Rehospitalization and Paying for Performance

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Message 1: Rehospitalization is our best opportunity to start reducing the fragmentation of health care.

Rehospitalization as symptom of fragmented care

- Many rehospitalizations result from care system failures in the transition from hospital to the next source of care.
- These care failures allow, and sometimes cause, the clinical deterioration that leads to rehospitalization.
- The failures reflect a lethal system design flaw.
- Our aim is to fix the system to prevent these care failures so the patient does not deteriorate and need rehospitalization.

Rehospitalization as a perfect crisis and opportunity

- Safety
- Cost
- Patient experience
- Urgency (trust fund bankrupt 2017)
- Growing momentum for change

Safety: A population at high risk

- 19.6% of live Medicare fee-for-service discharges are rehospitalized within 30 days.
- Two-thirds of Medicare fee-for-service medical discharges are rehospitalized or dead within a year.
- Half of Medicare fee-for-service surgical discharges are rehospitalized or dead within a year.

Cost

- At 30 days: about $17.4 billion trust fund dollars in 2004.
- Roughly 90% of 30-day rehospitalizations are unplanned and acute and therefore are targets for prevention.
- Achievable savings extremely uncertain, but clinical trials suggest 20-50% preventability.
- Costs to payers other than Medicare are roughly comparable.

Patient Experience

- Discharge-related elements get terrible scores on patient surveys.
- These reports do not tell us exactly what happened, but they do tell us what the patient experienced.

Evidence of growing momentum

- 250-400 hospitals engaged in collaborative projects to reduce rehospitalization
- 14 communities (QIOs)
- 3 states (STAAR)
- High likelihood of payment changes in Medicare to reward lowering rehospitalization rates (doesn't require major legislation).
- Growing recognition that this is not just a Medicare problem.

Rehospitalization as an opportunity

- This is a major opportunity to reduce fragmentation.
- If we succeed we have established a precedent for fixing other broken parts of the health care system.
- If we fail, not so good.

