Strategies to Reduce 30 Day Readmissions

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Overview

Objectives

- Provide Historical Background on Hospital Readmissions
- Review the LTCH QRP 30 Day Readmission Measure
- Discuss Hospital Data Reports Released by CMS
- Review Common Areas of High Rates and Effective Readmission Prevention Programs
Background

Hospital Re-Admissions

- Public reporting began in 2009
  - Hospital Readmission Reduction Program (HRRP) in 2012
    - AMI, CHF, Pneumonia, COPD, and total knee/hip surgery
    - Penalties up to 3% (of all base DRG payments)
    - Based on the patient’s primary discharge diagnosis during
      the initial STACH encounter
  - Impact on IPPS Reimbursement
  - Effort to transition from fee-for-service to value-based care
National Medicare Readmission Rates Started to Fall in 2012

Diagnosis for initial hospitalization:
- Heart Failure
- Heart Attack
- Pneumonia

NOTES: National readmission rates include Medicare fee-for-service unplanned hospitalizations for any cause within 30 days of discharge from an initial hospitalization for either heart failure, heart attack, or pneumonia. Rates are risk-adjusted for certain patient characteristics, such as age and other medical conditions.

SOURCE: Kaiser Family Foundation analysis of CMS Hospital Compare data files.
STACH Readmission Prevention Programs: Impact on Post-Acute Providers

Development of Post-Acute Care Networks

- Evolution and assessment of post-acute care providers
- Network narrowing
  - Increased control with reduced variations in care
  - Reputation for consistent quality
  - Longevity in the community
- Mechanism to control expenses and quality

Transitional Care Programs (Care Transitions)

- Dedicated ambulatory case manager/navigator
  - Following the patient across each level of care (including home)
  - Responsible for care coordination, communication, necessary follow-up, and patient/caregiver response (symptoms, follow-through, concerns)
Payment Initiatives
- Accountable Care Organizations
- Bundled Payments
  - Requires strategic post-acute positioning

Quality Initiatives
- Quality Reporting Program
  - Payment penalties
  - Public reporting

Care Coordination and Post-Acute Integration
- Readmissions
  - STACH readmission measure
  - LTCH readmission measure
Distribution of unadjusted unplanned readmission rates among LTCHs with at least 25 index stays, 2012-2013

Source: RTI analysis of 2012–2013 Medicare claims data
Measurement Overview

- All-Cause Unplanned Readmission Measure
- Data collection began in January 2015
- Claims-Based Measure
  - Medicare Fee-For-Service Patients
- Preliminary hospital reports released in November 2015
  - Calendar year 2012 through 2013 data
- QIES
- Public reporting will begin October 2016
  - Calendar year 2013 through 2014 data
Measurement Definition - Inclusion Criteria

- Those who are 18 years old or older and have been enrolled in Medicare Part A Fee-for-Service for 12 months prior to admission, and 30 days after discharge
- Must have had a prior hospitalization (STACH) within 30 days prior to the LTACH admission
- Discharged from the LTACH to a less intensive level of care
  - SNF
  - IRF
  - Home with Home Health
  - Community
- Must be followed 30 days post-discharge or until date of death (if death occurs before 30 days)
Measurement Definition - Exclusion Criteria

- Patients who expire during the LTACH stay
- Patients who are discharged to STACH or another LTACH
- Discharges Against Medical Advice (AMA)
- Patients whose prior hospital stay was for the medical treatment of Cancer
  - Defined by CMS Inpatient QRP
Measurement Definition - Numerator

- Related to the subset of stays in the denominator
- Unplanned acute (STACH) or LTACH admission within 30 days post-discharge
- Numerator excludes patients who are readmitted with a planned hospital stay
  - CMS planned readmission algorithm used in the inpatient QRP
  - Additional planned procedural codes (TEP)

Measurement Definition - Risk Adjustment

- Principal diagnosis
  - Based on prior hospital claim
- Comorbidities
  - Secondary diagnoses based on hospital claims x 1 year
- Age/Sex grouping
- Prior acute length of stay
- Prior acute ICU or CCU days and utilization (# of STACH d/c’s x 1 year)
- Ventilator - prolonged ventilations (LTCH procedure code)
Distribution of risk standardized readmission rates (RSRR) among LTCHs with at least 25 index stays, 2012-2013
CMS Provider Reports

Public Reporting Process
- CMS provider training call on the readmission measure
- Preliminary reports posted in November 2015
  - QIES
- Follow-up Call regarding reports and common Q&A’s
  - Submit questions!

Report Overview
- Count table
  - Number of eligible stays
  - Number of readmissions
  - Number of planned readmission
- Comparative table
  - Comparative performance
  - Crude readmission rate
  - Standardized Risk Ratio (SRR)
  - Risk Standardized Readmission Rate (RSSR)
Hospital Data

- External Sources
  - CMS dry run reports (2012-2013)
  - PEPPER reports (annually)
  - Post Acute Network
    - STACHs
    - Contracted agencies
- Internal Sources
  - Follow-Up Calls

Data Analysis

- External analysis provides comparative data/risk-adjustments
- Internal analysis provides insight into contributing factors and opportunities
- Opportunities
  - Based on above analysis
- Actions
  - Admission (predictive modeling/care management)
  - Post-Admission (care coordination and follow-up)
Identify Opportunities

- Hospital Specific
  - Population driven
  - Market driven

Actions

- Admission (predictive modeling/care management)
- Post-Admission (care coordination and follow-up)
Approaches in Readmission Prevention

