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 1–Summary Report

California Discharge Planning Collaborative San Francisco, California, January 2011

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 to 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 2009-10 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 a reduction 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.

The 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

I. Scope of the Problem

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 2009[2] 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.

"Readmissions are not primarily about people being rehospitalized because of mistakes made in the hospital. Readmissions is 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 Center for Medicare and Medicaid Services

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1 *Halfon P, Eggli Y, van Melle G, Chevalier J, Wasserfallen JB, Burnand B. 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*

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.

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.*

B. How Did Avoidable Readmissions Become Such a Problem and What Is Happening to Patients Today?

The daily reality of individual patients is often lost in policy-level discussions. The fact is, many patients, including Californian seniors, face painful and potentially life-threatening situations after leaving a hospital when there are unavailable services, unaffordable services, or inadequate planning for continued care. As Jencks notes, the basic question is about successful transitions from hospital to home. Anecdotal evidence has suggested for some time that the planning process has failed for many patients. The reason that these unsuccessful transitions now seem to loom so large has origins going back nearly thirty years.

1. History of Cost Containment Efforts Set the Stage for Early Discharges

In the 1980s and 1990s, cost containment was a major issue and a focus of much debate, particularly in hospital settings. Hospitals were uncomfortable being called to account for their accounting practices because many, including some major institutions, had no solid idea of what their costs per patient were. A nightmarish system of cross-subsidies, multiple pricing levels, and a high level of inefficiency made precise cost accounting impossible. Many institutions operated with the idea that if at the end of the year the amount that went out of the hospital or department was roughly comparable to the amount that had come in, things were going well.

Out and Back within 24 Hours

I was admitted to "…" Hospital for breast cancer surgery and was released at 11:00 pm on the same day. I had an allergic reaction to the general anesthesia. I had low, low blood pressure and hives in the middle of the night of the same day as the surgery. I had no one to help me and I had to wait until the next day to talk to my doctor. I had "… " health insurance from my job. I was readmitted to the hospital the next day after a horrible, horrible night of pain, misery and dangerous symptoms. —C.M.

A significant development in cost containment came with the introduction of the diagnostic related grouping, or DRG, model of reimbursement in the 1980s. Under this concept, all cases of a similar nature ("gall bladder removal," for example) were assumed to cost the same. A series of medical flat-rate fees were set by Medicare for specific DRGs. The theory was that this would incentivize high-cost providers to become more efficient (i.e. lower costs), and reward lower-cost providers with the savings. This was not the sole result, however, and patients across the country were soon being told "your DRG has run out," then shown the door. This problem continues today.

The widespread domination of the private health insurance system by the managed care model in the 1990s became a second force pressing for cost containment. The managed care model, however, came in two forms: 1) *the system model,* such as Kaiser, where the HMO actually owned the facilities and employed the staff, and 2) *the network or managed care model,* where an insurer contracted with providers for its insureds and controlled access to services.

The HMO system model pioneered by Kaiser had substantial appeal: it offered a "one-stop shop" approach where care was provided in its facilities by its own doctors, and it offered consumers a regular, flat monthly fee that covered "all medically necessary care." It did require that all services be provided by Kaiser, however. Managed care, at least in its initial phase, proved less popular with patients, in many cases severely restricting access to services. The alternative, an *indemnity* (or fee for service) model, simply paid within rough guidelines for whatever care was requested by the patient or his or her physician. It was popular with patients and physicians, offering "freedom of choice," but, because of the costs, it has become increasingly rare, now covering barely 2% of the marketplace in California.

For a few short years in the early 90s the shift from the indemnity (or blank check) model to the managed care or HMO model served to drive down costs ruthlessly, force consolidation of hospitals and physicians into provider groups, and briefly suggest that a new day in healthcare economics had dawned. But by the mid-90s this golden age had ended, and the relentless double-digit cost increases returned, becoming a seemingly permanent feature of the healthcare environment.

The tensions which still remain regarding when a patient is ready to go home relate directly to the cost of patient care. Since insurers, and the Medicare program, largely pay on a flat rate for a fixed menu of services, there is a significant incentive to move patients through hospitals as fast as possible. In the late 1990s in California, for example, a state law was required to end the "same-day mastectomy" and the "drive-through delivery" practices adopted by many providers and insurers.

Observers, advocates, and service providers have noted for some time that patients were often sent home either too soon or into an environment that could not support the level of required care. These were and continue to be major concerns, especially for seniors. A patient who has been in a hospital for a week, for example, could be discharged on a Friday afternoon and return home to a house or apartment with no food, no clean bed linen, no way to get to a pharmacy to fill a prescription, and little or no help with getting in and out of bed, dressing, using a toilet, bathing, doing laundry and preparing meals. Complicating the picture even further might be the need to change a dressing, clean a catheter, or self-manage a variety of medications with no standard labeling or instructions. Rapid medical decline and return to the emergency room became all too frequent occurrences, according to many advocates.

