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Readmissions NEWS

Post Acute Networks Continue to Reduce Costs and Readmissions

by Josh Luke

Many hospitals and health systems across the country host Post-Acute Network (PAN) or collaborative meetings regularly. These PAN meetings include local Skilled Nursing Facilities (SNF), and often include home health and hospice providers as well. At the meeting, hospital care management executives shares readmission and quality data, review star ratings and outlining expectations for the post-acute providers that provide care for the hospitals discharged patients. Because Accountable Care Organizations and bundled payment executives have developed strategies that strive to avoid acute rehab facilities and long term acute care hospitals (LTACH) due to the increased cost, most providers choose not to invite and include LTACH and acute rehab providers in their meetings.

In the book, ***Readmission Prevention: Solutions Across the Provider Continuum***, (available at ACHE.org/publications), a chapter is dedicated to creating an effective post-acute network. The book compares a hospital or health system sponsored and managed PAN meeting, with a community collaborative sponsored by multiple providers. To summarize the chapter, hospital-sponsored collaboratives have direct, specific agenda items that include clearly defined expectations for post-acute providers. Post-acute providers leave the meeting with a clear understanding of what is expected. Community collaboratives on the other hand, often have multiple providers with competing initiatives and it can be much more challenging to communicate clear expectations to the post-acute providers in attendance.

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Using Community Health Workers to Reduce Readmissions

by Andy Friedell

Preventable 30-day readmissions are estimated to account for more than $17 billion in Medicare expenditures annually. While all hospitals are focused on reducing avoidable utilization, it's proving to be an uphill battle for many. In 2017, more than half of the nation's hospitals will receive penalties, including a disproportionate number of teaching hospitals and other facilities that serve higher numbers of low-income beneficiaries.

For these patients, it's often the simple things – missed medication, poor nutrition choices or lack of transportation – that can stand in the way of recovery and drive up healthcare costs. As a result, common manageable conditions such as high blood pressure and diabetes are often admitting diagnoses for low-income patients, but only comorbidities for their higher-income counterparts.

This disparity underscores a simple, yet often overlooked truth: readmissions are not the primary problem. Avoidable utilization occurs when medically complex patients also have behavioral or social challenges that go unmanaged.

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In This Issue

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Editor's Corner

Greetings readers of *Readmissions News*! As we all recover from the initial shockwaves of the election of Donald Trump for President of the United States, people from across the healthcare spectrum are only just beginning to grapple with the consequences of some form of repealing and replacing the Affordable Care Act. Though our printing schedule did not allow for us to tackle this issue in our current issue, you can rest assured we will be exploring it in our December issue. Thank you for subscribing and please let me know if you have any questions, comments or concerns.

Regards,
Peter Grant; Editor, *Readmissions News;* pgrant@readmissionsnews.com

Using Community Health Workers to Reduce Readmissions...*continued from p 1*

A New Approach

Armed with this knowledge, Maxim Healthcare Services – a national provider of home health, medical staffing and population health and wellness services – set out to develop a program to address these non-medical factors. Rather than relying on home health aides or other medical professionals following discharge, the program uses community health workers (CHWs) to help patients navigate barriers to care, engage patients in their own recovery and, ultimately, reduce costs.

Community health workers are on the frontlines of healthcare, often providing non-clinical care to underprivileged communities facing social, religious, language and cultural barriers. Because they do not typically have a medical background and often have similar life experiences as their patients, CHWs are able to quickly build trust – which is essential to engaging patients in their own care. Studies show CHWs improve outcomes for patients with chronic issues, reduce 30-day readmissions, improve mental health, decrease hospital costs and increase patient and provider satisfaction.

> *"Studies show CHWs improve outcomes for patients with chronic issues, reduce 30-day readmissions, improve mental health, decrease hospital costs and increase patient and provider satisfaction."*

In February 2015, Maxim partnered with 232-bed University of Maryland St. Joseph Medical Center (UMSJMC) in Towson, Maryland, to offer the program to patients deemed at high risk for readmission due to a high degree of medical, psychological, functional and socioeconomic complexity. While Maryland hospitals are exempt from the federal government's Hospital Readmissions Reduction Program because of the state's all-payer rate setting system, they are nonetheless required to reduce their 30-day readmission rate to the national rate by 2018.

Patients enrolled in the program typically have a number of psychological factors and social determinants that reduce engagement, adherence to medical directions and access to care. When combined with several medical comorbidities and poor functional status, these psychosocial issues result in high cost avoidable utilization.

Immediately upon admission, patients under a technology-based risk assessment. For those deemed at high risk for readmission and prior to discharge, patients are then assessed in-person by a nurse practitioner. They are then reassessed by a registered nurse in their home following discharge. Finally, each patient is assigned a CHW who is uniquely trained to mitigate barriers to care and act as a liaison to existing healthcare services and increase care coordination.

Over the course of 30 days, CHWs regularly visit patients in their homes, helping them address any challenges they face after leaving the hospital.

