MANAGING HOSPITAL READMISSIONS

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March 27, 2014 (9:30 a.m. – 10:30 a.m.)
2014 NAMDRC 37th Educational Conference
Dr. Hamrick and Ann Latstetter have declared no conflicts of interest related to the content of their presentation.
Agenda

• The Why: Macroeconomics
  ▫ Debt
  ▫ Demographics
  ▫ Inflation
  ▫ Healthcare spending
  ▫ Clinical Variation

• The What:
  ▫ Pay for performance programs,
  ▫ Barriers to managing readmissions and
  ▫ Transitional care management programs/reimbursement

• What Makes a Hospital/Continuum of Care Program?
  ▫ Our Challenges
  ▫ Our Program
  ▫ Our Performance

• Wrap Up/Questions
The Why

Macroeconomics:
• Debt
• Demographics
• Inflation,
• Health Care spending and
• Clinical Variation
National Debt: 1940 - Present

$17,263,138,579,876.41

Source:
http://www.brillig.com/debt_clock/faq.html
Historical and Projected Number of Medicare Beneficiaries and Number of Workers per Beneficiary

Health Expenditures as a Share of GDP, OECD countries, Fact Book 2013

OECD Total: 9.50

USA Total: 17.6
Historical Consumer Price Index
All Urban Consumers (CPI - U): U.S. city average by expenditure categories

Percent change from previous December

Medical Care Category Includes: Drugs, Equipment/Supplies, Medical professional services, Hospital/Nursing Home services, Invalids/Elderly care and Health Insurance

Continued Growth in Volume of Physician Services per Beneficiary 2000-2011

Note: Volume is units of service multiplied by relative value units from the physician fee schedule. Volume for all years is measured on a common scale, with relative value units for 2011.

Source:
2010 Medicare Reimbursement

2010 Price-Adjusted Medicare Payments Per Enrollee Ratio to U.S. Average

<table>
<thead>
<tr>
<th>State</th>
<th>Ratio</th>
<th>$ Per Enrollee</th>
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<tbody>
<tr>
<td>VIRGINIA</td>
<td>0.89</td>
<td>$8,506</td>
</tr>
<tr>
<td>National Average</td>
<td>1.00</td>
<td>$9,584</td>
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<tr>
<td>90th Percentile</td>
<td>1.10</td>
<td>$10,502</td>
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<tr>
<td>50th Percentile</td>
<td>0.95</td>
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<td>10th Percentile</td>
<td>0.80</td>
<td>$7,646</td>
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</tbody>
</table>

Source: Dartmouth Atlas
Dimensions of Variation

The American Health Care System is characterized by high variation locally and high variation across geography.

Essentially all provider institutions have an opportunity to address and improve 2 dimensions of variation by (a) comparing aggregated local, regional and national utilization rates and (b) by studying inter-physician variation locally.
Both **Utilization** and **Variation** among Regions has increased over time.

Variation in Utilization: Knee Replacement
Select HRRs 2010

National Average 9.0
90th Percentile 11.8
50th Percentile 9.4
10th Percentile 7.2

HRR = Hospital Referral Region
The What

- Pay for Performance Programs
- Barriers to Reducing Readmissions
- Transitional Care Management
% of Medicare Operating Reimbursement Tied to Clinical Care

* Initially the VBP applies to Medicare Only, but the law requires expansion to Medicaid
HOSPITAL VALUE BASED PURCHASING
Moving from Process to Outcomes

- Efficiency/Spending: 20%
- Core Measures (process of care): 20%
- Outcomes (Mortality, CLABSI, Patient Safety): 30%
- HCAHPS (Patient Experience): 30%

2015 VBP Section Weight

Value based Purchasing At-Risk Percentage: 1.50%
THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

the gift that keeps on giving
Hospital Readmission Reduction Program

- Unlike Value Based Purchasing, HRRP is a penalty.
- Based on 30 Day Unplanned All-Cause Readmissions
- Use of “Excess Readmission Ratio” (Actual / Expected) to calculate penalty
- Ratios based on THREE years of discharge data.

