

Preventable Readmissions – CHCF Meeting



Strategy to reduce readmissions and increase quality needs to have the following elements

- A tool to identify preventable readmissions
- Payment incentives
- Public reporting
- Quality Improvement Strategy

3M HIS Clinical Research Experience

3M HIS Experience in developing classification and payment/quality systems includes:

- Development of the first DRG Prospective Payment System (PPS) in NJ in 1980
- Design and development of the first outpatient PPS for Iowa Medicaid
- Under contract with CMS, design, development and maintenance of acute long term care hospital PPS
- Design and development of ICD-10 PCS
- Design and development of Potentially Preventable Readmission (PPRs) and Potentially Preventable Complication (PPCs) using APR-DRGs
- Under contract to the Federal Government, development of Clinical Risk Groups (CRGs) and CRxGs (privately funded - using pharmaceutical data) for population profiling/ risk adjustment/ physician profiling

All classification tools including PPRs are developed jointly with NACHRI

Value can be measured for each of the 4 kinds of health care encounters

$$\text{Value} = \text{Max Outcomes Quality} / \text{Payment}$$

Value can be measured

Ambulatory Patient Groups (APGs) – Visits

All-Patient Refined DRGs (APR-DRGs) – Hospital Stays

Clinical Risk Groups (CRGs) – Year Long Person Based Episodes

APR-DRGs/CRGs plus Health Status - Long Term Care

Quality

Cost

In Every Country There Are Four Sources for Variation in Health Services

- Patient/family variation
- Caregiver/clinician variation
- Hospital/system variation
- Community variation

Payers rarely tie financial or quality incentives to any of these sources of variation. Today we have the tools such as **readmissions** to measure **each of these sources of variation** for each type of health care encounter. Payers need to offer quality and financial incentives to aggressively control the costs and improve the quality of this variation.


Key Attributes of the Medicare Inpatient Prospective Payment System (IPPS) That Were Critical to its Success – Attributes That Have Been too Often Forgotten

- Payment was based on a Categorical Clinical Model
- Separate Methodology for Computation of Payment Weights
- Separate Payment Adjustments for Nonclinical Factors
- Outlier Payments Specific to the Patient's Condition
- Payment based on national rates and regional cost variations not perpetuated


Categorical vs Regression Models

- *“The success of any payment system that is predicated on providing incentives for cost control is almost totally dependent on the effectiveness with which the incentives are communicated... Central to the success of the Medicare inpatient hospital prospective payment system is that DRGs have remained a clinical description of why the patient required hospitalization.”*
Federal Register, May 4, 2001
- Users need to decide whether they are using a methodology purely for payment incentives or for system change.

Research Approach for Development of PPRs

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- Not all readmissions are preventable
 - Define exclusion criteria for identifying initial discharges for which a subsequent readmission is excluded from consideration as a PPR (e.g. discharged against medical advice)
 - Develop criteria for determining if a readmission is potentially preventable (i.e. a PPR)
 - Develop a method of determining the risk of a PPR occurring and develop a method for computing actual and expected hospital PPR rates
 - Test methodology in large databases

The Maryland Experience

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- HSCRC in Maryland proposed using a subset of Potentially Preventable Complications (PPCs) to reduce payments to Maryland hospitals
 - HSCRC sets hospital payment rates for all payers using APR DRGs
 - Conservative methodology was proposed in which a payment adjustment for complications was applied at the hospital level:
 - The number of excess complications compared to statewide complication rates was computed for each hospital
 - The marginal cost of each type of complication was used to convert the number of excess complications in a hospital to a payment adjustment amount
 - The payment adjustment was hospital specific and not patient specific


Readmission Payment Design Issues- Methodological Questions

- Discharge severity of illness?
- Hospital and group practice MUST be able to replicate the data if we wish improvement. Only possible with a clinically precise categorical model.
- Age specific groups; other socioeconomic variables?
- Computation of separate actual to expected for beneficiaries with mental illness and/or substance abuse disorders (either as a pdx or sdx).

Readmission Payment Design Issues – Who gets what money and how?

- Readmission window of time
 - Fifteen day window for the hospital
 - Starting at day sixteen upside risk potential for redistribution of funding to well performing group practices
- Readmission to same hospital or any hospital
- Outlier chains: only possible with a categorical model.
- Payment: based on rates at the hospital and/or group practice level not on specific cases.

General Philosophical Approach

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- Although reducing payment for readmissions can create immediate savings, future savings from lower readmission rates are potentially much greater
 - IPPS was implemented on a budget neutral basis and the vast majority of savings from IPPS were achieved as a result of subsequent changes in hospital behavior that occurred in response to the inherent IPPS incentives for efficiency
 - Objective is to provide financial incentives for hospitals and group practices to reduce readmissions but not to create a financial crisis
 - 1-3 percent of payments would be redistributed


Designing a Hospital and Group Practice Specific Payment Adjustment for Readmissions

- The development of a payment adjustment for readmissions requires five steps:
 - Identify readmissions that are potentially preventable
 - Apply risk adjustment to potentially preventable hospital readmission rates
 - Compare the risk adjusted readmission rates of hospitals
 - Establish the magnitude of hospital specific payment reductions
 - Incorporate the payment reductions into the payment system


Designing a Hospital and Group Practice Specific Payment Adjustment for Readmissions [continued]

- The end result of these steps is an aggregate hospital or group practice specific readmission payment adjustment factor.
- The readmission payment adjustment factor would be computed based on a hospital's or group practices readmission rate computed from most recent available historical data and prospectively applied in the determination of the DRG payment amounts.


