Readmissions:
The Good, The Bad and The Public Policy Initiatives

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TRANSFORMING HEALTH CARE THROUGH RESEARCH AND EDUCATION

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Overview

- **Scope of the Issue**
- **Policy Initiatives**
- **Improvement**

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"The Billion Dollar U-Turn"

- 17.6% of all Medicare admissions are *readmissions* within 30 days
  - Accounting for $15 B in spending
- Not all re-hospitalizations are avoidable, but many are
  - 13.3% of all Medicare admissions; 76% potentially avoidable
  - Accounts for $12B in Medicare spending
  - Heart Failure, Pneumonia, COPD, Acute MI lead the medical conditions
  - CABG, PTCA, other vascular procedures lead the surgical conditions
- There is wide intra-state and inter-state variation
  - Medicare 30-day readmission rate varies 13-24% by state

Mark Taylor, The Billion Dollar U-Turn, *Hospitals and Health Networks*, May 2008
MedPAC Report to Congress, Promoting Greater Efficiency in Medicare. June 2007
Commonwealth Fund State Scorecard on Health System Performance. June 2007

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Epidemiology of Re-hospitalizations

- Preliminary 2007 Medicare data analysis finds:
  - 20% beneficiaries are re-hospitalized at 30 days
  - 35% are re-hospitalized at 90 days
  - 67% are re-hospitalized or deceased at 1 year
- Among medical patients re-hospitalized at 30 days:
  - 50% no bill for MD service between discharge and re-hospitalization
- Among surgical patients re-hospitalized at 30 days:
  - 70% were re-hospitalized with a medical DRG

Source: Jencks SF, Williams MV, Coleman EA. Rehospitalizations among patients in the Medicare fee-for-service program. *New England Journal of Medicine*. 2009; 360(14): 1418-28.

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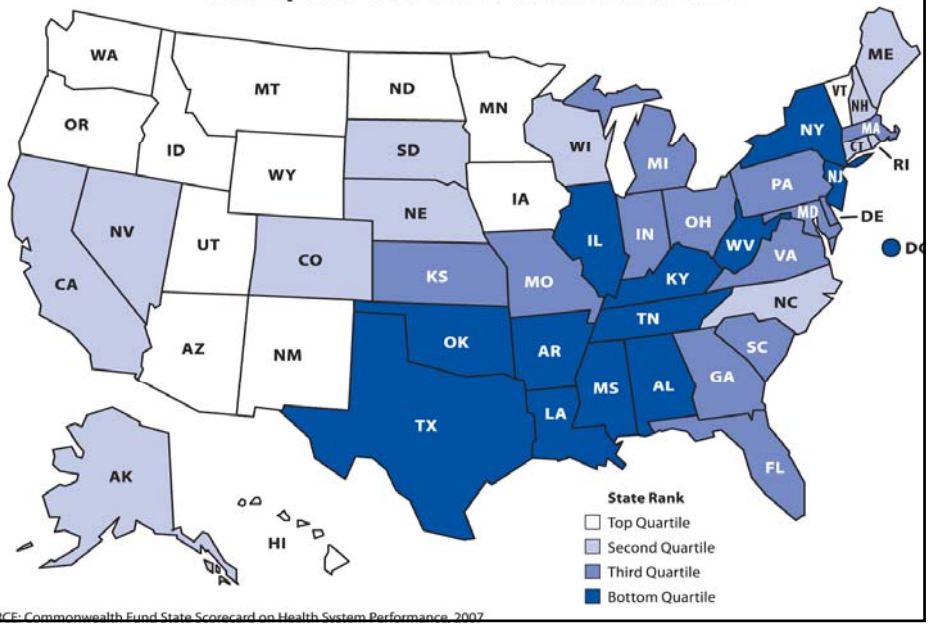
AVOIDABLE HOSPITAL USE AND COSTS

