ALL PAYER, ALL CAUSE, ALL THE TIME

Integrating segmented strategies into a comprehensive portfolio

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Collaborative Healthcare Strategies
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COLLABORATIVE
HEALTHCARE STRATEGIES

Overview

- Thank you CMS
- However, beware the blinders created by CMS priorities
- All payer all cause readmission stats
- Develop a portfolio strategy
- Recommendations for 2014

THANK YOU CMS

You've done a good thing……

COLLABORATIVE
HEALTHCARE STRATEGIES

6 Very Important Messages from CMS-1

1. Readmission reduction pays – or hurts to some extent
   - Avoidance in penalties, CMMI grants/ contracts
2. We will flood the market with all best ideas on our dime
   - Partnership for Patients, Hospital Engagement Networks (HENs) ~ $280M
1. Reducing readmissions is a cross-continuum effort
   - QIO 10th SOW, “Integrating Care for Populations and Communities”
   - Focused on engaging numerous providers within a community
   - SNF readmission penalties proposed for 2017

6 Very Important Messages from CMS -2

4. Attend to non-clinical issues
   - eg integral role of community based support services

5. Reducing readmissions requires really good data
   - QIO 10th SOW – social network analyses, readmissions from PAC providers, etc.

4. Hospitals must have updated processes in place
   - May 2013 newly issues CMS Hospital Conditions of Participation

CMS Discharge Planning COP Requirements*

(*Boutwell summary; not CMS')

1. **Have a process**
2. **Analyze the process;** track rates & review readmissions
3. **Assess & reassess** patients for post-hospital needs
4. **Teach** self-care to patients & caregivers
5. **Provide** a written discharge plan for all inpatients
6. **Communicate** effectively with "receiving" providers
7. **Know** the capabilities of area providers, including support services
8. **Arrange** for post-acute services, including support services

HOWEVER….

Powerful messages from powerful agencies can create blinders

Inadvertent Blinders….

1. HF, AMI, PNA
   - NOT the three most frequent causes of readmissions, even in Medicare FFS
   - Many other very important conditions, including social/high utilization

1. Driven a Medicare focus in the field
   - Medicaid adults have as high or HIGHER readmission rates than Medicare FFS

2. Preferred first move: hire a transitional care FTE
   - Lost a bit of the focus on the need to modernize & improve standard processes

ALL CAUSE ALL PAYER STATS

- 18 states, 14 million discharges
- 45% of all hospitalizations in US

COLLABORATIVE HEALTHCARE STRATEGIES

HCUP: Readmissions by Volume

condition	Discharges	Readmissions	Rate
CHF	847073	209017	25%
sepsis	696122	145896	21%
pneumonia	924160	144894	16%
mood disorder	883245	131125	15%
COPD	606186	126443	21%
complication of device	596062	121036	20%
arrythmia	705616	104607	15%
DM	480958	97784	20%
schizophrenia	397166	88629	22%
AMI	520901	85932	16%
UTI	522921	84858	16%
complications	453266	81353	18%
fluid/lytes	396551	73721	19%
CVA	520793	71174	14%
ARF	326586	70756	22%
cellulitis	576902	64680	11%
chest pain	601899	61465	10%
Gibleed	320613	54154	17%

