REMINGTON REPORT®

Business Intelligence, Insights, and Trends

- Outcome-Based Relationships with Physicians
- Average 30-Day Readmission Rates
- ACOs: Care Coordinator Roles

remingtonreport.com ◆ September/October 2024

VOLUME 32 ◆ ISSUE 5

Important Ways to Position Your Organization Competitively and Gain Referrals

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Message From The Publisher

Lisa Remington
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Important Ways to Position Your Organization Competitively

The Remington Report identifies multiple ways for your organization to get positioned competitively and gain referrals with ACOs, physicians, hospitals and health systems, and bundled payments. The healthcare landscape is rapidly evolving, demanding new approaches to collaboration between referrals and home care providers.

Outcome-Based Relationships

The healthcare and home care landscapes are rapidly evolving, demanding new approaches to collaboration between health care and home care providers. Outcome-based relationships not only position your organization more favorably in the market but also foster trust, accountability, and a commitment to continuous improvement. See the article titled, **"6 Ways to Develop Outcome-Based Relationships Between Physicians and Home Care."**

Bundled Payments: Competitive Positions

A new mandatory bundled payment model incorporates home care as an essential partner. The payment continues 30 days after discharge, holding participants accountable for all the costs of care for an episode. This incentivizes care coordination, improved patient care transitions, and decreases the risk of avoidable readmissions. Get the details in the article, **"Bundled Payments: 7 Ways To Position Home Care Competitively."**

Aligning Quality Measures

A new hospital quality measure for senior care will address the most critical factors affecting the health outcomes of older adults. The measure evaluates five domains and incentivizes team-based care. Five important domains within this quality measure stimulate a collaborative relationship between hospitals and home care. Get more in the article, **"2025 New Hospital Quality Measure For Senior Care."**

Readmission Rates

Competitively align with in-depth readmission data! Our article, "**What are The Average 30-Day Readmission Rates Across U.S. Hospitals?,"** breaks down readmission data related to average readmission rates, condition-specific readmission rates, and hospitals with high and low readmission rates.

By leveraging the strategies presented in the Remington Report, home care providers can significantly improve patient outcomes, reduce healthcare costs, and enhance their competitive positioning in the healthcare market.

READMISSIONS

What are the Average 30-Day Readmission Rates Across U.S. Hospitals?

By the Remington Editorial Team

Average Readmission Rates and Condition-Specific Readmission Rates

Readmission rates are critical for hospitals and ACOs as they work to improve patient outcomes and reduce unnecessary healthcare costs through better care coordination and patient education. In this article, we provide critical readmission data about average readmission rates, condition-specific readmission rates, and hospitals with high and low readmission rates.

High readmission rates can be indicative of poor care coordination, inadequate discharge planning, or the presence of chronic health conditions that are not being managed effectively. Conversely, low readmission rates are often associated with better patient outcomes and more effective healthcare delivery.

These rates are critical in identifying areas where healthcare systems can improve and are often used in conjunction with other performance metrics to guide healthcare policies and practices.

Factors Contributing to Readmissions

- **Comorbidities:** Patients with multiple chronic conditions are at higher risk for readmission across all conditions.
- **Post-Discharge Care:** Inadequate follow-up care and poor coordination between healthcare providers can increase the likelihood of readmission.
- **Socioeconomic Status:** Patients with limited access to resources and support systems may struggle with medication adherence and self-care, leading to higher readmission rates.

Average 30-Day Readmission Rates

The average hospital readmission rate in the United States typically ranges from 15% to 20%, depending on the patient population and condition. This rate can vary based on several factors, including the type of hospital, the specific medical condition, and the quality of care provided.

How Do Condition-Specific Readmission Rates Differ From Average 30-Day Readmission Rates?

Condition-specific readmission rates can vary widely depending on the type of illness, treatment, and patient demographics. Here are some examples of average 30-day readmission rates for specific conditions:

- **Heart Failure:** 22% to 25%
- **Pneumonia:** 15% to 20%
- **Chronic Obstructive Pulmonary Disease:** 20% to 24%
- **Acute Myocardial Infarction:** 17% to 19%
- **Hip and Knee Replacements:** 4% to 8%
- **Sepsis:** 15% to 30%

Hospital-Wide Readmission Rates

Another piece of readmission rate data is comparing hospitals nationally. According to CMS, here are the 10 hospitals with the highest and lowest readmission rates.