**Readmission Measures included in the HRRP:**

<table>
<thead>
<tr>
<th>AMI</th>
<th>Total Hip/Knee Arthroplasty (New FY2015)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Failure</td>
<td>Hospital Wide All Cause Unplanned (New FY2015)</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>Stroke (New FY 2016)</td>
</tr>
<tr>
<td></td>
<td>COPD (New FY2016)</td>
</tr>
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</table>

[http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html);
Hospitals can either maintain full payment levels or be subject to a hospital-specific payment penalty of up to 3.0 percent. This capped reduction amount will increase to 3.0 percent.
READMISSION CRITERIA

- **30-day time frame:** Outcomes occurring within 30 days of discharge can be influenced by hospital care and the early transition to the outpatient setting. The use of the 30-day time frame is a clinically meaningful period for hospitals to collaborate with their communities in an effort to reduce readmissions.

- **All-cause unplanned readmission:** From a patient perspective, an unplanned readmission from any cause is an adverse event. Planned readmissions are generally not a signal of quality of care.

- **Principal discharge diagnosis of AMI, HF, Pneumonia, COPD or Total Hip/Total Knee Arthroplasty.**

- **Enrolled in Part A and Part B Medicare** for the 12 months prior to the date of admission, and enrolled in Part A during the index admission

- **Aged 65 or older:** Medicare patients < 65 are not included in the measure because they are considered to be too clinically different from patients 65+

- **Multiple readmissions within 30 days of discharge only count as 1 outcome event**
TWO MIDNIGHT RULE

- CMS recognizes that the physician's medical judgment plays an important role in determining Inpatient or Outpatient status.
- CMS establishes a two midnight benchmark for physicians to use when determining whether to order IP admission or outpatient hospital care:
  - Physician should generally order Inpatient admission
    - If the patient requires hospital care that will **cross two midnights**
    - If the procedure to be performed is on the Medicare IP only list
    - Must meet all documentation requirements: order, certification and medical record documentation
  - Physician should treat the patient as an outpatient
    - If the physician expects to keep the patient in the hospital for only a limited period of time that does not cross two midnights.
    - If difficult to make a reasonable time prediction as to the patient’s length of stay, the physician should place the patient in outpatient status with or without observation services.
READMISSION EXCLUSION

- **In-hospital deaths:** Patients are not eligible for readmission.

- **Transfers to another acute care facility:** Readmission is attributed to the hospital that discharged the patient to the non-acute care setting.
  - Transferred patients are still included in the measure cohort, but the initial admitting hospital is not accountable for the outcome.

- **Discharged against medical advice (AMA):** Providers did not have the opportunity to deliver full care and prepare the patient for discharge.

- **Without at least 30 days of post-discharge enrollment in FFS Medicare:** Readmission outcomes cannot be assessed in this group since claims data are used to determine whether or not a patient was readmitted.

2013 (Year 1): % of Hospitals Receiving a Readmission Penalty by State

US Average: 66%;
Average penalty: 0.28%

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html; FY2013 IPPS Final Rule: Hospital Readmission Reduction Program Supplemental Data file
2014 (Year 2): % of Hospitals Receiving a Readmission Penalties by State

US Average: 66%; Average penalty: 0.38%

<table>
<thead>
<tr>
<th>Name</th>
<th>FY2013 Readmit Penalty (3Q08-2Q10)</th>
<th>FY 2014 Readmit Penalty (3Q09-2Q11)</th>
<th>Change</th>
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</thead>
<tbody>
<tr>
<td>CJW</td>
<td>0.05%</td>
<td>0.04%</td>
<td>↓</td>
</tr>
<tr>
<td>HDH</td>
<td>0.00%</td>
<td>0.00%</td>
<td>↔</td>
</tr>
<tr>
<td>JRMC</td>
<td>0.37%</td>
<td>0.27%</td>
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<tr>
<td>LGMC</td>
<td>0.64%</td>
<td>0.81%</td>
<td>↑</td>
</tr>
<tr>
<td>LGHA</td>
<td>0.25%</td>
<td>0.65%</td>
<td>↑</td>
</tr>
<tr>
<td>LGHM</td>
<td>0.31%</td>
<td>0.38%</td>
<td>↑</td>
</tr>
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<td>LGHP</td>
<td>1.00%</td>
<td>1.59%</td>
<td>↑</td>
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<tr>
<td>SRMC</td>
<td>0.21%</td>
<td>0.33%</td>
<td>↑</td>
</tr>
<tr>
<td>HCA Virginia</td>
<td>0.32%</td>
<td>0.45%</td>
<td>↑</td>
</tr>
</tbody>
</table>

