

What a Difference a Day Makes: **Cutting Avoidable Hospital Readmissions in California** **by Just One Day Could Save Medicare and Medi-Cal \$227 Million**

Part 2—What Must Be Done



California Discharge Planning Collaborative
San Francisco, California **November, 2010**

California Discharge Planning Collaborative

Members

California Alliance for Retired Americans
Community Living Campaign
Planning for Elders in the Center City’s HealthCare Action Team
Mercy Housing California
California Nurses Association
San Francisco Downtown Senior Center
University of California Berkeley Health Research for Action
San Francisco IHSS Public Authority

The Role and Work of the Collaborative

The hospital-to-home transition is of growing importance in healthcare nationwide. In response to economic pressures, hospitals today are releasing many patients who are unable to care for themselves without help. The failure to provide assistance with post-discharge planning has profound consequences for both patients and their caregivers. The California Discharge Planning Collaborative works to improve public awareness of this issue, develops community connections to assist care recipients and caregivers, and drafts legislation and regulations to improve transitions from hospital to home. Since 2008, members of The California Discharge Planning Collaborative have been taking their message throughout California, delivering **Know Your Rights** presentations and distributing tens of thousands of copies of the **Know Your Rights** brochure.

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Executive Summary

Going home after an acute hospital stay presents significant challenges, particularly for seniors. Discharge from the hospital does not mean that the need for care has ended. The critical issue is making sure *that after a patient goes home, he or she does not end up back in the hospital in a few days*. The rapid readmission of a patient strongly suggests that the return home was medically premature, poorly prepared for, or both. This report argues that the current design of the healthcare system results in a serious waste of financial resources. And this means that patients don't receive adequate care.

Reducing hospital stays from avoidable readmissions by just one day would save \$227,346,788 per year. For a fraction of this sum, we could greatly improve discharge planning and enhance home and community support services. This would result in better outcomes for patients and improved efficiency in the healthcare system. It's a win-win solution.

The avoidable readmissions issue was highlighted in a 2009 review of over 435,000 Medicare records by Jencks et al. They found that approximately 20% of cases resulted in readmission within 30 days without the patient first seeing a physician.

This report examines the costs and impacts of these avoidable readmissions and recommends three key ways reduce readmissions and save money:

- *increase levels of discharge planning staff and improve ways to pay for them*
- *fund higher levels of community-based long-term care support services that can assist patients in the community when they leave the hospital*
- *mandate coordination of healthcare services in the community regarding the discharge process*

Unneeded increased spending is a part of the readmission picture in two ways: 1) when additional acute care is needed, at an average in California in 2009–2010 of \$2,205 per day, and 2) in a significant likelihood of increased health problems and additional costs when patients are discharged prematurely or are not prepared to recover at home. The human cost of this issue can be measured in mortality rates and reduced quality of life for as many as 81,000 seniors annually in California alone.

Numerous studies have shown that readmissions can be significantly reduced. Keys to such reductions are better hospital discharge planning and more closely coordinated community-based support services. The patients served by these improvements will see a dramatically higher quality of life. Equally important, as the analysis below suggests, is that there is already plenty of money in the system to pay for these services. Policymakers and insurers who pay the bills could act and save the healthcare system from itself.

T-charts at the end of the report illustrate exactly how much money could be redirected to discharge planning and community support services. Statewide, roughly 4.5 million Californian seniors are covered by Medicare, and the Medi-Cal program pays a significant share of the cost for approximately 1.1 million “dual eligibles” (people covered by both Medicare and Medi-Cal), including the vast majority of nursing home residents.

This report argues that reducing the level of readmissions could substantially reduce costs to both programs and provide a major source of funding for improved discharge planning and in-home services in the community, as described below:

Cutting Hospital Stays from Readmissions in California by Just One Day

Program	Annual Savings	Full Time Discharge Planners that could be Hired with Cost Savings	Home Care Workers that could be Hired with Cost Savings
Medicare	\$179,200,350	3,746 Full Time Positions	14,933,360 additional hours
Medi-Cal	\$48,146,438	1,012 Full Time Positions	4,068,344 additional hours

Introduction

A. Why Are Avoidable Readmissions a Problem and What Must Be Done?

Many patients who are released from a hospital require additional or ongoing recuperative care. Hospitals can't produce miracles, and few patients walk away from the hospital experience fully healed and ready to resume their lives. Mismanaging this situation can lead to readmission, which a 2002 Swiss study defines in this way:

“Readmissions [are those admissions] related to a condition of the previous hospitalization and not expected as part of a program of phased care, occurring within 30 days after the previous discharge. A potentially avoidable readmission may be considered as the consequence of an adverse event or a too early discharge.”¹

The problem of avoidable readmissions revolves around three important questions:

- When is a person ready to go home?
- What needs to be done for the person at home?
- Who will do those things for the person at home?

In California, there are roughly 4.7 million Medicare beneficiaries (both those over 65 and persons with disabilities), about one fourth of whom (1.1 million) are also covered by Medi-Cal. Statistics indicate that this population is admitted to hospitals roughly 405,000 times each year. Research by Jencks et al. in 2009² suggests that in California about 81,000 hospital stays (one in five) end with a return to the hospital for some unresolved aspect of the same condition.

Jencks uses the word readmission to refer to an admission within 30 days of release for the same condition without the patient seeing a doctor (i.e. the return comes through the emergency department). The research of Jencks et al. provides clear evidence of the problem. For years there have been patients sent home from the hospital too soon, and in many other cases hospital staff have made unrealistic demands on spouses or families to provide care at home. In discussions with regulators and hospital staff, these concerns have often been dismissed as “anecdotal.” The Jencks et al. study now provides a clear demonstration of the issue. The cost and poor outcomes of avoidable hospital readmissions should be ignored no longer.

Since 2008, the California Discharge Planning Collaborative has been working to address this issue. Town hall meetings have drawn hundreds of seniors, who tell their own stories of going home too soon and being expected to cope with demanding medical treatments in their own bedrooms. We've also heard terrifying stories of what happens when things go wrong miles from the nearest hospital. The Collaborative has involved community activists, researchers, policy analysts, and advocacy organizations, all of whom have been working hard with the knowledge that the problem is real and readily addressed. Tens of thousands of copies of the brochure ***Know Your Rights*** have been distributed in print and electronic versions across the state in multiple languages. At the community level, people have been responsive to the idea that, at last, there is something they can do when family members or friends are hospitalized and told they are going home when it is painfully clear that it is too soon.

¹ Halfon P, Egli Y, van Melle G, Chevalier J, Wasserfallen JB, Burnand B. Measuring potentially avoidable hospital readmissions. *J Clin Epidemiol* 2002; 55:573-587

² Stephen F. Jencks, M.D., M.P.H., Mark V. Williams, M.D., and Eric A. Coleman, M.D., M.P.H., *N Engl J Med* 2009; 360:1418-1428 April 2, 2009

“Care transitions are an increasingly critical health and social problem for seniors and their caregivers. Hospitalization can be a turning point in the lives of seniors, whose physical and mental health often deteriorates after discharge. Many older adults experience breakdowns in care during the transition from hospital to home. This results in high rates of poor outcomes and re-hospitalization. Patients and caregivers are on the receiving end of a badly fragmented system of care, and both medical and caregiving support during the hospital-to-home transition are inadequate.”