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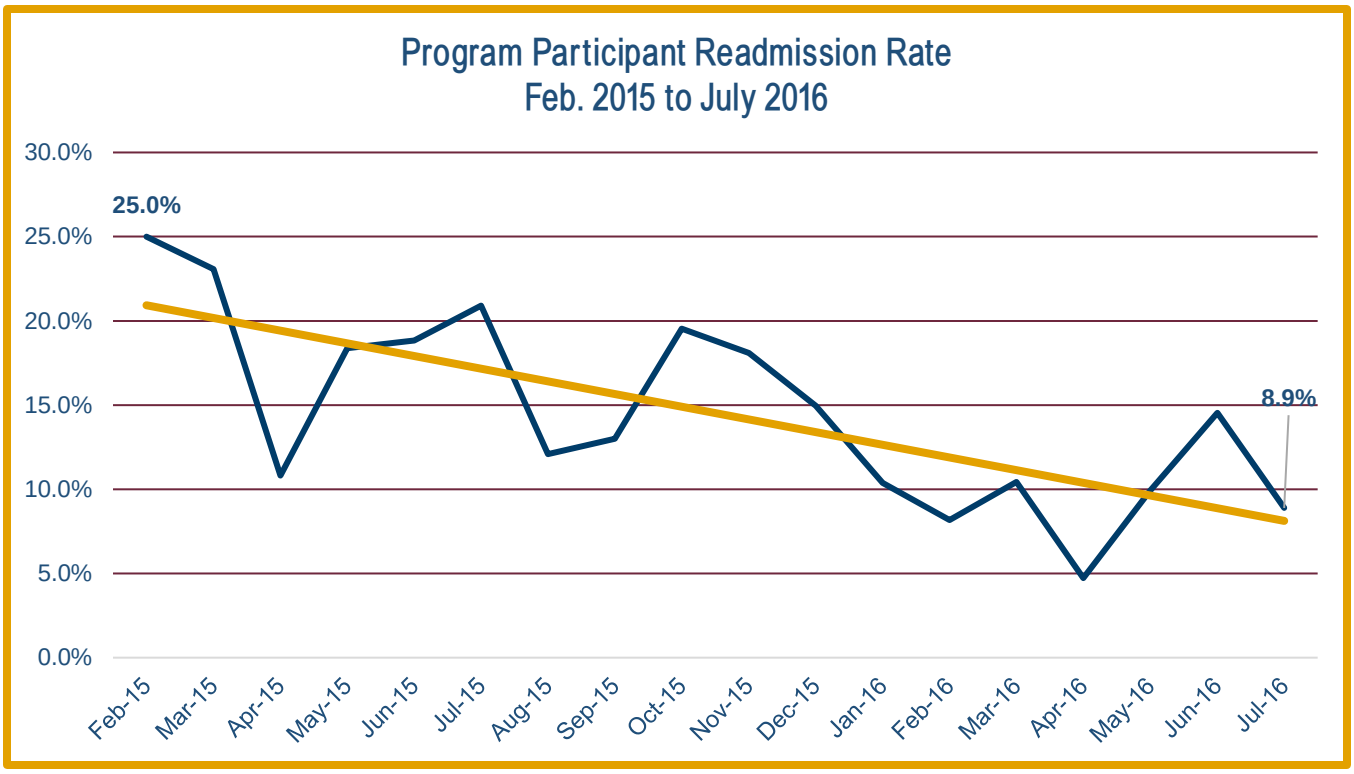
Using Community Health Workers to Reduce Readmissions...*continued from page 2*

This may include making follow-up care appointments, providing transportation, purchasing medical supplies, offering support and reinforcing health education and information on important warnings signs in a way that the patient understands.



The CHWs also serve as link to the care team, providing regular updates and discussing changes to the plan of care as necessary. Maxim employs all of the program's staff, including the nurse practitioners, registered nurse and community health workers. It also provides medical and non-medical training on techniques such as motivational interviewing, which helps CHWs engage with their patients and uncover intrinsic motivators that can play a key role in behavior change.

Program Results

Through this partnership, UMSJMC has stepped beyond the role hospitals have traditionally played in a patient's recovery to create a measurable positive impact on the health of the population it serves.

> *"Since the launch of the program, Maxim has provided over 11,000 hours of CHW services –following up on roughly 1,800 patient hospitalizations at UMSJMC. This work has helped reduce the readmission rate for program participants by roughly two thirds, from 25 percent to about 8.9 percent."*

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In July 2016, UMSJMC and Maxim renewed and expanded their partnership to engage more patients struggling with chronic medical, socioeconomic and behavioral complexity. The program will establish a new CHW role that will be dedicated to providing community-based support to patients with complex behavioral health challenges.

Conclusion

A small percentage of patients drive the majority of healthcare costs due to a high degree of complexity. These results provide further validation that CHWs can improve outcomes while reducing avoidable utilization of high-cost medical services.

While there are many readmission reduction programs and strategies in use across the country, this program is effective because of its highly personal, relationship-based approach. For this patient population, regular one-on-one visits from trusted a caregiver with a similar background or life experiences can be a powerful motivator that supports behavior change.

Andy Friedell is Vice President, Strategic Solutions at Maxim Healthcare Services.

Post Acute Networks Continue to Reduce Costs and Readmissions...*continued from page 1*

Other important traits of an effective hospital Post-Acute Network are hosting the meetings consistently, preferably every-other month. Monthly meetings can become monotonous and in contrast, quarterly meetings are often not frequent enough. Most hospitals will provide a meal at the meeting as well. Also, it is important that the meetings are hosted at the hospital, as it shows the hospital is committed to the process. Those hospitals who choose to host the meetings on a rotating basis at the various local SNF facilities have found the meetings to be less effective as the SNF's inevitably treat the gathering as a marketing or social event, which contradicts the goal of the business meeting.