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html; FY2013 IPPS Final Rule: Hospital Readmission Reduction Program Supplemental Data file
RESULTS: MEDICARE PER CAPITA SPENDING GROWTH AT HISTORIC LOWS

Source: CMS 02/27/14 Aspen Institute Care Innovation Summit; “Innovation and Health System Transformation”; Dr. Patrick Conway
MEDICARE ALL CAUSE, 30 DAY HOSPITAL READMISSION RATE

Source: CMS 02/27/14 Aspen Institute Care Innovation Summit; “Innovation and Health System Transformation”; Dr. Patrick Conway
Barriers to Reducing Readmissions Rates

1. Access to primary care
2. Access to hospice care
3. Medication adherence
4. Access to transportation
5. Cannot afford prescriptions
6. Health literacy
7. Access to health insurance
8. Family/caregiver support
9. Cultural barriers
10. Patient Handoffs

TRANSITIONAL CARE MANAGEMENT

• Health care professional accepts care of the beneficiary post discharge from the facility without a gap.

• The 30 day transitional care management period begins the date the beneficiary is discharged from the inpatient hospital setting and continues for the next 29 days.
  ▫ Three Components:
    • An interactive contact within 2 business days following discharge,
    • Certain non face-to-face services: obtain/review discharge information, provide education, arrange community resources
    • A face to face visit: One visit within:
      • 7 days of discharge for high complexity patients
      • 14 days of discharges for moderate complexity patients

• 2013 physician payment rule – CMS announced new payment codes to incentivize ambulatory care providers to participate in transitional care management.

WHAT MAKES A HOSPITAL PROGRAM?

CONTINUUM OF CARE
Preventing Unnecessary Readmissions

• Readmission rates are already publicly available on Hospital Compare, payment penalties for excess readmissions have taken effect.

• Hospitals are being held **accountable** for care provided beyond their four walls.
  • **We need to improve care coordination and data connectivity from the hospital to the discharged environment.**
  • **Need to change how we do our work.**
WHY FOCUS ON READMISSIONS?

• CMS is committed to promoting high quality health care and improving patient health outcomes.

• Readmission to a hospital may be an adverse event for patients and many times imposes a financial burden on the health care system.

• Successful efforts to reduce preventable readmission rates will improve quality of care while simultaneously decreasing costs.

• MedPAC identified 7 conditions and procedures that accounted for almost 30 percent of potentially preventable readmissions:
  • **Heart failure; COPD; Pneumonia; AMI; CABG; PTCA; and other vascular procedures**
TOP 20 MOST EXPENSIVE INPATIENT CONDITIONS

1. Septicemia (except in labor) — $20.3 billion
2. Osteoarthritis — $14.8 billion
3. Complication of device, implant or graft — $12.9 billion
4. Liveborn (general childbirth) — $12.4 billion
5. **Heart attack** — **$11.5 billion**
6. Spondylosis, intervertebral disc disorders, other back problems — $11.2 billion
7. **Pneumonia (except caused by tuberculosis and STDs)** — **$10.6 billion**
8. **Congestive heart failure** — **$10.5 billion**
9. Coronary atherosclerosis — $10.4 billion
10. **Adult respiratory failure** — **$8.7 billion**
11. Acute cerebrovascular disease — $8.4 billion
12. Cardiac dysrhythmias — $7.6 billion
13. Complications of surgical procedures or medical care — $6.9 billion
14. **Chronic obstructive pulmonary disease and bronchiectasis** — **$5.7 billion**
15. Rehab care, fitting of prostheses and adjustment of devices — $5.5 billion
16. Diabetes mellitus with complications — $5.4 billion
17. Biliary tract disease — $5.1 billion
18. Hip fractures — $4.9 billion
19. Mood disorders — $4.8 billion
20. Acute and unspecified renal failure — $4.7 billion

