Path to High Performance: Avoiding Re-hospitalizations

From Take Off to Landing: Assuring A Safe Transition Journey

National Medicare Readmission Summit
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Goals of Presentation

- Why Focus on Re-hospitalizations
- Health Care Reform Context: Economic, Political, Societal
- Is the nation ready?
  - Knowledge, Will, Action
- Harnessing knowledge and experience to get to nationwide impact
  - STAAR Initiative: State Action to Avoid Re-hospitalizations (IHI/CMWF)

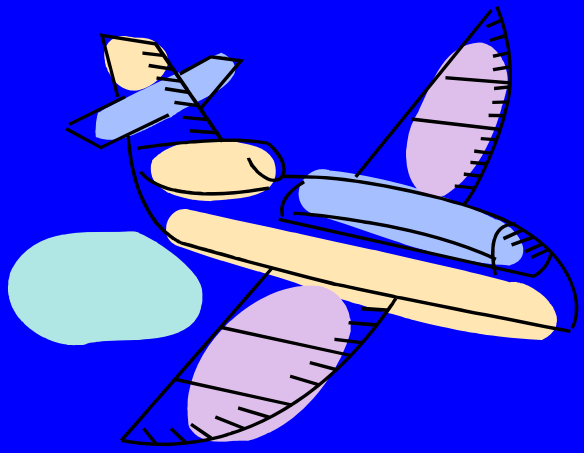
Why Focus on Re-hospitalizations

A Priority - why now?