— Health Research for Action

The readmission issue is alarming because it indicates that many patients suffer poor outcomes which jeopardize their health and well-being, sometimes fatally, that are linked to leaving the hospital too soon, being ill-prepared to cope at home, or both. After discharge, the underlying condition, or some aspect of it, can now be destabilized and once again demand hospitalization. Alternatively, or in addition, the health and safety of the individual may now be impaired as a result of care after discharge. For example, a wound or catheter may be infected, or there may be uncontrolled bleeding. Emergency room staff then assess the resulting problem(s) to be of sufficient severity that a return to the hospital is required to address the problem.

Jencks found that one in five patients is readmitted within 30 days, and one in three is readmitted within 90 days, without seeing a physician. This strongly suggests a significant, troubling, and costly disconnect between different parts of the healthcare system. Avoidable readmissions are not good outcomes. They cost nearly a quarter of a billion dollars each day. This money could be redirected to more effective discharge planning and/or to community-based long-term care services. This would not only produce better outcomes, but it would also dramatically reduce the overall cost of patient care.

The problem of avoidable readmissions is important to policymakers and the people who ultimately pay for Medicare and Medi-Cal: the public. Because of the high cost of hospital care, failure to reduce the growing number of readmissions is completely unaffordable. This study calculates that in California, Medicare pays \$179,000,000 annually for the first day of unneeded care. Medi-Cal, which is half supported by the State of California, could pay out as much as \$48,000,000 for the first day after readmission.

Avoidable readmissions are also important to insurers, since many seniors receive care through health maintenance organizations or other private healthcare plans. Insurers can end up absorbing the cost of hospital stays that could have been prevented with better planning and better-coordinated community-based services.

Avoidable readmission is a multifaceted problem, and every stakeholder seems to have a different solution. Some argue that the elements needed to reduce the level of avoidable readmissions are already funded and in place: discharge-planning staff in hospitals and community-based long-term care providers in the community. It is the opinion of this report that redirecting even a modest fraction of the cost of avoidable care to these established solutions would have a major impact. What is needed, however, are some changes in attitude about how these assets are used. Such changes might best be imposed by regulations and payment guidelines from Medicare, Medi-Cal, and private insurers.

Left to itself, the healthcare system is not going to respond to these violations of its traditional categories and prerogatives. However, policymakers who control funding (for Medicare and Medi-Cal) and private insurers who pay the bills, should take the lead in improving hospital-to-home transitions, not only for the clear financial benefits but also for the priceless impact of better health outcomes and reduced mortality for patients.

B. What is Avoidable Readmission?

According to Jencks, the basic issue revolves around successful transitions from hospital to home. The faults in this system develop when the many parts that must work together do not. When a discharge planner does not provide a clear care plan, or never sees the patient at all, and when home care and support services are not arranged beforehand, or do not begin in a timely fashion, the patient is left to fend for him or herself. The resulting outcomes are often poor and can result in an emergency readmission to the hospital.

A recent study of the issue by Health Research for Action³ emphasized the significance of the problem:

“We are failing to meet the needs of vulnerable populations. Some seniors are at very high risk for re-hospitalization and increased morbidity and mortality after discharge. Elders with multiple medical problems, functional deficits, cognitive impairment, emotional problems, and poor general health are at particular risk during this transition. Racial/ethnic minorities, non-English speakers, immigrants, and older adults living alone and in poverty are also at high risk. Informal caregivers also face health risks and increased mortality from providing complex care. A one-size-fits-all approach to transitional care is not sufficient, given the ethnic and economic makeup of the Bay Area and most areas of the United States.

Seniors and caregivers are not prepared. As hospital stays have been shortened and healthcare costs have risen, discharge planning has decreased in many hospitals. Patients are discharged ‘quicker and sicker,’ with little or no information on care in the home. Patients and caregivers—especially non-English speakers—have difficulty finding information about condition-specific home care, where or how to get help, eligibility for home and community-based services, home modification, and caregiver support. Informal caregivers (family, friends, and neighbors) play vital roles in assisting elders after discharge, but they are seldom included in discharge planning and receive little or no training in home care or support for their roles.”

When these circumstances combine, the stage is set for a hospital stay which ends before the patient, family, or caregivers are ready to make the successful transition back to the community.

Four factors may set the stage for an avoidable readmission:

- A patient may not be medically ready to go home,
- Adequate discharge planning may not have been done,
- Adequate home support or healthcare services were not provided, and/or the patient him or herself was unable to cope with the condition, and
- The patient does not see a physician to monitor condition and care when in the community.

Jencks et al. found that rates for these avoidable readmissions were from 17% to 20% within thirty days of discharge, and 33% within 90 days; that medical causes dominated the reasons for readmission; and that the total cost to Medicare nationally was \$15 billion to \$18 billion.⁴ This is not to say that every hospital readmission

³ Brown-Williams, H., Neuhauser, L., Ivey, S., Graham, C., Poor, S., Tseng, W., Syme, S.L. (2006). From Hospital to Home: Improving Transitional Care for Older Adults. Health Research for Action: University of California, Berkeley, California.

⁴ Jencks, S., Williams, M., & Coleman, E. (2008). “Rehospitalizations among Medicare fee-for-service patients”. Unpublished Manuscript. Medpac (June 2007). “Report to the Congress: Promoting Greater Efficiency in Medicare”, pp 103-120.

is avoidable. Nevertheless, other studies, such as those of McBride and MedPAC, agreed that the rate of avoidable readmissions could be cut by substantial amounts depending on the underlying condition.

What policymakers need to address is the disconnect between care (or the lack thereof) in acute and community settings. As noted by Jencks and others, unsuccessful transitions result in increased costs and poor health outcomes. The fact that the cost can now be quantified confronts policymakers with an unavoidable issue. Even modest declines in the number and length of readmissions, the “just one day” metric used for this report, could produce huge savings, as much as \$179 million per year. Moreover, even a modest fraction of this sum could be redirected to improve discharge planning and enhance home and community support services.

Take the “just one day” savings of \$179 million in Medicare as an example. If new discharge planners were hired at \$60,000 a year and handled just two cases per day, and if these new planners reduced the readmission period by just one day, a mere 150 of them could handle all 81,000 avoidable readmission cases in California, leaving \$170 million to go to other care needs.

Cost to Medicare of Potentially Avoidable Readmissions in California⁵

	Rate of Readmission for Medicare Patients		
	Less than 7 days	Less than 15 days	Less than 30 days
Total Rate of Readmission	6.0 %	10.8 %	16.9 %
Likely Avoidable	5.2 %	8.8 %	13.3 %
Cost of Potentially Avoidable Readmissions in California	\$500,000,000	\$800,000,000	\$1,200,000,000

I. What Must Be Done

The Existing Parts of the System Do Not Work Together

“Readmissions are not primarily about people being rehospitalized because of mistakes made in the hospital. Readmissions are about making transitions effectively. Taking care of people with ongoing problems or chronic illnesses and frailty. Transitions of care not done well...evidence suggests they wind up back in the hospital.”

