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HOME HEALTH CARE AS A VEHICLE FOR REDUCING AVOIDABLE HOSPITAL READMISSIONS

All healthcare providers, in recent years, have dealt with seismic shifts in the way they are paid for the care provided to patients. Especially if the Medicare program is involved. Pay for performance, in one form or another, has become a fact of life. The performance and quality initiatives that impact hospitals including the Hospital Readmissions Reduction Program (HRRP) have the potential to increase payment rates by as much as 3.5% or lower them by as much as 6%. For hospitals, most of which are already grappling with negative Medicare margins that could fall as low as -10% in 2018, the reimbursement swings can have a significant negative impact. To say the least, the financial balancing act has its challenges.

The problems with hospital discharges have been extensively reported. We know that about 19% of Medicare patients discharged from an inpatient stay are readmitted at least once within 30 days. The cost of avoidable Medicare readmissions has been estimated at upwards of $17 Billion a year. Currently, performance under HRRP is measured by same cause readmissions for about 180 primary diagnosis codes that indicate COPD, Heart Failure, Pneumonia, Stroke, or Acute Myocardial Infarction, as well as surgical procedures for CABG and elective knee or hip replacement. In its 2018 report to Congress, MedPAC reiterated its suggestion that the policy be expanded to cover all conditions rather than only the handful that are now included, and that the penalty formula be “fixed” to equate the financial consequence for each excess readmission to an amount approximating its cost.

As more and more baby boomers join the ranks of Medicare beneficiaries, the readmission problem is destined to get bigger. When increasing numbers of elderly patients are hospitalized, the pressure on the efficiency of hospital discharge planning and follow up processes will most certainly mount. And with nearly a third of Medicare beneficiaries now enrolled in Medicare Advantage plans, CMS has been joined by a host of commercial insurers all intent on one thing -- keeping discharged patients stable and protected from an expensive U turn back to the hospital. The commitment also involves holding hospitals accountable for their results.

A recent study done at the University of Pittsburgh and recently published in the Journal of the American Geriatrics Society suggested that improved discharge planning processes, particularly with better involvement and understanding of discharge plans by patients and their caregivers, would significantly reduce hospital readmission rates. Across 15 separate studies involving more than 4,300 patients, the conclusion was that more effective discharge planning would yield a 25% improvement in readmission rates. Clearly, one way to avoid readmissions is to have better informed patients and caregivers with access to care at home. But to achieve the aim, we must close the post-discharge home healthcare gap.

The challenge has been the inability to consistently connect adherence to readmissions rates, and so the discussion has lacked the data to quantify the opportunity. Excel Health has changed this by providing its customers with detailed home health adherence and readmission rates for every hospital in America. Our customers are leveraging this data today to more closely collaborate with partners in the care continuum to increase adherence and lower readmissions.

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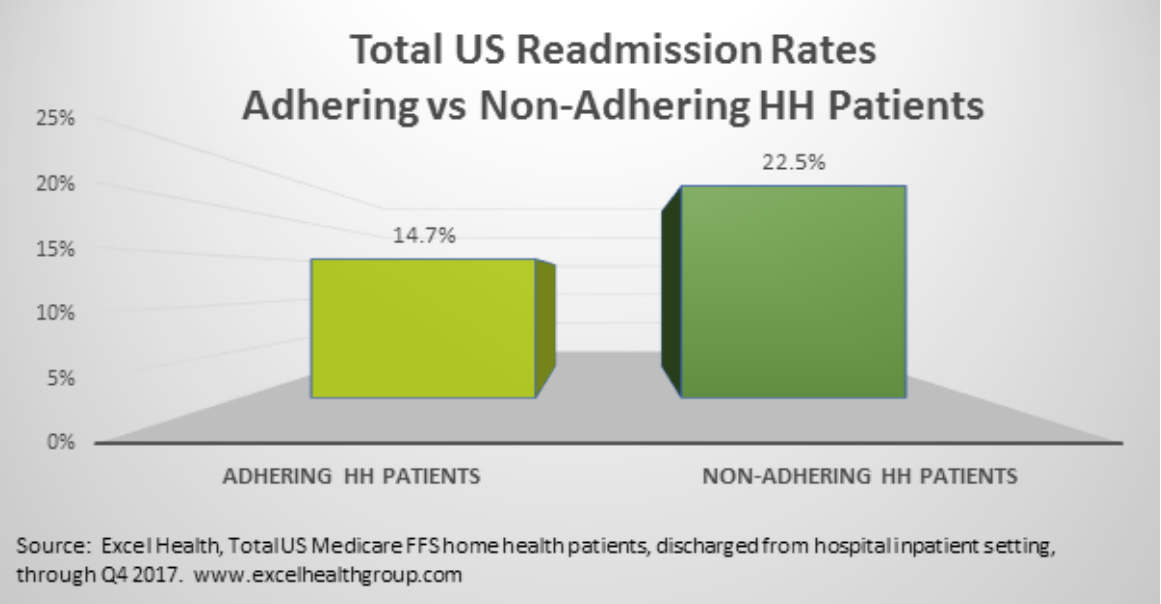
FALLOUT FROM THE HOME HEALTH ADHERENCE GAP

