Overview of Readmissions Policy: Implications for Hospital Operations and Finance

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Presentation Outline - Premises

Hospital Readmissions are a significant issue

Policy-makers are considering readmissions as a central issue for budget and healthcare reform

There are very promising uses of technology-enabled innovation

Leading industry efforts at improving hospital readmissions performance have a relatively small technology component

Achieving major performance improvement will require a thorough understanding of technology issues, capabilities, and adoption strategies

Hospital Readmissions are a Significant Issue

Readmission rates and spending are significant

- Aggregate levels of readmissions and related cost are high
- Current measurement, especially at the local level, likely underestimates the scale of the problem
- The implications for hospital finance are high – particularly if there is any movement toward methodologies like bundling and penalties for poor performance.
- Readmissions are intimately tied to a wide range of operational issues

Reducing readmission rates is both important and feasible

- Many readmissions viewed as preventable
- Wide variation in readmission rates between different hospitals, plans and geographic areas suggests room for improvement

Readmissions Data: Medicare Claims 2003-2004 (Jencks, et al.)

Readmission rates are high

- 19.6% of Medicare beneficiaries discharged from a hospital were readmitted within 30 days

Institutional readmission rates significantly understate the size of the issue

- 24.4% of rehospitalized patients were admitted to another facility
- 44.2% of patients in hospitals with fewer than 1,000 discharges were admitted to another facility

Cost of readmissions is high

- The estimated cost to Medicare of unplanned rehospitalizations in 2004 was $17.4 Billion

Readmissions are intimately tied to a wide range of operational issues

- Roughly 90% of rehospitalizations within 30 days appear to be unplanned and the result of clinical deterioration
- 50.2% of rehospitalized patients had no evidence of a bill for a visit to a physician's office

Readmission Data (cont'd)

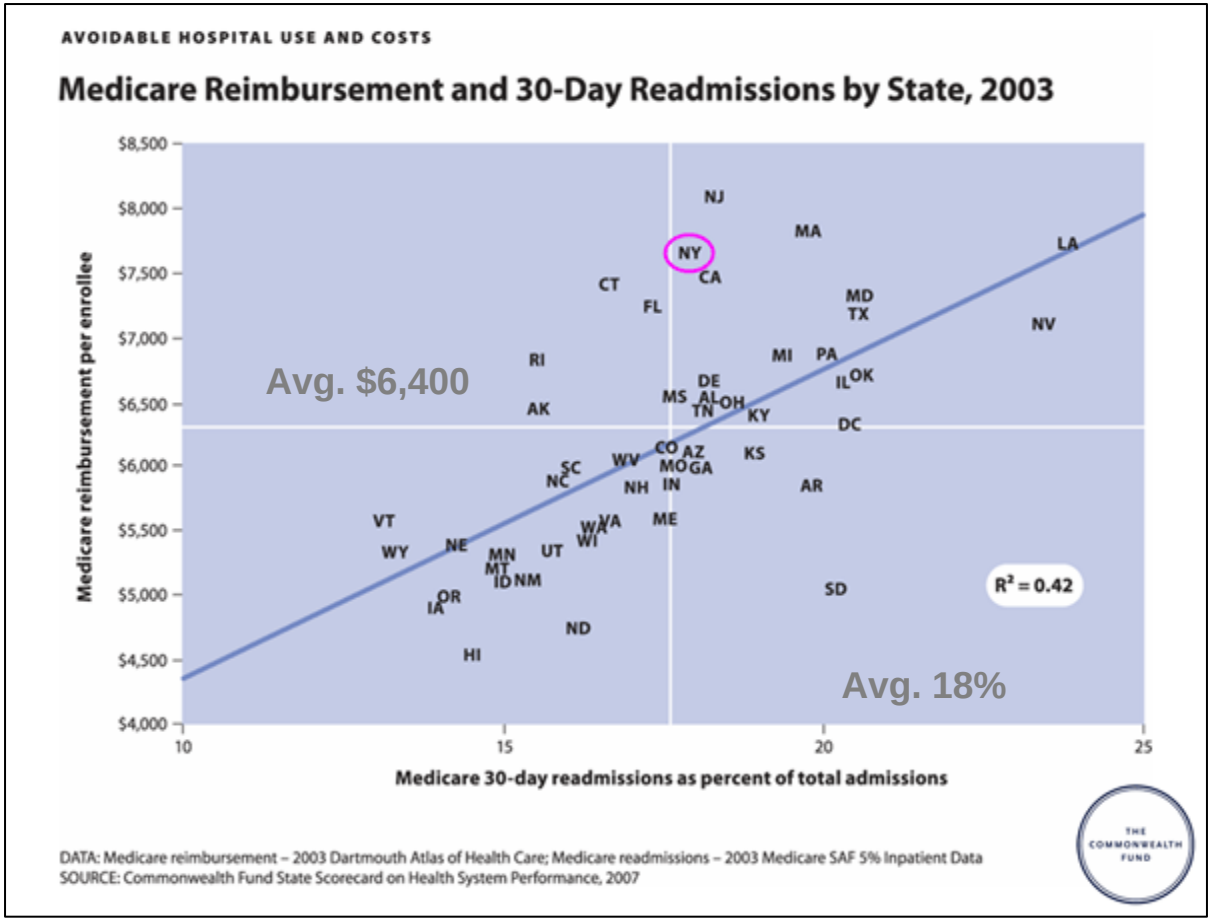
Many readmissions are viewed as preventable

- AHRQ study found that ~20% of patients had at least one preventable readmission within 6 months

Wide variation in readmission rates between different hospitals, plans and geographic areas suggests room for improvement

- Jencks, et al. found that rehospitalization rate was 45% higher in the five states with the highest rates that in the five states with the lowest rates
- PacifiCare Health System found that readmission rates at hospitals ranged from 0-44% for its enrollees