By the mid-2000s, cost had become a front-burner issue. A major formal study by Jencks et al. in the *New England Journal of Medicine* reviewed over 435,000 files from the MEDPAR or Medicare payment database. The study provides a working definition of an avoidable readmission as one where a patient is discharged from an acute care setting and returns within a period of 30 days without seeing a physician first.

Aside from a physician's referral, there are few ways to be admitted to a hospital except in an emergency situation.

It was found that for the majority of hospital stays, one of two chronic conditions was present: congestive heart failure or chronic obstructive pulmonary disease. Unlike a fall or a car accident, these conditions are the result of a sometimes lengthy degenerative disease process. A patient with one of these conditions has probably been seen by a physician a number of times and is likely already involved in a therapeutic regimen. Thus, the hospital admission follows a long period of medical care and professional observation.

As a result, the return home from such an episode is likely to require considerable in-home care for some period of time. For seniors without an available caregiver, or where a spouse is also of advanced age, the situation is almost wholly dependent on outside services provided in the home.

A professional discharge planner at the hospital typically arranges for these services. This person is generally expected to make an assessment of the home care situation, determine what sorts of services are needed for the particular condition, and contact the community providers so that they can have the services in place when the patient gets home. All of this is known as the "care plan." At home, a variety of private and public service providers are - in theory - able to address the care needs of the returning patient. These needs are often known as "activities of daily living," or ADLs, and include eating, dressing, getting in and out of bed, and toileting. There may be a number of additional needs for home-delivered skilled and semi-skilled medical care.

2. Current Hospital Patient Experience

The faults in our current system exist because the many parts that must effectively work together often do not. In addition, the system provides incentives for short hospital stays and reduced costs, which bring unintended consequences. When a discharge planner does not provide an effective care plan or never sees the patient at all and when home care and support services are not arranged beforehand or not in a timely fashion, the patient is left to fend for him or herself. In these circumstances, medical outcomes are usually very poor, often resulting in an emergency readmission to the hospital.

The following 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 was unable to cope with the condition without assistance.
- The patient does not see a physician to monitor condition and care when in the community.

When I left the Hospital I Slept in My Car for Two Days

I fell out of my wheelchair in Fresno, just before driving to Sacramento. I was not in a lot of pain at the time but by the time I got there I was in excruciating pain and couldn't get out of the car. I went to "…" Hospital, they took x-rays and I was admitted to the hospital for five days, during which time I saw the orthopedist two or three times. He was going to see me either Saturday or Monday. I don't remember which. On Friday the discharge person came into my room and said I was ready to go home. I explained that I was unable to get into my car. I asked to see my doctor and they sent someone in who said she was my doctor -- I had not seen her before then. She said she had read the orthopedist's notes and they said I was ready to go, that they could do no more for me there. They would not contact the orthopedic doctor. I refused to go, pointing out that I had gotten very little sleep during the time I was there -- less than two hours in the previous two days. So they sent in a bunch of staff. They said if I did not leave they would "pick me up and put me out." I went out to my car in my wheelchair but I was unable to get in it to drive and had to pay a guy and his friend two six-packs of beer to help me transfer into my car. Back in Fresno, my homecare worker was out of town over the weekend. Saturday and Sunday nights I slept in my car.

Three Flights of Stairs with a Broken Hip?

My friend G.F. called me at 10:00 pm to say that he was being discharged the next day at any time. He had been hospitalized with a broken hip and was in a wheelchair, unable to walk. He lived in an SRO up three flights of stairs with no elevator in the building. I called the social worker asking for a "letter of discharge" and then I called Lumetra for him. He got re-examined and sent to Laguna Honda for rehabilitation. Without my knowledge of Lumetra he would have had to crawl up three flights of stairs to get to his place. —B.A.

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.[3] This is not to say that every hospital readmission 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.

Cost to Medicare of Potentially Avoidable Readmissions in California[4]

	Rate of Readmission for Medicare Pattients		
	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

The widely decried practice of discharging patients on Friday commonly makes it very difficult for community service providers to even make an assessment, let alone assign staff to provide services over the weekend. The inability of hospitals to bill directly for discharge planning provides a strong incentive to understaff this function and cut back on the time taken to develop a care plan. In some cases, the incentive is so strong that a care plan isn't even developed at all. The debate about how to remedy this problem has raged at the local level for years with little progress.

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.

I Spent the Weekend with a Friend

I broke my hip and was in a rehab center. I needed a hip replacement. I was released at the weekend and would have been alone so "V" (in her 90s) let me come to her house to stay until I could get help. Home health finally came out on Wednesday. It probably took so long because I was released over the weekend. Once they came out, home health was very good. —R.N.