Lowest

- Hospital for Special Surgery (New York City): 10.1%
- St. Luke's Regional Medical Center (Boise, Idaho): 11.55%
- New England Baptist Hospital (Boston): 11.5%
- W.G. (Bill) Hefner Salisbury VA Medical Center (Salisbury, N.C.) : 11.8%
- Arkansas Surgical Hospital (Little Rock, Ark): 12.3%
- Kansas Spine & Specialty Hospital (Wichita, Kan.): 12.35%
- Baylor Scott & White Texas Spine & Joint Hospital (Tyler, Texas): 12.3%
- O.A.S.I.S. Hospital (Phoenix): 12.4%
- Lancaster (Pa.) General Hospital: 12.4%
- Intermountain Medical Center (Murray, Utah): 12.4%

Highest

- Oroville (Calif.) Hospital: 19.1%
- St. Lucie Medical Center (Port Saint Lucie, Fla.): 17.95%
- LA Downtown Medical Center (Calif.): 17.7%
- Lakeland (Fla.) Regional Medical Center: 17.5%
- Broward Health North (Pompano Beach, Fla.): 17.4%
- VA Boston Healthcare System-Jamaica Plain (Mass.): 17.4%
- Jefferson Stratford (N.J.) Hospital: 17.4%
- St. John's Episcopal Hospital at South Shore (Far Rockaway, N.Y.): 17.4%
- Baystate Medical Center (Springfield, Mass.): 17.3%
- Providence Saint Joseph Medical Center (Burbank, Calif.):17.2%

Readmission rates are important indicators of the quality of care and are often used by healthcare providers and policymakers to improve patient outcomes and reduce healthcare costs.

PHYSICIANS

6 Ways to Develop Outcome-Based Relationships Between Physicians and Home Care

By Lisa Remington, President, Remington's Think Tank Strategy Institute and The Remington Report

The healthcare and home care landscapes are rapidly evolving, demanding new approaches to collaboration between health care and home care providers. Outcome-based relationships are becoming crucial for home care organizations to stay competitive. By focusing on outcomes, organizations can ensure that their collaborative efforts are directly aligned with the goals of improving patient care. Outcome-based relationships not only position your organization more favorably in the market but also foster trust, accountability, and a commitment to continuous improvement.

An outcome-based relationship refers to a partnership or collaboration where success is measured by specific, predefined outcomes or results rather than just processes or activities.

This type of relationship focuses on achieving certain goals or benchmarks, which are typically related to quality, efficiency, patient satisfaction, or financial performance.

Defining the 6 Outcome-Based Relationships Between Physicians and Home Care

Outcome-based relationships between home care and physicians focus on improving patient health outcomes by fostering collaboration and aligning incentives. These enhance patient care, reduce hospital readmissions, and optimize resource utilization.

Here are some strategies and benefits of establishing outcome-based relationships between home care providers and physicians.

Strategies for Establishing Outcome-Based Relationships

Shared Patient Care Plans: Develop comprehensive care plans that are jointly created and managed by physicians and home care providers. These plans should be patient-centered and tailored to address individual needs.

Ongoing Communication and Collaboration: Establish regular communication channels between physicians and home care providers, such as case conferences, secure messaging platforms, and collaborative care meetings to discuss patient progress and adjust care plans as needed.

Shared Health Records: Utilize integrated electronic health records (EHRs) to ensure seamless data sharing between physicians and home care providers. This promotes continuity of care and keeps all parties informed about the patient's health status.

Performance Metrics and Incentives: Implement performance metrics that focus on patient outcomes, such as reduced hospital readmissions and improved management of chronic conditions. Align incentives to reward both physicians and home care providers for achieving these outcomes.

Coordinated Discharge Planning: Collaborate on discharge planning to ensure smooth transitions from hospital to home care. This includes detailed discharge instructions, medication management, and follow-up appointments to prevent complications and readmissions.

Patient Education and Engagement: Educate patients and their families about the importance of following care plans and engaging in their own health management. This can include providing resources and support to encourage adherence to treatment and lifestyle changes.

Why are Outcome-Based Relationships Important?

Outcome-based relationships ensure that all parties are working towards the same objectives, creating a clear alignment of goals. This helps in minimizing conflicts and ensuring that every stakeholder is invested in achieving the desired results.

Focusing on outcomes rather than just activities helps in building long-term relationships that are sustainable. Success is measured by the value created, which can lead to more enduring partnerships.

For example, an outcome-based relationship can help to:

Improve Patient Outcomes: Collaborative efforts between physicians and home care providers lead to better management of chronic conditions, reduced hospital readmissions, and overall improved health outcomes for patients.

Enhance Care Coordination: Seamless communication and shared care plans ensure that patients receive consistent and coordinated care, reducing the risk of medical errors and improving the patient experience.