Data Demonstrates Wide Variation in Readmissions Performance

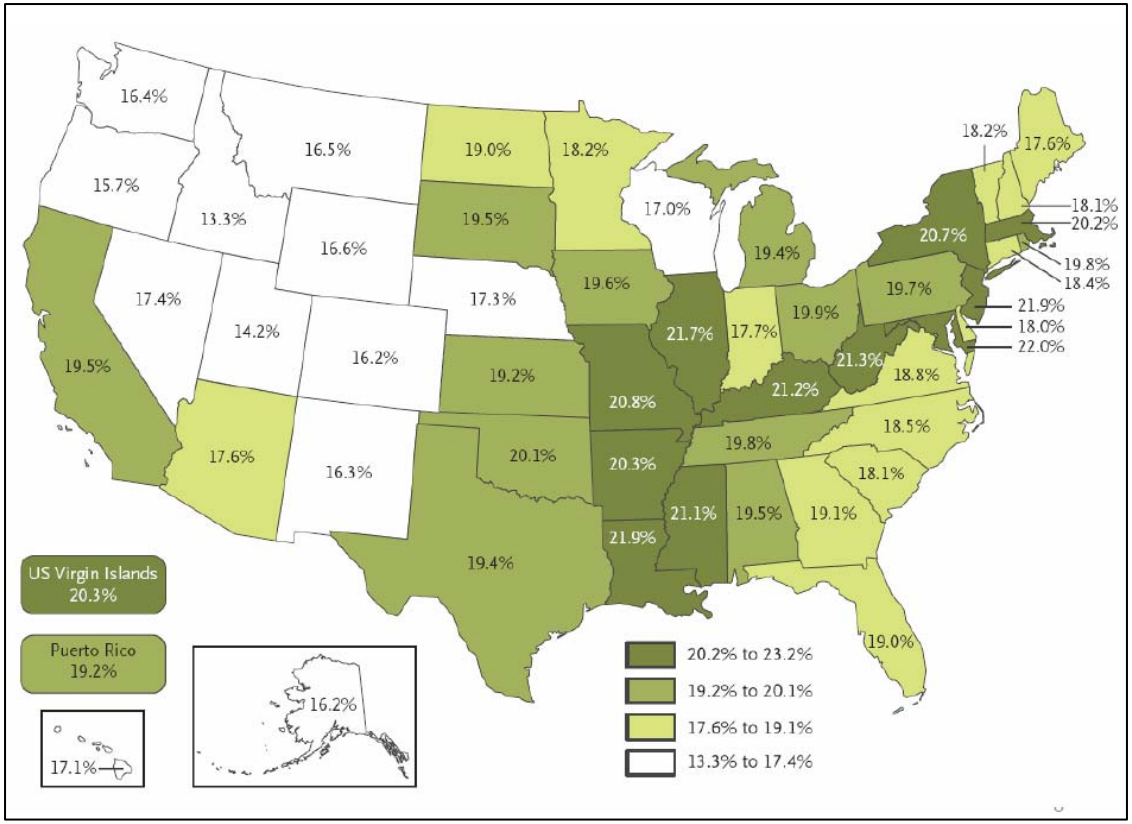


Readmission rates correlate with increased overall spending on Medicare beneficiaries

Large variation across states suggests opportunities for improvement

Source: Commonwealth Fund; Lit search

State Variation in Readmission Rates – the Latest Medicare Data



The results of the Jencks, et al. study indicate continued wide variation in performance by state – from 13 to 25%

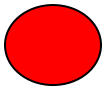
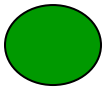
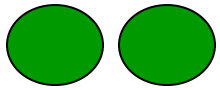
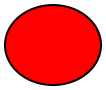
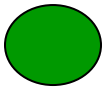
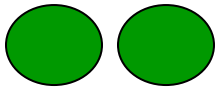
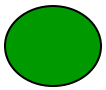
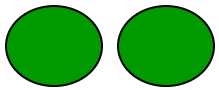
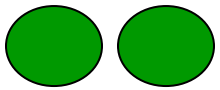
Source: Jencks, et al. N Engl J Med 2009,360:1418-28

Potential Losses from CHF in a Typical Hospital

Metric	Assumptions	Volume	Costs
Admits per year	250 bed hospital at 90% occupancy	21,000/yr	
CHF admits per year	5.7% of admissions are for CHF The average reimbursement for CHF is -$500-$1000/admission average loss to cost of care	1,150/year	$575,000
CHF 30-day readmissions per year	CHF DRG-specific 23% readmission rate Median CMS reimbursement for CHF is $6,000/discharge *-with more than a 3 fold variation not attributable to clinical condition*	265/year	$1,590,000
Total Annual Loss			$2,165,000