2011 across all payers, according to the AHRQ brief. The figures represent the hospital’s cost to produce the services; not the amount paid for services by payers and they do not include the physician fees associated with the hospitalization.
Geometric Mean Length of Stay 2008–2014
Contain cost prior to enactment of ACA

Source: CMS Table 5 List of MS-DRGs relative weighting factors and geometric and arithmetic mean length of stay
MANAGED CARE IN CONTROL

- Argue for additional days
  - Care Pathways
# COPD ADMISSION CRITERIA 2006

## Acute Respiratory / Chest

### SEVERITY OF ILLNESS

(Onset within 1 wk)

**RULE:** ≥ One SI

### CLINICAL FINDINGS

- **Asthma / Wheezing, ≥ two:**
  - PEF 50-70% (0.50-0.70) after, ≥ one:
    - Aerosol bronchodilators ≥ 3 doses (one episode)
    - ER treatment 1-3h
    - OP treatment ≥ 2d
    - Second OP visit (one episode)
  - *Moderate risk factors, ≥ one:
    - Difficulty perceiving airflow obstruction / its severity
    - Hx of sudden severe exacerbation
    - Illicit drug use
    - Low socioeconomic status and urban residence
  - Serious psychological problems
  - Respiratory rate ≥ 24/min, ≥ one:
    - Heart rate ≥ 120/min
    - Pco₂ ≥ 42 mmHg (5.6 kPa)
    - Po₂ ≤ 60 mmHg (6.0 kPa) / O₂ sat ≤ 91% (0.91)

Dyspnea and hemodynamic stability (systolic BP > 100), ≥ one:

- Arterial Pco₂ 45 - 54 mmHg (6.0-7.18 kPa) and arterial pH 7.31 - 7.35
- Continued deterioration despite ≥ 24h OP treatment
- Decompression sickness
- Heart rate > 100/min
- Hemoptysis > 50 mL
- O₂ sat < 89% (0.89) / Arterial Po₂ < 56 mmHg (7.5 kPa)
- Respiratory rate > 24/min
- Stridor
- Unresponsive to ≥ 2d OP corticosteroids / diuretics

### CLINICAL FINDINGS (Cont’d)

- **Hemoptysis, ≥ one:**
  - ≥ 200 mL/24h
  - Hct < 25% (0.25) (1)
  - Platelets < 60,000/cu.mm (60x10⁹/L)
  - Postural systolic BP drop > 30
  - PT ≥ 1.5x ULN (INR 2.0-3.0)
  - PTT ≥ 1.5x ULN

- **Hemothorax / Hydrothorax**
  - T > 104°F (40.0°C) PR ≥ one:
  - T > 102°F (38.9°C) PR, ≥ one:
    - WBC > 18,000/cu.mm (18x10⁹/L)
    - WBC > 15,000/cu.mm (15x10⁹/L) and > 7% (0.07) bands
  - T > 100.4°F (38.0°C) PR, ≥ one:
    - Absolute neutrophil count < 500/cu.mm (500x10⁹/L)
    - WBC < 1,500/cu.mm (1.5x10⁹/L)

### IMAGING FINDINGS

- Pleural effusion, post trauma
- Pneumothorax, spontaneous requiring chest tube
- Pulmonary edema / Heart failure
- Pulmonary embolus / infarct
- Pulmonary infiltrates ≥ 2 lobes (non-infectious)

### LABORATORY FINDINGS

#### Blood Gases

- Arterial Pco₂ > 51 mmHg (6.8 kPa)
- Arterial pH < 7.30
- Arterial pH > 7.50

#### Chemistry

- Carboxyhemoglobin 25-29% (0.25-0.29) and mental status change

---

Source: InterQual Criteria
COPD ADMISSION CRITERIA 2013

(Symptom or finding within 24h)
(Excludes PO medications unless noted)

RULE: Select Day, ONE

EPISODE DAY 1, One: \( T \) (1)