—Stephen Jencks, M.D., former senior clinical adviser to CMS⁶

The readmission issue is a great place to start addressing healthcare inefficiencies that are unfortunately overlooked. An enormous amount of money is currently spent in California on avoidable hospital readmissions. There are already a number of approaches being suggested to address this issue (see appendix C). This report argues for three strategies that make use of services that are already funded and in place, services that could, if better coordinated by providers, make substantial progress toward easing the transition from acute hospital settings to home. These three strategies are as follows:

⁵ Recreated from table within: Medpac (June 2007). “Report to the Congress: Promoting Greater Efficiency in Medicare”, p 107, from 3M analysis of 2005 Medicare discharge claims. – McBride, 2008. California figures estimated by this report.

⁶ Stephen F. Jencks, M.D., M.P.H., Mark V. Williams, M.D., and Eric A. Coleman, M.D., M.P.H., N Engl J Med 2009; 360:1418-1428 April 2, 2009

- *increase levels of discharge planning staff and improve ways to pay for them*
- *fund higher levels of community-based long-term care support services that can assist patients in the community when they leave the hospital*
- *mandate coordination of healthcare services in the community regarding the discharge process*

The two insurers that can make this happen are Medicare and Medi-Cal. The Medicare system is paid for by the federal government, with co-pays, deductibles and premiums contributed by beneficiaries. The Med-Cal system overlaps this with about 1.1 million “dual eligibles” and another 100,000 unique Medi-Cal beneficiaries in the same age category of over 65 years. Medi-Cal covers the co-pays, deductibles and premiums, as well as a portion of the drug costs for this group. Funding for Medi-Cal is shared equally by the state and federal governments.

Both of these systems could make provisions and requirements for two services that have been proven to smooth transitions from hospital to home: 1) discharge or transitional care planning, and 2) in-home support services, or the wider network of community-based long-term care services. Arguments against expanding access to these services have focused not on efficacy but cost and, more specifically, who pays for their delivery. The amount of money that could be made available by reducing readmissions is enormous. Jencks estimated that the cost of preventable readmissions in the first 30 days after hospital discharge was \$5 billion nationally. This report estimates the cost in California of avoidable readmissions within the first 30 days as 10% of the national figure, or \$500 million. This number represents the total estimated cost of avoidable readmissions, which will likely include a large number of multi-day hospital stays. The analyses which follow look at the way in which savings from the prevention of just one day of hospital care after avoidable readmissions could be made available to support discharge planning and community-based long-term care.

A. The Problem with Transitional Care and Discharge Planning *Why Is It So Rare and Who Ultimately Pays the Bill?*

The concept of discharge planning or transitional care planning seems simple enough. At some point after admission and prior to going home from the hospital, a social worker (or another skilled professional) assesses the patient’s needs for care, contacts the appropriate agencies, and works with the patient and or family (if one is present) to arrange education on these post-acute care needs. As described below, the process is one that requires careful attention to the patient’s clinical needs, methodical assessment of the situation, and, in some cases, considerable forethought and planning.

But the question is: why are these things often not done properly?

Paying for this service requires a staff of professionals who have experience matching medical care needs with community services. The fiscal impact section of this report uses a benchmark salary of \$60,000, or about \$29 per hour, for this position. This is a low estimate. As employees of a hospital, such individuals are often considered a “cost” since they do not generate revenue, unless there is a payor to bill for the service. As the discussion in Part 1 of cost containment efforts noted, managed care insurers, Medicare, and Medi-Cal have all sought to limit reimbursement for the costs of care. Without a billing mechanism, there is little incentive for acute care providers to expand such services; yet there are incentives to whittle away at staff, increase case loads, and strive for a minimum level of “cost.”

1. Who Decides When A Patient Goes Home?

Hospitalization occurs for a specific reason, such as a scheduled procedure, a pre-planned course of treatment, or care for an injury or accident. The stay is based on the idea that the patient needs care and/or tests of a specific nature, requires monitoring, or may need access to emergency interventions at a moment's notice. Today, most hospital stays are relatively brief, commonly a few days. Long gone are the lingering stays still seen on television medical dramas.

In part, this is because medical technology and services have dramatically improved in the past 30 years. Also important is the fact that many chronic diseases are now managed with drug therapy, which reduces acute incidents. And, of course, insurers and government programs such as Medicare and Medi-Cal are less willing to pay for high-cost hospital stays when less expensive placements (such as nursing homes) and services (such as home care) are available.

The cost containment efforts imposed on hospitals since the 1980s have created tensions among the staff (who are often paid at a flat rate for services regardless of circumstances), the physicians (who may also be paid at a capitated rate), and the patients (and their families, if the patients have families) who expect to be better as a result of their stays.

The increased sophistication of home-delivered services has created an incentive to discharge patients and shift the cost of care to another provider who can bill the payor. Patients and their families are also expected to do their bit to control costs by providing care themselves, at home.

In an ideal world, patients and their families would understand exactly what to expect after a particular procedure in terms of recovery time and the number of days of home-based services. A professional would be in place to coordinate this after-care, train family members or the patient in what was needed, and monitor success. This ideal might exist in other countries, but it certainly doesn't exist in the U.S.

Instead, factors such as cost, need for beds, and convenience take precedence. In a country where most people don't have insurmountable medical problems, it is tempting to be even more frugal when it comes to the transition from hospital to home. As a result, we now have a situation in which as many as one in five Medicare patients returns to the hospital within 30 days of discharge, and fully one-third come back within 90 days because of transition problems.

These avoidable readmissions can happen in a number of ways, sometimes more than one:

- The hospital has strong incentives to move people out as soon as possible to keep down costs. This is especially true over weekends, when staffing may be reduced or beds may be needed for weekend emergency cases; moreover, a patient may be taking up a bed for two days simply to wait for something to happen the following Monday.
- The hospital physician (hospitalist) is very likely not the physician who sees the patient before or after admission and may see the patient only once every few days in the facility. Once certain milestones are met, the patient can be discharged and become someone else's responsibility.
- The discharge planner, home care nurse, or other professional responsible for coordinating post-discharge care may not have the time to provide training or supplies or to ensure that prescriptions are filled. The decision to send a patient home the following day can leave little or no time to arrange services in the

community; in this situation, professionals often simply provide the patient with a list of numbers to call if there is a problem and a pamphlet on care. The patient may not have the resources to pay for services or qualify for a program to cover costs.

- The patient and his or her family may overestimate their ability to cope at home. They may see discharge from the facility as top priority and minimize any obstacles to that goal, agreeing to anything, especially if told "your DRG has run out" and/or faced with the prospect of a huge bill. People unskilled in providing healthcare are not likely to become well versed in how to maintain a sterile field when changing a dressing or cleaning a catheter, or know what to do when bleeding starts in the middle of the night.

Given the many players in this drama and the various ways they may fail to interact, it seems critical from a policy perspective to have a coordinator with responsibility for managing this process, rather than leaving so much to chance.