Putting the Evidence in Context

Economic value of readmissions depends on the “risk” of payment reform

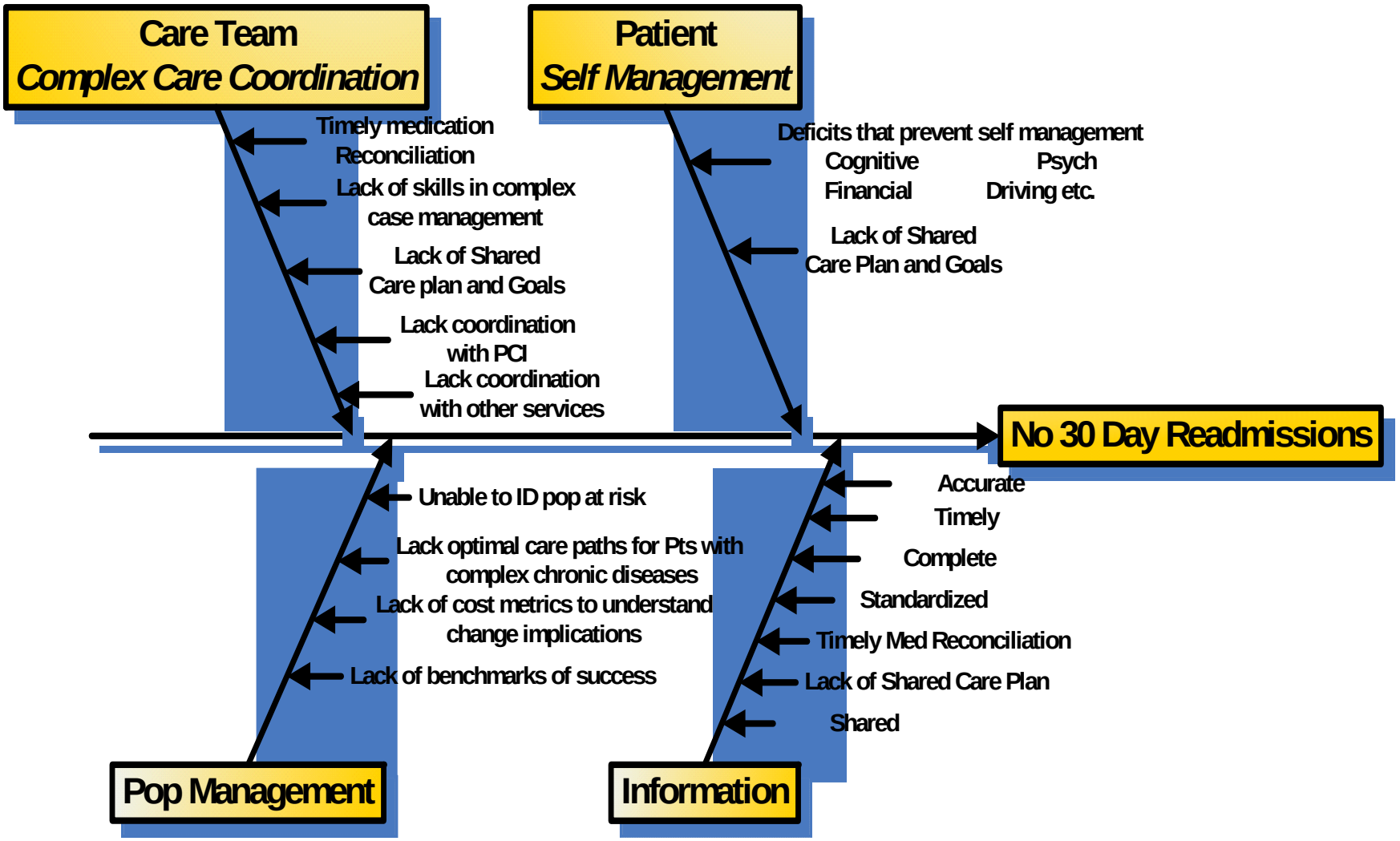
Metric	Structure of Payment:		
	FFS	Bundled	Full Risk
Decrease in Readmits			
Decrease in Bed Days			
Decrease in HH Visits/Pt			

Hospital Readmissions and Operations

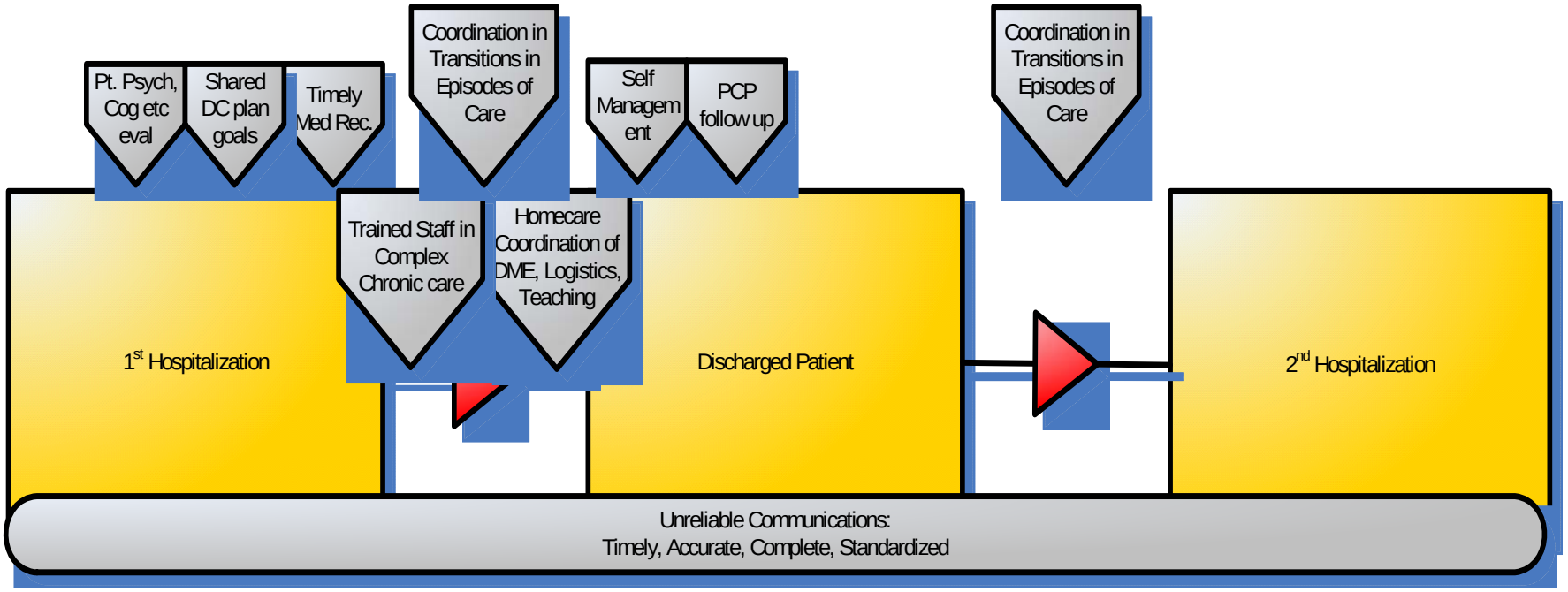
"Rehospitalization may be the most powerful single example of the cost of fragmented, provider-centered care. I believe that a successful campaign to reduce rehospitalization will also make care more patient-centered.“