Health Care Reform Context: Economic, Political, Societal

- Prevalent, nationwide problem
- Harmful to patients
- Costly
- Symptom of a fundamental flaw in our health care system:
  - Effective
  - Safe
  - Timely
  - Coordinated
  - Patient-centered
  - Efficicient (waste)
  - Equitable
- System based on siloes, isolationism vs integration, “globalization”

The Transition Care Journey



TAKE OFF

HOSPITAL

LANDING

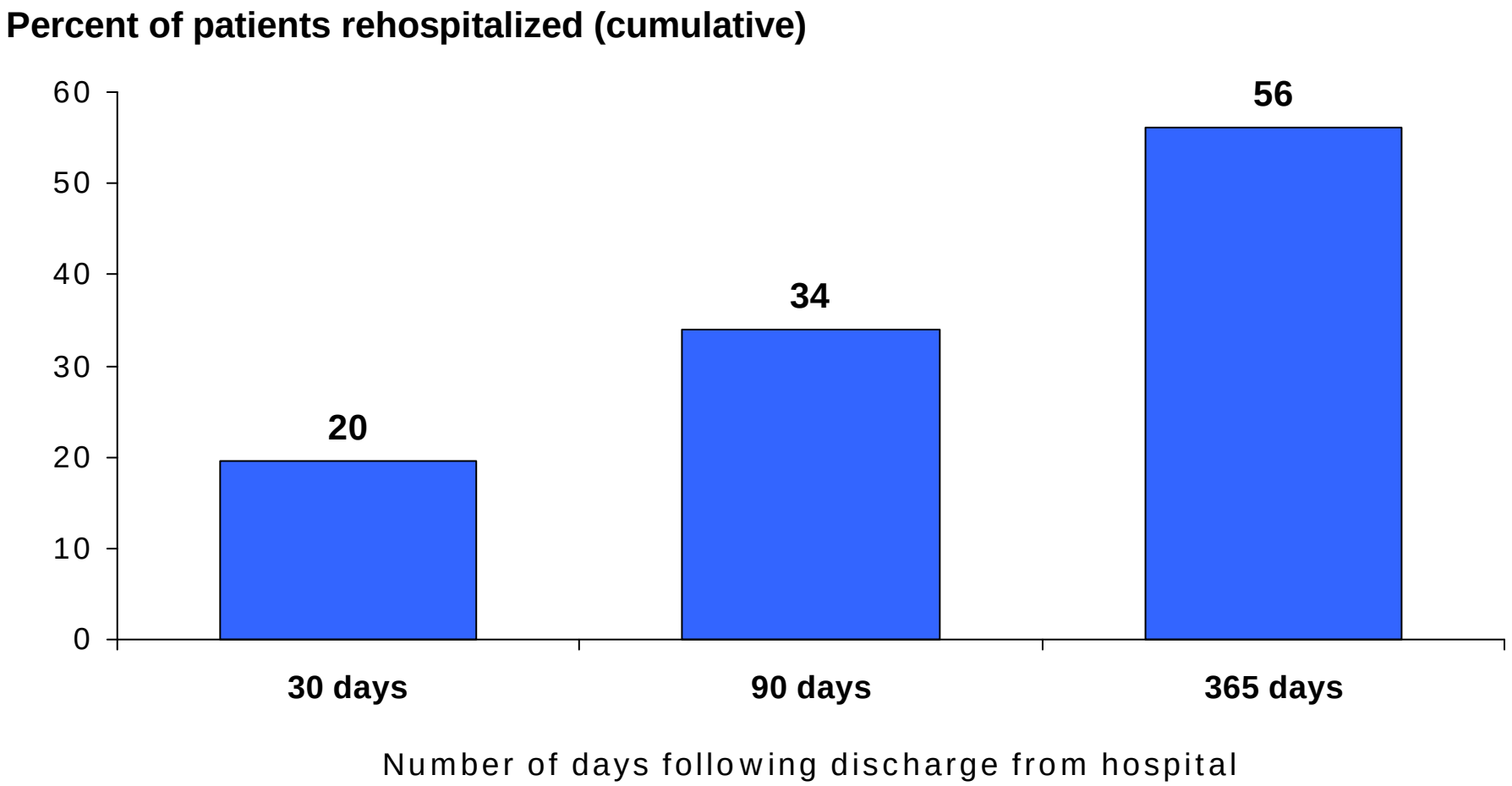
- **Home/ Home Health**
- **Nursing Home**
- **Primary Care Physician Office**
- **Rehabilitation**
- **Integrated Delivery System**
- **Community Health Center**
- **Etc…**