Create Cost Savings: Effective coordination of care can result in significant cost savings by reducing unnecessary hospitalizations and emergency room visits. This benefits both the healthcare system and patients.

Increased Patient Satisfaction: Patients benefit from a more integrated and responsive care experience, leading to higher satisfaction levels and greater trust in their healthcare providers.

Outcome-based relationships between home care providers and physicians are essential for delivering high-quality, patient-centered care.

Focusing on outcomes rather than just activities helps in building long-term relationships that are sustainable.

Success is measured by the value created, which can lead to more enduring partnerships By fostering collaboration, sharing data, and aligning incentives, partnerships can significantly improve patient outcomes, enhance care coordination, and reduce healthcare costs.

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>
> Lisa Remington

QUALITY MEASURES

2025 New Hospital Quality Measure for Senior Care

By the Remington Editorial Team

A new age-friendly quality measure for hospitals begins in 2025. Hospitals that participate in Medicare's Hospital Inpatient Quality Reporting (IQR) Program will be required to publicly report on how well hospitals address the factors that affect older adults' health.

The measure is a focused-composite metric that evaluates hospitals' commitment to providing high-quality care for older adults in various settings, such as the emergency department, operating room, and the hospital.

The quality measure evaluates hospitals on five domains, including:

- Eliciting patient health care goals,
- Responsibly managing medications,
- Implementing frailty screening and intervention (including for cognition and mobility),
- Assessing social vulnerability (e.g., social isolation, elder abuse), and
- Designating age-friendly leadership.

The measure also includes structural metrics, such as staffing and geriatrics-specific roles, and process metrics, such as delirium screening and frailty assessments.The measure aims to incentivize team-based care that's organized around geriatric patients.

Part of the 4Ms Framework

The Age Friendly Hospital Measure is based in part on the 4Ms Framework for age-friendly care (What Matters, Medication, Mentation and Mobility) and standards of surgical and emergency department care developed as part of John A. Hartford funded initiatives.

"With this essential new measure of quality in the Medicare program, hospital leadership will now publicly report on how well they address the most critical factors affecting the health outcomes of older adults, including their medications, mentation and mobility in the context of social vulnerability," Terry Fulmer, PhD, RN, president of the John A. Hartford Foundation, said in a news release.

REMIBURSEMENT

Bundled Payments: 7 Ways to Position Home Care Competitively

By Lisa Remington, President, Remington's Think Tank Strategy Institute and The Remington Report

CMS finalized the episode-based payment model Transforming Episode Accountability Model (TEAM). TEAM will be a five-year, mandatory episode-based payment model that will start in January 2026.

What Does TEAM Mean to Home Care Providers?

The TEAM model's five surgical procedures include:

- lower extremity joint replacement,
- surgical hip femur fracture treatment,
- spinal fusion,
- coronary artery bypass graft, and
- major bowel procedure.

These five procedures are a bundle. In other words, participation includes all surgical procedures.

Bundled Payment Extends 30-Days After Discharge

TEAM's bundled payment extends 30 days after the Medicare beneficiary leaves the hospital. CMS will provide participants with a target price that will represent most Medicare spending during an episode of care, which will include the surgery (including the hospital inpatient stay or outpatient procedure) and items and services following hospital discharge, such as skilled nursing facility stays or provider follow-up visits. Holding participants accountable for all the costs of care for an episode may incentivize care coordination, improve patient care transitions, and decrease the risk of avoidable readmission.

3 Participation Tracks

TEAM has three participation tracks: Track 1 will have no downside risk and lower levels of reward for the first year, or up to three years for safety net hospitals; Track 2 will be associated with lower levels of risk and reward for certain TEAM participants, such as safety net hospitals or rural hospitals, for years 2 through 5; and Track 3 will be associated with higher levels of risk and reward for years 1 through 5.

7 Ways to Position Home Care Competitively

1. Patient Experience

TEAM aims to improve the patient experience from surgery through recovery by supporting the coordination and transition of care between providers and promoting a successful recovery that can reduce avoidable hospital readmissions and emergency department use.