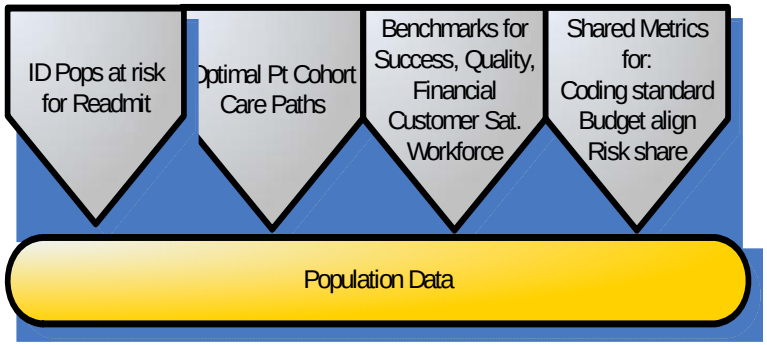
Stephen Jencks, MD

Operating Issues Surrounding Readmissions



Process Issues Surrounding Readmissions





Policy-Makers, Readmissions and Healthcare Reform

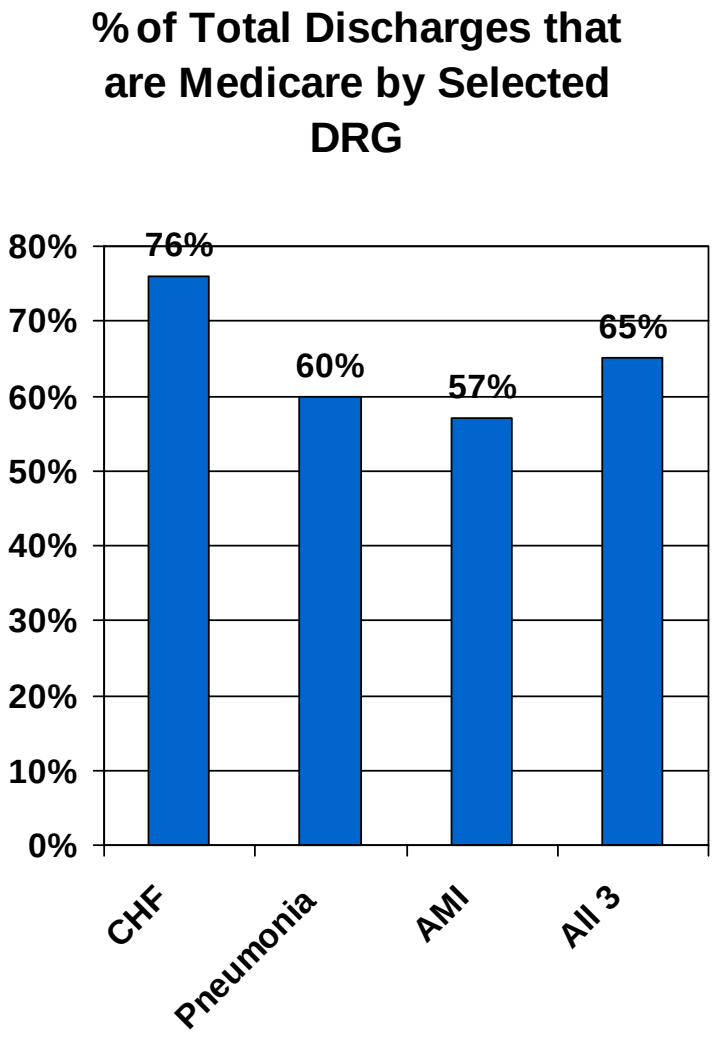
Policy-makers are considering readmissions as a central issue for budget and healthcare reform. Among the groups participating in the discussion:

- CMS
- OMB – the Obama Administration proposed budget
- MedPAC
- Senate Finance Committee

CMS Measures Readmissions Performance on Key DRGS, Solicits Comments on Policy Alternatives

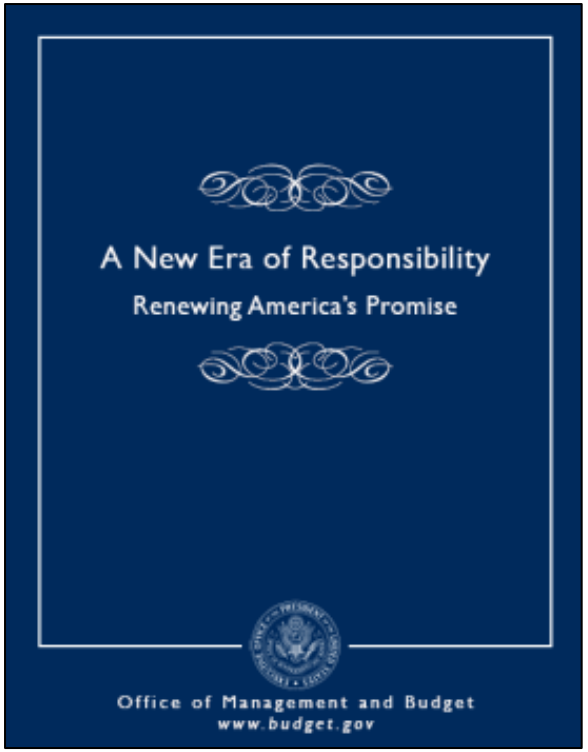
CMS has sought to track performance on three key DRGS - Congestive heart failure (CHF), Pneumonia, and Acute Myocardial Infarction (AMI) – and sought input on a series of policy alternatives