**OBSERVATION, One:** (G79)
- Persistent dyspnea following treatment with short-acting beta-agonist \( \geq 3 \) doses, **All:** (2, 3)
  - Oxygenation, **One:**
    - \( \text{O}_2 \text{ sat} \geq 92\% (0.92) \text{ or arterial } \text{Po}_2 \geq 60 \text{ mmHg (8.0 kPa)} \text{ (or baseline)} \) (G12)
    - \( \text{O}_2 \text{ sat} < 92\% (0.92) \text{ or arterial } \text{Po}_2 < 60 \text{ mmHg (8.0 kPa)} \text{ and < baseline requiring supplemental oxygen} \) (G83)
  - Bronchodilator \( \geq 6x/24h \) (includes MDI with spacer) (4)
  - Corticosteroid (includes PO) (5)
  - Oximetry or blood gas

**ACUTE, Both:** (G6)
- Persistent dyspnea following short-acting beta-agonist \( \geq 3 \) doses and continued deterioration despite 24h OP treatment,
  \( \geq \) **One:** (3, 6)
  - \( \text{O}_2 \text{ sat} < 89\% (0.89) \text{ and < baseline} \) (G12)
  - Arterial \text{Po}_2 40-55 mmHg (5.3-7.3 kPa) and pH 7.45-7.49
  - Arterial \text{PCO}_2 45-54 mmHg (6.0-7.2 kPa) and pH 7.31-7.35
- **Intervention, All:** (2)
  - Bronchodilator (includes MDI with spacer)
    \( \geq 6x/24h \) (4)
  - Corticosteroid (includes PO) (5)
  - Oxygenation, **One:**
    - \( \text{O}_2 \text{ sat} \geq 92\% (0.92) \text{ or arterial } \text{Po}_2 \geq 60 \text{ mmHg (8.0 kPa)} \text{ (or baseline)} \) (G12)
    - \( \text{O}_2 \text{ sat} < 92\% (0.92) \text{ or arterial } \text{Po}_2 < 60 \text{ mmHg (8.0 kPa)} \text{ and < baseline} \)

EPISODE DAY 1 (CONT’D)

**CRITICAL, Both:** (G27)
- Impending or actual respiratory failure, \( \geq \) **One:**
  - Arterial \text{Po}_2 \leq 39 mmHg (5.2 kPa)
  - Arterial \text{PCO}_2 \geq 60 mmHg (8.0 kPa)
  - pH \leq 7.24
  - Confusion, lethargy, or coma and change from baseline
- Corticosteroid, \( \geq \) **One:**
  - Bronchodilator (includes MDI with spacer)
  - q1-2h or continuous (4)
  - Mechanical ventilation or NIPPV,
    \( \geq \) **One:** (G77)
  - Respiratory interventions q1-2h (G93)
  - Weaning

Source: InterQual Criteria
## Reimbursement Per Case

<table>
<thead>
<tr>
<th>MS-DRG</th>
<th>Estimated DRG Operating Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>190 COPD w MCC</td>
<td>$5,808</td>
</tr>
<tr>
<td>191 COPD w CC</td>
<td>$4,786</td>
</tr>
<tr>
<td>192 COPD w/o CC/MCC</td>
<td>$3,520</td>
</tr>
<tr>
<td>193 Simple PNE &amp; pleurisy w MCC</td>
<td>$7,430</td>
</tr>
<tr>
<td>194 Simple PNE &amp; pleurisy w CC</td>
<td>$4,984</td>
</tr>
<tr>
<td>195 Simple PNE &amp; pleurisy w/o CC/MCC</td>
<td>$3,498</td>
</tr>
<tr>
<td>291 Heart failure &amp; shock w MCC</td>
<td>$7,461</td>
</tr>
<tr>
<td>292 Heart failure &amp; shock w CC</td>
<td>$5,077</td>
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<tr>
<td>293 Heart failure &amp; shock w/o CC/MCC</td>
<td>$3,358</td>
</tr>
<tr>
<td>280 AMI, discharged alive w MCC</td>
<td>$8,898</td>
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<tr>
<td>281 AMI, discharged alive w CC</td>
<td>$5,705</td>
</tr>
<tr>
<td>282 AMI, discharged alive w/o CC/MCC</td>
<td>$3,905</td>
</tr>
</tbody>
</table>
• With Value Based Purchasing/Pay for Performance and the Accountable Care Act priorities are focused around efficiency, clinical outcomes and continuum of care.