Path to High Performance: Where is the Nation?

- Prochaska's model of change and levels of preparedness

Stages	Resources
Pre-contemplation	Knowledge: scope of problem
Contemplation	Will: motivation/incentives
Preparation	Knowledge of solutions: Tools, Models, Resources
Action	Knowledge, Will, Tools, Resources
Maintenance	

Exhibit 1. Rehospitalizations After Discharge from the Hospital Among Patients in Medicare Fee-for-Service Programs



Source: Adapted from S.F. Jencks, M.V. Williams, and E.A. Coleman, “Rehospitalization Among Patients in the Medicare Fee-for-Service Program,” New England Journal of Medicine, Apr. 2, 2009 360(14):1418-28.

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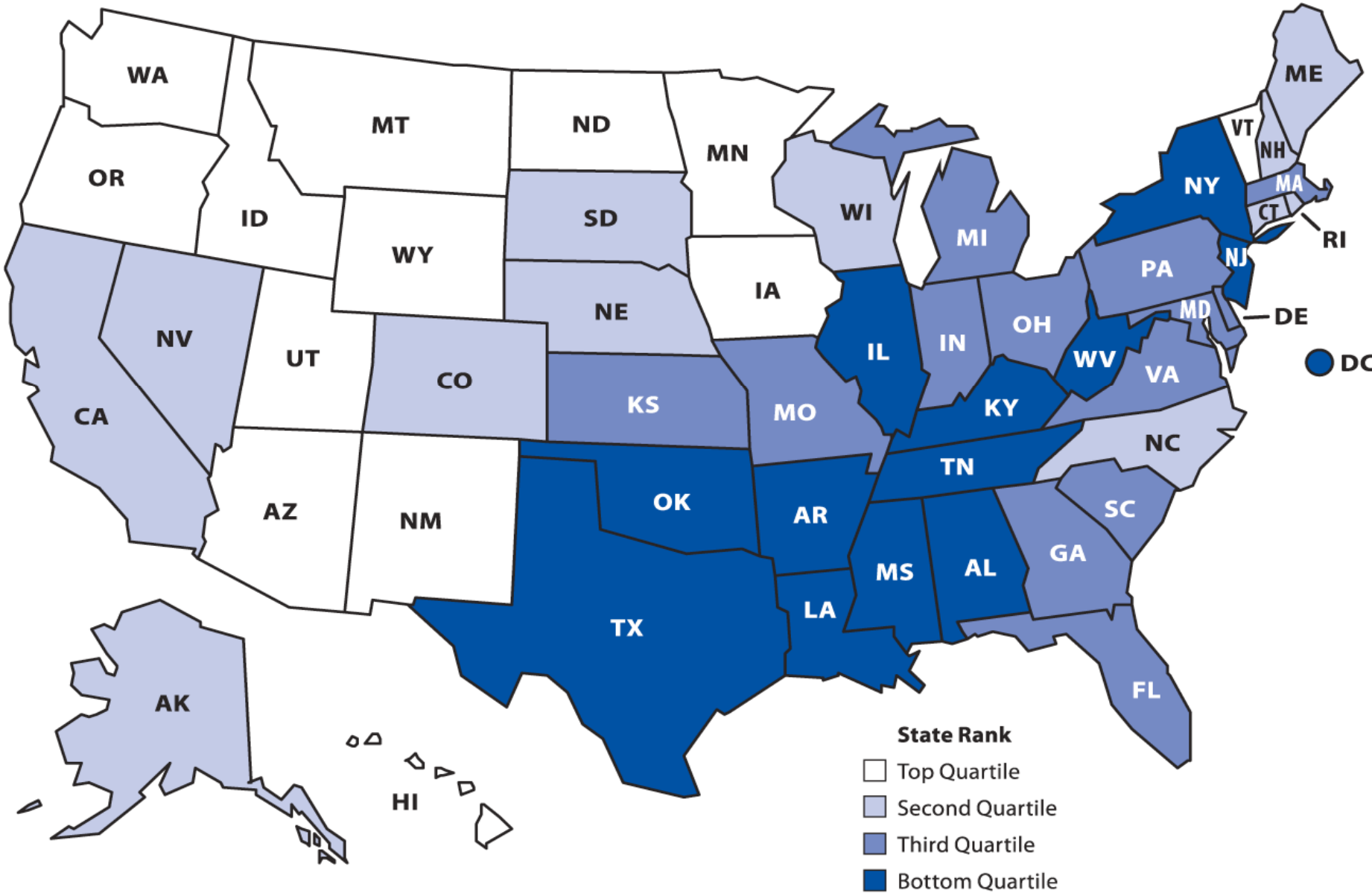
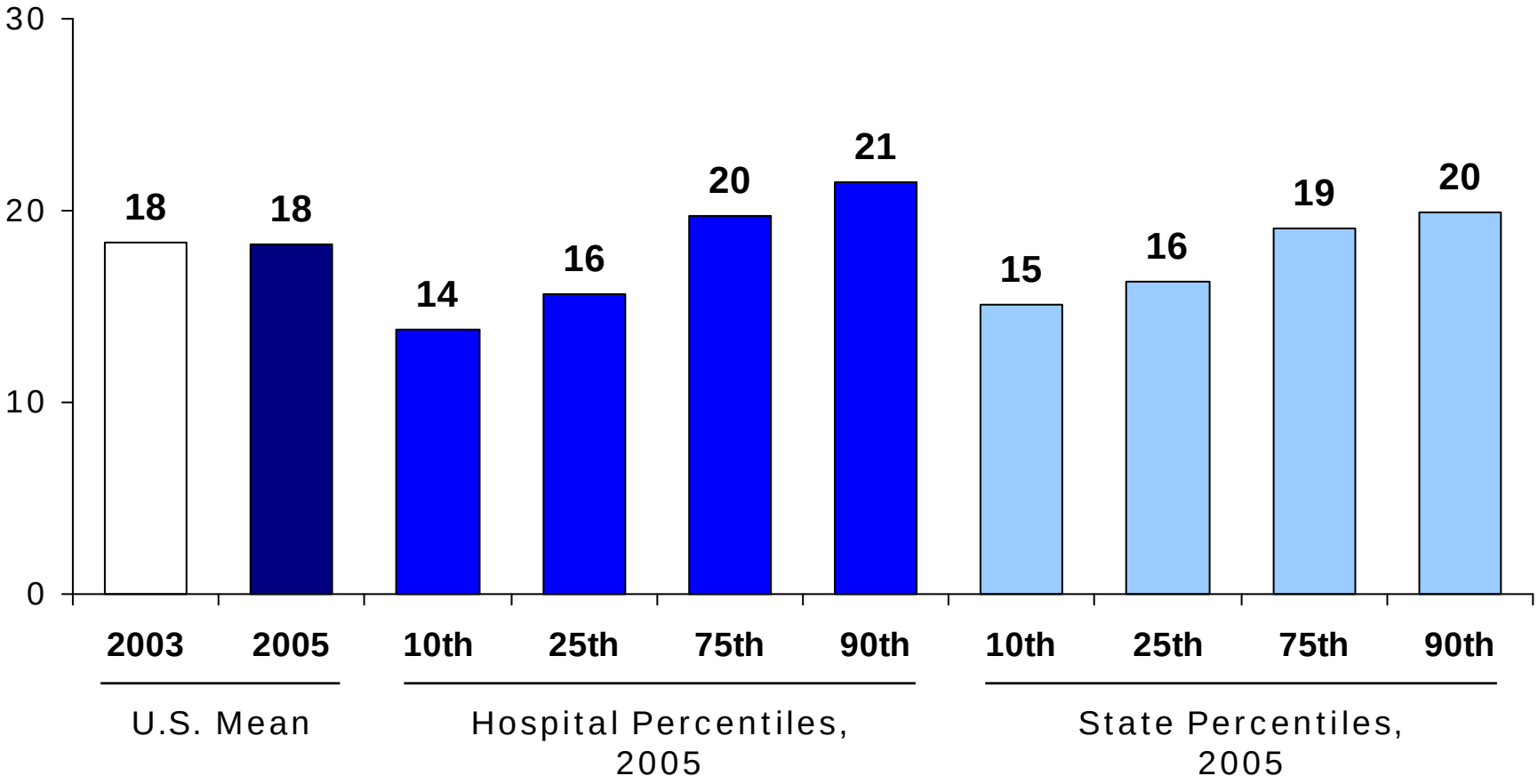
State Ranking on Potentially Avoidable Use of Hospitals and Costs of Care Dimension



