

# Rehospitalization: From Emerging Problem to National Solution

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# A Perfect Crisis

- Safety: 20% at 30 days;
- 2,500,000 a year: 500k – 1,000k preventable
- Cost: \$17 billion in Medicare hospital payments
- Patient experience: poor HCAHPS scores
- Healing healthcare: part of the fragmentation that medical home, accountable care organizations, and others are keyed to.
- Roughly equal numbers and costs in non-Medicare

# Plan:

- Assume general familiarity with problem. If not, see supplementary slides and NEJM.
- Review sections of recent legislation and the timeline.
- Review competing approaches to counting and measuring rehospitalizations.
- Summarize the potential for a national effort to reduce rehospitalization

# Patient Protection and Affordable Care Act (PPACA)

- Sec 3025 payment penalties for excess readmissions.
- Sec 3026 funding for technical assistance
- Sec 3021 Center for Medicare&Medicaid Innovation
- Sec 3015 data collection and public reporting
- Sec 3502 community health teams to support medical home

# Penalties for excessive rehospitalizations

- Starting 10/1/11, hospitals with rehospitalization rates above expectation will have overall Medicare payments reduced enough to recapture payments for excessive rehospitalizations.
- Reduction limited to 1% in FY 2012, 2% in FY 2013, and 3% thereafter.
- Measurement limited to heart attack, heart failure and stroke in first year but must expand.

# Care transitions technical assistance

- \$500 million over next 5 years to support entities providing community-based transition programs, especially associated with safety-net and rural hospitals.
- Program can be implemented by program instruction (i.e.: without rule-making).
- Could clearly become a benefit if it saves money.

# Center for Medicare & Medicaid Innovation

- New CMS Center with mission of developing new programs that improve quality at same cost or decrease cost without decreasing quality.
- Has authority to go from demonstrations to national implementation with new law if certified to meet above standard.
- Demonstrations need not be budget-neutral.

# Counting Rehospitalizations



# Four Kinds of Rehospitalization

TYPE	FREQUENCY	EXAMPLES
Related-unplanned	~90% by 30 days.	Heart failure, pneumonia, stroke
Related-planned	~5-10% by 30 days	Chemotherapy, procedures to complete care
Unrelated-planned	uncommon by 30 days	Unrelated, planned procedures
Unrelated-unplanned	uncommon by 30 days	Some kinds of trauma and harm from the environment

# Clinical Causes of Rehospitalization

- 90 percent or more appear to be the result of clinical deterioration – related to the index hospitalization and not part of a treatment plan.
- Even if some planned rehospitalizations are not necessary, improving care transitions is not an efficient solution.
- Good clinicians do not agree on which related, unplanned rehospitalizations are preventable.

# Discharged patient are vulnerable

	Start	-----End-----	
Days after discharge	Percent still at risk	Cumulative rehospitalizations	Cumulative outpatient deaths
0-30	100.0%	19.6%	3.5%
31-60	76.9%	28.2%	4.5%
61-90	67.3%	34.0%	5.1%
91-180	60.9%	44.8%	6.0%
181-365	49.3%	56.1%	6.8%
>365 days	37.1%		

# A possible working rule

- Many rehospitalizations for procedures are unplanned and not gameable, but most are scheduled continuation of care and some are gameable.
- 70% of rehospitalizations after surgery are not for procedures.
- Almost all related, unplanned rehospitalizations are potentially preventable; few can be “gamed”.
- Assume rehospitalizations for procedures are planned and exclude them; count all others.

# Measuring Rehospitalization Rates and Change

# Available measures of rehospitalization rates: Hospital Compare (CMS)

- Will likely be basis for Medicare penalties starting next year.
- Limited to Medicare FFS discharges for heart attack, heart failure, and pneumonia.
- Sophisticated risk adjustment but requires ambulatory claims data.
- No exclusions for scheduled rehospitalizations.
- Can only change slowly with time (sample size).
- NQF endorsed.

# Available measures: Potentially Preventable Readmissions (3M)

- Under consideration or adopted in several states.
- Produces rates about half of CMS and UHC.
- Many exclusions but no explicit criteria for them and many seem debatable.
- Proprietary, and the major market is hospitals, not payers or public agencies.
- NQF declined to endorse.

# Available measures of rehospitalization rates: UHC

- The simplest model.
- Almost no exclusions.
- Produces overall rates similar to CMS.
- Not in broad use, but is very similar to NEJM paper.
- NQF endorsed.



# Measuring change

- If a hospital or community decreases its rehospitalizations it will generally decrease the number of discharges.
- If the numerator and the denominator of a rate both change, the result is unpredictable.
- It may be better to look for change in the actual number of rehospitalizations than change in the rate.

# Time Windows and Survival Modeling

# Calibration Range

- How few rehospitalizations is too few?
- Example of pneumonia?
- Calibration range is the range over which we know what the measure means – that less is better.
- Importance of balancing measures and patient reports.

# Balancing Measures

- Consumer reports
- Emergency room and observation days
- Rehospitalizations in the 31-40 days window.

# Preventing Rehospitalization

# Targeting Prevention

- History of rehospitalization
- Longer stay than expected
- High-risk DRGs (e.g.: heart failure, psychosis)
- On dialysis
- Disabled
- Poor

# Targeting Prevention – Why Not?

- The effective changes are system changes, which are often easier to implement across the board than selectively.
- Screening accurately costs resources that could be used in prevention.
- Most screening models still miss many patients who will be rehospitalized.

# Basic Tools

- Framework: Checklist or other framework for delivering an agreed-upon set of transitional services
- Assessment: Patients are assessed to identify risk for rehospitalization and needs for transition support



# Teaching:

- Patient and family are engaged in the plan of care
- Education supporting the plan is confirmed with “teachback”
- Patient and family are trained in self-management and in overcoming the challenges of using the care system.
- Patient and family understand and can obtain all medications to be taken and discontinued

# Communication:


- Timely communication occurs with providers/practitioners in next setting of care

# Teaching and Follow-up

- Patient and family understand danger signs and know who to contact
- Timely post-discharge follow-up occurs (may include hospital-based phone contact, in-home coaching, front-loaded home care services, and timely physician office visits)
- Intensive clinical follow-up is provided for patients at high risk.

# A National Effort?

# Framing Questions

- Most payers and plans are interested in reducing rehospitalization, not just Medicare.
- What is lost by collaborating?
- Can plausible kinds of collaboration be effective?
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# What steps toward a national effort?

- Define leadership
- Create a forum or meeting place/time for coordination, learning, and interested parties.
- Bring in timely data, analyze for progress, make results available to decision-makers and the public.
- Develop rapid responses to early returns in order to maintain momentum.

# Summing Up

# Take Home Messages

- Healthcare Reform has changed the landscape for rehospitalization efforts.
- Technical measurement problems remain incompletely resolved but should not be deal-breakers.
- There are effective interventions.
- This is a perfect crisis.
- A coordinated national effort is feasible, desirable, and a reasonable pilot for broader healthcare changes.