HCUP: Readmissions by Volume & Rate

Diagnosis	Discharges	Readmissions	Rate
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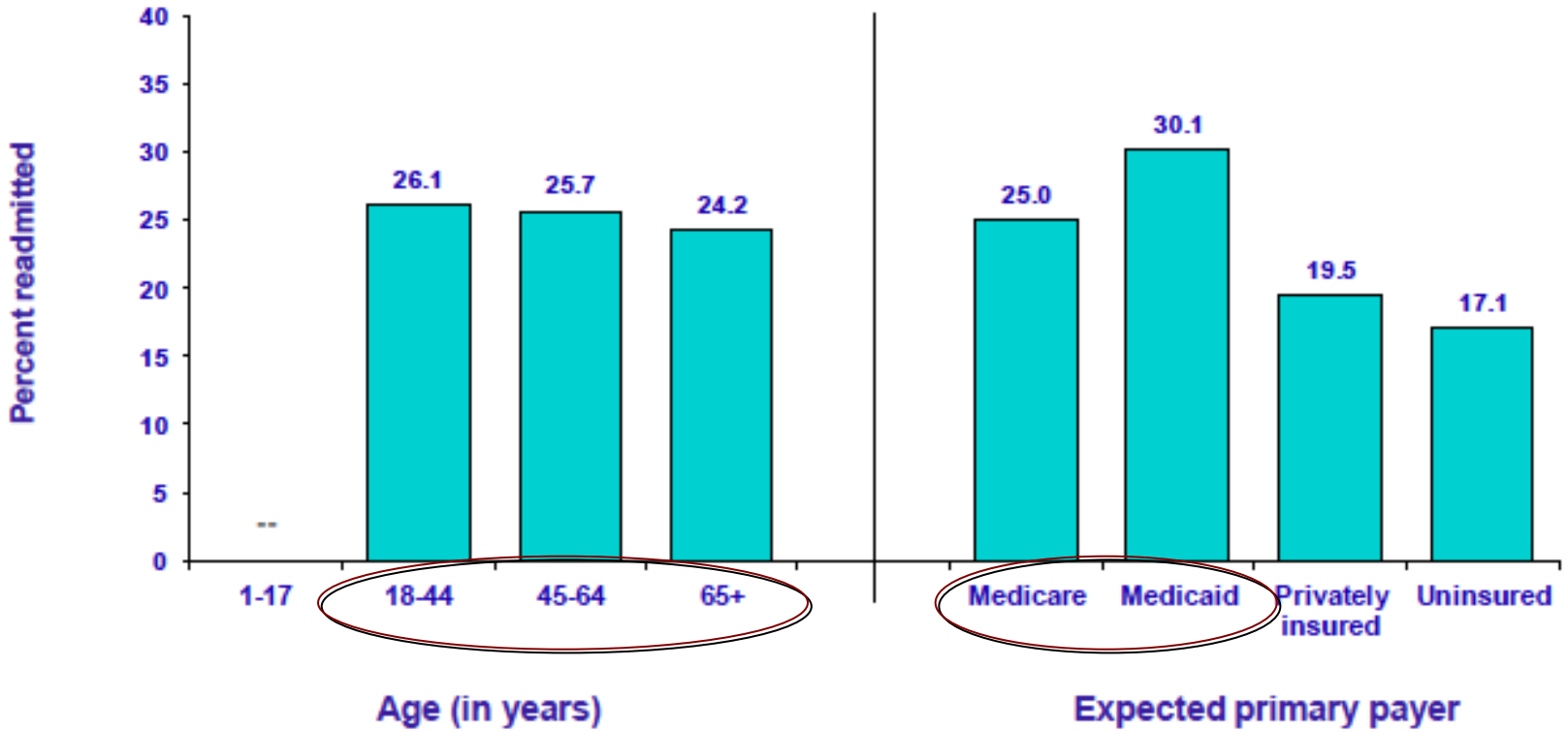
Gibleed	320613	54154	17%
AMI	520901	85932	16%
UTI	522921	84858	16%
obstruction	315128	51135	16%
pneumonia	924160	144894	16%
mood disorder	883245	131125	15%
arrythmia	705616	104607	15%

HCUP: Highest Rates

Table 2. All-cause 30-day readmissions ranked by conditions with the highest readmission rates,* U.S. hospitals, 2010

Rank	Principal diagnosis for index hospital stay **	Number of index stays	30-day all-cause readmissions	
			Number of readmissions	Percent readmitted
1	Sickle cell anemia	87,326	27,837	31.9
2	Gangrene	33,786	10,693	31.6
3	Hepatitis	37,480	11,593	30.9
4	Disease of white blood cells	54,861	16,771	30.6
5	Chronic renal failure	17,394	4,766	27.4
6	Systemic lupus erythematosus and connective tissue disorders	18,850	5,123	27.2
7	Mycoses	23,026	6,222	27.0
8	HIV infection	34,958	9,230	26.4
9	Screening and history of mental health and substance abuse	60,417	15,695	26.0
10	Peritonitis and intestinal abscess	25,219	6,315	25.0