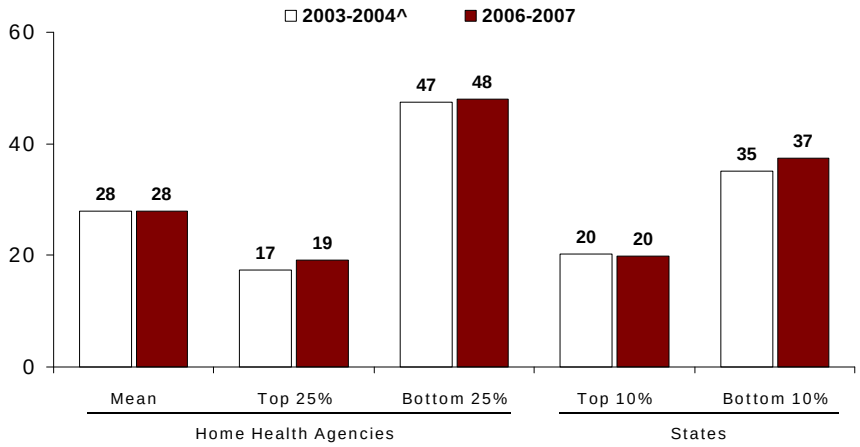
State Ranking on Potentially Avoidable Use of Hospitals and Costs of Care Dimension



SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007

Home Health Care: Hospital Admissions

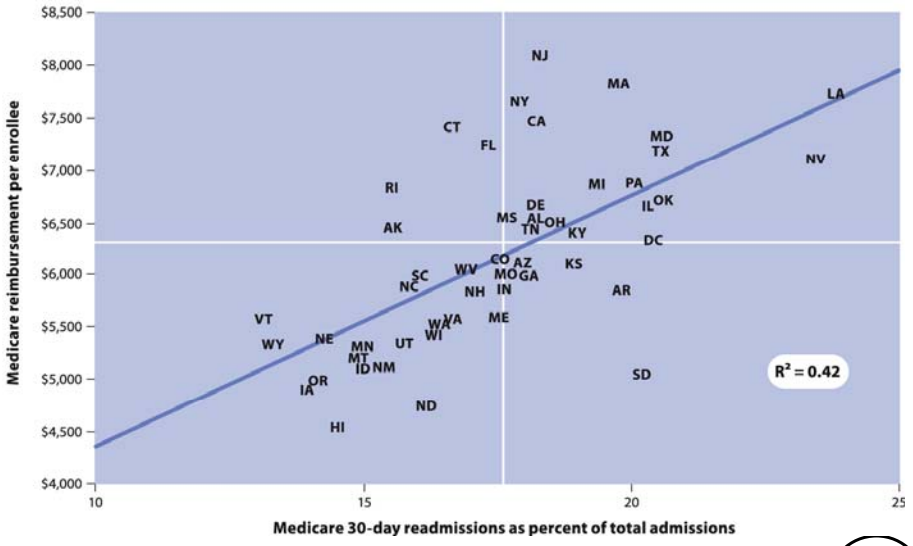
Percent of home health care patients who had to be admitted to the hospital



^ 2003 data for state estimates.
Data: Outcome and Assessment Information Set (Retrieved from CMS Home Health Compare database at http://www.medicare.gov/HHCompare, Pace et al. 2005)

6 **Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008**

Exhibit 3. Medicare Reimbursement and 30-Day Readmissions by State

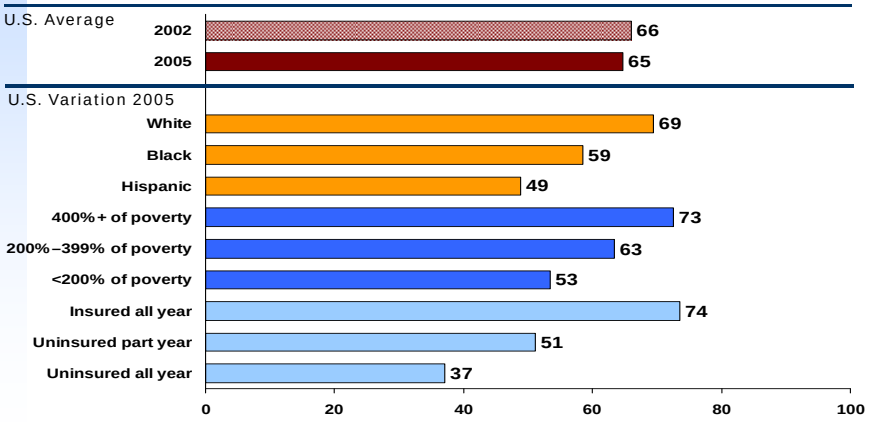


THE COMMONWEALTH FUND

Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008.