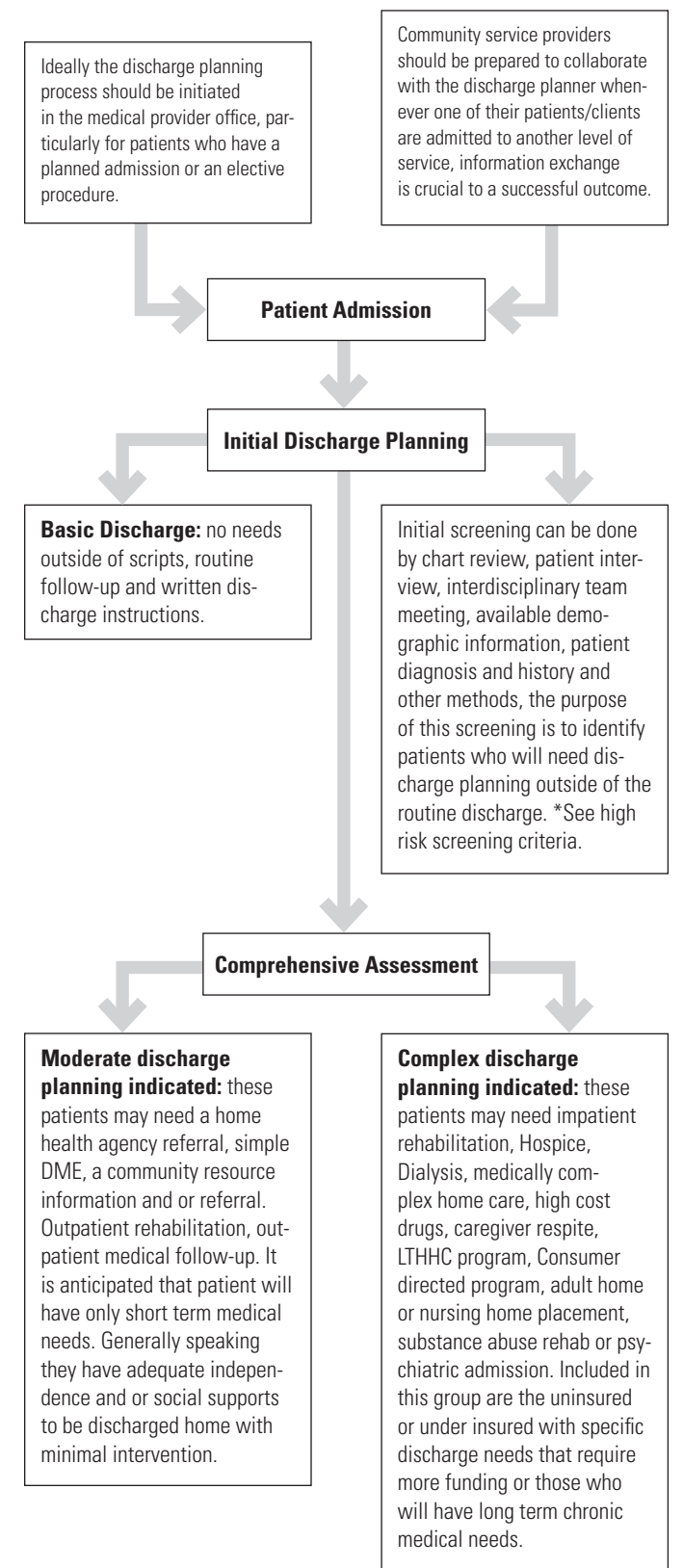
2. What Does a Discharge Planner Do?

In the discharge process, there are two parties which sometimes have conflicting needs and resources: the patient (and family if there is one) and the acute care facility which employs the discharge planner. In 2008, a New York State⁷ task force established a series of criteria for discharge planning that included:

- a person-centered assessment process that is proactive and careful in assessing problems/concerns;
- a person-centered assessment process that focuses on the person's strengths vs. deficits to ensure consumer-directed care and control;
- communication and coordination among formal and informal caregivers and stakeholders that is designed to mobilize resources and identify potential solutions;
- engagement and support from the multi-interdisciplinary team, including physicians;
- collaboration with community advocates concerning safety issues and solutions as needed;
- utilization of peer support to prepare people for transition between different levels of care and to help sustain people in the least restrictive setting possible.

An appropriate patient discharge planning process involves both planning and assessment components, since the success or failure of the discharge process depends on several variables, including the condition of the patient, his or her ability to function at home, availability of a caregiver, and the level of resources in the community.

Transitional care planning is a patient-centered, comprehensive process that begins with an initial assessment of the patient's potential needs at the time of admission and continues



7 http://www.health.state.ny.us/professionals/patients/discharge_planning/

throughout the patient's stay. Ideally, ongoing consultation with the patient care team and reassessment of the patient's changing medical, functional, social and cognitive capabilities assures that the comprehensive needs of the patient are addressed. Patients and families are apprised of the appropriate community resources available and encouraged to participate in all phases of the transitional care planning process. The aim is for referral mechanisms with community providers to occur in a timely and systematic manner so that the patient can gain access to required resources. The process should then conclude with the coordination and implementation of services and transition to the least restrictive level of care in keeping with the individual's wishes.

Transitional care planning considers not only the patient's medical, physical, cognitive, economic and emotional strengths and abilities, but also different aspects of his or her support system. Proper planning involves the following:

- Assessment of the patient's level of functioning prior to admission provides insight into post-discharge services required.
- Ongoing collaboration between the patient, family and the interdisciplinary team facilitates the process of informed decision making.
- Patients and families receive verbal and written information about the range of services available in the patient's community.
- Patients and families are given the opportunity to select the providers of services whenever possible.

The questions below should allow the discharge planner to determine whether the patient is likely to need a more comprehensive assessment, as determined by an initial preliminary screening:

- *Was the patient independent prior to admission, and will this current episode of illness impact the patient's independence in the short-term or long-term?*
- *Does the patient have adequate informal supports to manage any loss of independence?*
- *Does the patient have adequate resources to provide for post-discharge needs, such as medicine, equipment, rehab, or follow-up treatment?*
- *If the patient had prior home care services, were they adequate? Are they likely to be adequate after discharge?*

3. How Should the Planning/Assessment Process Work?

Certain patients will clearly be at higher risk of readmission and should be screened for criteria which are more closely associated with unsuccessful discharges. Research has indicated that the presence of one or more of these circumstances is a solid predictor of a readmission:

- over the age of 70
- lives alone, and/or lacks family or friends who can assist with caregiving
- multiple hospital admissions or emergency room visits
- multiple diagnoses and co-morbidities
- impaired mobility and/or self-care skills
- poor cognitive status and/or mental health issues
- catastrophic injury or illness
- poor social supports or homelessness
- anticipated long-term healthcare needs (e.g. new diabetic) or chronic illness
- substance abuse
- low income
- primary language is not English and/or ethnic or cultural challenges

A comprehensive assessment of such a patient by a discharge—or transition—care planning professional needs to look at the factors listed above. Patients who are identified as high risk or those for whom a more comprehensive assessment is necessary should be evaluated using the following five broad criteria:

- 1) **Mental Status**—A cognitive assessment may be required. What is the patient's understanding of his or her illness? Is the patient capable of participating in his or her own discharge planning? If not, does he or she have someone who can represent him or her in the process? Does the patient have a history of non-compliance, which may impact the ability to be managed at home?
- 2) **Patient Expectations**—What are the patient's goals for discharge? What does the patient need to do functionally to achieve these goals? What services might be available to the patient to achieve these goals? Does the patient understand the risks/benefits associated with his or her choices?
- 3) **Personal Ability and Supports**—A functional assessment may be required to determine the patient's ability to perform Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). Who are the patient's informal supports? What are the abilities of the informal supports? What is the availability of the informal supports?
- 4) **Circumstances at Home**—What is the patient's living arrangement (i.e. house, apartment, with family, congregate living, homeless)? This should include a description of the setting, such as entry stairs, wheelchair accessibility, functional plumbing, heat, cooking facilities, etc.
- 5) **Services and Finances**—What services did the patient have prior to admission? Does the patient have a preference of service provider? Does the patient's insurer have a preferred provider network? Does the patient have insurance or funds to pay for necessary care? If not, what resources are available to the patient?

B. Community-Based Long-Term Care / In-Home Support Service *How Does Care Continue When a Patient Returns Home?*

1. Definitions

Many people, even those who work in social services, are unclear about what is involved in community-based long-term care. Some feel uncomfortable including nursing homes, while others feel there has to be a separate category for short-term services. Dividing services into smaller categories may cause us to miss the larger issue. The services in the community, of whatever sort or duration, together form a continuum. At its heart, this entire continuum is focused on keeping people out of institutions and, to the greatest extent possible, living independently.

This continuum of support services and programs comprises community-based long-term care. It may include but is not limited to:

- In-Home Support Services (IHSS)—a vast collection of direct services and providers
- Home Healthcare—a specific Medicare covered service linked to hospital stays
- Short or Long-Term Case Management—where a professional staff person coordinates the delivery of community services.

2. How Does Long-Term Care Work in the Community?

In the 1980s, a demographic shift in California brought a growing number of people (largely women) over the age of 85. For several years, California actually had more people over 85 than it had teenagers. A moderate but growing number of these people needed long-term custodial care, or placement in a nursing home or convalescent hospital. These facilities were generally grouped under the heading of “skilled nursing facilities,” or SNFs, which are licensed by the state. As this industry grew, so did a consumer advocate movement calling attention to issues of staffing and levels of care. Because Medi-Cal was a reliable payor for these institutions, there was a rapid growth of new facilities. Business boomed, and many national, for-profit chains moving into the industry, displacing many of the “mom and pop” and non-profit operators of earlier decades.

The price of “placement” was high, however. These facilities can cost upwards of \$4,000 a month at the most basic level. Additionally, the human cost of removing people from their homes was high. The move to create alternatives to nursing home placements grew, leading California to adopt a policy of restricting licensing for the construction of new SNF beds since the mid-80s. At the same time, estimates projected that between 1980 and 2000, the population of people over 85 in California, the primary age group for SNF placement, would quadruple.

California implemented a wide variety of diversion programs, such as the Multi-Purpose Senior Services Program (MSSP), Linkages, and more elaborate efforts, such as On Lok and PACE programs. These programs were meant to serve the medical and social needs of the growing elderly population, while avoiding the expense and negative impacts of nursing home placements. Today, California houses roughly 160,000 people in skilled nursing beds on a long-term or lifelong basis, and this number has not changed substantially for many years.

The In-Home Support Services program arose from this difficulty of a rapidly expanding elderly population coupled with a frozen number of SNF beds. It was designed from its inception as a way that community-based services, now known as “community-based long-term care,” could foster a higher level of independence for seniors, allowing them to continue to live at home, with supports. These supports can include delivered meals, homemaker/chore worker services, more sophisticated assistance with activities of daily living, home-delivered healthcare and long-term case management to coordinate the broad range of supports. While not inexpensive to operate, all of these components of the community-based long-term care system had one feature in common: they were designed to be a less costly and more humane answer than SNF placement. Since new SNF construction has been virtually non-existent in California for more than 20 years, and the SNF occupancy rate is typically in the mid-90% range, it is fair to ask where people would go if not home.

This same system of service providers smoothes patients’ transitions from staying at acute care hospitals to living at home, and it will continue to do so as long as it exists.

3. What Are Community-Based Long-Term Care Services?

Long-term care services may include the medical, social, housekeeping, or rehabilitation assistance a person needs over months or years in order to improve or maintain function or health. Such services can be in nursing homes, in patients’ homes, or in community-based settings such as assisted-living facilities. California has many services and programs which function as alternatives to nursing home

care. Both medical and non-medical care may be received at home or in residential settings and can range from simple (light housekeeping) to complex (nursing care or physical therapy) services.

The variety of potential payors for these services can be confusing. A patient may be able to receive a service or participate in a program through private health insurance, a managed care agency, Medi-Cal or Medicare. Qualification can depend on financial and medical eligibility and whether a person meets the service program criteria. In some cases, patients must pay for it directly. Some services are available to persons who are eligible for Medi-Cal, have Medicare coverage, use their own funds (“private pay”), or have private long-term care insurance. Some services are available only to persons who are eligible for Medi-Cal. Services funded by health plans are generally short-term and tied to the patient’s likelihood of improving.

Qualifying can be complicated and difficult. In determining whether a person is medically and financially eligible, programs may require him or her to undergo an assessment and authorization process that includes orders from a healthcare provider. Generally, the fact that a person needs a certain service or form of assistance does not necessarily mean that he or she will qualify for a program that supplies that service or assistance.

The range of services is extensive and sometimes confusing. Different agencies provide different services, and many patients must contact all of them to inquire about qualification, be placed on a waiting list, and determine if personnel are available at the time the patient needs help.

Community-based long-term care services include:

- meals
- housekeeping
- personal care (for example, help with dressing, bathing or getting into bed)
- respite care for family members who care for the patient
- skilled nursing care at home
- services for the elderly, such as adult day healthcare
- transportation
- occupational therapy
- physical therapy
- case management or referral coordination
- residential facilities, such as assisted living
- specific services for patients with brain injuries
- specific services for patients with HIV or AIDS who need help getting access to doctors and home healthcare or paying for prescriptions
- home modification to improve accessibility or for injury prevention

C. State and Federal Initiatives to Reduce Avoidable Readmissions

The issue of avoidable readmissions after an acute hospital stay has by no means been ignored. Indeed, when the topic reached a boiling point in 2009 (when the Jencks study was published), federal funding for innovative demonstration projects had been underway for several years. A number of different models were advanced as solutions in the healthcare reform debate of 2009-2010. These models may yet see wider application and form the basis for a systemic change in the way healthcare is provided. The issue was also part of the national healthcare reform legislation passed in 2010.

What about Those Steps?