Hospitals should contact the SNFs they desire to attend and let them know that the expectation is that the SNF will attend. The three individuals from each SNF that should attend are the Administrator, the Director of Nursing and the Director of Marketing/Admissions. Data shared and discussed at the meeting includes readmission rates and communicating the preferred home health referral patterns of the hospital.

"We all recognize that it is the only way to achieve our objective of readmission reduction and quality outcomes for all our patients."

Los Alamitos Medical Center in Southern California, owned by Tenet Healthcare, has one of the oldest and most successful post-acute networks – which they call their readmission meeting. Karen Games, Senior Director of Process Improvement, who leads the monthly meeting, has a guest speaker each month and also reviews a readmission dashboard comparing the SNF's readmission rates. When one SNF shows improvement in a key target area, that SNF is asked to share that Best Practice program with the other attendees to ensure the best practice is being utilized by all SNF's that support the hospital.

The monthly community collaborative at Los Alamitos Medical Center focuses on reducing readmissions and brings together post-acute care groups that used to be competitors. These groups now work together toward a common goal. The collaborative shares readmission data and performs root cause analysis on all readmitted patients, with the goal of shared learning and accountability.

"We all recognize that it is the only way to achieve our objective of readmission reduction and quality outcomes for all our patients," Games said.

"Setting clear expectations for post-acute providers and sharing hospital readmission data during the events has strengthened the relationships between the hospital and its post-acute partners…These are the pillars which support a successful monthly event."

Los Alamitos sister facility, Fountain Valley Regional Medical Center also has a robust monthly post acute network. Qiana Hines, Director of Case Management, was recently nominated by its members for a Senior Care Hero Award in Orange County, California. The FVRMC Community has proven an invaluable success as it has seen a double-digit drop of SNF readmission rates since its inception in August 2014.

"Setting clear expectations for post-acute providers and sharing hospital readmission data during the events has strengthened the relationships between the hospital and its post-acute partners," Hines said. "These are the pillars which support a successful monthly event."

St. Josephs Health System actually started its senior network meeting as far back as 2001. Although the agenda has transformed significantly since then, since Providence recently acquired St. Josephs Hoag, each of the four Orange County, California hospitals in the chain recently hosted a joint post-acute network meeting. More than 70 attendees participated, including SNF, home health, non-medical home care and assisted living. In addition to presentations on policy updates, Brookdale Senior Living gave a presentation on its successful Bridge program from SNF-to- assisted living-to-home, and Stryker presented its CJR dashboard that identifies discharge patterns and trends by doctor and by facility.

The Stryker dashboard is generated from claims data and is one of the most useful tools available in tracking physician and case manager discharge patterns, particularly within the BPCI program. Having worked with health systems all over the country on enhancing their post-acute network and improving efficiency in bundled payment programs, Stryker is likely the most useful and accurate tool I have been exposed to in providing organizations the data that illustrates inefficient physicians and case manager referral patterns.

"Stryker's Dashboard, Episode Performance Manager, is a web-based data analytics and communications solution for managing bundled payment initiatives. Hospitals and providers need a turnkey solution to managing, sorting, analyzing and reporting CMS data as well as communicating with the entire care team" says Robyn McGann, BSN, MBA, Senior Consultant and BPCI Compliance Officer for Stryker's Performance Solutions Division. "With access to a detailed analysis of the effectiveness and costs associated with post-acute care providers and by drilling down into claims data 'live' with the care team, customers are making faster decisions and progress toward developing a preferred post-acute network."

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Post Acute Networks Continue to Reduce Costs and Readmissions...*continued from page 4*

In 2016, the presence of non-medical home care at these meetings has become more common as well. Organizations like HomeHero and LHC Group are becoming part of the mainstream conversation as hospitals adopt a "home-first" mentality and accompanying "SNF avoidance" strategies. Santa Monica based HomeHero has entered hospital, payer and SNF partnerships in multiple states in recent months, with Cedars-Sinai Health System in Los Angeles investing in the company as well, via their Healthcare Accelerator program. In early November 2016, another hospital group announced a formal, profit sharing joint venture with a home based services company when LifePoint Health partnered with the LHC group to provide non-medical home care services to discharged patients. Thus, Cedars Sinai, UCLA, UCSD Health, LifePoint Health and Kaiser are among the growing list of leading national health systems turning to a "home-first" mentality and partnering with non-medical home care to fulfill this objective. At the PAN meetings, the concept of non-medical home care and working with the hospitals preferred provider is a key objective.

"Hospitals and SNF's are looking beyond local mom-and-pop providers for partnerships and we are fielding calls from all over the country to partner and joint venture," said Kyle Hill, co-founder and CEO of Santa Monica, California based HomeHero. "We are finding that health systems are seeking two key traits in a home care provider: 1) A successful track record of delivering care over several years as we have been doing at HomeHero since 2013, and 2) Data gathering and sharing of a patients home based care patterns. Our technology based platform and successful track record accomplishes both."