- In 2010 three readmission measures may be calculated using Medicare administrative claims data: Heart failure (HF) 30-day risk standardized readmission measure, Pneumonia (PN) 30-day risk standardized readmission measure, Heart Attack (AMI) 30-day risk standardized readmission measure (for Medicare patients) (pg 23648)
- CMS is taking public comment on three potential policy options: public reporting of performance, payment incentives for superior performance, and payment reductions for inferior performance (pg 23674)



The Obama Budget and Healthcare Reform

"… Hospitals will receive bundled payments that cover not just the hospitalization, but care from certain post-acute providers the 30 days after the hospitalization, and **hospitals with high rates of readmission will be paid less if patients are re-admitted to the hospital within the same 30-day period**."

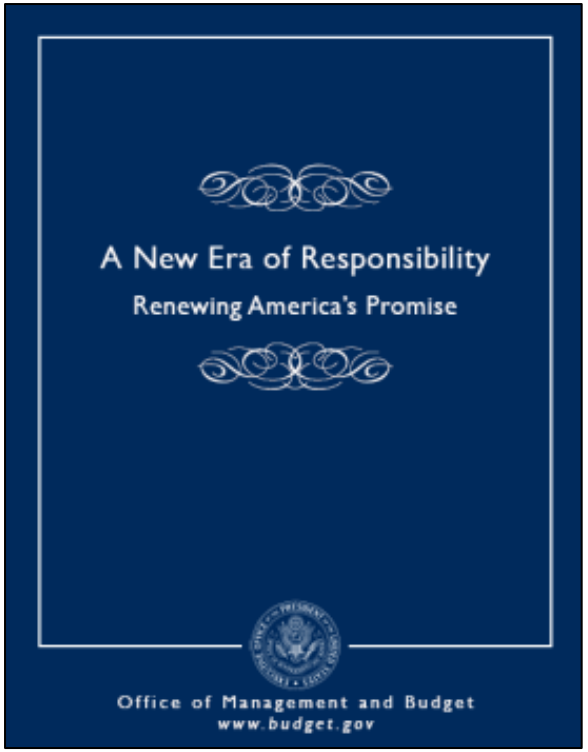


A New Era of Responsibility

Table S-6: Mandatory and Receipt Proposals

- **Encourage hospitals serving Medicare beneficiaries to reduce readmission rates (projected savings $8,430,000,000)**
- **Create Hospital quality incentive payments (projected savings $12,090,000,000)**
- **Promote efficient provision of acute care through bundled Medicare payments covering hospital and post-acute settings (projected savings $17,840,000)**

Total expected savings by 2019 for these 3 initiates = $38,360,000,000



The View of MedPAC

“The Commission recommends changing payment to hold providers financially accountable for service use around a hospitalization episode. Specifically, it would reduce payment to hospitals with relatively high readmission rates for select conditions. Conditions with high volume and high readmissions rates may be good candidates for selection. “

“The Commission recommends that this payment change be made in tandem with a previously recommended change in law (often referred to as gainsharing or shared accountability) to allow hospitals and physicians to share in the savings that result from reengineering inefficient care processes during the episode of care.”

Statement of Glenn M. Hackbarth, J.D.
Chairman, Medicare Payment Advisory Commission
Before the Committee on Energy and Commerce, U.S. House of Representatives

MedPAC Policy Recommendations

#1 Medicare should:

- Confidentially report readmission rates and resource use around hospitalization episodes to hospitals and physicians.
- Beginning in the third year, providers' relative resource use should be publicly disclosed

#2 Medicare should

- Reduce payments to hospitals with relatively high readmission rates for select conditions
- Allow shared accountability (i.e., gainsharing) between physicians and hospitals.

Anne Mutti
Medicare Payment Advisory Commission Staff
April 2, 2009
"Reducing rehospitalizations: A national priority:" A Commonwealth Fund webinar

Senate Finance Committee: Withholds and Bundling

"Starting in fiscal year 2013, hospitals with readmissions above the 75th percentile for selected conditions would be subject to a payment withhold on a MS-DRG-by-MS-DRG basis. Such a withhold would be based on the prior year's performance and would be equal to 20 percent of the MS- DRG payment amount…

Beginning in fiscal year (FY) 2015, acute IPPS hospital services and post-acute care services occurring or initiated within 30 days of discharge from a hospital would be paid through a bundled payment. Under this policy, post-acute payments would include home health, skilled nursing facility, rehabilitation hospitals, and long-term care hospital services. "

Description of Policy Options
"Transforming the Health Care Delivery System:
Proposals to Improve Patient Care and Reduce Health Care Costs"
April 29, 2009

Senate Finance Committee

Proposed Timeline for Implementation of Readmissions and Bundling Policy

Calendar Year	Readmission Policy	Bundled Payment Policy
2010	CMS would develop readmissions policy and data parameters	CMS would develop bundling policy
2011 - 2012	CMS would provide readmission rate information to hospitals and compare that to national readmissions benchmarks for selected conditions	CMS would develop bundling policy
2012	April-August: CMS would issue proposed and final rules FY 2013: Readmissions policy would start in October CMS would publicly report readmission rates	CMS would develop bundling policy
2013	Readmissions policy would continue for those hospitals not paid under the new bundled rates	CMS would develop policy