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3 *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*

4 *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.*

II. Community Financial Impact

Cutting avoidable care for one day in California can result in huge savings and still fund improvements in services

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 Med-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

State of California

Medicare 4,515,000 (65+ and Disability) 11.9% of population		**Medi-Cal (65+ and Disability) 1,220,362* 3.3% of population**	
Estimated Cost of Avoidable Care to Medicare		**Estimated Cost of Avoidable Care to Medi-Cal**	
1 Day	1 Week	1 Day	1 Week
$179,200,350	$1,254,402,450	$48,146,438	$339,053,174

Here is what the potential cost savings could pay for:

Medicare			
Home Care Workers	$96 / day	1,866,670 days	7,179.5 workers
Discharge Planners	$23 /hour	973,915 hours	3,746 planners
Medi-Cal			
Home Care Workers	$96 / day	508,543 days	1,941 workers
Discharge Planners	$23 /hour	263,240 hours	1,012 planners

Estimated First Day Savings for Reducing Avoidable Hospital Readmissions in California

County	Medicare	Medi-Cal	County	Medicare	Medi-Cal
Alameda County	**$6,707,054**	**$2,082,971**	**Orange**	**$13,485,154**	**$3,066,727**
Alpine County	$5,636	$1,151	Placer	$2,013,672	$231,393
Amador County	$312,241	$30,283	Plumas	$183,685	$26,830
Butte County	$1,550,807	$370,744	Riverside	$9,766,796	$2,058,244
Calaveras County	NA	NA	**Sacramento**	**$6,816,321**	**$1,912,621**
Colusa County	$90,969	$29,252	San Benito	$213,294	$50,764
Contra Costa	**$5,204,907**	**$962,959**	San Bernardino	$7,720,102	$2,175,726
Del Norte	$142,805	$57,670	**San Diego**	**$14,444,818**	**$3,154,402**
El Dorado	$1,086,315	$131,215	**San Francisco**	**$4,721,006**	**$1,904,048**
Fresno County	**$3,988,091**	**$1,325,330**	San Joaquin	$3,062,163	$882,904
Glenn County	$177,176	$41,794	San Luis Obispo	$1,676,506	$232,226
Humboldt	$856,788	$207,768	San Mateo	$3,774,757	$715,809
Imperial	$830,870	$449,370	Santa Barbara	$2,307,537	$415,157
Inyo	$147,131	$24,608	Santa Clara	$7,622,703	$2,304,838
Kern	$3,418,023	$1,023,962	Santa Cruz	$1,186,136	$262,152
Kings County	$3,525,961	$161,181	Shasta	$1,433,285	$311,765
Lake County	$522,598	$142,170	Sierra	$25,799	$5,557
Lassen County	$158,601	$34,372	Siskiyou	$406,386	$85,095
Los Angeles	**$42,995,195**	**$16,311,439**	Solano	$1,892,141	$440,916
Madera	$730,852	$178,287	Sonoma	$2,700,587	$451,156
Marin	$1,572,875	$184,400	Stanislaus	$2,469,948	$792,502
Mariposa	$150,465	$20,123	Sutter	$501,166	$151,814
Mendocino	$614,798	$142,447	Tehema	$456,395	$111,013
Merced	$1,009,753	$360,266	Trinity	$120,697	$23,655
Modoc	$83,706	$17,821	Tulare	$1,836,496	$667,467
Mono	$40,523	$3,929	Tuolumne	$476,161	$64,337
Monterrey	$1,809,666	$413,133	Ventura	$3,897,955	$761,532
Napa	$887,945	$120,658	Yolo	$814,002	$207,896
Nevada	$761,850	$87,874	Yuba	$351,336	$107,838
			State of California	**$179,200,350**	**$48,146,438**

For a more complete county by county analysis of the impact of cost savings at the county level, see Part II of this report

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What a Difference a Day Makes Part II
What Must Be Done

Both Medicare and Medi-Cal 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 analyses in Part II look at the way in which savings from the prevention of just one day of avoidable hospital care could support discharge planning and community-based long-term care services:

- Section I provides a review of the problems with transitional care planning and delivery, issues of coordination from hospital to community, and outlines a model of how services could work.
- Section II describes the role Community Advocates and the need to educate individual consumers.
- County by County Summary of the Fiscal Impact and estimates of what local services could instead be supported
- Appendix: Capsule Descriptions of 14 models to reduce avoidable readmissions and resource information
- Appendix: Consumer Stories of Hospital Discharge Problems
- Appendix: Consumer Information and Education Materials

To Download a copy of Part II of this report see one of the following web sites:
www.californiaalliance.org
www.planningforelders.org
www.healthresearchforaction.org.