My husband is a very large man (over 250 pounds), and we are both in our mid-60s. When it became apparent he needed a hip replacement, his physician went over his needs after the operation with us. We were both concerned about getting him home, because we live in a two-story house, and it takes 28 steps to get to the door from the street. While my husband could spend some days in the hospital after surgery, there was going to be a month or so of recovery that would need to take place somewhere, and we both resisted the idea of a nursing home. This care would include occupational therapy, getting the shower re-arranged, and simple issues like getting in and out of bed for basic needs.

Our physician was very supportive of the recovery needs and made detailed notes about the case, about our house, and about how post-operative recovery should be coordinated, given the demands of getting into the house, and around inside, even the transportation we'd need to just get home. He wrote all this up and we understood it would be sent in so that the details could be arranged.

At the hospital, all this went out the window. There was nothing in the chart about the notes our physician had sent. No one seemed to understand that getting up the steps and so forth would be a big issue, and require some special arrangements, let alone the ongoing problems in the recovery process. When it came time to leave the hospital, the idea was to simply take him home and...I don't know what, leave us at the curb, or in the front hall and let me "deal with it."—H.K.

The finding of Jencks that patients are readmitted at a rate of 20% within 30 days of discharge, and 33% within 90 days, suggests there is a significant, troubling, and costly disconnect between different parts of the healthcare system. The need for good transitional care is clear, and researchers have developed a wide variety of models to address the issue. As this report shows, there is a lot of money currently going to waste that could pay for these models. ***This point needs to be emphasized: there is neither a shortage of potential remedies nor a shortage of money to pay for them; there are therefore no more excuses for lack of progress.***

See Appendix E for brief discussions of 15 models for reducing avoidable readmissions.

D. Is The Healthcare System Its Own Worst Enemy?

The Fragmented Healthcare System

When people enter hospital as patients, they are often anxious about what is to come. Few people who work in hospitals would describe them as comfortable, quiet places; equipment beeps; schedules are disrupted; sleep is often a problem; and there is a constant parade of new people coming in and out, some of whom come seeking blood in the middle of the night. And, of course, there is the reason a person is there in the first place: sickness, some untreated condition, or a planned procedure that carries its own risks. For these reasons, it is not uncommon for patients to feel they have entered a *Twilight Zone* where the familiar is suddenly menacing. In such cases, one's greatest ambition may be simply to get out.

Too often, it seems the hospital experience, and the medical care provided inside, are in fact isolated from the "real" world where the patients and their physicians live and work. Several of the model projects mentioned above look at ways to improve communication, break down barriers, or better coordinate care between the acute care setting and the community.

This study asserts that one of the three main concerns underlying the issue of avoidable readmission is this problematic relationship between what goes on inside the hospital and what goes on in the community. How is it that a person can be working with a primary care provider, then shift to a whole new system and way of life in hospital, and then, after a few days and some potentially life-changing treatments, return to the community as if nothing had happened? Why, in other words, is there this disconnect between the branches of the healthcare system?

Most consumers feel it is reasonable to ask why the full spectrum of care requirements is not outlined prior to a hospital stay to everyone concerned, including patients and healthcare providers. Policymakers might ask, given the huge financial incentives to reduce avoidable readmissions, why the healthcare system does not encourage the primary care providers (the physicians in the community) to communicate with staff in the hospital, which would include sending notes that should go in the patient's chart and communicating with the discharge planner about post-discharge care needs. Physicians themselves have taken notice of the problem, evidenced by an editorial in the April, 2010 issue of *Annals of Internal Medicine* entitled "Frustrations With Hospitalist Care: Need to Improve Transitions and Communication."

Policymakers need to find ways of reducing the friction between different components of the healthcare system. Emphasizing the role of transition (discharge) planning in the acute setting shows recognition that healthcare does not end at the curb. Focusing on community-based long-term care services can build or enhance a network that can respond appropriately to the needs of people leaving the hospital and minimize the prospect of a sudden, unexpected return to the emergency room.

Left to itself, the healthcare system is not going to respond to these violations of its traditional categories and prerogatives. However, policymakers who control funding (for Medicare and Medi-Cal) and private insurers who pay the bills, should take the lead in improving hospital-to-home transitions, not only for the clear financial benefits but also for the priceless impact of better health outcomes and reduced mortality for patients.

II. Educating Consumers about Their Rights

The Role of Individual Consumers and Community Advocates

A. What Issues Do Patients and Families Face after a Hospital Stay?

Discharged hospital patients often fit a definition of "recovered" that says something like "restored to full functional ability and ready to resume life." But that doesn't tell the whole story. After a multi-day hospital stay with poor sleep, odd interruptions, unfamiliar circumstances, needles, beeping monitors, and a multitude of other discomforts and annoyances, most people would jump at the chance to return home to familiar surroundings.

Patients who are thinking ahead, however, may have a lot of questions about how successful they will be at home, especially if they are expected to care for themselves or rely on household members to look after them. The patient and family have the right and responsibility to be involved in the plan of care after discharge. To the greatest extent possible, consumers should be active participants in developing their care plans, assessing whether it is time to go home, and determining if care can be provided there.

The questions remain: does this happen in practice, and what resources can a patient look to for help and a "second opinion" on the issue of going home?

The decision to return home should involve the patient or family's own checklist, which would include the following questions:

- Is your current medical and mental health status stable enough for you to be discharged to home care? Is your home adequately equipped for you to be cared for at home?
- Do you need people to take care of you? Are family members or other people at home to assist you? Or are you comfortable taking care of yourself?
- What are your physician's expectations about your health status and decision to be cared for at home? What are your short-term healthcare needs? What are your long-term care needs? Can you or someone else make important decisions about your healthcare? Is it necessary to consult a professional about your decision-making status?
- How will care be paid for? Are you eligible for Medicare and/or Medicaid? Do you have private insurance or will you and/or your family be paying for your care? Do you have your insurance cards or other documents available?
- What services did you have prior to admission? Do you know the name of the provider? Will those services be provided at the same level or is an increase in hours needed? Is your provider willing to reinstate services? If not, why? Do you know how to access services?
- Does your primary care physician or person on your medical team need to be contacted? Which physician will be responsible for overseeing your care at home?

Happy to Go Home – No Matter What

*I went to "****" Hospital with chest pain and trouble breathing and after an afternoon in the ER (Saturday) was admitted to the hospital cardiac unit. Several days went by when I saw no one but nursing staff. My "personal" physician, whose office was literally across the street, was either uninformed or uninterested in my admission. Several days later, after a radioactive dye test, I refused a cardiac catheterization to rule out what by then was clearly to me a non-existent heart problem. By Thursday afternoon it was decided the cause was anemia, a vitamin deficiency (B-12 so low it could not be measured). I got a shot and was told Friday morning (by a nurse) I could go home after a second shot. So I left, thrilled, about 1 pm. By the time I walked to the hospital pharmacy and then the front door (about a block), called a cab, and walked up the (eight) steps to my apartment, I could barely sit down before falling asleep in the chair until the next day.*

The problems were: 1) no exercise all week, 2) no showers or bathing, 3) limited diet and meds all week, 4) no info from staff about meds (to be taken at 4, or 6, or 8 hour intervals, but all in the same bottles), 5) no food at home- and no way to get out and walk 4 blocks to the market. I ate Chinese takeout and delivered pizza for 3 days. No instructions on diet from the hospital – i.e. cramps, etc. when food was reintroduced into body. I live by myself and could not change bed linens, do laundry, shop or anything except look at the TV until the following week. I could not walk as far as the bus stop, and had to take cabs to and from work for ½ days of work over the next week.