Approach

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- Use PPRs to identify readmissions that are potentially preventable and use discharge APR DRGs to risk adjust readmission rates
 - Using available data from all hospitals, the PPR rate for each APR-DRG is calculated to establish a PPR norm by APR DRG
 - Applying indirect rate standardization to the PPR norm, the expected number of PPRs for each hospital and/or group practice can be computed and used to determine the number of “excess PPRs” in each hospital


Setting the PPR Norm

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- Using the PPR rate across all hospitals or group practices establishes the average PPR performance as an acceptable standard
 - Although the Medicare IPPS used the national average cost per discharge as the basis of establishing the initial DRG payment level, the 1982 HHS IPPS Report to Congress anticipated that other alternatives such as median or geometric mean cost per discharge would be considered for future implementation
 - The initial PPR standard should be stricter than the average PPR rate across all hospitals

Establishing a Best Practice PPR Norm

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- Identify the subset of hospitals or group practices that have the lowest ratios of actual to expected PPR rates based on the average PPR rates across all hospitals
 - The subset of hospitals with the best relative PPR performance are likely to differ depending on the type of patient under consideration
 - Assign each of the 314 base APR-DRGs to one of 35 different hospital service lines (e.g. cardiac surgery, obstetrics, etc)
 - For each service line, rank order hospitals in terms of the percent difference between the actual and expected number of PPRs

Establishing a Best Practice PPR Norm [continued]

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- For each service line, select the subset of hospitals with the best performance (i.e. actual lower than expected) that comprise at least 25 percent of the overall patient population in that service line
 - Using the subset of patients selected in this manner, a PPR best practice norm for each APR-DRG in each service line can be computed
 - Use the best practice norm to compute the number of excess PPRs in each hospital


Establishing the magnitude of hospital specific payment reductions

- Each initial admission is followed by one or more PPRs
- Each PPR is assigned to an APR DRG and has an associated payment weight
- The payment weight of all PPRs associated with the initial admissions in each APR DRG can be used to compute the average relative payment for all the PPRs that follow an initial admission
- This average, referred to as the “PPR relative weight”, is not a measure of the relative costliness of the initial admission but is a measure of the relative costliness of the PPRs that follow an initial admission
- The PPR relative weights can be used to convert the number of excess PPRs in an APR DRG to a payment reduction amount

Issues for Discussion in Public Reporting

- Start with one number and then allow the user to dig deeper – how deep?
- Types of hospitals – like with like or across the board?
- Minimum numbers needed for comparison
- Age range breakout reports
- Visual display

Quality Improvement Strategy: Readmission causes

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- Poor understanding of the patient's capacity to manage in the home environment because the patient and family caregivers are not involved in identifying needs and resources and in planning for the discharge
 - Transfer to a care venue that does not meet the patient's needs due to a lack of understanding of the patient's functional physical and cognitive health status
 - Medication errors and poly-pharmacy
 - Worsening clinical status in the hospital is not recognized
 - Discharge is ordered too early
 - An advanced care directive is not obtained

Quality Improvement Issues that need to be addressed if we are to decrease readmissions




Patient Issues

- Health Status
- Depression and Cardiac Disease
- Major mental health disorders and carve outs
- Cardiac medical and other co-morbidities.
- “Frequent fliers” – why do they keep coming back?

Hospital/Provider Issues

- Follow-up contacts
 - Phone vs in person
 - Need to be able to pay; payer source
 - Need to be able to do at least one home visit for which people?
- Improving patient understanding - using regular “teach back”
- Medication reconciliation is key – multiple provider issue

Phase In Approach to Decrease Readmissions in California

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- Year 1
 - Analyze pooled plan/Medi-CAL/ OSHPD data using whatever methodology you choose
 - Put up a state wide public report card that includes drop down menus for consumers on teach back on all aspects of discharge planning process
 - Discuss payment redistribution options for years 2 implementation for both group practices and hospitals. Preparations would need to be made for incorporation into hospital and group practice contracts.
 - Begin a state wide collaborative that has a group practice section and a hospital section

Phase In Approach to Decrease Readmissions in California [continued]

- Year 2 :
 - Using agreed upon redistribution option, redistribute dollars to group practices and hospitals – excluding readmissions where the pdx is an MH/SA disorder (exc pilots)
 - Pilot projects with Medi-CAL in particular that redistribute dollars for MH/SA readmissions for housing/employment pilot efforts.
 - Worst hospitals/group practices can apply for improvement grants
 - Public report card as consumer engagement measure. Results given to collaborative

Year 3:

- Include MH/SA disorders.
- Use improved Best practice norm in continuous improvement manner