# Reducing Readmissions and Post-Discharge No-Shows

## INTRODUCTION

Reducing readmissions is one of our key initiatives at MedPOINT Management (MPM). Achieving a reduction would strengthen our utilization management program, improve our HEDIS performance in the all-cause readmission measure, strengthen our relationship with our partner hospitals, and most importantly, help patients attain a higher quality of care.

Our readmission rate varies across the 13 independent practice associations (IPAs) we manage, but at the end of 2017, it averaged 14.2% for Medi-Cal members and 13% for Medicare members. Despite a very devoted and hard-working inpatient utilization management (UM) team, we knew there was an opportunity for improvement.

## CHALLENGE

Structuring a program to reduce readmissions was a significant undertaking. We identified that patients return to the hospital within 30 days of their initial stay for a few main reasons, most commonly related to:

- The initial hospitalization
- A secondary condition
- Poorly managed transitions of care
- An unrelated admission

To add to the challenge, many of our patients have negative social determinants of health (SDOH)—including homelessness, transportation issues, and lack of a support system.

It is important to note that most of MPM's IPAs support the hospitalist model. While it can be argued this strategy is more efficient, the disruption of primary care physician (PCP) continuity of care can't be overlooked. This was also a consideration when structuring the workflow.

Despite significant investments in inpatient utilization infrastructure, we recognized that staff alone could not improve engagement. The process needed to be revised.

> "Several health centers are very excited to see that the new process has resulted in more patients showing up for their appointments. Our team is now getting access to some of the live scheduling systems, which is optimizing this process further."
>
> *—Jorell Ludovico, In-Patient UM Team Lead*

## INTERVENTION

Transition-of-care (TOC) strategies are key to program success. Built on the premise that more-effective handoffs and improved provider communication can have a positive effect on lowering readmission rates, MPM has clinical and nonclinical staff focused exclusively on TOC.

Our initial TOC workflow consisted of the following:

1. E-fax the face sheet to the PCP upon admission notification. A report of "patients in house" was e-faxed to the PCP on a daily basis.
2. Upon discharge, the PCP received the history and physical, consult notes, list of procedures, radiology, lab results, and the discharge medication list.
3. Once discharged, the patient was called by MPM's TOC staff to schedule a PCP visit, preferably within seven days of discharge.
    a. The follow-up PCP visit included medication reconciliation and addressed all diagnoses documented in the discharge summary.

While this workflow seemed like a good process on paper, the results were poor. Only 37% of members kept their appointment, which further burdened the overloaded scheduling at provider offices.

After recognizing our metrics were stagnant, we knew change was required. In 2018, we revised the workflow—adding two important steps (No. 2 and No. 5). Here is the new process:

1. E-fax the face sheet to the PCP upon admission notification.
2. Once notified of a medical/surgical admission, the TOC staff calls the patient—while the patient is still hospitalized—to establish a rapport and begin discharge planning and SDOH discovery. This includes scheduling a PCP visit within seven days following discharge.
3. A report of "patients in house" is e-faxed to the PCP on a daily basis.
4. Upon discharge, the PCP receives the history and physical, consult notes, list of procedures, radiology, lab results, and the discharge medication list.
5. The member outreach team places a reminder call to the patient and provider the day before the scheduled PCP visit. This also gives MPM an opportunity to discuss HEDIS gaps and encourage the provider to schedule these services.

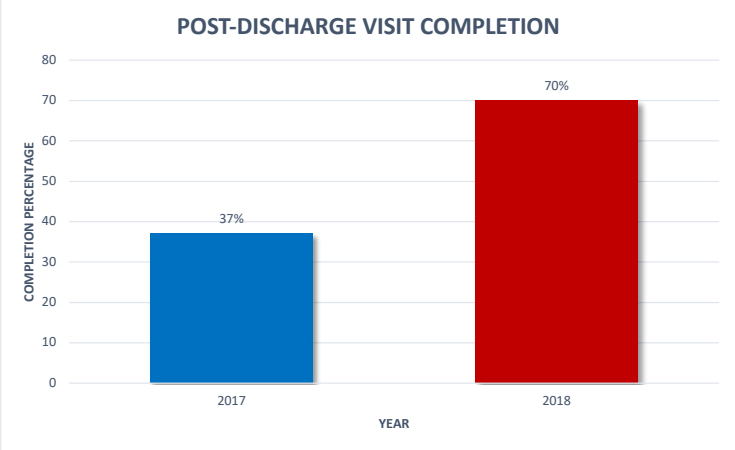
## RESULTS

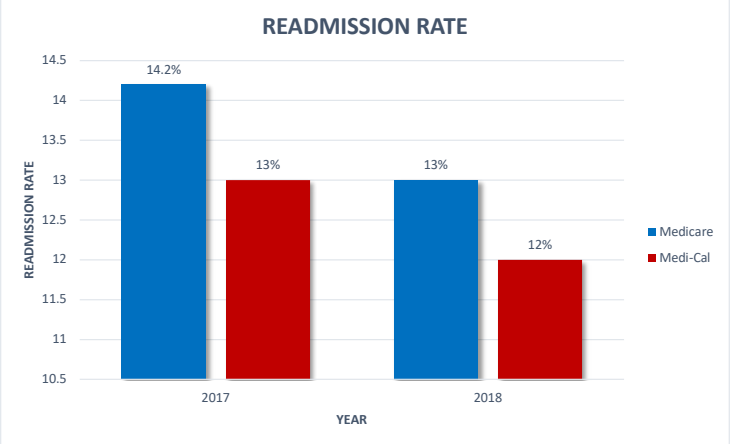
These program adjustments have resulted in steady improvements—both direct and indirect. Holding true to the premise that readmission rates can be reduced by focusing on quality discharge information, well-coordinated care, and timely communication with PCPs, readmission rates improved from 13% in 2017 to 12% in 2018 for Medicare members. For Medi-Cal members, rates fell from 14.2% in 2017 to 13% in 2018.

We have also seen a reduction in patient "no-shows" for post-discharge visits. Overall, 70% of patients contacted now complete the post-discharge visit—an 89% increase from before. Another benefit has been improved physician engagement in transitions of care.

One important aspect of the new TOC process is the scripted call while the patient is in the hospital. Obvious questions about transportation, social support, and home needs are asked, but perhaps most importantly, the call allows patients to express their individual needs. The "caring" element goes a long way with healing.

We are still tweaking the program to achieve even greater success. Our TOC and case management teams remain very involved with the discharge planning process and participate in daily huddles with the medical director and hospitalists. We are striving for a 12% or lower readmission rate for all lines of business and have made a significant investment in human capital. We look forward to more success in the future.




## WHO WE ARE

Founded in 1987, **MedPOINT Management** is a management services organization (MSO) that serves more than a million members in California—92% Medi-Cal, 2% Covered California, 2% Medicare and/or Medicare-Medi-Cal, 3% commercial, and 1% point-of-service (POS). We provide all aspects of managed care management services to IPAs and hospital clients. Our customized approach allows us to successfully manage single physician practices, large networks of federally qualified health centers, and all practice models in between.