Senate Finance Committee

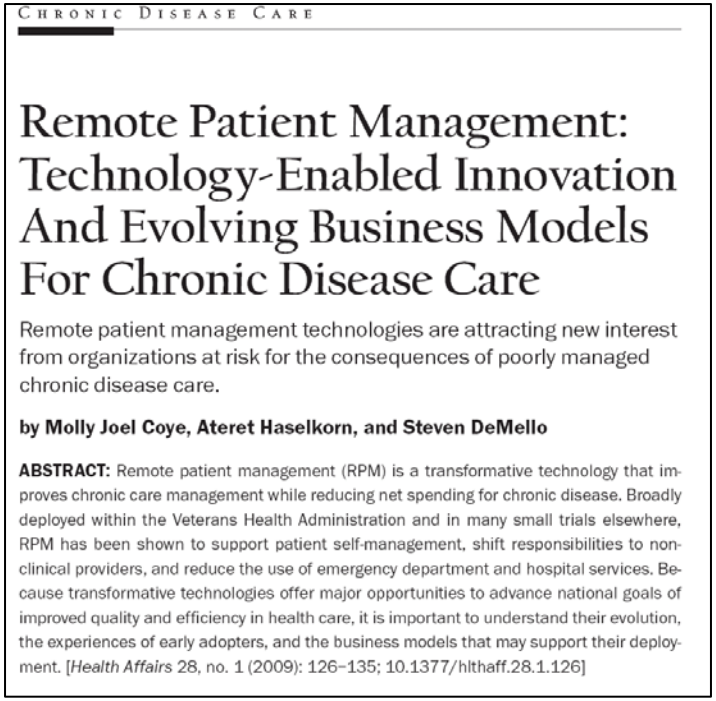
Proposed Timeline for Implementation of Readmissions and Bundling Policy

Calendar Year	Readmission Policy	Bundled Payment Policy
2014	Policy would continue for those hospitals not paid under the new bundled rates	April-August: CMS would release proposed and final rule FY 2015: 1st phase would start in October (would apply to first 20% of post-acute spending)
2015	Readmissions policy would continue for those hospitals not paid under the bundled rates	1st phase continues
2016	Readmissions policy would continue for those hospitals not paid under the bundled rates	April-August: CMS would release proposed and final rules FY 2017: 2nd phase would start in October (would apply to next 30% of post-acute spending)
2017	Readmissions policy would continue for those hospitals not paid under the bundled rates	1st and 2nd phases would continue
2018	FY 2019: Readmissions policy would end in October	April-August: CMS would release proposed rule on final phase of bundling FY 2019: final phase would start in October (would apply to remaining 50% of post-acute spending)

Technology Enabled Innovation: Disruptive and Transformative

Transformative technologies enable a wide range of disruptive and positive changes in clinical care and administrative processes, **reducing net expenditures and improving the value of health care**.

- IOM Annual Meeting 2007



CHRONIC DISEASE CARE

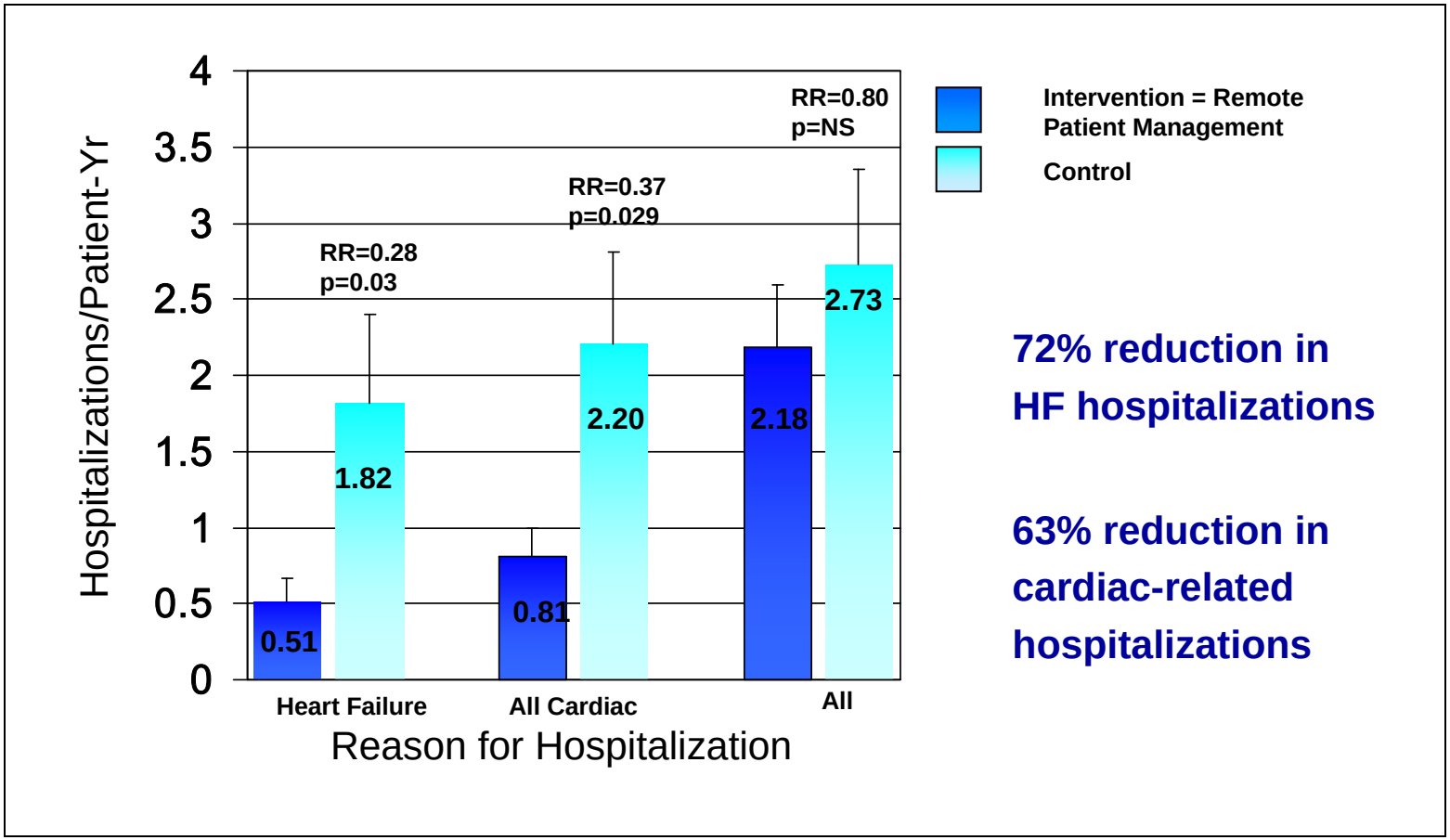
Remote Patient Management: Technology-Enabled Innovation And Evolving Business Models For Chronic Disease Care

