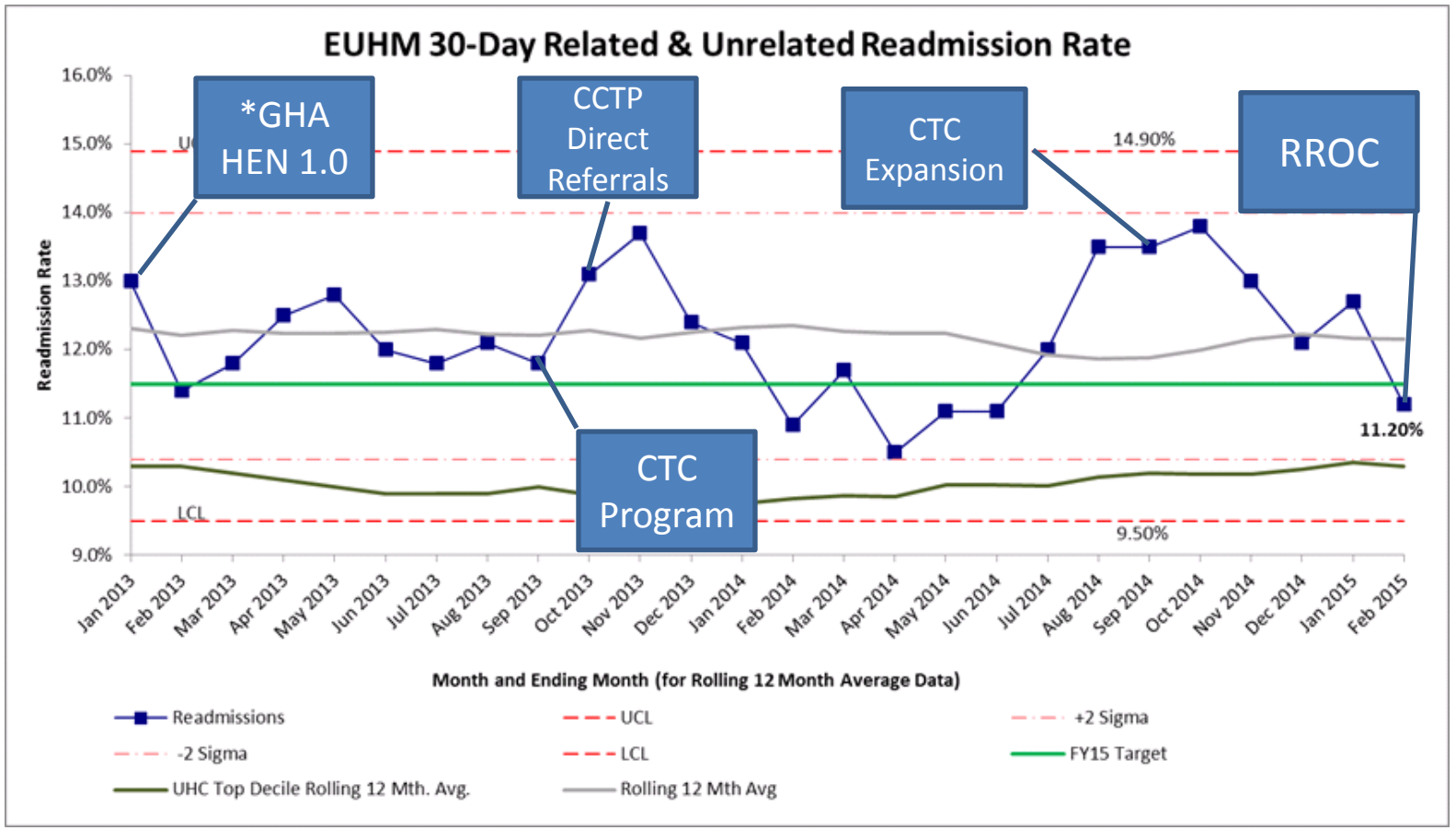
=

Quality

Cost

Avoidable Readmissions

The EUHM Story



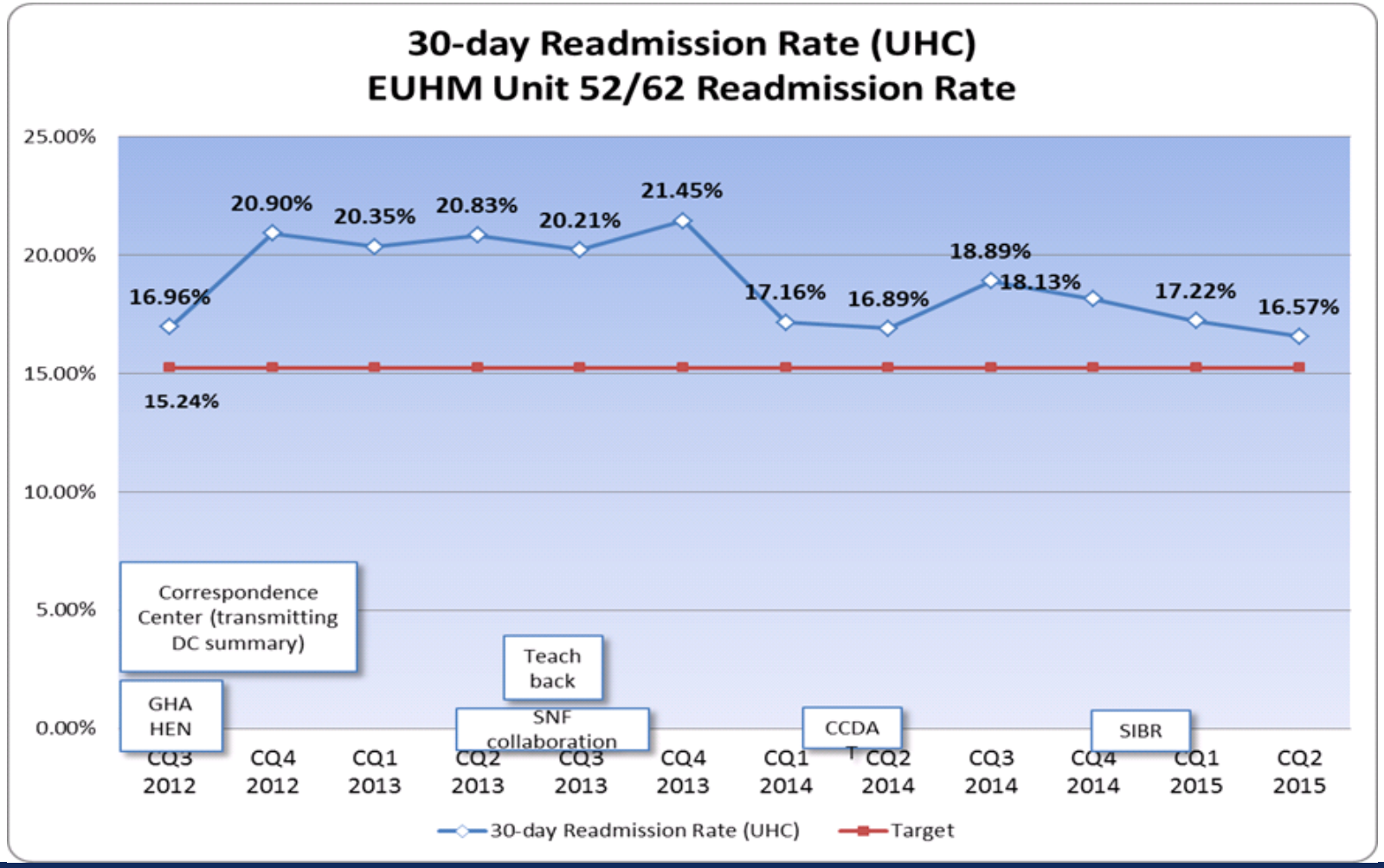
Readmission Reduction Efforts

- GHA Hospital Engagement Network 1.0
- Community Care Transitions Program – Atlanta Regional Commission
- Care Transition Coordinator Program
- Readmission Reduction Oversight Committee