Adults with an Accessible Primary Care Provider

Percent of adults ages 19–64 with an accessible primary care provider*



* An accessible primary care provider is defined as a usual source of care who provides preventive care, care for new and ongoing health problems, referrals, and who is easy to get to.
Data: B. Mahato, Columbia University analysis of Medical Expenditure Panel Survey.

Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008

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Linking Coordination and Risk

- Topic receiving attention: Readmissions
  - MedPAC estimates $18B spent on readmissions of Medicare patients within 30 days of discharge (2008 Report)
  - Readmission rates vary by major diagnoses and regions of the country
- Proposals emerge
  - MedPAC
  - President's budget
  - Senate Finance Committee Options Paper on Delivery System Reform

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What Do Proposals Do?

- Single out hospitals with relatively high rates of readmissions
- Impose financial incentives to keep readmission rates low
- House Bill would:
  - Penalize hospitals with readmission levels in excess of the expected level of readmissions for a hospital with their same patient mix of heart attack, heart failure and pneumonia patients
  - Give the Secretary the opportunity to expand from those three conditions to others beginning in 2013

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AHA Perspective

- Unnecessary readmissions are to be avoided
- Readmissions are manifestation of many different problems
- All readmissions are not equal
  - Planned and unplanned
  - Related and unrelated

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AHA Perspective

Classification of Readmissions		
	Related to Initial Admission	**Unrelated to Initial Admission**
Planned Readmission	A **planned** readmission for which the reason for readmission is **related** to the reason for the initial admission.	A **planned** readmission for which the reason for readmission is **not related** to the reason for the initial admission.
Unplanned Readmission	An **unplanned** readmission for which the reason for readmission is **related** to the reason for the initial admission.	An **unplanned** readmission for which the reason for readmission is **not related** to the reason for the initial admission.

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AHA Perspective

Classification of Readmissions		
	Related to Initial Admission	Unrelated to Initial Admission
Planned Readmission	Follow up surgery for burn patient	Biopsy of lung growth discovered while patient admitted for knee surgery
Unplanned Readmission	Patient sent home after heart surgery experiences blood clot	Patient in traffic accident after discharge from hospital

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Public Policy Is In Flux

What Will Be Expected of Hospitals?

- **More coordination**
  - Work with other providers to manage care across episodes
- **More financial risk**
  - Opportunity to benefit from efficient care management
- **More transparency**
  - Continued reporting of important quality measures to the public

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The Reasons Behind Unplanned, Related Readmissions Are Complex

- Hospitals have responsibilities, but they are not alone
- Readmissions occur when:
  - Patients don't understand or can't comply with discharge instructions
  - Patients in some communities lack access to primary care, post acute care, pharmacies
  - Patients have multiple diagnoses that make them more vulnerable to complications.

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Some High-Leverage Opportunities for Action

Executing an effective transition from the hospital to post-acute care settings

- Early assessment of discharge needs
- More intensive management of chronic medical conditions during hospitalization
- Evidence: transition coaching, nursing phone call follow-up, hospital – generated phone call and coaching, collaboration between sending and receiving facilities on what data is needed during transfers

Facilitating timely follow-up care in the post-discharge setting

- Work with outpatient providers to schedule appointments prior to discharge
- Consider early follow up for "high risk" patients which may be hospital-generated call, hospitalist discharge clinic
- Increase referral to home health when indicated (evidence of low percentage of referrals even in presence of indication)
- Consider enhanced outpatient support

Engaging patients/caregivers as active participants/managers of their care

- Including medications, monitoring for and acting on clinical deterioration
- Hospital-based enhanced assessment of patient understanding of their condition, early and repeated teaching opportunities during the hospitalization (not just at time of discharge)
- Assess understanding by patients' ability to "teach back" what their condition is, what diet/medications are required to stay stable, symptoms to watch for and what to do if those symptoms occur

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Take Home Messages

- Hospitals and their communities need to become better at avoiding readmissions by improving the reliability of the care provided
- Congress is willing to achieve cost savings by penalizing hospitals perceived as performing poorly
- Greater integration of care throughout patient episodes will help us address care challenges

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