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

Exhibit 2. Medicare Hospital 30-Day Readmission Rates

Percent of Medicare beneficiaries admitted for one of 31 select conditions who are readmitted within 30 days following discharge*



Data: G. Anderson and R. Herbert, Johns Hopkins University analysis of Medicare Standard Analytical Files (SAF) 5% Inpatient Data.

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

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Re-hospitalizations for Congestive Heart Failure

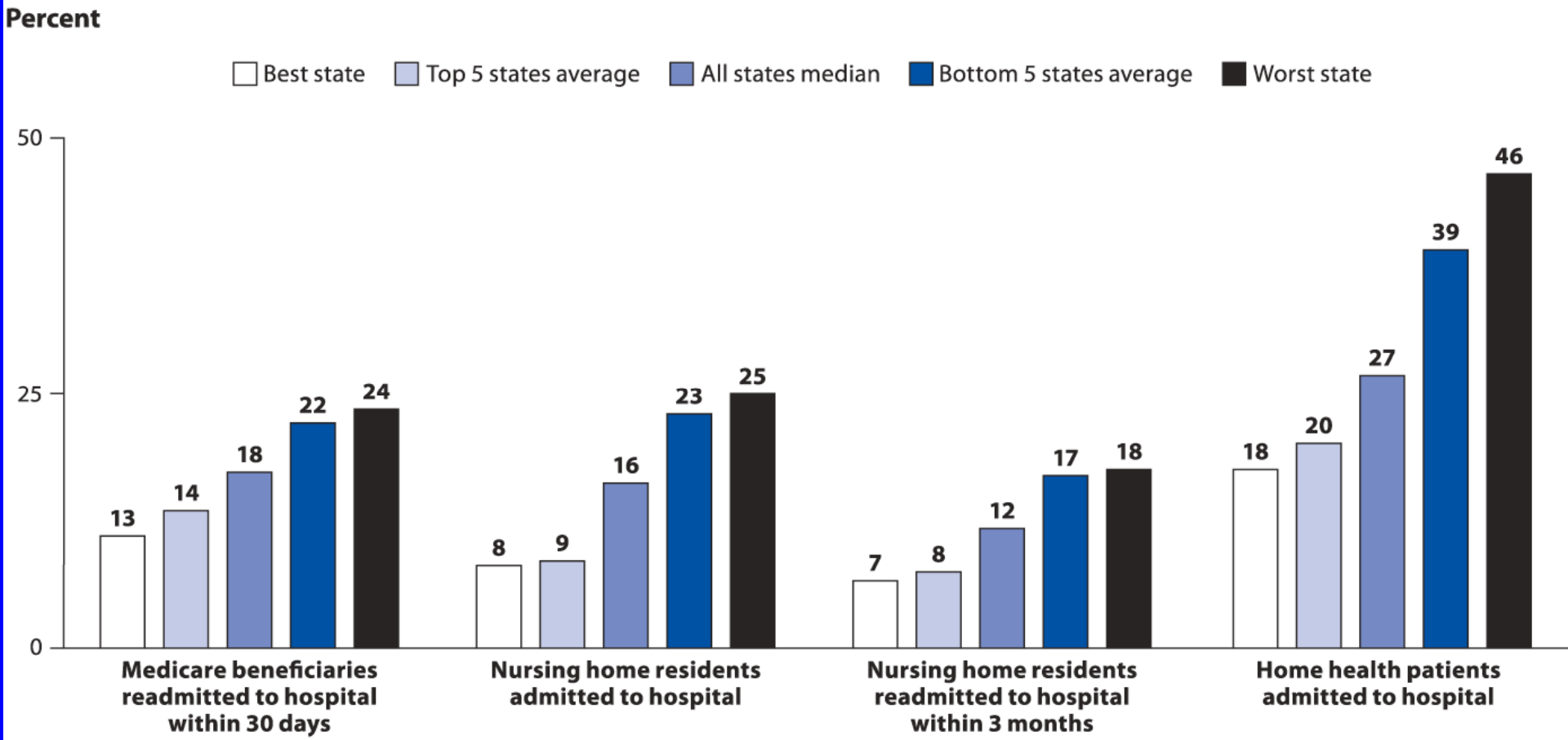
Per 1,000 Initial Admissions for CHF for adults

		2004		2005	
Age category	**State**	**Rate**	**SE**	**Rate**	**SE**
Ages 18-64	State A	140	1.00	140	1.00
	State B	190	1.00	230	1.00
	State C	180	1.00	190	1.00
	State D	260	0.00	270	0.00
	State E	230	1.00	220	1.00
	State F	220	1.00	240	1.00
	State G	230	1.00	230	1.00
	State H	240	0.00	250	0.00
	State I	240	1.00	250	1.00
Age 65+	State A	110	1.00	110	1.00
	State B	170	0.00	160	0.00
	State C	180	0.00	170	0.00
	State D	190	0.00	190	0.00
	State E	210	0.00	200	0.00
	State F	210	0.00	200	0.00
	State G	200	1.00	200	0.00
	State H	210	0.00	210	0.00
	State I	220	0.00	210	0.00
All ages (18+)	State A	120	1.00	120	1.00
	State B	170	0.00	180	0.00
	State C	180	0.00	180	0.00
	State D	210	0.00	210	0.00
	State E	210	0.00	200	0.00
	State F	210	0.00	210	0.00
	State G	210	0.00	210	0.00
	State H	220	0.00	220	0.00
	State I	220	0.00	220	0.00

Note: Data are for adults 18 years or older. Annual rates are adjusted for age and gender)

Source: Agency for Healthcare Research and Quality, Healthcare Cost and Utilization Project, State Inpatient Databases, 2004 and 2005.