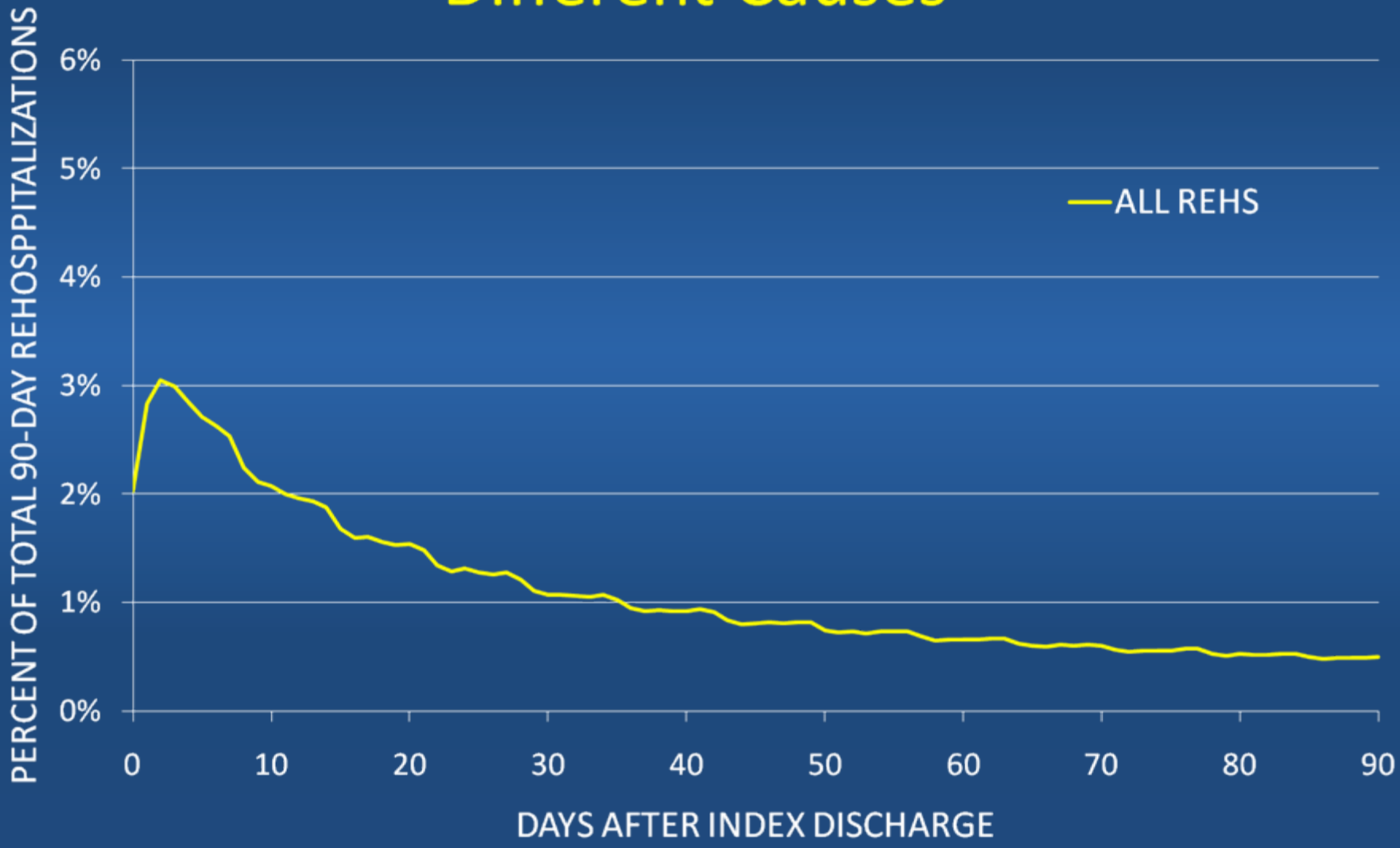
Clinical Causes of Rehospitalization

Message 2: Rehospitalization is very largely attributable to unplanned and potentially preventable causes.

Clinical Causes of Rehospitalization

- About 90 percent of all rehospitalizations seem to be related to the index hospitalization, and not be part of a treatment plan.
- The majority of rehospitalizations are not for the principal diagnosis of the original hospitalization (exceptions: chemotherapy and psychosis.)
- 70 percent of post-surgical hospitalizations are for medical reasons – largely conditions like pneumonia, heart failure, and gastrointestinal that cause most hospitalizations in the elderly.

Patterns of Rehospitalization for Different Causes



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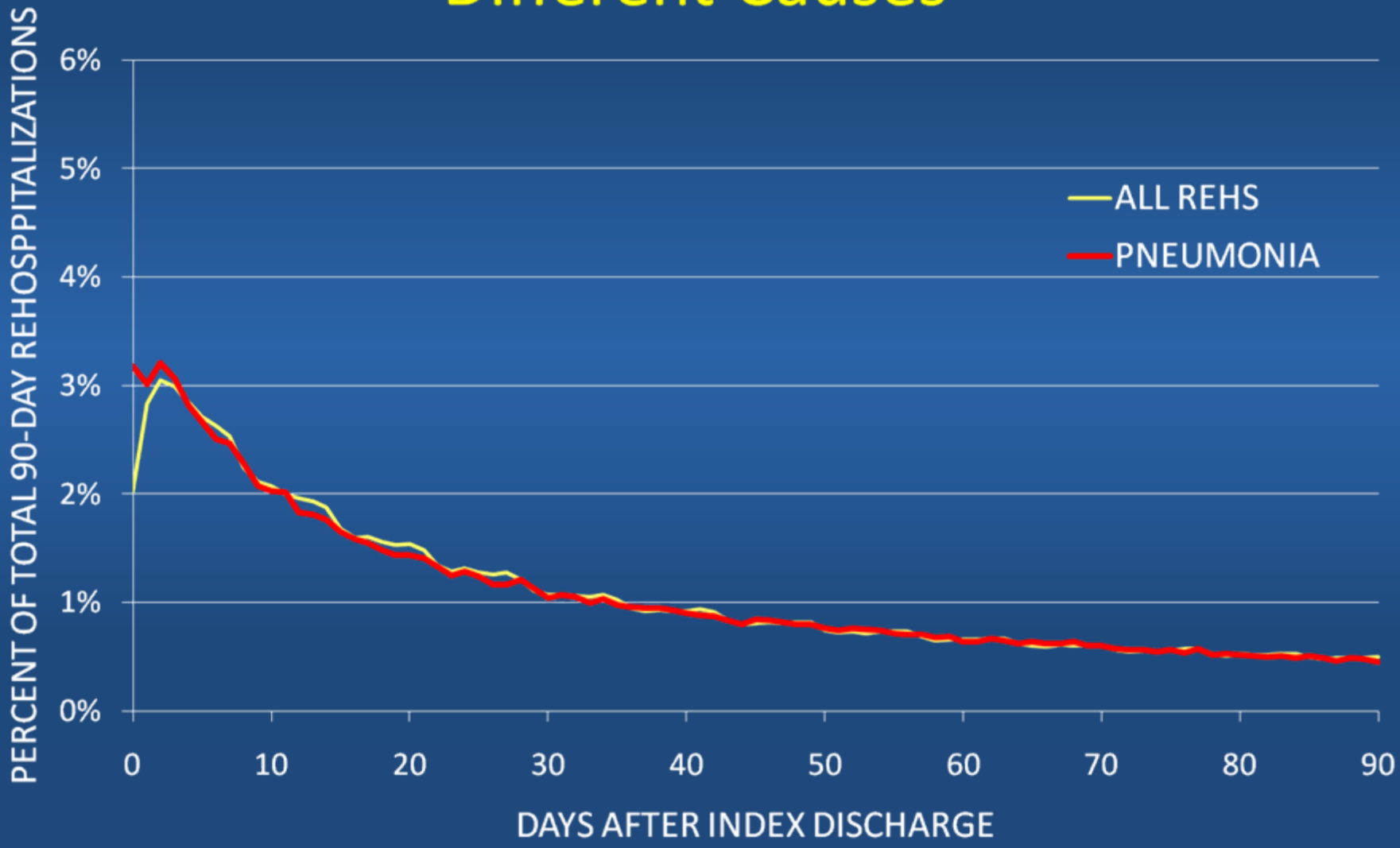