—D.G.

B. What Do Consumers Need to Know about Their Abilities and Responsibilities?

When a patient is finished with acute medical care, concern for his or her medical condition does not suddenly end. Indeed, the system can sometimes be thought of as “care that keeps on giving,” often times whether you want it to or not.

For patients with newly acquired disabilities, the patient needs to understand what his or her condition means from a medical perspective and what it will mean to live with a disability. Physicians should discuss with the patient physical changes, probable care needs, possible complications, and other things to watch for related to the disability. The patient needs to have a firm understanding of what assistance he or she will need or want and how to best benefit from the available assistance. Patients should know they have the right to receive services in the most integrated setting as well as who to contact if they feel that right is not being fulfilled.

In other more temporary circumstances, the patient needs to understand what services and supports are available to meet his or her needs and desires. The discharge planner needs to know what services are available to meet the needs and desires of the patient and the eligibility requirements of available services and supports. As part of long-term planning, patients should be given information on what services or supports are available, and contact information for assistance and advocacy, should their needs change.

It is important to identify future sources of help. The patient and discharge planner must also have a clear understanding of the role of any informal supports. The patient and discharge planner should candidly explain this role to the informal supports in order to ensure understanding. If informal supports have agreed to be part of the discharge plan, the patient and discharge planner must ensure that the informal supports understand what will happen if they do not fulfill their roles.

There can be difficulty when it comes time to pay for supports. Patients need to understand what types of services and supports are covered by their medical insurance and what public benefits they may be eligible for. Discharge planners should be familiar with basic guidelines for Medicare and Medi-Cal coverage and refer consumers to the appropriate person or entity that can explain specific coverage benefits and limitations.

C. Who Can Help Reverse a Discharge Decision?

What Patients Need to Know About Going Home

Most importantly, patients should have a firm understanding of their rights to appeal adverse coverage and care decisions, starting with the decision to be sent home in the first place.

It is a popular misconception that all hospital discharges occur on Friday afternoons; nevertheless, the experience is often the same regardless of the day of the week. To be notified of a discharge one afternoon and be sent home the next day provides little time to accomplish much at home. Patients, families, and even service agencies are poorly equipped to scramble for services, find help, get supplies, and receive training in care issues. And since all patients and home situations are not identical, some people are simply not ready to go home, regardless of the opinions of the hospital staff and billing office.

As the ones who pay the bills, insurers – Medicare, Medi-Cal, and private companies – set the standards for care and reserve the right to decide if those standards have been met. But at present only some patients have these legal protections. The

best covered are Medicare beneficiaries (some 4.5 million seniors and persons with disabilities). Under the Medicare program, a national network of government funded contractors, called Quality Improvement Organizations (QIOs), was created in the 1980s to review, and in some cases, overrule, decisions to send patients home. This was at the same time the DRG system was introduced, which first threw light on the issue of premature hospital discharge. Few people know of the existence of QIOs, let alone the right 1-800 number to call or the rules that specify when a call must be made.

In the 1990s, federal Medicare regulations required that patients be informed at admission of their rights, especially the right to ask for a review of a discharge decision. A formal written notice was also required when a patient was informed of a discharge. Over time, these measures have gone by the wayside. In the present environment, if, and only if, a patient objects to a discharge decision is that person informed of the existence of the QIO and the number to call for a review.

QIOs offer significant protections. A patient’s file is sent off for a medical review, and the patient stays in the hospital, at no personal cost, while the review is completed (usually 24 hours, although a weekend or holiday can extend the stay period substantially). If discharge is deemed inappropriate, the QIO can require additional days of care in the hospital, also at no cost to the patient. But these protections are worthless if the patient does not know they exist or when to invoke them.

The California Discharge Planning Collaborative was created in 2008 to help inform people across California of their rights to this review and appeal of a hospital discharge decision. The project has been focused on a series of town hall outreach events, and distribution of a *Know Your Rights* pamphlet. Ultimately, the aim of the Collaborative has been to raise public consciousness of the discharge issue and press for greater public accountability in the process.

D. The Human Impact

Often lost in policy-level discussions is that fact that individual patients, including seniors living in California, can face painful and often life-threatening situations after leaving a hospital as a result of inadequate planning for support services. If these services are unavailable or unaffordable, the problem is exacerbated. Anecdotal evidence has suggested for some time that the discharge planning process has been problematic for many patients. The Jencks study in 2009 quantified the problem, showing that one in five patients are readmitted within 30 days of discharge, and fully one third are readmitted within 90 days. ***There are an estimated 405,000 hospital admissions in California each year for the 4.5 million Medicare beneficiaries. As many as 81,000 of these are avoidable readmissions.***

See Appendix D for a selection of personal stories about hospital discharges. III.

III. Summary and Recommendations

Avoidable hospital readmissions are a significant financial drain on the healthcare system. In California, re-admissions related to Medicare patients are estimated to cost as much as \$500,000,000 each year. This report calculated that the cost of the first day back for an avoidable re-admission was \$227,000,000. With more than \$48,000,000 coming from the Medi-Cal program, the State of California has a strong fiscal incentive to reduce these instances of poor transitions home from the hospital.

There are a number of proven techniques to achieve this end. This report argues that the two most direct and effective options are increased use of discharge or transitional care planners in hospitals, and increased coordination of acute care

facilities with the community-based long-term care services network. Both of these can be supported by fraction of the funds now spent on avoidable hospital care. The \$227,000,000 currently spent on avoidable readmissions could be redirected to a dramatic increase in discharge planners and sizable increases in community based services.

Recommendations to Reduce Avoidable Readmissions

1. In the Hospital

- *Discharge planners need to be active, and must work with patients and their caregivers on a post-acute care plan as part of the admissions process.*
- *Discharge planners need to be involved in care plans once people leave the hospital, coordinating services with community-based providers.*
- *Patients and family caregivers need to be carefully educated and included in the discharge planning process.*
- *Discharge planning needs to be considered a billable service by insurers so that hospitals have incentives to use this tool to reduce readmissions.*
- *Discharge planners and hospital staff should be required to coordinate their actions with the primary care provider in the community, both prior to admission and after discharge from the hospital.*

2. In the Community

- *Community-based long-term care services need to be recognized as important parts of the healthcare system; they are essential to successful efforts to reduce readmissions and are coordinated much more closely with acute care facilities.*
- *Funding for community-based long-term care needs to be preserved, especially by redirecting money now spent on avoidable hospital care.*

3. At the Government or Private Insurance Program Level

- *Medicare and Medi-Cal need to make changes so that hospitals can bill for discharge planning services as a way to reduce avoidable readmissions; they must also insure that proper discharge planning takes place.*
- *Medicare needs to reexamine its elimination of requirements of notice to patients about their discharge rights at the time of admission to a hospital.*
- *Medi-Cal needs to recognize the direct connection between in-home support services and community-based long-term care services; Medi-Cal also needs the ability to facilitate and fund the discharge of acute patients back to the community by funding in-home and community-based services.*
- *Insurers need to demand that hospitals more closely coordinate post-acute care and discharge planning; this includes active coordination with and, potentially, payment to community-based long-term care providers.*

IV. Community Financial Impact

What cutting hospital stays after avoidable readmissions by one day in California could mean financially to local communities.