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While the SNF's that attend these meetings are still often frustrated by the message being shared at these meetings, as value based care models are significantly reducing profit margins in the SNF, they are grateful to be included in the information exchange as many SNF's are not invited once a hospital narrows its SNF network. SNF's realize that they must be included in the hospitals narrow network of providers and in attendance at the meetings or it will be perceived that they are not interested in being a part of the hospitals network. Because SNF's often lack the resources to provide significant training and education on value based care, these meetings serve as a key source of education for SNF administrators. For more information or examples of post acute networks, please email me at lukej@usc.edu.

Josh Luke is an Award Winning and Internationally recognized Healthcare Futurist and Innovator. He is Chief Strategy Officer and Sr. Health Policy Analyst for Nelson Hardiman Law, NH Strategy & Compliagent. He founded of the National Readmission Prevention Collaborative and his most recent book,* Ex-Acute: A former hospital CEO tells all on what's wrong with American healthcare, What every American needs to know*, is now available on Amazon.com.

Understanding Workload as a Driver of Readmissions

by Dan Nottingham

Becoming a doctor is not easy. And these days, staying a doctor can be just as difficult. The daily demands placed on physicians in nearly every medical and surgical specialty are increasingly linked to a condition known as physician burnout. Unlike stress, physician burnout sufferers are not able to recover during their time off which in turn leads to physical and emotional exhaustion – and unfortunately, this troubling consequence is not rare. Numerous global studies indicate that approximately 1 in 3 doctors are experiencing burnout at any given time; some more recent studies indicate that the prevalence of physician burnout is as high as 60%. Many scholarly articles have gone as far to describe burnout as an "epidemic," with professional medical societies taking the issue on at annual meetings in order to stem the potential loss of physicians from practice.

So, why are so many physicians experiencing burnout? There are several factors that contribute, but in the hospital setting the most significant issue is excessive workload – too many patient encounters and not enough time. In fact, according to a survey[1] published in the *JAMA Internal Medicine*, 40% of hospitalists, who are typically on the front line of acute care, reported having an unsafe workload at least once a month.

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The result of burned out physicians who are assigned an unsafe workload include poor patient satisfaction and outcomes with a direct impact on 30 day readmissions. In fact, 14% of hospitalists surveyed reported an increase in 30 day readmissions due to suboptimal planning and other factors related to an excessive patient workload.

More Complicated Than Meets the Eye

And what are the consequences of an excessive workload? Many of the drivers are tied to readmissions including diagnostic errors and premature discharge.

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Understanding Workload as a Driver of Readmissions...*continued from page 5*

So given tools such as electronic medical records at the physician's disposal, and multi-pronged programs seeking to enhance both physician engagement and patient satisfaction (not to mention the fact that reimbursement is now tied to this latter measure), how do high workloads even happen in this day and age? Generally, hospitalized patients are distributed for daily medical care via assignment to hospitalists who are on service, covering patients on a medical floor. If there are 48 admitted patients and three hospitalists working, each hospitalist would be given responsibility for 16 patients.

However, the problem with this approach is that all patients are not the same. Some patients require much more time and effort than others creating a workload imbalance to the point that some workloads are unsafe. Additionally, when a provider feels s/he is consistently given a roster that is more labor and time intensive than his or her peers, that provider will start to feel frustration that over time can evolve into burnout.

"The retrospective, cohort study of more than 20,000 hospitalizations across Christiana Care Health System found that LOS increased along with workload, particularly in hospitals with less than 75% occupancy where LOS increased linearly from 5.5 days to 7.5 days across low to high workload levels. The estimated net result? Nearly $7500 of additional cost per admission."

Unsafe workloads can also have an impact on length of stay (LOS). For example, consider research published in a 2014 issue of *JAMA Internal Medicine*.[2] The retrospective, cohort study of more than 20,000 hospitalizations across Christiana Care Health System found that LOS increased along with workload, particularly in hospitals with less than 75% occupancy where LOS increased linearly from 5.5 days to 7.5 days across low to high workload levels. The estimated net result? Nearly $7500 of additional cost per admission.

Applying Automation for Fair Distribution

Understanding that workload is a critical factor around patient outcomes, cost of care and provider satisfaction, MedAptus has introduced software that seeks to automatically solve the workload problem. The solution, called Assign, uses a configurable protocol engine to optimally match rounding providers, such as hospitalists, to patients. With Assign, each admitted patient is given weight based several factors that impact physician time and effort, and this is calculated along with the capacity of each provider on service. These factors, processed through Assign's protocol engine, allow workload to be fairly distributed, significantly reducing the chances of unsafe workload assignments.

As one example of how this might work, patients who are approaching discharge and thus have stable vital signs and in-range lab values will require less effort from a physician than a newly admitted patient that has severe pain, problematic vital signs and has yet to receive a diagnosis. So, while one provider may be aligned with 11 patients and the other 14, the workload involved with both census' is equitable.

Another benefit of the Assign technology is the potential to establish a "PCP in the hospital." Beyond aiding with workload balancing, the software also helps maintain continuity of care within an admission and between admissions. If a patient with a chronic condition is able to form a relationship with a hospitalist, and that physician is given the opportunity to learn more about the patient's home life, medical history, and so forth, there is better chance for compliance which can range from medication adherence to follow-up with the actual PCP. Taking this a step further, patients can even be assigned based on their PCP so that over time, the key medical contacts in both the acute and office settings can team on approaches to keep the patient out of the hospital.