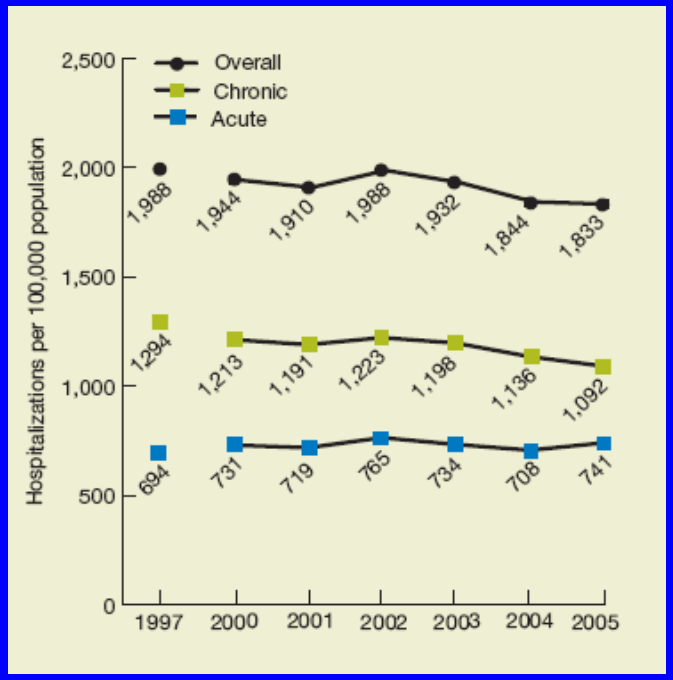
State Variation: Hospital Admissions Indicators



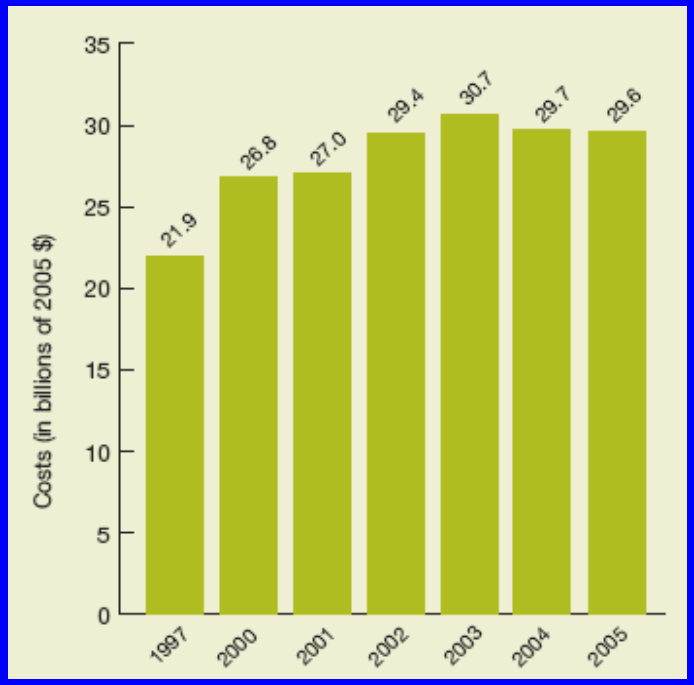
DATA: Medicare readmissions – 2003 Medicare SAF 5% Inpatient Data; Nursing home admission and readmissions – 2000 Medicare enrollment records and MedPAR file; Home health admissions – 2004 Outcome and Assessment Information Set
SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007

Care Efficiency

National trends in potentially avoidable hospitalization rates, by type of hospitalization, 1997 and 2000-2005



