Preventing Readmissions: A Primary Care Strategy

HEALTHCARE MATTERS: CLIVE FIELDS, MD

The reduction of avoidable readmissions is a high clinical priority for hospitals, physicians, and patients alike. To date, most of the energy toward meeting this challenge has focused on the hospital discharge process and telephone outreach by hospital employees to discharged patients. However, without the engagement of patients' primary sources of medical care—i.e., primary care physicians and clinically appropriate medical subspecialists—readmission reduction strategies will never be as successful as they should be.

No one is better suited to identify a patient's risk for readmission than a physician who has a long-term relationship with that patient. Every model used to stratify the risk for readmission is improved with data not always found in an ICD-10 code, but available from a physician or the physician's electronic health record (EHR). Such data include marital and financial status, ambulatory status, psychosocial stressors, and available support networks—all of which can have a bearing on readmission risk.

Engagement of primary care physicians requires simple but sometimes difficult steps involving communication and education, with an additional focus on post-acute care.

Communication

The hospitalist movement has improved care during hospital stays but has created a gap between patients and their most trusted physicians, many times during serious medical illnesses. Identifying a patient's primary care physician at the time of admission to a hospital or emergency department (ED) is critical for successful post-discharge care. At a bare minimum, primary care physicians should be able to count on hospitals to notify them of their patients' admissions, and they should be able to expect that, with every admission, the hospital routinely will transfer timely and pertinent information to the patient's medical home.

My experience at Village Family Practice, my practice in Houston, is that even the largest systems continue to struggle with this. Many times, a patient's primary care physician is neither identified nor contacted—even after the patient has specifically requested that this step be taken. Post-discharge transfer documents can be 10 pages long without even including a discharge diagnosis.

All too often, tests requiring follow-up are hidden in the middle of computer-generated pages, and patients are frequently referred to specialists outside of their insurance network. Such a lack of communication, which could easily be avoided, leads to poor outcomes as well as avoidable readmissions. Moreover, the communications are important, especially if one considers that such contact often can be the most frequent type of contact a primary care physician has with a hospital. A hospital that discounts the importance of such communications risks seeing an exodus of its primary care physicians in search of facilities that recognize and respect their role in the process. Hospitals typically view themselves as being exemplary in this area. But to truly know how you fare, ask your physicians.

Education

The codes that the Centers for Medicare & Medicaid Services (CMS) has established for transitional care management (TCM) and chronic care management (CCM)—i.e., CPT Codes 99495 and 99496 for TCM and CPT Codes 99487, 99489, and 99490 for CCM—remain woefully underutilized in primary care. These codes were designed to compensate

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physicians for the cognitive services they provide to patients with multiple complex conditions and in the post-acute period. Enhanced access, medication education and reconciliation, disease education, care coordination, and early detection of disease exacerbations all improve the management of chronic illness and, in the post-acute period, the reduction of readmissions. These clinical interventions are designed to improve outcomes and eliminate redundant and unnecessary utilization.

At Village, we use both services across all our primary care partners, and the approach works. We developed a predictive model to identify which patients are at highest risk of readmission. The model uses inputs such as LACE scores, social determinants, and several other variables, and is unique in that it was built for primary care and developed by physicians with support from operations staff and analytics teams.

Patients are contacted by phone within 48 hours after discharge and scheduled for an appointment—based on complexity—between one and 14 days post-discharge. For patients at highest risk for readmission, physicians and advanced practice providers provide home visits, delivering a full suite of primary care services. This process consistently drives readmission rates 20 to 40 percent lower than local market averages. For large groups with resources and clinical protocols, this opportunity is working as CMS planned: Pay for coordinated care, and you get better outcomes.

Although many primary care practices are now part of health systems, many small-to-medium-size independent groups remain. Many of these groups are banding together to add TCM and CCM services to their practices. Hospitals would be well-advised to work with these practices to give them the data they need to be successful and help them gain access to analytical tools.

For a primary care physician network that requires help in making TCM and CCM education a continuing medical education activity, a hospital can be an invaluable resource for education and guidance on how to deliver better care and be fully compensated for it. And when educating the physician network on the Medicare Access and CHIP Reauthorization Act and the Merit-based Incentive Payment System, the hospital should not only tell the clinicians what they will be measured on but also show them how to be successful at those measures. A successful, growing, and aligned primary care physician network should be part of any hospital's long-term strategy.

Post-Acute Care

With more than 35 percent of Medicare patients being discharged to a post-acute care facility or service, it's no surprise that the choice of facility to which a patient is discharged can have a significant impact on readmissions. Hospitals should work with their primary care physicians to identify the home health agencies and skilled nursing facilities (SNFs) they believe will provide the best care for their patients.

A key objective should be to identify those facilities and admitting physicians that make communication and engagement with a patient's primary care physician a priority in the post-acute period. Post-acute communication should be included among a hospital's quality measures, and those facilities that communicate effectively should be rewarded with preferred status in the hospital's networks. A SNF that has an engaged medical director, responsive attending physicians, and access to an X-ray device and a laboratory won't be as quick to send patients back to the hospital's ED with minor trauma or a urinary tract infection if the patients can be safely treated in the SNF. To find out which facilities provide the best level of care, communicate well with patients' primary care physicians, and avoid using EDs as minor care clinics, ask the physicians.

Commitment Required

Readmission reduction starts long before an admission, with a stratified approach to high-risk patients and aggressive outpatient management. If you want to see improved clinical outcomes, reduced readmissions, satisfied patients, and improved primary care provider engagement across your health system, make an ongoing commitment to communicating, educating, and consistently engaging with each patient's primary care physician.

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