In medicine, nothing is simple, and there are few islands. Burnout is a complex phenomenon just as re-admissions are multi-factored and often simply not avoidable. On the surface, it might not be obvious that a provider who is unhappy and feeling negative about his/her chosen profession may be making decisions that impact a patient down the line. But by understanding the most prominent feature of a provider's burnout, which in the case we have made here is workload, the fix could be a relatively simple one. With technology such as Assign, there is no significant impact to the provider's day-to-day (except feeling less pressure, sleeping better at night, having more time to spend with family and better focus to make the best treatment decisions possible).

[1] Michtalik HJ, Yeh H, Pronovost PJ, Brotman DJ. Impact of Attending Physician Workload on Patient Care: A Survey of Hospitalists. *JAMA Intern Med*. 2013;173(5):375-377. doi:10.1001/jamainternmed.2013.18642
[2] Elliott DJ, Young RS, Brice J, Aguiar R, Kolm P. Effect of Hospitalist Workload on the Quality and Efficiency of Care. *JAMA Intern Med.* 2014;174(5):786-793. doi:10.1001/jamainternmed.2014.300

Dan Nottingham is the Vice President of Product Management for MedAptus. Dan has over 20 years of experience in healthcare technology and has been a key contributor to the MedAptus care coordination vision.

Thought Leaders' Corner

Q. What role will big data and analytics have in reducing preventable readmissions?

Each month, *Readmissions News* asks a panel of industry experts to discuss a topic of interest to the hospital community. To suggest a topic, write to Editor@ReadmissionsNews.com.

"With financial penalties incentivizing hospitals to comply with readmissions related quality measures, how should they go about addressing readmission rates? One possible solution is advanced analytics. Sophisticated analytics are able to comb through terabytes of clinical data to reveal opportunities to improve quality and efficiency. What's more: analytics provide a way for hospitals to leverage their data to analyze and better manage specific patient populations.

It is important for hospitals to understand the current readmission rates for their patients. Why? Because you can't improve what you don't measure. It is important to establish readmission baselines, track performance metrics, and distribute information to everyone who is trying to reduce readmissions.

This is the first step towards quality improvement. Health systems operating at level 5 or above on the Healthcare Analytics Adoption Model will be able to achieve this goal. Realize, however, that if you're looking old data, it's difficult to engage clinicians in clinical improvement initiatives. Adopting an enterprise data warehouse (EDW) as described below could help ensure the data is current."

Marcus Gunderson, DNP, APRN
Senior Vice President Clinical Improvement Line, Delaware Health Coordinators
Dover, DE

"Predictive analytics has been gaining ground over the past several years. Simply put, predictive analytics uses a variety of statistical techniques including: modeling, machine learning, and data mining, that analyzes current and historical facts in order to make predictions about the future. In the healthcare setting predictive analytics is effective in addressing such things as: length of stay management, preventable readmissions, and hospital acquired infections. It has been predicted that organizations that use predictive business metrics will increase their profitability by 20 percent by 2017.

Nevertheless, predictive analytics can also be challenging. Predictive analytics can be difficult to operationalize because it can be complex and time consuming. In addition, there is a shortage of data scientists. Business can't see past these challenges to how predictive analytics will improve daily outcomes. Some barriers to adoption of predictive analytics include a lack of understanding of the benefits, lack of appropriate skills, and difficulty in quantifying ROI. However, most industry observers believe that predictive analytics will continue to play a major role in the healthcare sector."

Emily Bennett, MPH
Senior Healthcare Consultant and Technologist, Kaplan & Freeman Consulting
Denver, CO

Industry News

Preventing Blood Clots, Costly Complications or Readmissions in Orthopedic Patients

ActiveCare, a trademark brand of Medical Compression Systems (MCS), will be presenting its latest outcome results at the 26th American Association of Hip and Knee Surgeons' (AAHKS) annual meeting. ActiveCare is a platform of smart-compression treatment alternatives to anticoagulant drugs in the prevention of deep vein thrombosis (DVT), costly complications and readmissions in total joint replacement procedures. Those interested in learning more are invited to learn more about ActiveCare at conference booth #1213.

Venous thromboembolism (VTE) is a common complication following total joint replacement procedures. This condition includes both DVT, a blood clot in a deep vein in the lower extremities; and pulmonary embolism (PE), where the blood clot becomes dislodged and migrates to the lungs. An estimated 1 million hip and knee replacements are performed in the U.S. annually, primarily in patients over the age of 50 years old. Studies have found that this age group is disproportionately affected by VTE.

The new results will showcase the platform's effectiveness at reducing the risk of VTE while simultaneously reducing the risk of costly readmissions and complications, such as major bleeding and infections often associated with anticoagulants together with increased patient satisfaction.

Enabling Improved Patient Outcomes with Smith & Nephew's Pioneering Episode of Care Assurance Program (eCAP)

ActiveCare, Smith & Nephew, the global medical technology business, announced that the U.S. health and wellness organization, Provider PPI LLC, has adopted its Episode of Care Assurance Program (eCAP), an innovation designed to mitigate risk associated with readmissions in value-based healthcare reimbursement models. Provider PPI LLC is a subsidiary of Highmark Health that provides group purchasing benefits to the hospitals of Allegheny Health Network and 60 additional healthcare providers in the western Pennsylvania region.