• Building block for Accountable Care organizations, medical homes, clinically integrated networks and beginning to take risk in population health management
In quality push, hospitals face Medicare penalty over readmissions

By Jordan Bau, Kaiser Health News
Wednesday, August 15, 2012 10:31am

WakeMed among Triangle hospitals fined for excessive Medicare readmissions

BY JOHN MURAWSKI
jmurawski@newsobserver.com  August 6, 2013

Most of region's hospitals to get penalties for readmissions

By Curtis Skinner, Inquirer Staff Writer
POSTED: August 14, 2013

Local hospitals hit with readmission penalties
WHERE’S THE LEVERAGE?
WHO OWNS IT???

IF EVERYONE OWNS IT....

......THEN NO ONE OWNS IT
**HOSPITAL READMISSION REDUCTION PROGRAM PREVIEW REPORT**

30 Day Risk Standardized Readmission Results for Federal Fiscal Year 2013 Program

Discharges between July 2008 - June 2011

<table>
<thead>
<tr>
<th>Hospital</th>
<th>AMI # of Eligible Discharges</th>
<th>Excess Ratio*</th>
<th>HEART FAILURE # of Eligible Discharges</th>
<th>Excess Ratio*</th>
<th>PNEUMONIA # of Eligible Discharges</th>
<th>Excess Ratio*</th>
</tr>
</thead>
<tbody>
<tr>
<td>CJW</td>
<td>513</td>
<td>0.9837</td>
<td>1205</td>
<td>0.9104</td>
<td>563</td>
<td>1.0283</td>
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<tr>
<td>HDH</td>
<td>344</td>
<td>0.9785</td>
<td>1009</td>
<td>0.9686</td>
<td>573</td>
<td>0.9030</td>
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<tr>
<td>JRMC</td>
<td>53</td>
<td>0.9639</td>
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<td>1.0426</td>
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<td>0.8747</td>
<td>627</td>
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<td>LGHA</td>
<td>23</td>
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<td>254</td>
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<tr>
<td>LGHM</td>
<td>55</td>
<td>1.0352</td>
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<tr>
<td>LGHP</td>
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<td>1.1414</td>
<td>203</td>
<td>1.1214</td>
<td>240</td>
<td>1.1102</td>
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## HCA Virginia: Richmond and Southwest Virginia Markets

<table>
<thead>
<tr>
<th>Name</th>
<th>FY 2014 READMIT PENALTY</th>
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<tbody>
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<td>CJW</td>
<td>0.04%</td>
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<td>0.65%</td>
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<tr>
<td>LGHP</td>
<td>1.59%</td>
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<tr>
<td>SRMC</td>
<td>0.33%</td>
</tr>
<tr>
<td>HCA Virginia</td>
<td>0.45%</td>
</tr>
</tbody>
</table>

Is this enough to change practice?

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html; FY2013 IPPS Final Rule: Hospital Readmission Reduction Program Supplemental Data file; FY2014 performance period 3Q09-2Q11
IMPORTANCE: DEPENDS ON YOUR VIEW

- Contracted for risk
  - You care about length of stay

- Bundled payments
  - You care about the episode of care
Challenge at HCA Capital

- Movement to value based contracts; readmit rules changing
- HCA Capital set out to ensure that its readmission numbers would meet or exceed national standards (23%) in the future. Generally, readmission numbers were good across the system, but one region’s readmission rates were a concern when compared with national standards; future penalties a concern.
- Leadership also looked to see where the system could take the biggest financial loss if readmission rates were to decline.
- Chronic Heart Failure Clinic had increased volume due to Medicare changes, but no additional staff resources.
- Tool and processes need to continue what they were doing in the clinic when the patient headed home and to follow up with patients NOT coming to the clinic but discharged with Heart Failure
Why So Difficult?

