



TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER
Anita Thigpen Perry School of Nursing

Health Care Quality Improvement focused on Readmissions

State Quality Meeting

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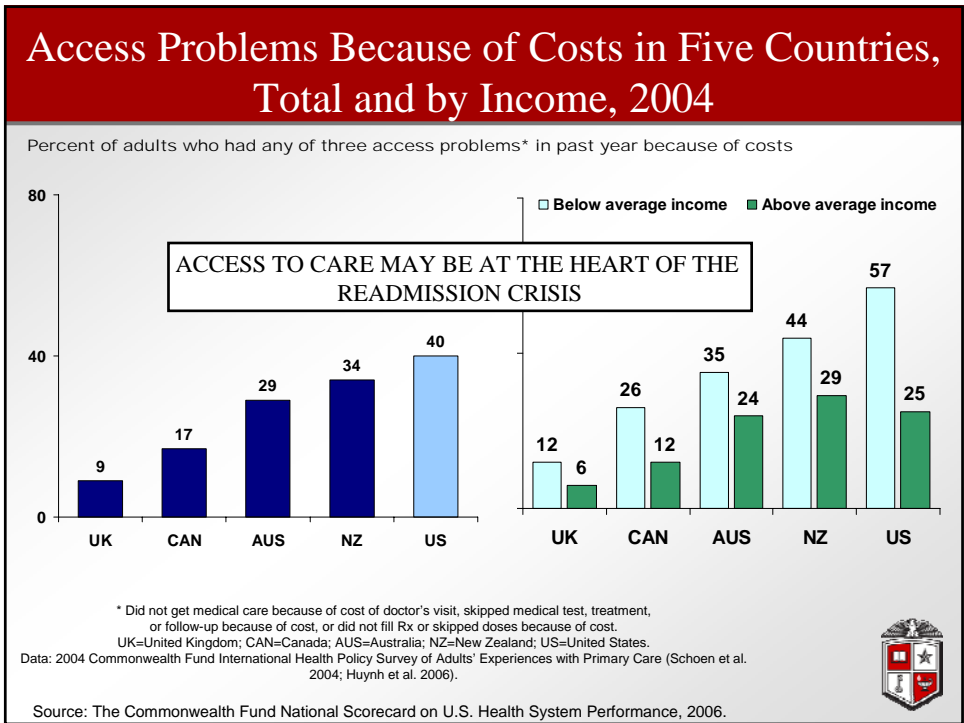
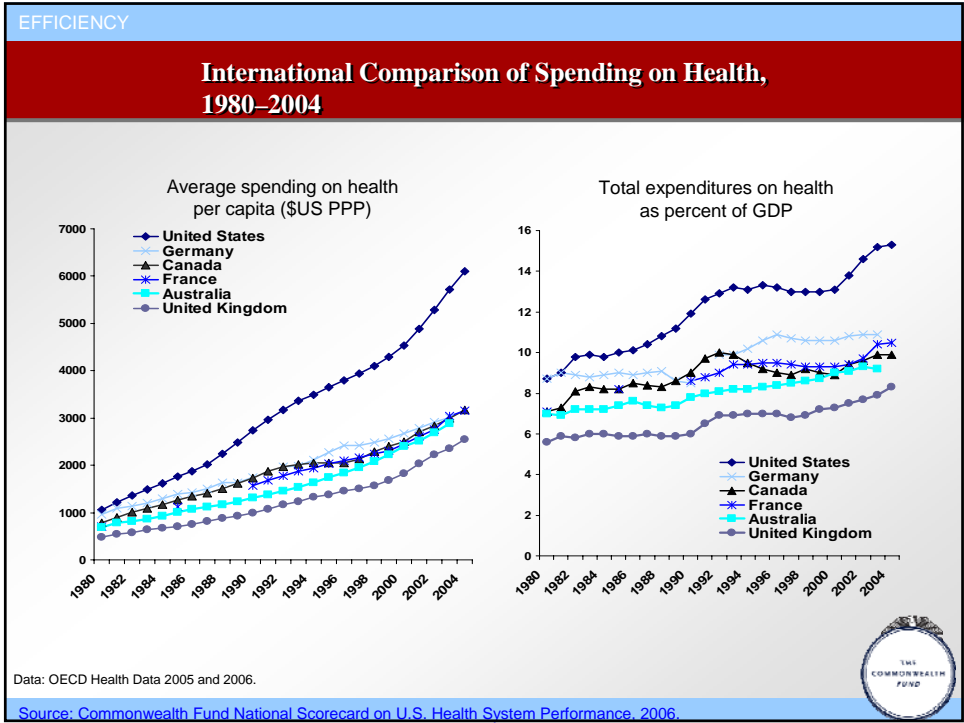
Professor