Enabling Improved Patient Outcomes...*continued*

Unplanned readmissions are costly to hospitals, surgeons and patients and can result in significant financial implications under the Comprehensive Care for Joint Replacement Model (CJR) and Bundled Payments for Care Improvement (BPCI) initiative. For patients, an unplanned readmission can turn an elective procedure into an emergent procedure, complicating and extending the 90-day episode of care. For hospitals and surgeons focused on value, as defined by quality outcomes achieved through efficiency, unplanned readmissions can negatively influence overall quality scores.

The eCAP initiative pairs together Smith & Nephew's entire line of primary total hip and knee reconstructive systems with two of its most innovative wound care products: PICO™ Single Use Negative Pressure Wound Therapy and ACTICOAT™ Flex 7 Silver-coated Antimicrobial Barrier Dressing. Smith & Nephew warrants the performance of its primary total knee systems, primary total hip systems, PICO Single Use Negative Pressure Wound Therapy System and ACTICOAT Flex 7 to perform as expected. If a patient is readmitted within 90 days following a procedure for a surgical site infection or to revise the implant due to a failure of a Smith & Nephew product, Smith & Nephew will pay a hospital's unreimbursed costs for the readmission up to the purchase prices of the implant, PICO and ACTICOAT Flex 7. This pioneering program can provide value and help to improve quality associated with lower extremity joint reconstruction surgery (LEJR).

Building strong partnerships with healthcare institutions and providers is the core of Smith & Nephew's mission and has been a central pillar of the company for over 160 years. By providing viable solutions in healthcare, Smith & Nephew supports healthcare professionals in their daily efforts to improve the lives of patients.

StayWell unveils Krames Health Engagement Platform

The StayWell Company announced the launch of a new patient engagement solution that powers patient-provider interactivity at all points of care across the patient's health care journey, to optimize outcomes and improve quality and safety. The new Krames Health Engagement Platform is powered by Doctella Smartlist technology, which emerged from industry-leading quality and safety research.

Industry News

StayWell unveils Krames Health…*continued*

Effectively engaging patients and caregivers is essential to hospitals and health systems in new value-based payment models, because engagement − which can be fostered by interactive education, communications and positive feedback − can contribute to improved patient compliance and clinical outcomes.

However, according to a 2015 study published in the journal *Risk Management and Healthcare Policy*, the percentage of patients who were not compliant with care plans ranged from 25-50 percent, depending on disease state, patient characteristics and insurance coverage. The Krames Health Engagement Platform addresses this challenge by augmenting verbal instructions and print materials with state-of-the-art, customizable and interactive, multimedia tools that can be easily shared with family and caregivers.

The platform is accessible anytime, anywhere. It facilitates open communication with clinical staff and allows for previously unavailable monitoring of patient behaviors and compliance. For health care providers, the platform is designed to align with quality and value-based payment systems that focus on clinical outcomes and patient-centered care. The platform delivers improved patient satisfaction scores and helps providers manage costs by reducing last-minute surgical cancellations and readmissions.

OUR LADY OF LOURDES MEDICAL CENTER

Lourdes Offers Cardiac Rehabilitation Patients New Telemonitoring Program

Despite its value and importance, cardiac rehabilitation is vastly underutilized by patients recovering from heart events, according to a recent paper published in the *Journal of the American College of Cardiology*. As such, the paper advocates for a new model of cardiac rehab delivery. Our Lady of Lourdes Medical Center is leading the way to offer patients such a model.

Lourdes has partnered with San Francisco-based Moving Analytics to implement a hybrid cardiac rehab program aimed at increasing patient compliance and breaking the barriers that lead to underutilization.

Lourdes is the first hospital in the tri-state area to implement the hybrid model. Cardiac rehab is a comprehensive program that helps patients not only physically recover from a heart event but also teaches individuals the skills needed to make healthy lifestyle changes, improve quality of life and reduce risk of a future heart event.

Lourdes Offers Cardiac Rehabilitation...*continued*

They are excited to offer patients this new model as a more convenient way to complete cardiac rehabilitation− potentially preventing hospital readmission and ultimately helping improve their overall health.

say transportation, work schedules and affordability prevent many individuals from completing the program or participating at all. Fewer than half of heart attack patients who receive referrals to cardiac rehab enroll within six months following their event.

Lourdes is hoping to change that with Moving Analytics. The mobile health platform runs on an app, called Movn, which is delivered to the patient through a mobile device or tablet. The app guides patients through a care plan created by Lourdes cardiac rehab team. For the clinician, a web-based portal enables staff to track patient progress, communicate with patients and administer care plans.

homecare homebase℠
Empowering Exceptional Care℠

Homecare Homebase Announces Integration with Health Recovery Solutions

Homecare Homebase announced their partnership with Health Recovery Solutions (HRS), a patient engagement software company dedicated to population health management and the reduction of readmissions with its advanced telehealth platform that streamlines care coordination and saves times for clinicians.

Integration into the Homecare Homebase system allows two-way communication between HCHB and the HRS PatientConnect monitoring platform. The cloud based interface feeds patient demographics information into the HRS platform, enabling expedited set-up time for nurses, and allows an inbound flow and storage of vital signs, survey questions, and clinical notes generated through the monitoring process.