A. The Fiscal Impact on Medicare and Medi-Cal in California

As discussed earlier, this study is based on the work of Jencks and his team's analysis of the rate of avoidable readmissions for Medicare patients nationally. Using this work as a basis imposes some constraints in the analysis of the funding implications for California:

- Our analysis is limited to patients over age 65 and younger people with disabilities who are covered by Medicare. Approximately one quarter of these people are eligible for Medi-Cal as well.
- Medi-Cal covers far more people (6.7 million) in California than Medicare (4.5 million), but the vast majority of these people (5.6 million) are mothers and infants, children under 18, and adults under 65, for whom readmission data was not analyzed.
- Medicare is a federal program, funded wholly by the federal government. Any savings to Medicare which result from reducing readmissions will need to be affirmatively shifted to increase discharge planning and community based long-term care; that is, they won't simply "happen."
- Medi-Cal is a program funded equally by the state and federal governments. Medi-Cal's involvement in the readmission question comes from its coverage of "dual-eligibles" who have both Medicare and Medi-Cal coverage and is limited to payment of co-pays, deductibles, and premiums to Medicare. The state's general fund share of readmissions is limited by the number of people it covers, the limited costs it incurs, and the funding formula. Medi-Cal, however, has enormous leverage in that it pays for community-based long-term care services and could directly shift savings from one category to another.

Even a broad discussion of national healthcare costs impacts California heavily.

Representing roughly 10% of the Medicare enrollment in the country and the same proportion of the overall population, California is an important part of the healthcare market. Historically, the Medi-Cal system has been run as a "lean" or "efficient" system, which means low-cost. The low reimbursement rates compared to those of other states, such as Massachusetts, have meant that while the Medi-Cal program is more "efficient" in this state, cuts to it go much deeper than elsewhere.

Even more troubling has been the approach by state legislatures to cut the In-Home Support Services (IHSS) program. Given the rationale for the program's creation, and the Supreme Court requirement to provide Medi-Cal services in the least institutional, most integrated manner, this attitude seems, at best, foolishly short-sighted, particularly in light of a number of court cases and legislative policies. In 1999, the Supreme Court noted in the *Olmstead v. L.C.* case that the Americans with Disabilities Act places a strong requirement on states to maintain people in the community, as opposed to placing them in institutions. The U.S. Solicitor General at the time argued "The unjustified segregation of people in institutions, when community placement is appropriate, constitutes a form of discrimination prohibited by Title II [of the ADA]."

Again, not all readmissions are avoidable. The point Jencks et al. make is that a large portion of them are, and that the cost of ignoring the problem is enormous - between \$13 and 18 billion nationally each year to Medicare alone. On one level, it seems like fairly simple math: \$X is spent on avoidable care, and a small fraction of \$X could prevent this avoidable care. If cost is a major concern, why would we spend \$X? This report argues that there are two financial issues at the root of the problem: **1) hospitals do not see discharge planning as a high priority because there is no secure funder for it, and 2) healthcare systems (providers and insurers) do not see care in the community as a part of the treatment process and see no reason to pay for it.**

Some commentators argue that these issues stem from a “silo” mindset, which sees the parts of the healthcare system as discrete, and unconnected. Historically this may have been more commonly the case. Still, why have large-scale, integrated systems, such as Kaiser and other HMO’s, or Medi-Cal, for example, not moved more aggressively to address this problem?

One reason may be that until 2009, when Jencks reported the data, it was too easy to dismiss the complaints of advocates about low quality outcomes simply as “anecdotes.” Combined with inertia, this made it easy to simply ignore the whole problem. However, as a well-known senator once said, “A billion here, a billion there, and pretty soon you are talking real money.” As noted earlier, the savings potential is too large to be ignored, and the potential sources of funding for community services are too compelling to pass up.

B. Methodology for Calculating Cost Savings

For this report, a cost-calculating spreadsheet was developed to see how much money can be freed up in California in both the Medicare and Medi-Cal systems by shifting from avoidable hospital care to improved transitional care planning and community-based long-term care services. The calculations, as seen in the charts which follow, are all based on the same publicly available data. These are:

- California Medicare enrollment (2007 county data report)
- California Medi-Cal enrollment (June 2010 estimate of January 2010 county enrollment)
- California Hospitalization Rate–90 per 1,000–Kaiser Foundation Health Data
- Readmission rate (for Medicare population)-20% as estimated by Jencks, et al
- California Hospital per day cost–\$2,205–Kaiser Foundation Health Data

Costs are calculated by taking the patient population (state or county level), dividing it by 1,000, and multiplying it by 90. This number is then multiplied by 20% to get the number of first day readmissions (the model does not count the length of stay, which could be much larger). These days are then multiplied by the hospital daily rate, a statewide average of \$2,205 for California, which will vary for other states. To keep comparisons fair, the same general population groups (those over 65 and adults with disabilities) are included in both the Medicare and Medi-Cal figures, with Medicare having a roughly four times larger enrollment than Medi-Cal for this group.

It is certainly possible to argue over specific values in the calculation. Jencks, for example, pegs the readmission rate at 20%, while MedPAC reports it at 17.6%. MedPAC reports the total cost of readmission care as \$15 billion, whereas Jencks gives a range of \$13-\$18 billion. These discrepancies, however, do not undermine the fundamental truth that avoidable hospital care is a massive expenditure which could instead support far more effective alternatives.

In California, we are confident in projecting an estimated Medicare savings of \$179 million for one day of eliminated hospital care, and \$48 million saved for Medi-Cal for the same reduction in care. Commercial Medicare Advantage providers, such as Kaiser and a range of other private insurers, should enjoy major reductions in costs as well. The section that follows shows the potential savings for the state and outlines what services and personnel could be paid for instead of providing acute care for avoidable readmissions.

To further demonstrate the impact of our “one day” recommendation, a series of county charts follow, showing the same impact extrapolated at the county level.

It should be emphasized that there is not a direct, one-to-one, correlation between the savings projected here and funds that are then available in the community. The aim of these comparisons is to drive home the point that while discharge planning and in-home support services are expensive to provide, they are nowhere near as expensive to Medicare and Medi-Cal as ignoring the need for them in the first place. Services are estimated at the following rates:

- *Discharge Planner* - \$60,000 full-time employee (FTE) salary
- *IHSS Worker* - \$12 a hour, or \$96 per day

What a Difference a Day Makes–Part 1

Part 1 of this report provides a summary discussion of the issues and recommendations, and a convenient condensed table of county by county cost savings. It is available at: www.planningforelders.com, or www.californiaalliance.org