Excel Health, with access to over 1.2 billion annual Medicare fee-for-service claims housed in the CMS Chronic Conditions Warehouse, recently researched an interesting aspect of the hospital readmission problem – the number of patients who don't get anticipated post-discharge home health services and how the absence of planned follow up care affects overall readmission rates.

With a focus on hospital inpatient discharges, Excel found that, over a four-quarter period between 2016 and 2017, approximately 1.3 Million inpatient discharges were coded for follow-up home healthcare; meaning skilled intermittent nursing and/or therapy at home. A half million of these patients – about 40% - did not receive the follow up care that was anticipated upon discharge. The 60% who did "adhere" to their discharge instructions had measurably lower 30-day readmission rates. Looking at 2017 alone, home health patients that adhered to their discharge instructions were approximately ***35% less likely to be readmitted.***

Hospitals in the northeast, particularly NH, VT, and ME, along with DE and SC had the highest home health adherence rates while WY, TX, NM, MN and HI had the lowest.

Non-adhering patients represented a $2.5 Billion foregone revenue opportunity for home health providers. More to the point, the failure to get the needed home health care also ended up affecting the discharging hospitals' readmission calculations as the very diagnoses that make up the penalty group are also among the most prevalent conditions treated by Medicare-certified home health agencies. Medically fragile patients with COPD, Heart Failure, a history of Stroke, Acute Myocardial Infarction or Pneumonia are frequently treated by home health agencies well equipped to handle restorative and maintenance therapy as well as skilled teaching to expand the patient's understanding of the disease process, safety at home and need for medication compliance.



Source: Excel Health, Total US Medicare FFS home health patients, discharged from hospital inpatient setting, through Q4 2017. www.excelhealthgroup.com

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CHARACTERISTICS OF ADHERING VERSUS NON-ADHERING PATIENTS

AGE

- Younger Medicare patients with long-term disabilities are less likely to adhere to their discharge instructions for home health and significantly more likely to be readmitted within 30 days.
- Whereas 70% of the beneficiaries aged 75-85 received post-hospital home health services, only 60% of the beneficiaries under the age of 65 got care. Approximately 27% non-adhering under age 65 group were readmitted within 30 days; only 22% of the adhering patients were readmitted in the same time frame. In comparison, adhering patients between 65 and 74 were readmitted only 15% of the time. Older, adhering beneficiaries over the age of 75 were readmitted 17% of the time versus their non-adhering counterparts with a 24% readmission rate.

GENDER

- Women are slightly more likely to adhere to discharge instructions for home health than men and less likely to be readmitted when they do. Non-adhering men and women have the same readmission rate of 24%.

DIAGNOSIS

- Patients being discharged following lower extremity joint replacement procedures have the highest post-discharge adherence rate of 82%. This bears out the strong relationships between orthopedic surgeons and specific home health providers with robust restorative therapy programs.
- On the other hand, only 67% of the cardiac patients discharged to home health actually received home health services and only 63% of patients hospitalized for respiratory events received home health following their discharge.
- The adherence difference between patients with joint procedures versus those discharged following a cardiac or respiratory event, likely points to the overall involvement of the inpatient physician in specific discharge planning as one element of better adherence. To wit, the more involved the physician, the greater the likelihood of getting needed follow up care.