Remote patient management technologies are attracting new interest from organizations at risk for the consequences of poorly managed chronic disease care.

by Molly Joel Coye, Ateret Haselkorn, and Steven DeMello

ABSTRACT: Remote patient management (RPM) is a transformative technology that improves chronic care management while reducing net spending for chronic disease. Broadly deployed within the Veterans Health Administration and in many small trials elsewhere, RPM has been shown to support patient self-management, shift responsibilities to non-clinical providers, and reduce the use of emergency department and hospital services. Because transformative technologies offer major opportunities to advance national goals of improved quality and efficiency in health care, it is important to understand their evolution, the experiences of early adopters, and the business models that may support their deployment. [*Health Affairs* 28, no. 1 (2009): 126–135; 10.1377/hlthaff.28.1.126]

Hospital-Led Deployment of Remote Patient Management



72% reduction in HF hospitalizations

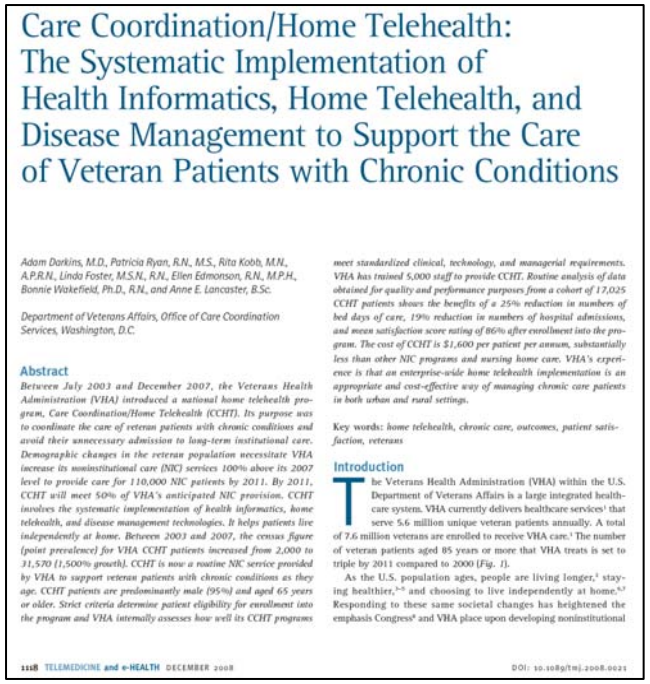
63% reduction in cardiac-related hospitalizations

SPAN-CHF II: Tufts-New England Medical Center; Lahey Clinic; Beth Israel-Deaconess Medical Center; Rhode Island Hospital. Weintraub et al AHA 2005

The Early Adopter Experience: Veterans Health Administration

Findings from comparative studies conducted on patients enrolled in the VA's Care Coordination/ Home Telehealth program in 2006 and 2007 show:

- 25% reduction in bed days of care
- 20% reduction in numbers of admissions
- 86% mean satisfaction score rating



Care Coordination/Home Telehealth: The Systematic Implementation of Health Informatics, Home Telehealth, and Disease Management to Support the Care of Veteran Patients with Chronic Conditions

Adam Darkins, M.D., Patricia Ryan, R.N., M.S., Rita Kobb, M.N., A.P.R.N., Linda Foster, M.S.N., R.N., Ellen Edmonson, R.N., M.P.H., Bonnie Wakefield, Ph.D., R.N., and Anne E. Lancaster, B.Sc.

Department of Veterans Affairs, Office of Care Coordination Services, Washington, D.C.

Abstract

Between July 2003 and December 2007, the Veterans Health Administration (VHA) introduced a national home telehealth program, Care Coordination/Home Telehealth (CCHT). Its purpose was to coordinate the care of veteran patients with chronic conditions and avoid their unnecessary admission to long-term institutional care. Demographic changes in the veteran population necessitate VHA increase its noninstitutional care (NIC) services 100% above its 2007 level to provide care for 110,000 NIC patients by 2011. By 2011, CCHT will meet 50% of VHA's anticipated NIC provision. CCHT involves the systematic implementation of health informatics, home telehealth, and disease management technologies. It helps patients live independently at home. Between 2003 and 2007, the census figure (point prevalence) for VHA CCHT patients increased from 2,000 to 31,570 (1,500% growth). CCHT is now a routine NIC service provided by VHA to support veteran patients with chronic conditions as they age. CCHT patients are predominantly male (95%) and aged 65 years or older. Strict criteria determine patient eligibility for enrollment into the program and VHA internally assesses how well its CCHT programs meet standardized clinical, technology, and managerial requirements. VHA has trained 5,000 staff to provide CCHT. Routine analysis of data obtained for quality and performance purposes from a cohort of 17,025 CCHT patients shows the benefits of a 25% reduction in numbers of bed days of care, 19% reduction in numbers of hospital admissions, and mean satisfaction score rating of 86% after enrollment into the program. The cost of CCHT is $1,600 per patient per annum, substantially less than other NIC programs and nursing home care. VHA's experience is that an enterprise-wide home telehealth implementation is an appropriate and cost-effective way of managing chronic care patients in both urban and rural settings.