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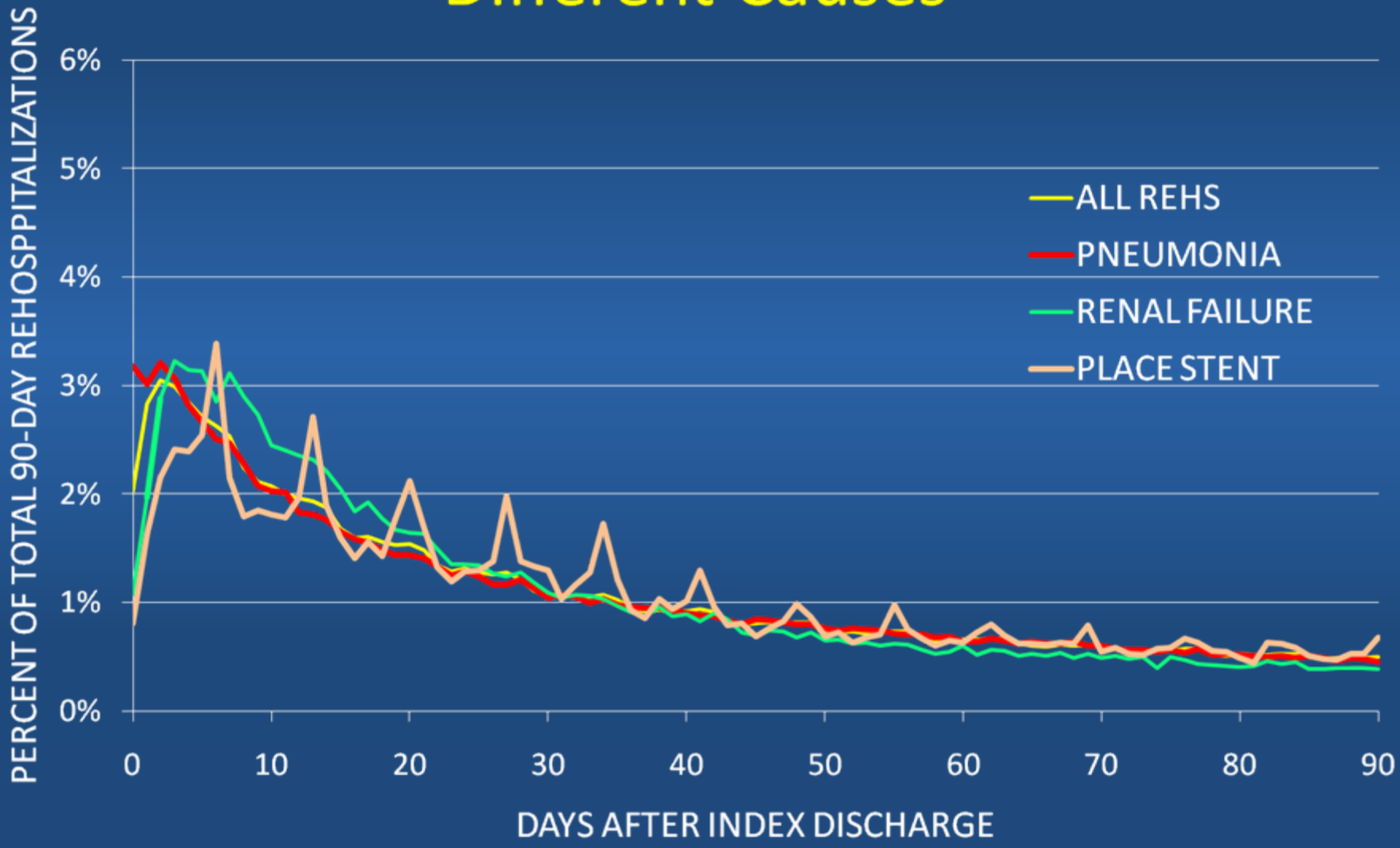