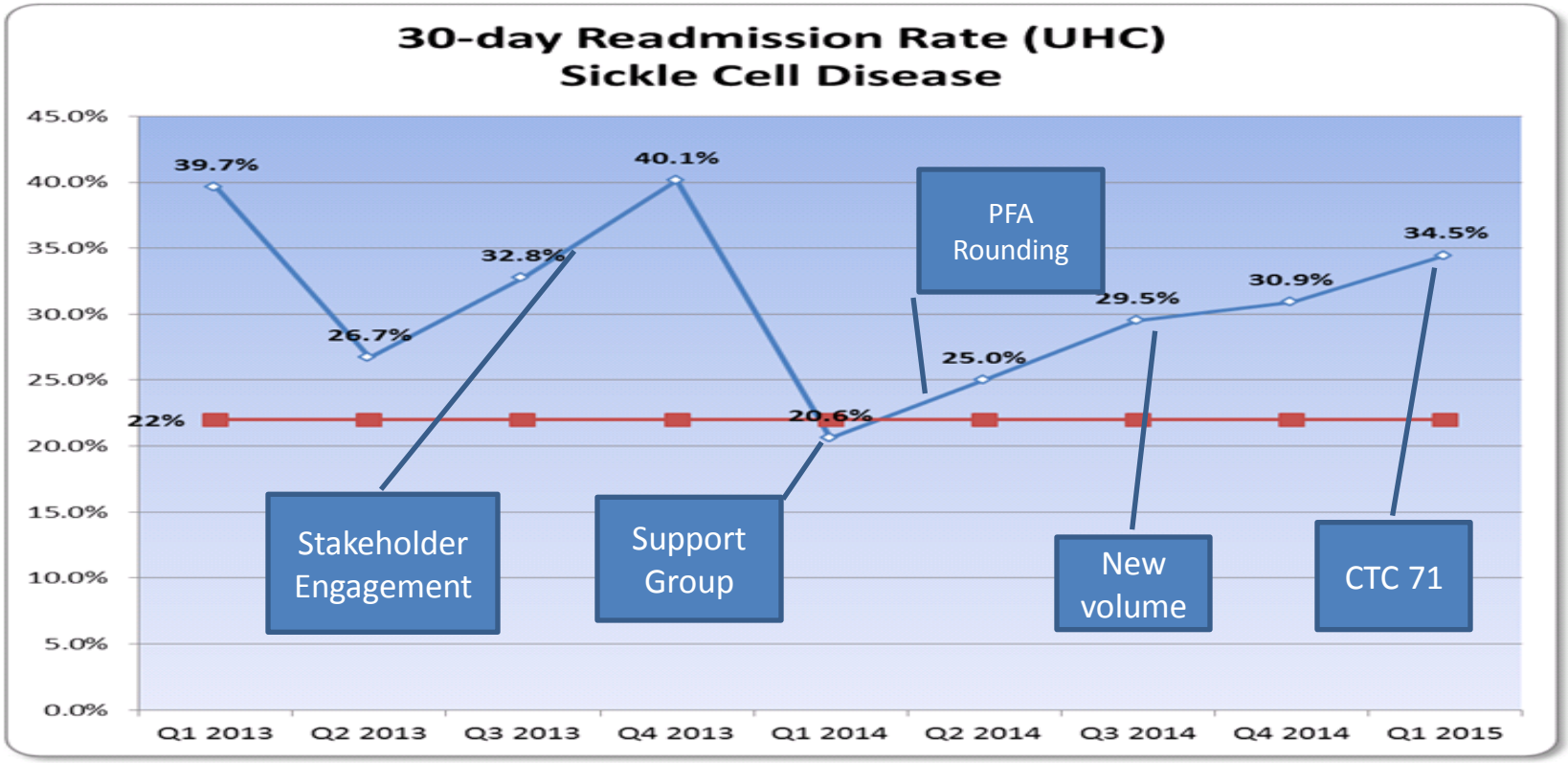
GHA HEN 1.0

- Readmission Reduction Target 20% All cause readmissions
- Population Focused
- EUHM
  - Renal
  - Sickle Cell