Improved clinical workflow avoids double documentation by nurses, and streamlines data across clinical teams to ensure actionable insights and speedy responses. Developed by industry veterans,

Homecare Homebase has over 15 years experience dedicated to providing hospice and homecare companies with the fast and flexible, world-class healthcare information system.

In an evolving marketplace HCHB leads the way, allowing customers to not only manage their business more effectively, but ultimately provide their patients with the best possible care.

Industry News

Optima Health Medicare Ranked Among Top National Plans

Ranking among the top Medicare Advantage Prescription Drug plans in the United States, Virginia-based Optima Health received an overall Star Rating of 4.5 out of 5 from the Centers for Medicare & Medicaid Services (CMS) for its 2017 plan, Optima Medicare. Optima Medicare was also listed in the U.S. News Best Medicare Advantage Plans 2017, which is based on the government's Star Ratings, as well as an independent rating methodology.

2017 is the first year Optima Medicare has been eligible to be awarded an overall CMS quality rating, due to its being new in the market. The current CMS Star Rating strategy is designed to support three all-encompassing goals: better care, healthier people and communities, and lower-cost care. Particularly, the ratings provide a measurement of quality across nine domains of member outcomes and experience with a Medicare plan's Parts C and D.

In the Part C domain "Staying Healthy: Screening, Tests and Vaccines," Optima Medicare achieved 5 Stars, the highest possible rating, for all quality measures that contribute to its overall Star Rating. These measures encompass whether members received an annual flu vaccine and appropriate screenings for certain cancers, monitored their physical activity and assessed adult BMI. Five-Star Ratings were also achieved for measures within "Managing Chronic Conditions," including control of blood sugar and blood pressure, and lowered hospital readmission rates.

Presidio Surgery Center the First in California to Receive Prestigious Joint Commission Recognition

The Joint Commission announces Presidio Surgery Center, affiliated with Sutter Health's California Pacific Medical Center, as the first in California to be recognized with the prestigious Joint Commission Gold Seal of Approval® for Advanced Certification for Total Hip and Total Knee Replacement. The advanced certification is for Joint Commission-accredited hospitals, critical access hospitals and ambulatory surgery centers seeking to elevate the quality, consistency and safety of their services and patient care. Active adults needing hip, knee and shoulder replacement demand the convenience of outpatient surgery and now recent advances in anesthetics and surgical technique make it possible for patients to recover comfortably in their own home.

Presidio Surgery Center the First in CA...*continued*

Presidio Surgery Center meets this demand by providing individualized concierge care from the moment a patient books a surgery through to the one-year follow up.

Having patients recover in the comfort of their own home reduces exposure to hospital acquired infections, and according to studies reduces the likelihood of an unplanned hospital readmission. The cost to patients is generally significantly less than at a hospital.

WellCare to Pilot In-Home Telemonitoring Program in Arkansas, Mississippi and Tennessee

By 2025, chronic diseases may affect an estimated 164 million Americans − nearly half of the current U.S. population. To address this looming crisis, WellCare Health Plans, Inc. is piloting an in-home telemonitoring program for its Medicare Advantage members with chronic conditions in Arkansas, Mississippi and Tennessee. The pilot will include up to 500 members diagnosed with congestive heart failure and diabetes.

Telemonitoring in the home enables live, real-time access to patient vital signs, allowing for immediate medical response to concerning changes. Clinicians triage the vital signs in real time and notify the member's physician and care team of changes and exacerbations of the member's condition, which drive adjustments to the member's plan of care.

Recent studies examined the impact of telemonitoring on the quality, access and cost of care for managing certain chronic diseases. The results were encouraging. The studies showed that the benefits of telemonitoring included reduced hospital admissions and readmissions, reduced length of hospital stays, fewer visits to the emergency department and reduced mortality rates.

Through its interactivity, telemonitoring is aimed at increasing member compliance through education and progress reporting. Through a better understanding of their health condition, members are better equipped to react to symptoms more quickly and correctly, encouraging increased quality of life, comfort and independence. The program will deploy connected devices to monitor a member's daily vital signs such as blood pressure, pulse, weight and blood glucose levels and provide voice connectivity 24/7 to clinicians.

As of June 30, 2016, WellCare serves 98,000 Medicare Prescription Drug Plan members and 41,000 Medicare Advantage members in Arkansas, Mississippi and Tennessee.

Industry News

GoMo Health Announces HEALTHY CITIES

GoMo Health announces Healthy Cities, extending the availability of its award-winning, evidence-based population health management and mobile care coordination solution, Concierge Care, for use by cities, states, and government organizations for use in economically disadvantaged communities in North America, Europe, Asia, and Latin America.

Healthy Cities includes programs for pre-admission, discharge and managed long-term care for prevention and to improve the quality of life for their residents. The program is used to scale the efforts of Federally Qualified Health Clinics (FQHCs) and Community Health Clinics (CHC) and addresses conditions including congestive heart failure, hypertension, asthma, COPD, diabetes, maternity, pediatrics and behavioral health.