Many Factors Contribute to Complexity of Effective Care Management

**Lack of Visibility**
*into one patient*

- Incomplete view of the patient
- Siloed providers across the continuum
- Limited visibility into impact on productivity and outcomes

**Lack of Scalability**
*for thousands of patients*

- Limited Avenues for clinician communication
- Lack of centralized documentation
- Care manager volume constraints
- Lack of standardized care plans and guidelines
- Challenge predicting tomorrow’s high-risk patients
Six strategies were associated with significantly lower risk-standardized 30-day readmission rates:

1. Partnering with community physicians or physician groups;
2. Partnering with other local hospitals;
3. Having nurses take responsibility for medication reconciliation;
4. Arranging follow-up appointments prior to discharge;
5. Having a process in place to send all discharge papers or electronic summaries directly to the patient’s primary physician;
6. Assigning staff to follow up on test results that return after the patient is discharged.

“Our findings … underscore the potential value of greater coordination between hospital and other providers for addressing readmissions.”
Reducing Readmissions Requires Partnerships across providers lines

HOSPITAL

Admission to Hospital → Treatment in Hospital → Discharge Planning

Modified Treatment in Hospital?  Improved Discharge Planning?

Community

Community Physician → Home Health → SNF → DME

Improve Community Care & Self Management?

Outcome

“Poor Outcome” → Hospital Readmit → “Good Outcome”
• Protocol developed through use of tertiary setting has the ability to develop the state of the art post discharge care.

• Hospitals have access to the highest level of specialist and practitioners within the community.

• Protocols then shared with external support services such as SNF, Home Health, DME, etc.
HCA Capital Solution

- Utilize technology to standardize follow up in the 30-day post discharge period; protocols generated based on patient data and discharge disposition

- Engage sub-acute providers; users (HF APNS, home health and SNF staff) prompted to call or document on a patient within 72 hours of discharge and then weekly for a 30-day period

- Open communication lines – if HHA/SNF identifies an issue a note can be sent to alert the APN
Technology, Processes Critical to Scale Effective Care Management

Streamlining Every Stage of Care Management Process

1. Full Patient Dataset
   - Jane relies on having visibility across the care continuum to provide quality care.

2. Prioritized Patient Panel
   - Jane needs to plan her activities for the day based on her risk-stratified patient panel and current tasklist.

3. Focused Interventions
   - Jane needs to be aware of patient-specific interventions that will achieve the most optimal outcomes.

4. Balancing Workflow
   - Workflow process is crucial for Jane to engage the extended care team to complete interventions in an efficient, timely manner escalating acute events.

5. Results Tracking
   - Jane’s manager wants to track caseload progress across the entire team and observe patient outcomes.

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Identifying High-Risk Patients and Drivers of Readmissions

Follow-Up with Distinct Patient Populations
- Patient discharged with diagnosis of HF
- Patient followed up with by phone

Identify Readmission Risks at the Emergency Department
- Recently discharged patients arrive at the ED, quality staff alerted
- When possible, quality staff discuss next steps with ED prior to admission

Partnering with Community Providers
- Communication vehicle and enable community post-sub acute providers to discuss issues that may result in readmission
- Quarterly meetings engage community partners
HF MODEL: CHF 1-2-3

• Inpatient rounding (primary dx of HF)

• Telephone follow-up within 72 hrs post-discharge

• First visit with APN within 7 days of discharge (referral)
  ▫ Strong focus on medications, diet and patient education
  ▫ 2\textsuperscript{nd} visit with pharmacist & APN
  ▫ 3\textsuperscript{rd} visit with dietician & APN– all visits within 90 days

• Provide telephone triage for symptoms of fluid overload during clinic hours
FOR CONSIDERATION

- Interface with Emergency Department to intercept admit
- Use of rehabs: pulmonary, cardiac, physical
- Risk stratification
- Preventive Vaccines
- Education for DME, SNF, HHA care takers
- Develop Clinic
  - Optimize quality of life through smoking cessation, medication/inhaler education, diet/exercise, and stress reduction techniques.
- Thanks to Dr. George Burton
Successful Readmission Program

- A big part of preventing readmissions is increased use of community services such as home health, rehab, SNF etc.

- Tool to communicate with our community partners to ensure proper heart failure follow-up.
Connect with Post Acute Providers and Patients

- In September 2012 HF coordinators implemented a technology tool.
- The technology tool is a web-based platform that supports care coordination through protocols and date-driven tasks for managing patients post-discharge.