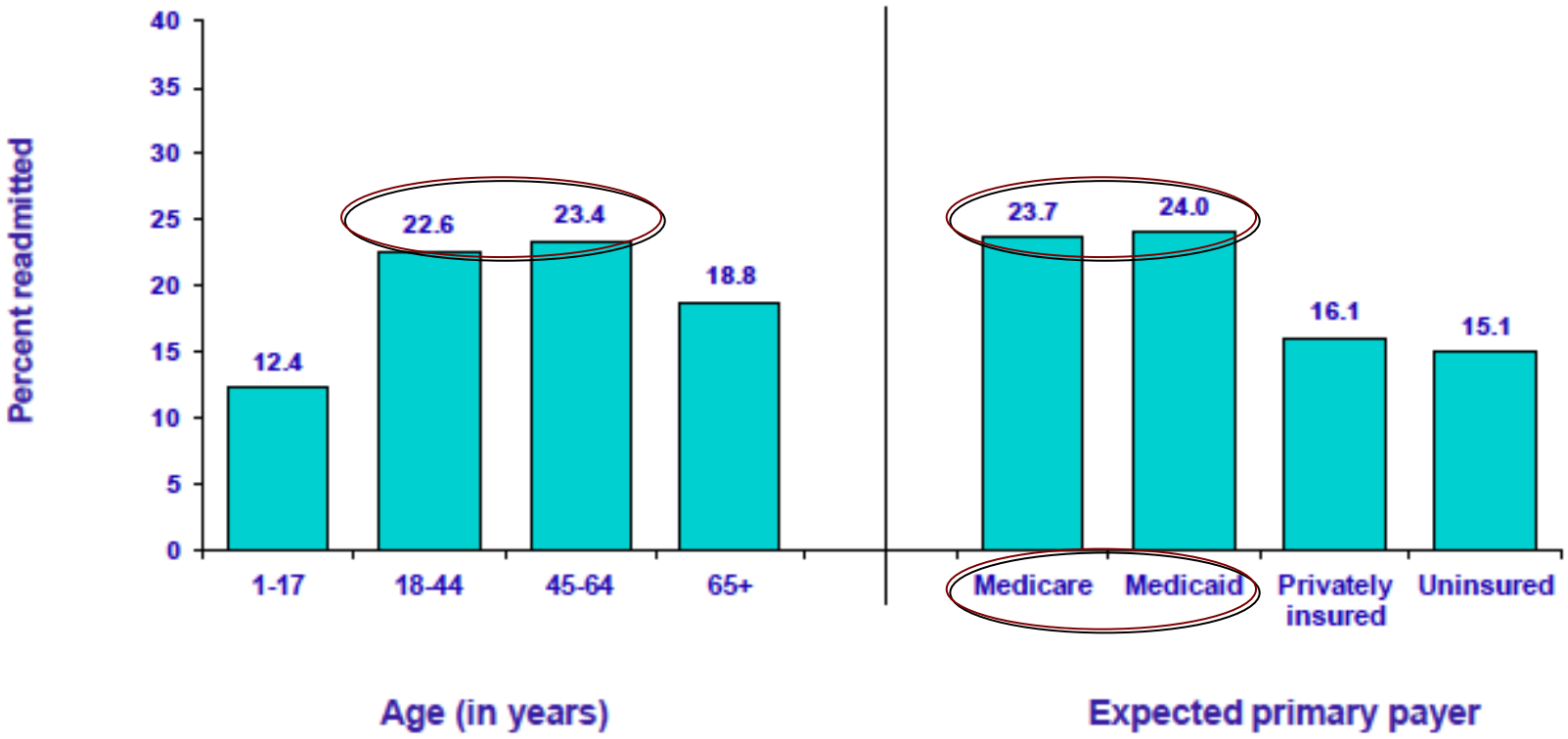
Figure 1. All-cause 30-day readmission rates for congestive heart failure by age and insurance status, U.S. hospitals, 2010



Source: Weighted national estimates from a readmissions analysis file derived from the Healthcare Cost and Utilization Project (HCUP) State Inpatient Databases (SID), 2010, Agency for Healthcare Research and Quality (AHRQ).