Renal Population



Sickle Cell Population



New Model:
RN Care Transitions Coordinator (CTC)

- Performs risk stratification to identify patients at high risk for readmission
- Assists in coordinating and providing quality patient care of patients assigned to specific units or populations
- Works closely with the Interdisciplinary Team (IDT) to ensure care is appropriate and timely
- Helps team to manage patients' length of stay (LOS)
  - Including tracking barriers to discharge

Additional Challenges/Barriers

Challenge/Barrier

- CTC role confusion
- House staff education and turnover
- Lengthy patient selection process
- Discharging patients without all care needs

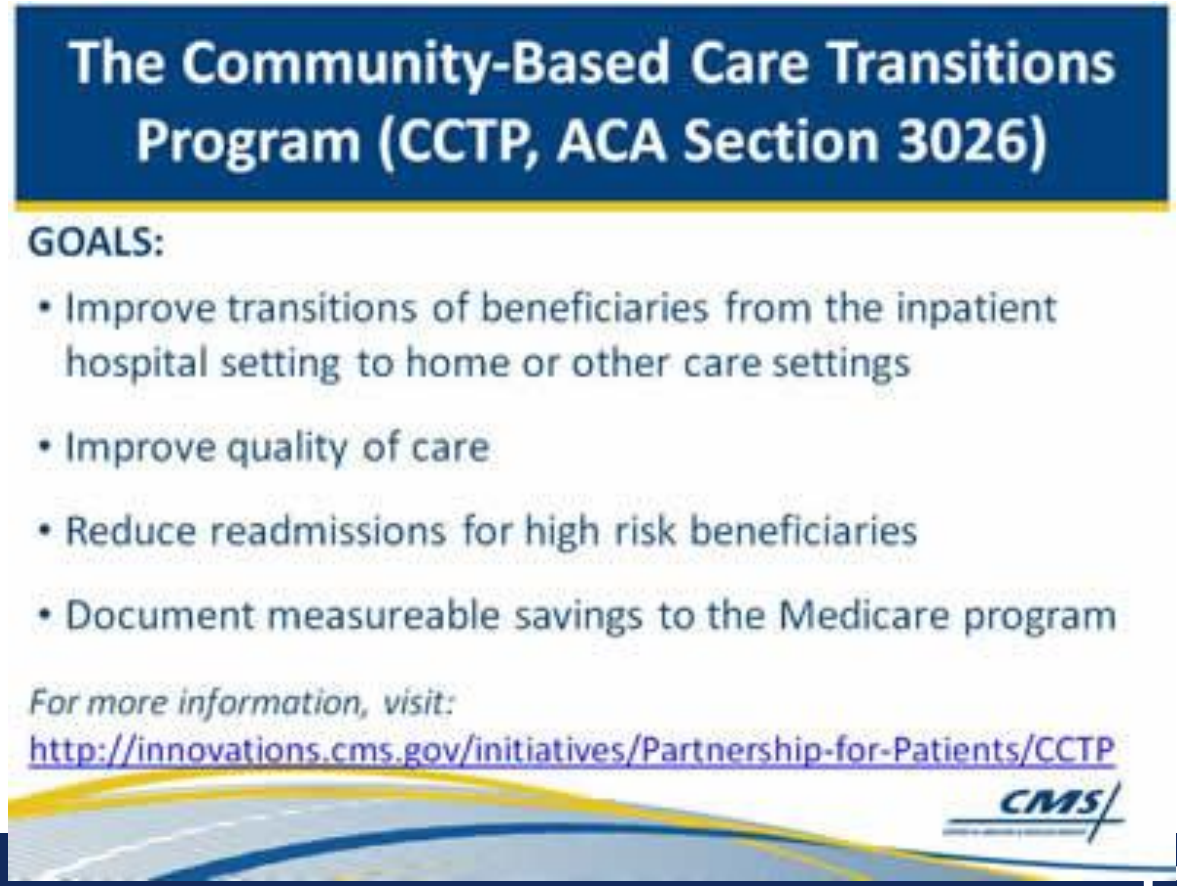
Solutions

- Unit/clinic based education on CTC Program
- Dyad teams established (CTC and SW)
- Medical Director of Care Coordination and unit / clinic champions assigned
- Education of CTC role in physician orientation
- Social Worker hired for department
- Early identification and procurement of home services