STUMBLING BLOCKS TO ADHERENCE

There are several impediments to realization of the discharge plans involving home health services. Lack of communication, lack of understanding of the disease process and treatment medications, lack of awareness, involvement of primary care physicians in the process and caregivers' misunderstanding of the patient's care requirements all conspire to produce less than ideal adherence rates.

It is a fact that most patients who are discharged following a hospital stay are not at their best. Stays have gotten shorter and the natural by-product of more abbreviated hospital courses of treatment is that patients are usually weak and often overwhelmed by the array of instructions handed out as they return to their homes. Various studies have concluded that, as they are being discharged, only 37% of patients are able to articulate the reasons for their medications; only 14% understand the potential side effects of those medications and only 42% can confirm their diagnosis.

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Caregivers can also be significantly stressed by events and the reality of taking care of a loved one with significant care requirements at home. Caregivers are can be reluctant to engage in a discussion of home health for a variety of reasons, including not wanting strangers in their homes or even a misunderstanding of home healthcare and what it can do to assist the patient and his/her caregivers.

Discharge planners who can be simultaneously involved in facilitating multiple patient discharges often compound the communication and information gaps that contribute to non-adherence and post-discharge problems that can lead to a readmission.

TIMELY DATA CAN FACILITATE PROCESS IMPROVEMENT AND REDUCE AVOIDABLE READMISSIONS

With access to all of the claims data for both Medicare Part A and Part B services, Excel Health helps industry partners understand and address readmission challenges and improvement opportunities. Here are two real world examples, direct from the Excel Health Market Intelligence Portal:

Hospital A is a teaching institution with 800 beds.In the three quarters ended September 30, 2017 approximately 3,000 patients were discharged with home health instructions. Only 53% of those patients received home health services; representing a five-percentage point deviation from the State adherence rate of 58%. With improved adherence, this hospital had the potential of lowering its 30-day readmissions by 109 patients annually.

Patients Discharged with Home Health Instructions (Inpatient only)

	Percent of All Patients Who Received Discharge Instructions				% Readmitted: 30 Days		
	Total Patients	This Facility	Country Average	State Average	This Facility	Country Average	State Average
Patients Admitted to Home Care	1,577	53.4%	55.6%	58.0%	16.1%	14.8%	14.8%
Patients Not Admitted to Home Care	1,375	46.6%	44.4%	42.0%	24.0%	22.3%	22.7%

Source: Excel Health 2017 Medicare FFS patients through Q4 2017.

Hospital B is a 425-bed facility and part of a health system in the southwest. The home health adherence rate was 56% which trailed the County average by 7%. Non-adhering patients were 64% more likely to be readmitted. With improved home health adherence, the hospital could potentially readmit 27 fewer patients and lessen its penalty exposure.

Patients Discharged with Home Health Instructions (Inpatient only)

	Percent of All Patients Who Received Discharge Instructions				% Readmitted: 30 Days		
	Total Patients	This Facility	Country Average	State Average	This Facility	Country Average	State Average
Patients Admitted to Home Care	405	56.0%	62.7%	62.3%	13.4%	13.0%	13.0%
Patients Not Admitted to Home Care	318	44.0%	37.3%	37.7%	22.0%	20.1%	19.5%

Source: Excel Health 2017 Medicare FFS patients through Q4 2017.

HOSPITALS AND THEIR HOME HEALTH PARTNERS COLLABORATE TO MAKE A DIFFERENCE

The stories above illustrate very low hanging fruit. But thus far, the connection between home health adherence and readmission rates has not been a focus. Furthermore, the lack of visibility to readmissions to other hospitals has eluded many hospital executives that rely on internal data. Now that very recent performance metrics are available from Excel Health, home health agencies and hospitals can collaborate on ways to increase adherence to home health instructions. The result will be much better patient satisfaction, lower cost and better outcomes. Isn't that what the Triple Aim is about?

We believe that change happens one hospital at a time. We encourage those involved with home health discharge and care to take a deep dive into your own local data and devise plans to increase home health adherence in your market. If you would like to compare the home health adherence and readmission data for hospitals in your market, go to www.excelhealthgroup.com and request to speak to a sales consultant.