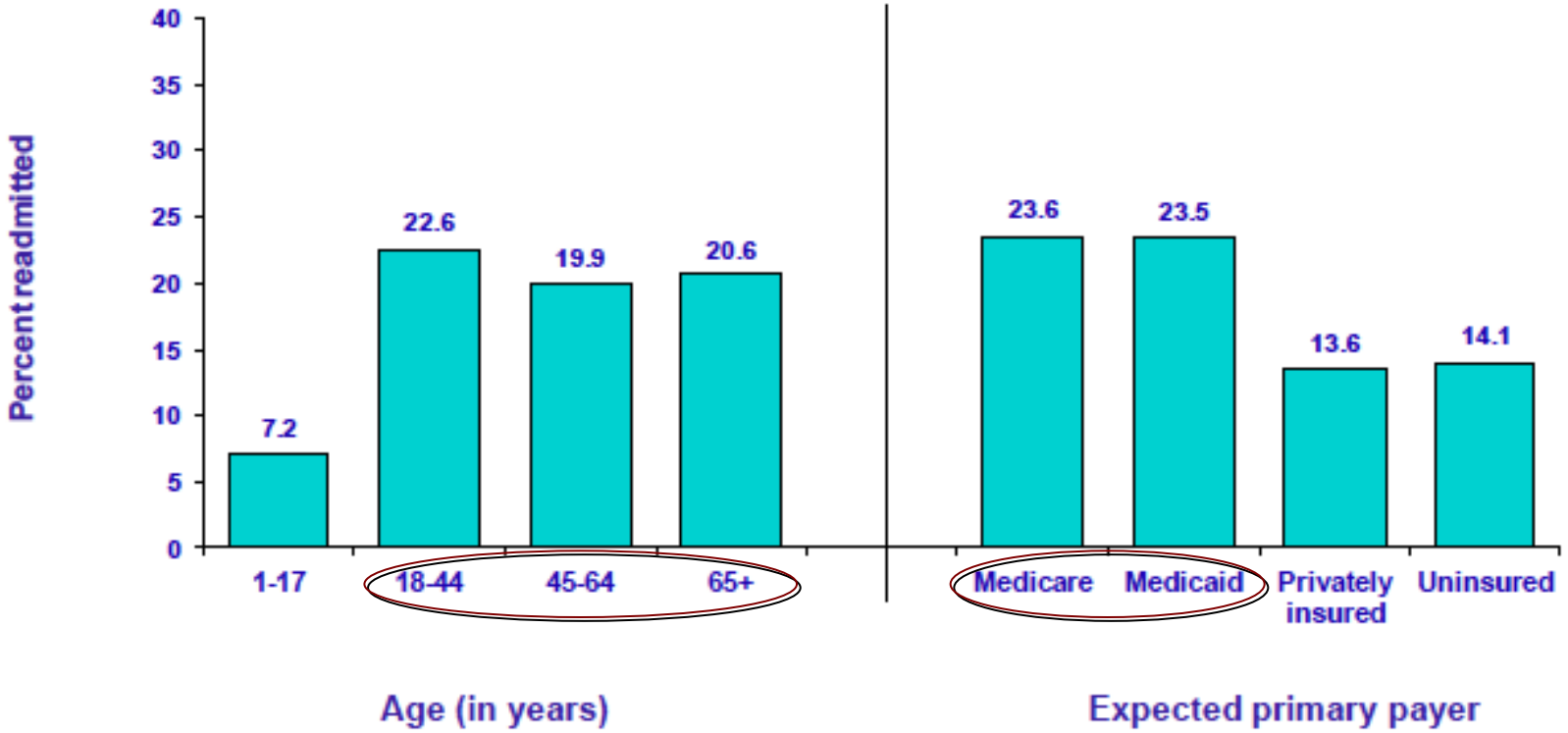
-- Indicates too few cases to report.

Figure 2. All-cause 30-day readmission rates for schizophrenia and other psychotic conditions by age and insurance status, U.S. hospitals, 2010



Source: Weighted national estimates from a readmissions analysis file derived from the Healthcare Cost and Utilization Project (HCUP) State Inpatient Databases (SID), 2010, Agency for Healthcare Research and Quality (AHRQ).

Figure 4. All-cause 30-day readmission rates for diabetes with complications by age and insurance status, U.S. hospitals, 2010



Source: Weighted national estimates from a readmissions analysis file derived from the Healthcare Cost and Utilization Project (HCUP) State Inpatient Databases (SID), 2010, Agency for Healthcare Research and Quality (AHRQ).