Key words: home telehealth, chronic care, outcomes, patient satisfaction, veterans

Introduction

The Veterans Health Administration (VHA) within the U.S. Department of Veterans Affairs is a large integrated healthcare system. VHA currently delivers healthcare services[1] that serve 5.6 million unique veteran patients annually. A total of 7.6 million veterans are enrolled to receive VHA care.[1] The number of veteran patients aged 85 years or more that VHA treats is set to triple by 2011 compared to 2000 (*Fig. 1*).

As the U.S. population ages, people are living longer,[2] staying healthier,[3–5] and choosing to live independently at home.[6,7] Responding to these same societal changes has heightened the emphasis Congress[8] and VHA place upon developing noninstitutional

1118 TELEMEDICINE and e-HEALTH DECEMBER 2008 DOI: 10.1089/tmj.2008.0021

Medication Adherence: Significant Economic Opportunity

- Medication non-adherence results in approximately **$177 billion** annually in direct and indirect costs to the U.S. economy.
- **$47 billion** each year is spent for drug-related hospitalizations.
- Not taking medications as prescribed has been associated with as many as **40%** of admissions to nursing homes with an additional **$2,000** a year per patient in medical costs for visits to physician's offices.

Medication Adherence – Broad Range of Enabling Technologies

"Smart" Pill Bottles

- Rex Talking Pill Bottle - offered at over 140 Northern California Kaiser Permanente pharmacies and health care facilities

Remote Medication Dispensing

- Med-eMonitor – improved adherence rates in diverse chronic illnesses from baseline levels of 35-55% to levels in excess of 90%

VA Experience Demonstrates Value of Segmenting Population

- First level – patient, peer-led coaching and problem solving
- Second level – medication management technologies
- Third level – in-home remote patient management

Technology-Enabled Innovation Exists – But Not Widely…

Leading industry efforts at improving hospital readmissions performance have a relatively small technology component

- Of the "15 Promising Interventions" identified by IHI, only one is technology-based (home health telemedicine), and there is little explicit use of advanced technology

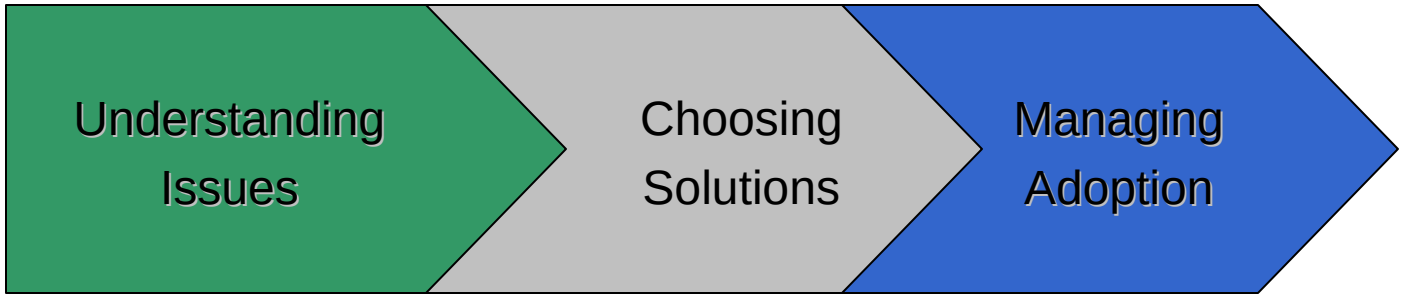
The scarcity of technology-enabled solutions comes from a number of reasons:

- Little focus on finding technology solutions for specific issues
- Lack of clinical evidence supporting technology use
- Poor alignment with current business models

Two key questions:

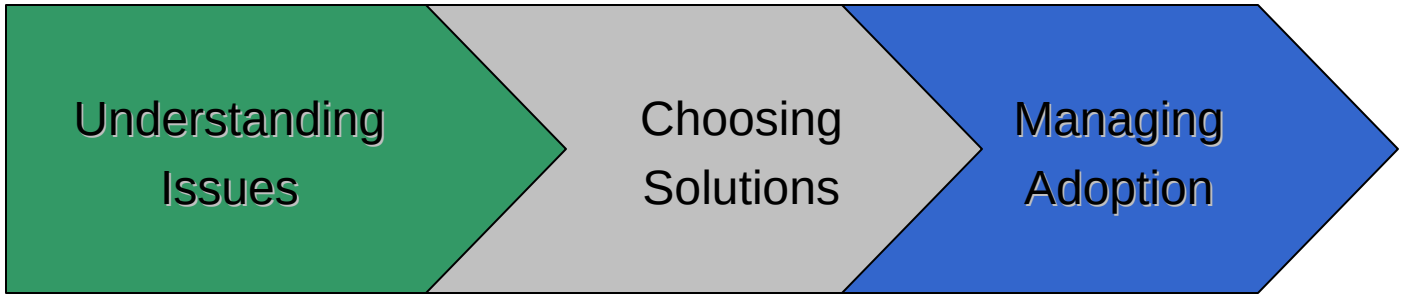
- Are there promising technology-based, disruptive solutions?
- How can technology augment performance of other initiatives?

Successful Execution Builds on Three Elements



Understanding Issues	Choosing Solutions	Managing Adoption
What is the impact of this issue?	**What solutions are available?**	**How do I manage a successful test?**
What is the likely impact on my organization?	**Which solutions fit best with my organization?**	**How do I manage broad diffusion?**

Flow of the Pre-Conference Presentations



What is the impact of this issue?

What is the likely impact on my organization?

What solutions are available?

Which solutions fit best with my organization?

How do I manage a successful test?

How do I manage broad diffusion?

Overview

Innovations & Techs/Case Studies

Project Management

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