Concierge Care for Healthy Cities is a resident, patient and caregiver engagement solution that is like having a "nurse concierge" at your side; where complex health information is distilled into "snackable bites" of information, sprinkled with general wellness and lifestyle information, creating an experience that's personalized, easily understood and followed. Requiring no app to download, information is delivered throughout the day via secure mobile messaging. This behavioral methodology builds trust and credibility, establishing a path to reciprocity as people become further engaged and empowered to manage their care, leading to increased compliance and reduced readmissions and costs.

Mount Sinai Hospital (NY) and CloudMedx Inc Collaborate on Congestive Heart Failure to Improve Workflows and Patients Care Management

CloudMedx Inc. and Mount Sinai Hospital (MSH), NY have announced a collaboration designed to improve clinical outcomes for patients with congestive heart failure (CHF). This collaboration is meant to leverage intelligent predictive insights from CloudMedx in order to identify patients who are at higher risk of CHF and use evidence based care interventions to improve their outcomes such as reduced readmissions and overall wellbeing. Both CloudMedx and MSH are dedicated to realizing high quality, low cost care through intelligent implementations of information technology in the clinical space.

Mount Sinai Hospital (NY) and CloudMedx...*continued*

The Hospital system wanted to combine evidence based digital medicine technology with a team of remote monitoring experts, therefore MSH is partnering with CloudMedx who will provide an advanced analytics solution that works seamlessly within MSH's workflows. CloudMedx has a fast, scalable platform that can allow us to do just that. We found CloudMedx to be very intuitive and useful.

CloudMedx has a robust Clinical AI platform that has the ability to 1) ingest and process large amounts of data; 2) do big-data analytics fast; and 3) perform natural language processing on unstructured notes to surface patient risk profiles in real time. All of this reduces time, effort, and expense drastically.

According to Medicare, some 20% of Medicare patients being discharged all across the country get readmitted within 30 days of discharge with an estimated cost of unplanned re-hospitalizations being more than $17.4 billion. These adverse events occur because of a variety of reasons ranging from discharge plans not being followed to complications as a result of comorbidities or medications. Programs like the one at MSH are geared towards identifying patients who are at-risk for certain adverse events using a combination of clinical and socio-economic data.

Once the parameters are analyzed and the relevant patients are determined, the cohort is enrolled in specialized connected health program like HealthPROMISE to help them better manage their condition and symptoms. This initiative is in line with large scale reform programs like the Delivery System Reform Incentive Payment Program (DSRIP), a state-wide, $8 billion effort that aims to reduce avoidable hospital use by 25%. Therefore, one of the main objectives for organizations like MSH is to reduce these costly events across multiple disease areas such as CHF and other chronic diseases.

Given the innovative track record of MSH, the use of digital technology is a primary weapon against these occurrences. Specifically, CloudMedx predicts patient clinical risks during their visits, including any gaps in their care that need to be addressed immediately. It also determines which of these patients are at high risk and therefore would be likely to get readmitted within a certain amount of time. These risks can then be countered by custom tailoring treatment guidelines to ensure that patients do not fall sick again. This process reduces waste, expense, fatigue, and time, while improving outcomes and freeing up resources for other patients. CloudMedx is leveraging its large scale predictive algorithms to deliver cross sectional analytics on patient profiles including clinical risks, gaps in care, and certain outcomes. CloudMedx predictive analytics are currently helping health systems stratify, track and improve value based initiatives leveraging machine learning and natural language processing.

Catching Up With …

John J. Harper, MPA

Director, Patient Care Services
Evangelical Medical Center
Boise, ID

Readmissions News: What do we know regarding the impact patient engagement has on readmissions?

Mr. Harper: While there is much we do know about patient engagement as it relates to readmissions, there is also much we have to learn. Sadly, the patient perspective on readmissions is lacking in the literature despite evidence that improved patient satisfaction is associated with decreased 30-day readmission rates and that patient-centered communication may improve health outcomes and reduce expenditures. In the emerging era of patient engagement in which patients increasingly desire to participate in their medical care, patient perspectives on readmissions warrant further investigation. It will be important to amplify the patient voice on readmissions, focusing on factors that patients associate with preventable readmissions and the extent to which patients and physicians agree on readmission preventability.

Readmissions News: In what context should patient engagement occur?

Mr. Harper: That is a great question. The challenge for most health care providers is to identify and implement systems/processes to optimize patient care transitions and avert costly new penalties for Medicare readmissions. This can be accomplished through a team approach. A patient's post-discharge team includes hospitals, hospitalists, primary care physicians, nursing and rehab centers, community health workers, family members – and last but not least, the patients themselves. This "team" must be on the "same page" to ensure compliance with some very important processes.

Readmissions News: What role do patient families have to play?

Mr. Harper: Patient/family discharge preparation is known to reduce avoidable readmissions. Hospitals working on this topic will focus on ensuring that processes are in place to engage patients/family, elevate the status of family caregivers as essential members of the team, and prepare the patient and family to manage care at home. Interventions may include such methodologies as teach back, collaborative conversations and communication, and simulations with the patient and family member. Studies have shown patient engagement is central to improving readmission rates. Hospitals that ensure patients are able to self-manage their conditions have better outcomes; informed patients are prepared for procedures and hospitalizations' and patient education at discharge can reduce the relative risk of readmission.

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

Mr. Harper: I spend most of my time with my lovely family, consisting of my wife and two daughters. They are the light of my life.

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