Disease Specific Approach
- Identify target disease/clinical specific opportunities
  - CHF, MI, Pneumonia
  - Respiratory failure
  - Sepsis
- Protocols
- Linear Approach
- Resource Intense

Comprehensive Approach
- Tactics for all cause readmissions
- Includes care management and coordination post-discharge for all patients
- Increases Post-Acute Integration
  - With STACH
  - With other Post-Acute Providers
Risk Assessment and Planning

- Data capture is key!!
  - Electronically
    - Health Information Exchanges (HIE)
    - Software
  - Manually
    - Clinical liaison/navigator
    - Nursing
    - Pharmacy
    - Case Management
    - Physician
Admission Phase

Risk Assessment

- Pre-admission screening assessment
  - Integral in health information exchange from STACH to LTACH
- Nursing
  - Medical
    - Acute care diagnosis and comorbidities
    - Number of hospitalizations in the past 12 months
    - Knowledge of clinical risks and complications
  - Demographics
  - Other pertinent history (medical and social)
- Medication Management
- Baseline literacy levels
- Pharmacy
  - Medication reconciliation (admission/discharge)
  - Medication management
    - Genetic testing results
Risk Assessment

- Case Management
  - Social component
    - Living situation
    - Care providers/support systems
  - Transportation
  - Food and hydration sources
- Physician
  - PCP Availability
  - Knowledge of medical risks and complications

Goal of the risk assessment is to identify high risk patients...
Five Primary Reasons for Hospital Readmissions

- Patients do not fully understand what is wrong with them
- Patients may be confused over which medications to take and when to take them
- Hospitals do not provide the patient or other care providers with important information or test results
- Patients do not schedule a follow-up appointment with their doctor
- Family members lack the proper knowledge to provide adequate care

Source: Dartmouth Institute; Kahn 2013
Physician Orders for Life-Sustaining Treatment (POLST)
- Patient chart
- On or near the door of a patient’s room
- Sent with patient at time of transfer

Disease Management
- Clinical Monitoring and Interventions
  - Protocols
  - Early identification of signs and symptoms
- Transitioning patient/caregiver ownership in the disease management process

Genetic Testing
- Increasing utilization in Home Health and SNF’s
- Only covered by Medicare Part B
Care Management Tactics

Patient Education
- Disease processes
  - Clinical risks and complications
  - Precautions
  - Signs and symptoms... AND what to do!
- Medication Management
  - Medication administration schedule
    - Transition to self or caregiver administration
- Education and return demonstration

Promoting Self-Management
- Individualized care management process
  - Medical conditions
  - Home environment
  - Social history
  - Patient literacy
  - Patient/caregiver response
Genetic Testing

- Increasing utilization in Home Health and SNF’s
- Covered under Medicare Part B
- Significant impact on medication management
  - Improved medication regimens unique to patient
  - Reduces medication errors
  - Lowers overall medication costs
- Explore options or integrate into physician discharge orders
Care Transitions/Discharge Planning

National Transitions of Care Coalition (NTOCC)
- Medications management
- Transitioning planning
- Patient and family engagement and education
- Information transfer
- Follow-up Care
- Healthcare provider engagement
- Shared accountability across providers and organizations

Medication REACH (Pioneered by Einstein Healthcare Network)
- Reconciliation
- Education
- Access
- Counseling
- Health patient at home
Transition Planning

Information Exchange
- Patient/family
  - Discharge instructions
- Post-Acute providers
  - Continuity of care
- Referring physician
- Primary Care Physician

Post-Acute Integration/Networks
- Skilled Nursing Facilities
- Home Health Agencies

Local Transitional Care Programs
- Hospital specific programs
  - BOOST
  - CTI
- Community programs
  - Agencies
Post-Discharge Tactics

**Post-Discharge Appointments**
- Primary Care Physician
- Specialty Physicians
- Services
- Home Health Agencies

**Post-Discharge Follow-Up**
- Phone calls
  - Seventy-two hours
  - End of first week
  - Thirty days post-discharge

**Other Service Offerings**
- Remote monitoring
- Ambulatory case management
LTACH Tactics

Health Information Exchanges
- STACHs
- Other post-acute providers

Networks
- Hospital
  - Are you in or out?
- Post-Acute Care
- Community

Contract Alignments
- Health plans

Consistent Marketing Plan
- Referral specific
- Consistent data
LTACH Discharge Disposition

- SNF: 28% (CY 2012), 27% (CY 2013), 27% (CY 2014), 28% (CY 2015 YTD)
- Community: 12% (CY 2012), 10% (CY 2013), 10% (CY 2014), 11% (CY 2015 YTD)
- STACH: 6% (CY 2012), 6% (CY 2013), 7% (CY 2014), 7% (CY 2015 YTD)
- IRF: 6% (CY 2012), 6% (CY 2013), 7% (CY 2014), 7% (CY 2015 YTD)
Summary: Readmissions

**Individualized Approach**

- Data - do you have it?
  - Acute transfers
  - Thirty day readmissions
  - Patient-level data

- Priorities - what is your focus?
  - Care management
  - Care transitions
  - Post-discharge
  - Network integration
    - STACH
    - SNF
Resources/References

Interventions to Reduce Acute Care Transfers (INTERACT)
http://interact2.net

Project BOOST
(Better Outcomes for Older Adults Through Safe Transitions)

Bridge Model (Enhanced Discharge Planning Program)
www.transitionalcare.org

Care Transitions Interventions (CTI) model
www.caretransitions.org

Readmission Prevention: Solutions Across the Provider Continuum
Questions?
assistance@ltrax.com

Next: January 7, 2016
Ventilator Associated Events