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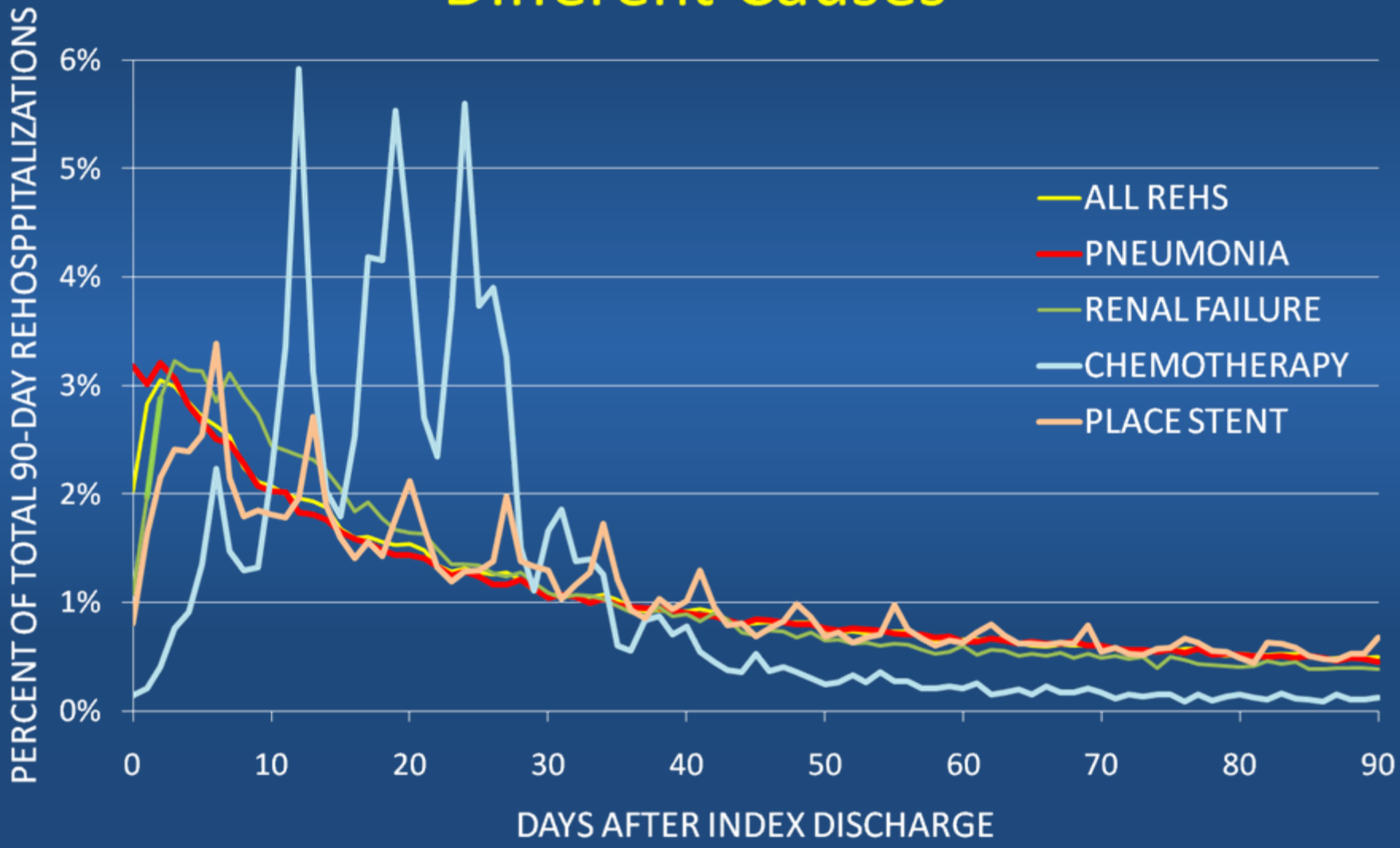