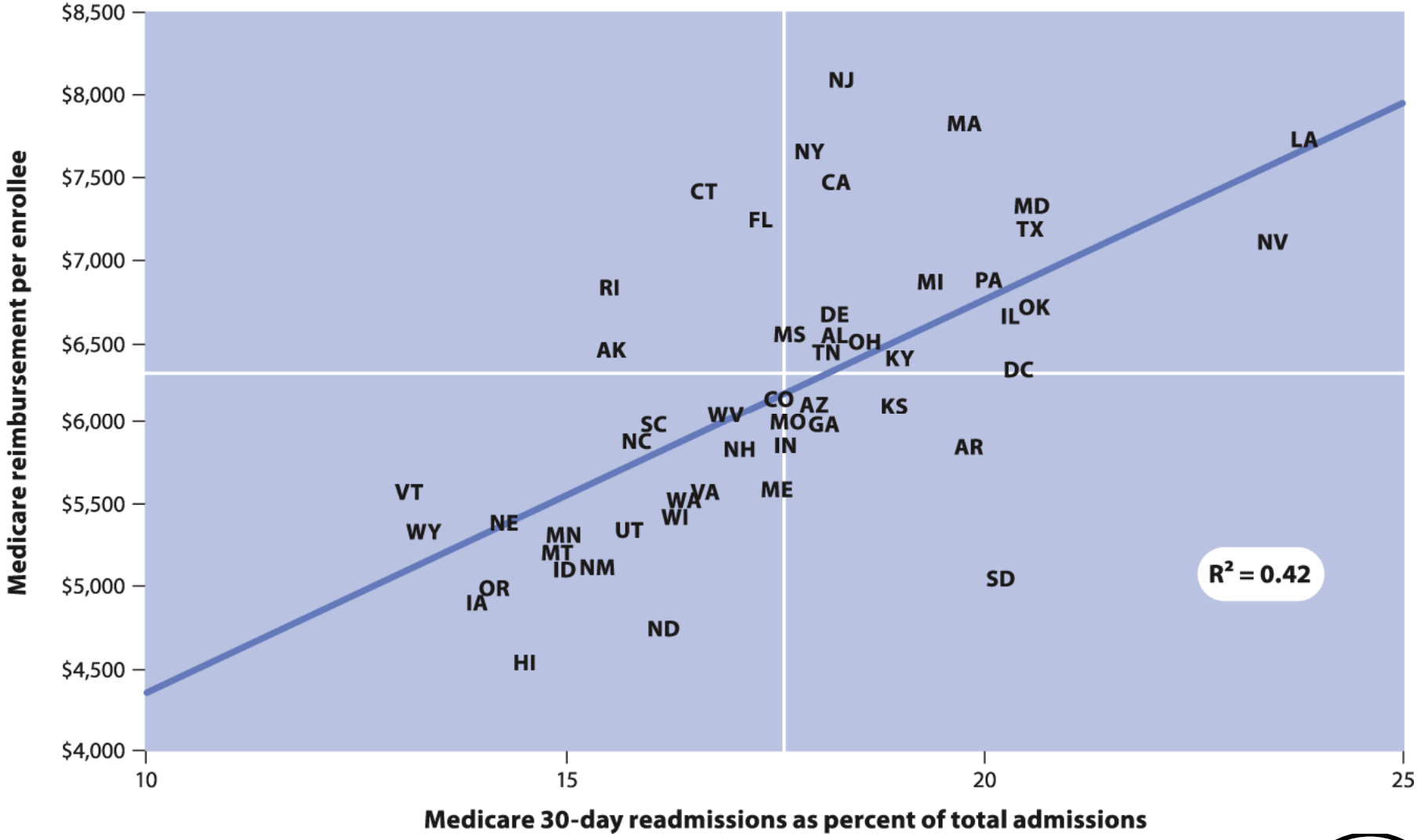
Total national costs associated with potentially avoidable hospitalizations, 1997 and 2000-2005.



- **From 1997 to 2005, avoidable hospitalizations for chronic conditions decreased significantly, from 1,294 per 100,000 to 1,092 per 100,000.**
- **Avoidable hospitalizations for acute conditions did not significantly change from 1997 to 2005**
- **Although avoidable hospitalization rates have decreased overall since 2000, total national costs associated with potentially avoidable hospitalizations have increased since 2000. Costs exceeded $29 billion in 2005, which was 35% greater than what these costs were in 1997 when adjusted for inflation.**

Note: Data are for adults 18 years or older. Annual rates are adjusted for age and gender)
Source: Agency for Healthcare Research and Quality, Healthcare Cost and Utilization Project, State Inpatient Databases, 2004 and 2005.