Texas Tech University Health Science Center

Quality Issues & Cost Set the Stage

- Total health care expenditures in 2006 totaled \$2.1 trillion (16% of GDP) and are projected to reach \$4.1 trillion (19.6% of GDP) by 2016 ¹
- Only 55% of the time patients receive the proper diagnosis and treatment ²
- Disparities in health care quality and access are not getting smaller ³





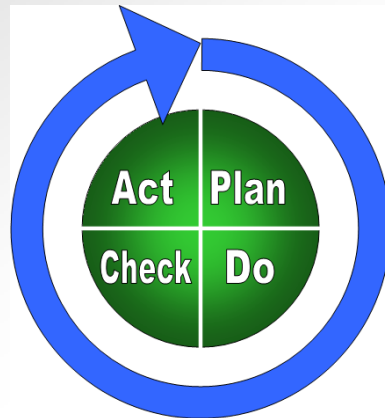
So, what about Quality?

New models are emerging to address the issues,...



Traditional Approaches to Healthcare Quality are not sufficient to address the issues

Traditional Deming Improvement Cycle



The Evidence Triad: Fundamental Principles of Evidenced Based Practice



<http://www.libraries.psu.edu/instruction>



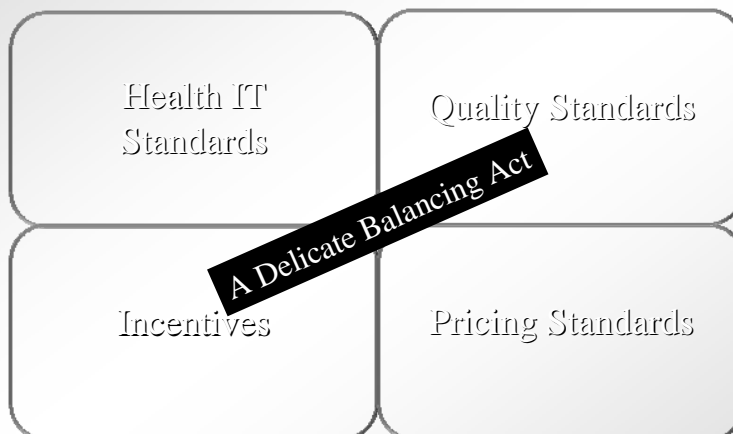
Major National Initiatives to Improve Quality and Cost of Services

- Health Information Technology
- Emphasis on comparative effectiveness research
- Chartered Value Exchanges:

❖ A “Value Exchange” is a multi-stakeholder collaborative that has taken clear action in its community to convene community purchasers, health plans, providers, and consumers to advance the four cornerstones of Value-Driven Health Care.



What are the Four Corner Stones of Value-Driven Healthcare?



<http://www.hhs.gov/valuedriven/fourcornerstones/index.html>



New Regulatory Requirements: Federal & State

- The Deficit Reduction Act of 2005 (signed into law 2006)
- Present on Admission Implementation (Oct 07), financial impact (Oct 08)
- MS-DRGs: Severity Adjusted DRG reimbursement
- Hospital Compare Measures increasing substantially
- MRSA Legislation: Federal & State requirements likely
- Healthcare Associated Infection Rate Reporting: State & Federal
- Recovery Audit Companies (“RAC” Audits)
- Changing roles of QIOs and other regulatory review organizations
- Other Health Plans no longer paying for Never Events
- Patient Safety Organizations emerging concept
- Medicaid Reform bills emerging across the US



New focus by CMS and other Payers: Readmissions believed to be a costly proposition,...

Medicare Trust Fund to Run Dry in 2017



The Biggest Bang for the Buck

**Readmissions: Estimated cost to Medicare:
\$15 to \$18.3 billion in annual spending**



Readmissions is a National Conversation

- A growing interest in developing methods for public reporting and readmissions analysis for:
 - ❖ *Quality and safety analysis*
 - ❖ *Pay for performance (cost reductions)*
- Adequate methods and measures are still under development but standardization is important to:
 - ❖ *Pay for Performance*
 - ❖ *Use of data to improve care*
 - ❖ *State and national public reporting*
- CMS will report on the following readmissions beginning in June 2009
 - ❖ *CHF, Acute MI, and Pneumonia*



What is a readmission?