CTC Program Outcomes

- Significant reduction in readmission rate year over year
- Reduction of CMS readmission penalty to approximately $100,000
- Improved care coordination by the IDT (meeting Length of Stay goals)
- Improved employee engagement
- Case in Point Platinum Award for Best Transitions of Care Program

Care Coordination across the continuum

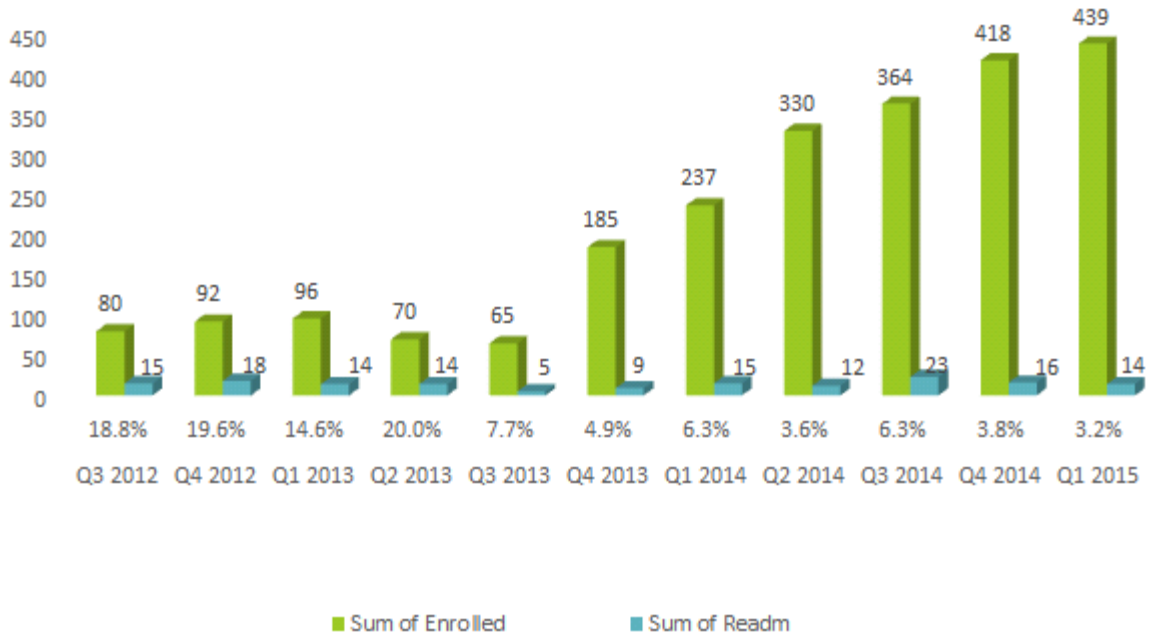


EUHM CCTP Partnership

Q3 2012 – Q1 2015

2376 enrolled; 155 readmitted *

Readmission rate = 6.5% (below programmatic overall readmission rate)