Measurement

Message 3: Measurement can be simple, transparent, and fair.

Issues for Measurement

- 15 v. 30 day window doesn't matter much
- Excluding rehospitalization for procedures removes most of the clearly problematic rehospitalizations.
- Excluding "clinically unrelated" rehospitalizations appears to require unreliable decisions and causes controversy.
- Risk adjustment may not have a large effect at the hospital or community level.

Purposes and risk adjustment

- Improvement: changes in measured rehospitalization rates are not very useful, but process measures are.
- Public information: risk adjustment is useful but so tricky that it may not be worth it.
- Payment: risk adjustment is very important.

Risk adjustment issues

- Most risk adjustment systems were built to predict mortality, not rehospitalization.
- The correlation of DRG-adjusted and unadjusted rates is >0.95.
- Evidence and logic suggest that a large part of case mix variation is the result of recycling.
- Trends are hard to interpret when the numerator and the denominator are both changing.

Balancing measures

Purpose: measure possible unintended effects

- Observation days
- ED return rate
- 31-35 days rehospitalization rate

Four objectives:

At discharge:

1. Every patient/family knows what medications to take and can get them.
2. Every patient/family knows the signs of danger and who to call if they occur.
3. Every patient/family has a prompt follow-up appointment and can keep it.
4. Every patient/family understands and can follow diet and activity limitations.

Measuring success on the objectivess

Ask the patient and the family

- Ask at before discharge
- Ask those who are rehospitalized

Processes believed to be effective

- Risk screening
- Discharge protocols
- Medication reconciliation
- Family and patient education with teachback
- Coaching/Care Transition Management
- Coffee and donuts
- Contact point/follow-up call.
- Follow-up appointments/visits
- Prompt information forwarding
- Nursing home protocols

We do not know which work best.

Propelling Change

Message 4: P4P in some form is probably necessary, but relying exclusively on P4P is dangerous.

P4P

- Reward low rehospitalization rates or penalize high rates. Bundling post-acute services is another strategy.
- Generally directed at hospitals, but other providers and practitioners are vital partners.
- Starting with Medicare?

P4P – Intended effects

- Incentive:
  - Creates the financial case that hospitals and improvement advocates have said is necessary.
- Message
  - This matters
  - We no longer penalize you for doing it right
  - We reward, or at least prevent penalties, if you succeed

P4P – Risks

- Access barriers
  - Diversion of recently-hospitalized patient in the ER into extended ER/observation stays.
  - Delays of rehospitalization by physicians called for advice or disposition
  - Damage to safety net providers because the poor are at higher risk.
- Cheating and dysfunctional responses.

Some promising strategies to supplement P4P

- Leadership
- Technical assistance
- Community partnerships
- Measure standardization
- Rapid data availability
- Patient/family empowerment
- Accreditation and licensure

How Do We Start?

Message 5: Local initiatives are the starting point.

Reasons to hope:

- Project RED (ReEngineering Discharge) -- Jack
- Transitional Care Model -- Naylor
- Care Transitions Program -- Coleman
- Evercare Model
- Community Care of North Carolina
- Many heart failure projects

Steps forward

- QIO Care Transitions
- IHI-Commonwealth Project STAAR
- SHM Project Boost
- ACC Hospital 2 Home
- Many state level activities
- Very limited national leadership so far

Courage

- Overcoming fragmentation and reducing rehospitalization will be really hard work.
- Those who are comfortable with the status quo will resist change actively and passively.
- If we blow this one we are in very deep trouble.
- We know a lot about how to do this work
- We have momentum and allies as never before.