- Protocols are generated based on:
  - patient data
  - discharge disposition

- Protocols include queries related to medications, weight, signs and symptoms, diet and MD follow-up.
• Engage with physicians/groups as an extension of their office and practice (yes even independent physicians).

• Reaching out to community partners to strengthen transitions of care (home health, nursing home, care education)

• We enhance the quality of life for patients we are serving by building this partnership

• Provide a centralized electronic tool to remotely manage patients.
Connecting the Care Team

• Prior to readmission program implementation, HF follow-up was disjointed and inconsistent across patient dispositions. We now have a consistent method to follow every HF discharge.

• The benefits are measurable by decreased readmission rates and also immeasurable by anecdotes from patients, HF APNs and sub-acute providers.

• Many near misses have been caught via phone calls such as medication misunderstandings, unmade MD appointments and missed home health visits.

ANECDOTE

While reviewing a heart failure patient’s information, we noticed that the patient’s address was wrong in our system.

During the follow-up phone call, we discovered that the patient only had his large home O2 tank and had not received his portable tanks.

The O2 company had tried to deliver them to the wrong address.

The patient had NOT filled any of his medications because he could not leave his house without his oxygen.

We were able to determine the problem and coordinate the delivery of the O2 to the patient’s home and he could obtain his medications.

Source: Hospital Care Navigator
HF Readmissions Reduced Substantially in High and Low Performing Markets

**Southwest Market**
(including LGMC, LGHM, LGHP, LGHA)

- 35 Active Partner Organizations
- 32 Partners represent: (14) Home Health or (18) SNF

**Richmond Market**
(including CJW, HDH, JRMC)

- 71 Active Partner Organizations
- 51 Partners represent: (30) Home Health or (21) SNF

Source: Internal Metrics at Pilot sites
Heart Failure Readmission Rate
(Risk Standardized)

September 2012 – August 2013

Source: VHHA Final 3rd quarter 2013 report; Patients ages 18 or older residing in Virginia; Ranking based on State Ranking
AMI Readmission Rate
(Risk Standardized)

September 2012 – August 2013

Source: VHHA Final 3rd quarter 2013 report; Patients ages 18 or older residing in Virginia
Pneumonia Readmission Rate
(Risk Standardized)

September 2012 – August 2013

Source: VHHA Final 3rd quarter 2013 report; Patients ages 18 or older residing in Virginia
What NEW measures were added to the 2015 CMS Readmission Reduction Program?

a. AMI, Heart Failure, and Pneumonia
b. Hospital Wide All-Cause and Total Hip/Knee Replacement
c. Stroke and COPD
d. All of the above
What NEW measures were added to the 2015 CMS Readmission Reduction Program?

a. AMI, Heart Failure, and Pneumonia
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c. Stroke and COPD
d. All of the above
What is the 2015 CMS Readmission Reduction Programs penalty percentage?

a. 1.0%
b. 1.5%
c. 2.0%
d. 3.0%
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a. 1.0%
b. 1.5%
c. 2.0%
d. 3.0%

Answer: d. 3.0%
What is the 2015 CMS readmission Reduction Program performance period?

1. 3Q2008 - 2Q2011
2. 3Q2009 – 2Q2012
3. 3Q2010 – 2Q2013
4. All of the above
What is the 2015 CMS readmission Reduction Program performance period?

a. 3Q2008 - 2Q2011
b. 3Q2009 – 2Q2012
c. 3Q2010 – 2Q2013
d. All of the above

[Diagram showing percentages: 8%, 15%, 67%, 10%]
What are strategies to lower readmission rate?

a. Partnering with community physicians and physician groups
b. Arranging follow up appointment
c. Assign staff to follow up on test results
d. All of the above
What are strategies to lower readmission rate?

a. Partnering with community physicians and physician groups

b. Arranging follow up appointment

c. Assign staff to follow up on test results

d. All of the above

Correct answer: d. All of the above
What are barriers to reducing readmission rates?

a. Access to Primary Care  
b. Medication adherence  
c. Access to transportation  
d. All of the above
What are barriers to reducing readmission rates?

a. Access to Primary Care
b. Medication adherence
c. Access to transportation
d. All of the above

[Diagram showing distribution of options: 0% for a, b, and c, 100% for d]