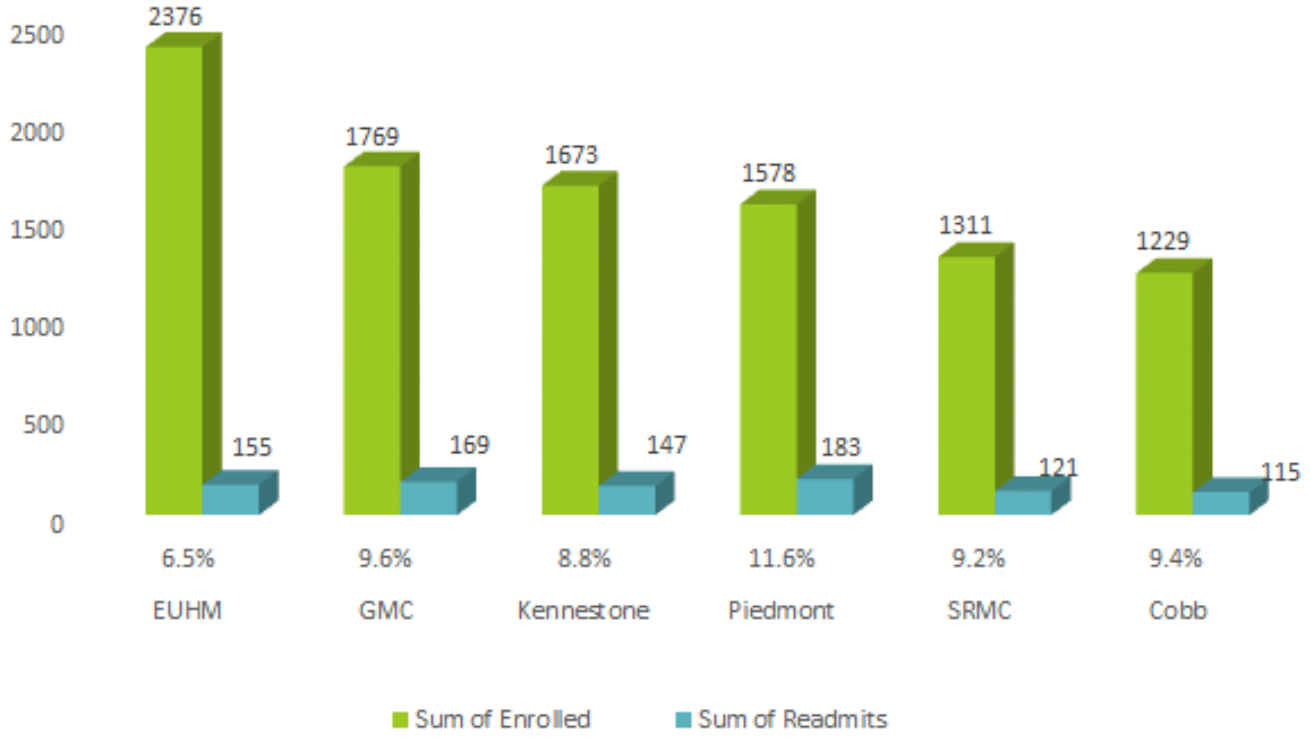


Partnership Summary

Feb 2012 - Mar 2015

Total enrolled – 9936; Total readmitted – 890 *

Readmission rate – 9%



EUHM/CCTP

Medicare Cost Saving Summary

June, 2012 – February, 2015

Total Enrolled	2376
Total Readmissions	155**
Readmission Rate	6.5%
Medicare Cost Savings *	$,2,985,600 > 974,946 **$2,010,654**

Calculating Reduced Medicare Spending = Σ Avoided Medicare Payments > Σ CCTP Payments

Sum of Avoided Readmissions = (.196 x 2376) = 466 – 155 = 311
Avoided Medicare Payments = 311 x $9600 = $2,98
Sum of CCTP Payments = $974,946

Avoided Medicare Payments = Avoided Readmissions x Average Medicare Hospital Payments for CCTP eligible ($9600) ***Where***
Avoided Readmission = (Baseline readmission rate for CCTP x # of CCTP enrollees) - # of readmissions for CCTP enrollees

RROC

- Readmissions Reduction Oversight Committee
- Unit/Service Line Teams presenting
- Improving Observation Admissions
- Increasing Home Health Utilization
- Communication & Coordination of Early Discharge Planning

Next Steps

- Application of CCTP model beyond Medicare Patients
- Palliative Care Referrals
- Care More Model for Medicare Beneficiaries