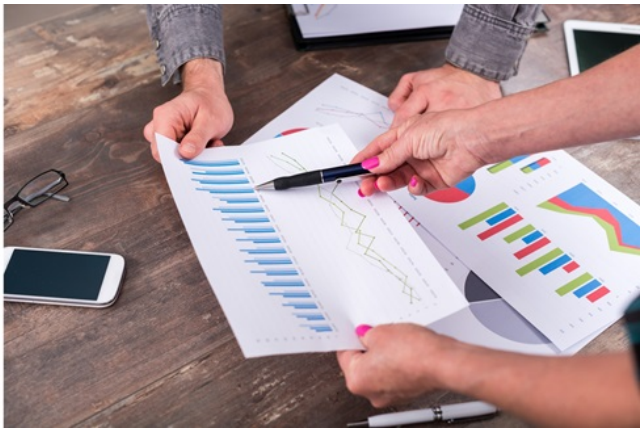
2. Quality of Care Indicator: Patient Satisfaction

Patient satisfaction is a direct reflection of the quality of care provided. In the TEAM bundle model, patient feedback is often used as a key performance metric. High patient satisfaction scores indicate that the care provided met or exceeded patient expectations, which is crucial for maintaining the integrity of the bundled payment model.

3. Coordination of Care

Effective coordination with hospitals, physicians, and other home care providers is essential. Home care providers play a critical role in managing the patient's transition from hospital to home, reducing the risk of readmissions, and ensuring continuity of care. Strong communication and collaboration with other care team members are crucial.

> *Holding participants accountable for all the costs of care for an episode may incentivize care coordination, improve patient care transitions, and decrease the risk of avoidable readmission.*
>
> Lisa Remington



4. Quality of Care and Outcomes

Under TEAM bundles, home care providers are often evaluated based on patient outcomes, such as readmission rates and patient satisfaction. High-quality care that leads to positive outcomes is not only beneficial for patients but also ensures that home care providers can remain competitive and financially viable under the bundled payment model.

5. Cost Management

Home care providers need to manage their costs efficiently to remain profitable under the fixed payments provided by TEAM bundles. This includes optimizing resource utilization, reducing unnecessary visits, and avoiding costly complications that could erode profit margins.

6. Data Reporting and Analytics

Participating in TEAM bundles requires home care providers to collect and report data on various performance metrics. Providers must invest in data analytics capabilities to track patient outcomes, identify areas for improvement, and demonstrate their value in the care continuum.

7. Compliance with Regulations

Home care providers must stay updated on regulations and guidelines associated with TEAM bundles. This includes understanding the criteria for patient eligibility, covered services, and reporting requirements to ensure compliance and avoid penalties.

By focusing on these key areas, home care providers can successfully navigate the challenges and opportunities presented by TEAM mandatory bundles and contribute to better patient outcomes and more efficient healthcare delivery.

ACOS

ACOs: The Role of Care Coordinators in Managing Complex Patients

By Lisa Remington, President, Remington's Think Tank Strategy Institute and The Remington Report

Lessons from 20 Medicare Shared Savings Programs (MSSP) provide insight into how ACOs manage complex care patients. In this article, we describe strategies and provide examples of successful approaches.

Beneficiaries with costly or complex care needs account for a disproportionate amount of total healthcare spending. These beneficiaries – as well as beneficiaries who are at future risk of needing high-cost or complex care – have a wide variety of health conditions, such as diabetes, chronic lung disease, or congestive heart failure. Without intervention, their cost of care can dramatically increase over time. These beneficiaries are also especially vulnerable to poor-quality outcomes associated with fragmented care.

Let's take a look at the role of care coordinators at discharge and care transitions.

The role of care coordinators within ACOs (Accountable Care Organizations) is pivotal to enhancing patient care, improving outcomes, and reducing costs. Care coordinators are the linchpin between patients and the complex healthcare system, ensuring seamless communication and coordination among various healthcare providers. By proactively managing patient care, care coordinators help prevent hospital readmissions, ensure compliance with treatment plans, and address any gaps in care. Their work is essential in aligning the goals of ACOs with patient needs, ultimately driving success in value-based care models.

The Role of Care Coordinators

To help manage the care of beneficiaries with costly or complex care needs, almost all ACOs use care coordinators. ACOs typically provide care coordinators with a customized list of beneficiaries. The care coordinators monitor these beneficiaries closely and help them transition from one care setting to another. For example, care coordinators ensure that when beneficiaries leave the hospital, they have the correct medication and equipment, as well as a follow-up visit with their primary care provider.

Care coordinators also help beneficiaries schedule appointments and ensure that beneficiaries have care plans in place. In many ACOs, they also periodically check with beneficiaries in between physician visits to monitor changes in their health.

If a beneficiary reports a condition that requires follow-up, the care coordinator directs the beneficiary to a registered nurse who can request a pharmacy consultation to identify any medication errors or arrange for hospital, home health services, or primary care services, if appropriate. For these beneficiaries, the ACO reported over a 43% reduction in emergency department visits and a 47-percent reduction in hospital readmissions by the second year of the program.

Providing Care Outside of the Physician's Office

Many ACOs also provide additional support – such as home visits, telephonic support, and monitoring devices – to beneficiaries with costly or complex care needs. These services help manage beneficiaries' conditions between physician visits.

