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Enhancing Care Coordination Across the Continuum

A guidebook to reducing readmissions

Readmissions are a significant challenge with a high price tag—amounting to over $26 billion annually for Medicare patients alone. While there are many factors contributing to readmissions, a theme is the increasing complexity of healthcare. Providers are taking on more and more patients. At the same time, there are ever-growing documentation requirements, as well as the need to interact with more systems and tools. The average health system has multiple different EHR systems in place across their network. The result is cumbersome data integration and access, which creates care coordination challenges.

Many readmissions occur when patients move between care settings. Given the fragmented healthcare landscape, information can fall through the cracks, leading to suboptimal care transitions that put patients at risk. Collective Medical, a PointClickCare company, believes readmissions can be reduced by using care coordination tools that enable real-time data sharing and care collaboration. Collective Medical offers an integrated care coordination solution spanning the full continuum, offering the network, infrastructure, and capabilities needed to share information bidirectionally among different participants in the patient or member journey.

To learn more about how organizations are reducing readmissions, Becker's Hospital Review spoke with three healthcare experts on readmissions:

- Amy Boutwell, MD, Developer, STAAR, ASPIRE and MVP Methods and President at Collaborative Healthcare Strategies
- Enrique Enguidanos, MD, CEO and Founder of Community Based Coordination Solutions
- Nikki Starrett, MS, Director of Value-based Care at Collective Medical, a PointClickCare company

This white paper is based on these conversations.

Reducing readmissions is difficult, but success stories abound

Effective strategies for lowering readmissions include creating a community dialogue, leveraging technology, and using proven toolkits.

"One way we promote community dialog is by creating a multidisciplinary team with hospital and outpatient providers, law enforcement, emergency medical services, behavioral health centers and jails," Dr. Enguidanos said. "It covers all the touch points where there are complex readmissions."

The High Utilizer Mat-Su program in Alaska, which was launched to reduce barriers to care for community members, provides an example of successfully engaging patient populations and exchanging information. The program reduced readmissions by more than 50 percent in the first year through common community dialog, a shared information platform and incorporating changes based on the patient perspective.

Another useful tool for reducing hospital readmissions is the Agency for Healthcare Research and Quality's ASPIRE Guidebook (Designing and Delivering Whole Person Transitional Care). Thousands of teams in the United States have used this guide, which Dr. Boutwell authored.

"When I first came to Maryland, the state was ranked 47th out of 50 states and D.C. for the worst readmission rates in the country," Dr. Boutwell said. "Over a five-year period using data and fostering cross-continuum collaboration, the state went to meeting and beating the national average for Medicare readmission rates. It's a robust testimony to the power of our abilities to reduce readmissions."

The emergency department is an important intervention site

As the gateway to the hospital, emergency departments represent a critical arena for preventing readmissions. The ED also offers opportunities for healthcare providers and other care team members to discover why patients are showing up there.

It can be incredibly powerful to stand up readmission reduction teams and processes in the emergency room. "When Maryland switched from fee-for-service to a global capitated budget for Medicare, the first thing all 46 hospitals did was to place social workers and case managers in the emergency room 24/7 to serve as a hub and spoke of triage and appropriate discharge for people not having acute medical events," Dr. Boutwell said.

Tools like Collective Medical that automatically push care guidelines and care plans can support patient triaging and identifying opportunities for safe, appropriate discharge, helping reduce unnecessary readmissions. "EDs are great at stabilizing crisis events," Dr. Enguidanos said. "We can find out the critical issue behind why a person showed up, but there are often a lot of underlying issues. For example, a homeless renal patient with cellulitis may come to the ED. If their renal status is stable, they could be discharged. However, if we don't have a mechanism in the community to address the cellulitis and homelessness, we will probably admit them. When we have access to information from sources beyond the hospital, it makes it a lot easier for the emergency department to make a decision to discharge."