Diagnoses that Frequently Lead to Readmission

Maryland 2012, all payer, not just Medicare

1. Heart failure
2. Sepsis
3. COPD
4. Pneumonia
5. Renal failure
6. Bipolar disorder
7. Kidney & UTI
8. Arrhythmia
9. Major depression
10. Schizophrenia
11. Cellulitis
12. Stroke

COLLABORATIVE HEALTHCARE STRATEGIES

Leading Readmission Diagnoses

Beware of blinders created by diagnosis-focus

	% of All Readmissions
• Heart failure	•4.9%
• Sepsis	•4.7%
• COPD	•2.8%
• Renal Failure	
• Post-operative	

What is the impact of focusing on the top cause of readmissions?
Estimate 30,000 RA in MD per year; 5% of RA are due to HF
5% x 30,000 = 1,500 HF readmissions
Aim for a **20% reduction** in HF readmissions
.2 x 1,500 = **300** avoided readmissions
Total impact of the successful targeted effort on overall RA
300 / 30,000 = **1%** reduction overall

COLLABORATIVE HEALTHCARE STRATEGIES

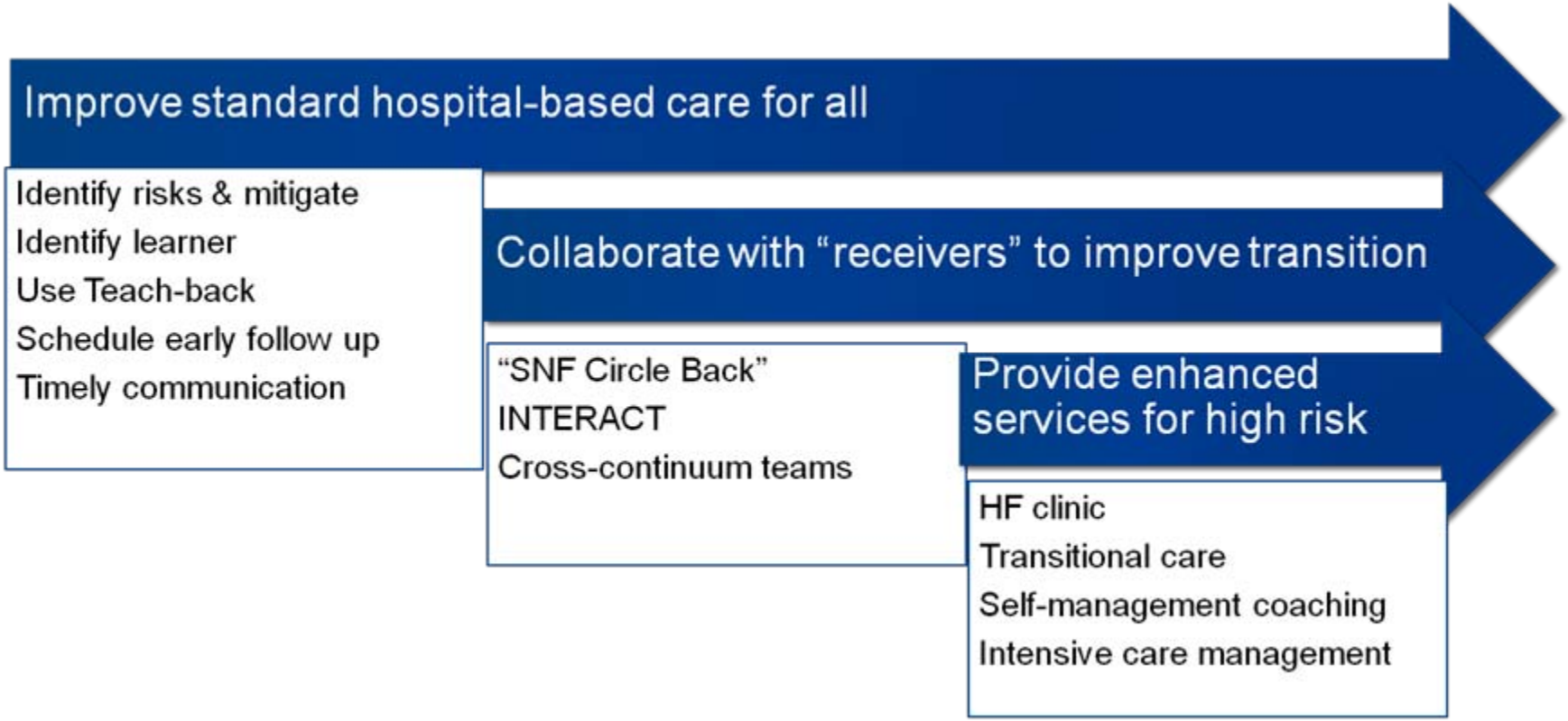
CRUNCHING THE NUMBERS

Will your current strategy get you to your goal?