- “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., a former senior clinical adviser to CMS



What is a readmission?

- May be a “Failure of the system”
- May be the best and safest course of treatment for the patient
- Planned versus unplanned (potentially avoidable)
- Reflective of process of care and an outcome

“Clinically Specific Conditions and Considerations for Tracking Readmissions”
National Consensus Conference on Readmissions. Funded by AHRQ. Sponsored by NAHDO, 2008.



What is a readmission?

- A readmission is a component of care within an overall context of patient care that is reflective of:
 - ❖ *Medical vulnerability relating to chronic illness*
 - ❖ *Social needs of the patient*
 - ❖ *Provider system issues*
- All factors which can be estimated as we measure readmissions
- Providers will need good information on these issues in order to effectively target improvements.
- Much of the data needed is not under the immediate control of the hospitals.
- Hospitals do not currently have effective analytic tools to analyze and get to some of the patterns of care that need to be targeted.

“Clinically Specific Conditions and Considerations for Tracking Readmissions”
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Scope of the Problem

Medicare Expenditures for Readmissions

- 18-20% (1/5th) of Medicare Beneficiaries readmit within 30 days of discharge
- 33% (1/3rd) readmit within 90 days
- Readmissions have a 0.6 day longer LOS than other patients in the same DRG
- Medical causes dominate readmissions
- Estimated cost to Medicare: \$15 to \$18.3 billion in annual spending

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.



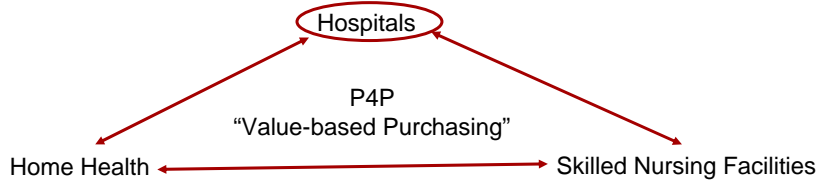
CMS is targeting readmissions

- CMS is targeting readmissions to the hospital within 30 days of discharge as a probable marker for both poor quality of care and money going down the drain.
- While CMS weighs Medicare reimbursement cuts for readmissions, it also is investing in strategies to lower readmission rates to improve quality of care.
- One CMS-funded study by the Medicare quality improvement organization (QIO) for Colorado found that coaching patients during and after their hospital stays can reduce readmissions by as much as 50%.
- CMS is funding as many as 18 QIO projects aimed at reducing readmissions in communities around the country.



What is CMS's "Game Plan"?

CMS recognizes there are System of Care Issues



Other important considerations:

- Patient responsibility/accountability
- Fee-for-service providers

CMS has initiated a two stage process:

- 1) Public disclosure of readmissions rates
- 2) Follow with payment changes

Medpac (June 2007). "Report to the Congress: Promoting Greater Efficiency in Medicare", p 105.



Hospital Readmission Rates

Hospital readmission rates for Medicare Beneficiaries

Percent of patients readmitted
to hospital within:

	7 days	15 days	30 days
Total	6.2%	11.3%	17.6%
Non-ESRD	6.0%	10.8%	16.9%
ESRD	11.2%	20.4%	31.6%

Note: ESRD: end stage renal disease

Source: Recreated from table within: Medpac (June 2007). "Report to the Congress: Promoting Greater Efficiency in Medicare", p 107.



Potentially preventable hospital readmission rates

Potentially preventable hospital readmission rates

Largest Potential Impact

Patients readmitted to hospital within:

	7 days	15 days	30 days
Rate of potentially preventable readmissions	5.2%	8.8%	13.3%
Spending on potentially preventable readmissions	\$5 billion	\$8 billion	\$12 billion

Source:

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.



Readmissions vary across states

- Jencks, et al. (2008) findings on readmission rates by state for 2004 Medpar discharges:

- 20.6% to 23.3% 14 states
- 19.6% to 20.5% 14 states
- 18.0 to 19.2% 12 states
- 13.4% to 18.0% 13 states

- States inpatient treatment intensity by quartiles indicate similar patterns by state with the readmission rate quartiles