If emergency room physicians and case managers have real-time visibility into why a patient came to the ED, full encounter history, and other context beyond the immediate presentation, that may impact the course of treatment and patient journey.

Importantly, these patient insights must be available at the fingertips of busy ED personnel. "I try to safely and appropriately discharge patients in collaboration with my emergency medicine colleagues," Dr. Boutwell observed. "But it's so much easier to admit them. It takes me four times as long to discharge a patient as it does to click through the Epic admission driver and admit them. Part of the change management is closing that time differential."

For this reason, it's essential that care plans and other actionable information are readily available, directly in provider workflows – a core capability of Collective Medical's solution. "If we have tools like PointClickCare and Collective Medical that can serve as a database for care plans, we need to ensure that staff understand how to use them," Dr. Enguidanos said.

Post-acute care partners play a key role in reducing readmissions

The crisis moment in the ED is only one piece of the readmissions puzzle. Reducing readmissions also requires a focus on post-acute care, as patients in post-acute settings are at higher risk of readmission. In fact, Medicare patients discharged to a skilled nursing facility have a 25% likelihood of readmission within 30 days.

The INTERACT (INTErventions to Reduce Acute Care Transfers) methodology is specifically designed to address hospital readmissions in the post-acute setting. This set of recognition tools and evidence-based protocols enables supervising providers to respond to small changes in clinical status safely and manage them on-site, rather than reflexively sending people to the emergency room for evaluation. The INTERACT toolkit has reduced readmissions among post-acute patients an average of 35 percent.

Similar to providers in the emergency department, SNFs typically have a limited understanding of patient history and needs beyond the current episode of care—information such as who is on the patient's outpatient care team and whether a plan of care is in place. Through a shared care coordination platform, SNFs can be made aware of previously identified patient risks and take proactive measures to address them, perhaps involving the patient's dedicated case manager throughout the patient's SNF stay. Connecting the dots between the point of care and the community can result in more effective patient care and better outcomes including reduced readmissions.

To proactively address readmissions, real-time patient-level and population-level data are key

In addition to engaging ED and post-acute providers, an effective readmissions strategy must also focus on supporting organizations that manage patients across the continuum, such as ACOs, health plans, and other risk-bearing entities.

This requires real-time data that allows individual care managers to understand what's happening with patients they are responsible for. "To support care transitions, care managers must be aware in real time of acute and post-acute encounters happening inside and outside the health system," Ms. Starrett explained. "It's also important to stay engaged during a patient stay. Clinical data and other information can provide early warning signs." Care managers often have particularly limited insight into what's happening during a SNF stay. It's important that these care managers can identify patients who may require attention—for example if a patient, has long length of stay, low functional status, or is at high risk of readmission—and be empowered to act.

Data analysis at the population level is equally important, providing broader insights to help tackle readmissions. "Ask not only what subgroups have the highest actual readmissions. Take a broader view and look at the readmission data analysis and the root causes," Dr. Boutwell said. "What was going on right before the patient came to the emergency room? Many times, it's a failure of the community to respond fast enough."

Readmission data analysis should also look at readmission trends at the facility level, including discharging hospitals and SNFs. "To reduce readmissions, you need to understand how the network is performing. If individual facilities are driving readmission rates, you must address those problem areas proactively," Ms. Starrett said.

Conclusion

As the adoption of value-based payment models continues to increase, so will the importance of reducing readmissions. "In emergency medicine, what we're called to do every day is to make good treatment, admission and discharge decisions," Dr. Boutwell said. "Physicians need information and visibility to make more discharge decisions that are safe and appropriate. We must provide the tools and processes required to make that easier."

PointClickCare enables true, integrated care coordination. It provides the leading health information platform with the largest network of post-acute care providers, including 22,000 SNFs and long-term care facilities. PointClickCare and Collective Medical are uniquely positioned to help organizations with care coordination through real-time, bi-directional data that supports information exchange between EHRs, as well as workflow integration.

Connect with the PointClickCare team to learn more.
CollectiveMedical.com

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