Let's Run the Numbers:
One Strategy Won't Get Us There

	Number	Rate
Medicare admits/year	5,000 admissions	
Medicare RA rate		20%
# Medicare RA /year	**1,000** readmissions	
Pilot project	200 high risk patients	
Pilot group RA rate		25%
Expected # RA pilot	50	
Expected effect of pilot		20%
# RA reduced by pilot	**10**	
# Medicare RA/year	=1000 – 10 = **990**	**1%**

Develop Portfolio Strategy



COLLABORATIVE HEALTHCARE STRATEGIES

Let's Run the Numbers:
Three-part strategy

	Number	Rate
Medicare admits/year	5,000 admissions	
Medicare RA rate		20%
# Medicare RA /year	**1,000** readmissions	
1. Improve standard care	5,000 admissions	(20% RA rate)
Expected effect		10%
Expected # RA reduction	**100 RA avoided**	
2. Collaborate with receivers	1650 admissions (1/3 total)	(30% RA rate)
Expected effect		20%
Expected # RA reduction	**99 RA avoided**	
3. Enhanced Service for Pilot	200 admissions	(25% RA rate)
Expected effect		20%
Expected # RA reduction	**10 RA avoided**	
Total (*illustrative)	**209 RA avoided***	209/1000 = 20% overall*

Let's Run the Numbers: *Community Hospital ABC*

	Admissions	**Readmissions**	**Rate**
Total Admissions/year	6,000 admissions	500 readmissions	8%
Medicare Admissions	2,100 admissions	310 readmissions	15%
Non-Medicare Admissions	3,900 admissions		
Adult non-ob, non-peds	1900 admissions		
Medicaid/uninsured	1200 admissions	140 readmissions	12%
Medicare HF admissions	125 admissions	30 readmissions	24%
Reduce HF RA by 20%		**6 readmissions avoided**	
Success in the HF pilot	Hospital RA rate:	500 – 6 = 494	8%
	Mcare RA rate:	310- 6 = 304	14%
Mcare HF+COPD	250 admissions	60 readmissions	24%
Reduce HF/COPD by 20%		**12 readmissions avoided**	
HF+COPD+PNA		**20 readmissions avoided**	etc

COLLABORATIVE HEALTHCARE STRATEGIES

Let's Run the Numbers: *Community Hospital ABC*

	Number	Rate
Admissions/year	6,000 admissions	
RA rate		8%
# RA /year	**500** readmissions	
1. Improve standard care	6,000 admissions	(8% RA rate)
Expected effect		10%
Expected # RA reduction	**50 RA avoided**	
2. Collaborate with receivers	700 admissions (1/3 of MC)	(25% RA rate)
Expected effect		25%
Expected # RA reduction	**45 RA avoided**	
3. Enhanced Services	200 admissions	(25% RA rate)
Expected effect		20%
Expected # RA reduction	**10 RA avoided**	
Total (*illustrative)	**105 RA avoided***	105/500 = 20% reduction

COLLABORATIVE HEALTHCARE STRATEGIES

Recommendations - Providers

1. Know your data for ALL readmissions
   - Don’t forget sepsis, behavioral health, renal failure, cancer, “frailty”
   - Recognize all these risks are the whole of general medicine
   - Specifically break out medicare, medicaid, commercial, uninsured
2. Move beyond Medicare only or disease specific only
3. Recognize Medicaid as independent risk of RA
4. Know what your current strategy is expected to achieve
   - Implement a diversified portfolio, including improving standard care

Recommendations – Payers

- Liberate Insights Available Through Claims Data
  - Providers want to see “full picture”
- Mirror data assets that CMS QIO program provides
  - Social network analysis
  - Post-acute readmission rates
  - Broadly defined dashboard of readmission & related metrics
- Move forward on readmission penalties
  - Do not assume that the CMS policies will accrue benefit to your membership

THANK YOU

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