Over half of the ACOs have care coordinators or physicians who visit beneficiaries in their homes. One ACO sends a respiratory therapist to beneficiaries with chronic obstructive pulmonary disease, while another provides high-risk beneficiaries with at-home services that range from blood draws to ultrasounds. A few ACOs provide home visits by a multidisciplinary team, including a physician, pharmacist, and care coordinator to address beneficiaries' multiple needs.

Other ACOs offer telephonic support to beneficiaries to help manage their conditions between physician visits. These ACOs provide beneficiaries with 24-hour access to a care coordinator, a physician, or a nurse. For example, at one ACO, care coordinators provide their phone numbers to high-risk beneficiaries so that they can call for advice about their health condition. If a call is insufficient to address the beneficiary's concern, care coordinators triage the symptoms and coordinate with physicians as needed.

Targeting Frequent Users of Emergency Room Services

Many ACOs identify beneficiaries who frequently visit the emergency room unnecessarily so that providers can work with them. Providers in a few of these ACOs educate these beneficiaries on alternatives to the emergency room. Other ACOs collect information on why these beneficiaries are visiting the emergency room and create customized solutions for them to address their needs, such as ACO officials connecting them to social services.

For example, one ACO identified a beneficiary who had 30 emergency room visits in a year; by offering a standing weekly appointment with a primary care physician, the ACO reduced the number of emergency room visits to two the next year.

Improving Care Coordination at Hospital Discharge

To help ensure smooth and safe transitions from the hospital, ACO staff commonly participate in discharge planning, assess beneficiaries' post-discharge needs, and monitor transitions of care. They often educate beneficiaries about their symptoms, arrange for transportation, secure medical equipment, and reconcile their medication to reduce errors.

At one ACO, a pharmacist works with its beneficiaries to address medication adherence issues. Another ACO reconciles its beneficiaries' medication and provides 30 days of all medications to beneficiaries when they are being discharged from the hospital. This initiative is targeted toward beneficiaries who have numerous medications or who indicate they may not fill their prescriptions right away. As a result of this initiative, the ACO saw a large reduction in medication errors and a significant reduction in the hospital's readmission rate.

In addition, ACOs emphasize the importance of follow-up visits with beneficiaries' primary care physicians following a beneficiary's discharge from a hospital. These visits ensure that beneficiaries understand their instructions and identify any outstanding needs. Many ACOs schedule these visits for the beneficiaries shortly after discharge.

One ACO created its own quality measure to ensure that primary care visits occur within14 days after discharge. Another ACO had a 50% drop in readmissions for beneficiaries with chronic heart failure due to its transition of care efforts, combined with scheduling follow-up visits within seven days.

Conducting Warm Handoffs to Improve Care Transitions

Several ACOs conduct "warm handoffs" – where ACO staff engage in an in-person transfer of a beneficiary between different care settings, such as a hospital to an SNF or HHA. These handoffs help build relationships between care coordinators, providers, beneficiaries, and their families and provide opportunities to clarify or correct information and improve care coordination. At one ACO, care managers establish relationships with beneficiaries prior to discharge from the hospital to facilitate a more seamless transition; they are responsible for handing off each beneficiary to a post-acute facility and for monitoring his or her care for 30 days after discharge. During this time, they help reconcile medication to prevent any errors and ensure that beneficiaries have adequate transportation to appointments and that medical equipment is delivered.

Background of Medicare Shared Savings Program ACO

The Medicare Shared Savings Program is one of CMS's largest alternative payment models that incentivizes efficient and quality care. In the program, healthcare providers voluntarily form ACOs and enter into a multiyear contract with Medicare.

Providers in each ACO coordinate to reduce Medicare spending and improve quality of care. If an ACO is successful and meets certain Medicare requirements, it is eligible to receive a portion of the savings it generates for Medicare.

Remington's ACO and Home Care Collaborative

The ACO and Home Care Collaborative is an executive insight exchange for building outcome-based relationships, improving patient outcomes, and sharing best practices. The ACO and Home Care Collaborative is an educational membership platform that brings together ACOs and Home Care stakeholders to actively drive better patient outcomes, align common goals, tackle challenges, and establish a robust foundation for continuous collaboration.

Get More Details to Stay Future-Ready →

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REMINGTON'S ACO and Home Care Care Collaborative

An Executive Insight Exchange for Building Outcome-Based Relationships, Competitive Positioning, and Sharing Best Practices

A one-stop, 360° resource for ACO market trends, workshops, strategy planning, and competitive positioning

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