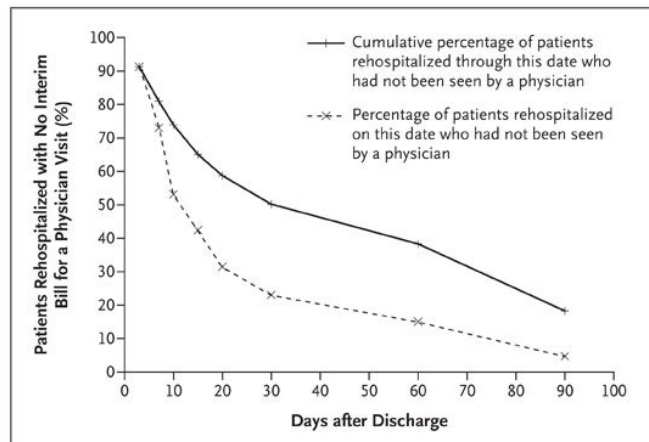
- Higher intensity = higher readmission rates by state
- Lower intensity = lower readmission rates by state

Jencks, S., Williams, M., & Coleman, E. (2008). "Rehospitalizations among medicare fee-for-service patients". Unpublished Manuscript.

Minott, J. (2008). "Report on One-Day Invitational Meeting January 25, 2008: Reducing readmissions", AcademyHealth.



Patients for Whom There Was No Bill for an Outpatient Physician Visit between Discharge and Rehospitalization



Jencks S et al. N Engl J Med 2009;360:1418-1428



Opportunities for Improvement: Fragmented Systems of Care

- Current delivery system is unsustainable and contributes to fragmented care
- To address readmissions we must examine characteristics and care processes along the care continuum.
 - *Before, during and after hospital readmission*
- Access to timely primary care is an issue with some areas of the nation impacted more heavily than others
- Coordinating care with multiple chronic conditions (2 or more) is challenging
 - *Many care givers involved with the delivery of care post discharge*
 - *Lack of clarity of the lead provider directing care*
- Transitions of care from inpatient to outpatient care are critical
- Lack of communication and lack of seamless information is an issue
 - *EMRs and team-based care across regions may help to create "systemness"*

Academy Health One-Day Invitational Meeting: "Reducing Hospital Readmissions". January 25, 2008



Best Practices for reducing hospital readmissions

- Discharge planning beginning on the day of admission for critical events
- Medication reconciliation-another opportunity for health information exchange improvements
- Transitional care models with needs assessments and education from advance practice nurses during admission and post discharge (36% reductions in readmissions)
- Collaborative models between states and providers financially incenting improving readmissions



Academy Health One-Day Invitational Meeting: "Reducing Hospital Readmissions". January 25, 2008

Policy Implications:

- Healthcare financing systems do not currently reinforce initiatives to decrease readmissions
- Providers have no financial incentive to reduce readmissions
- Routinely measuring and publically reporting readmissions will apply pressure to improve care
- In order to effectively implement public reporting measurements must be carefully crafted and considered to promote shared accountability.
- Consider public reporting followed by financial incentives
- Consider financial impacts on the hospitals within your state as reducing readmissions will impact hospitals margins (small hospitals and public hospitals operate on very thin margins)



Academy Health One-Day Invitational Meeting: "Reducing Hospital Readmissions". January 25, 2008

To Examine the issues States might consider?

- What is the prevalence of hospital readmissions within 7-30-90 days among the enrolled Medicaid or state population?
- What are the patient propensity and subsequent care factors associated with a hospital readmission for the State &/or Medicaid population?
- What are the most prevalent disease or diagnostic conditions associated with hospital readmission for the State &/or Medicaid population?
- What are the costs of hospitalization for readmitted and non-readmitted State &/or Medicaid population?
- What are the risk factors associated with hospital readmission among the State &/or Medicaid population?



Suggested next steps:

- Clearly define the purpose of the Medicaid Improvement Initiative
- Clearly state the issues or questions you hope to address
- Decide on data requirements
- Develop data dictionaries and participation requirements & agreements
- Consider HIT tools available to support the effort
- Create multi-stakeholder groups to analyze and address the issues
- Budget/funding considerations



The BIG QUESTION:

How do we define readmissions and discern the readmissions that are preventable or should be preventable, and allow readmissions that are important for the safety of the patient?



The Readmission Conundrum

- Access to care issues, chronic illness, mental health infrastructure challenges, patient non-compliance, AND provider quality, are likely etiology to the problem.
- Providers will need community partnership and good data and information to effectively address readmissions.

Sample Reports Provided on one organization attempting to address readmissions and quality of care



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2. McGlynn E, Asch S, et al. The Quality of Health Care Delivered to Adults in the United States. *N Engl J Med* 2003;348:2635-45.
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