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



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

Care Access and Coordination

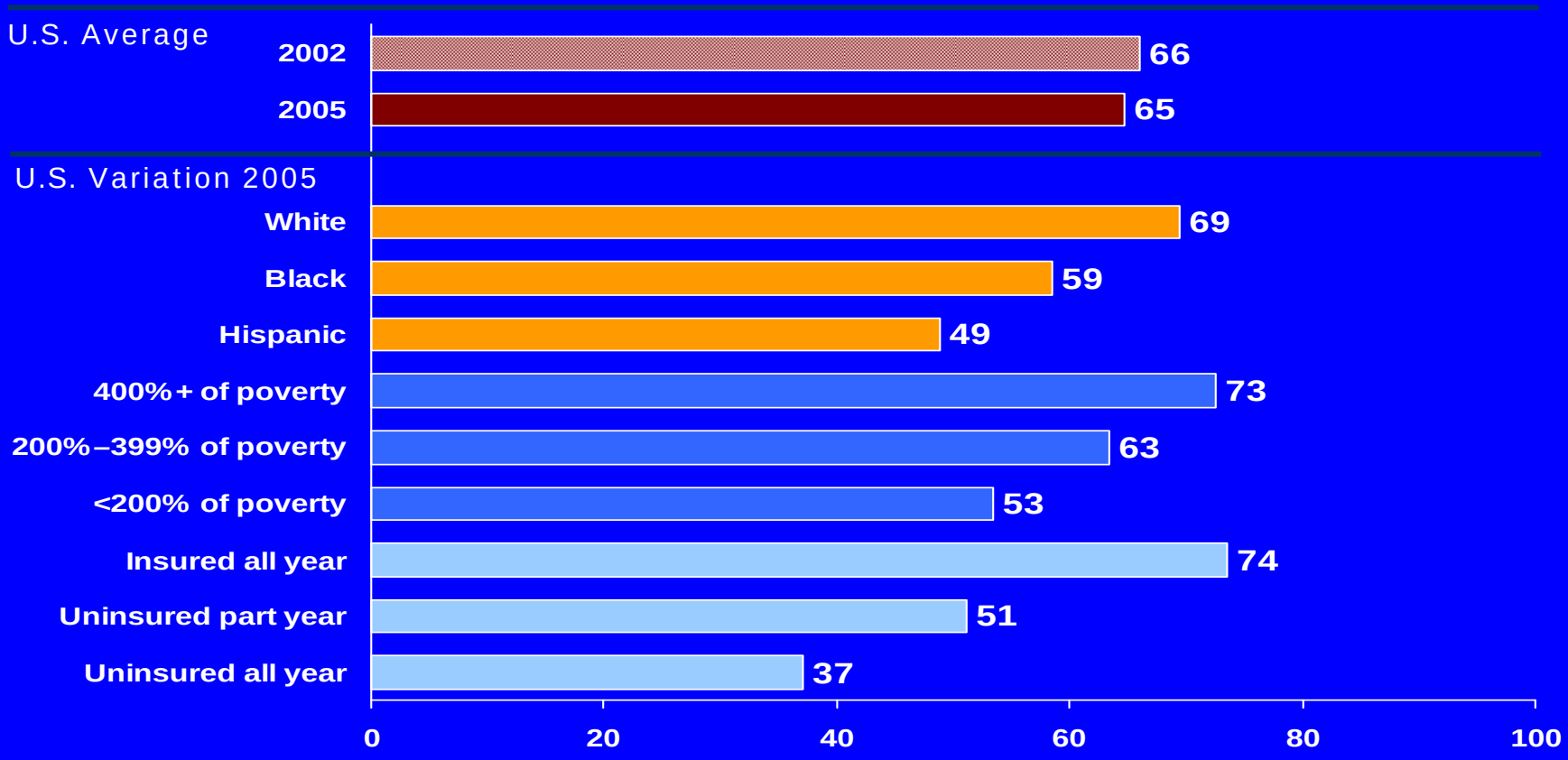
Scored Indicators:

1. Adults under 65 with an accessible primary care provider
2. Children with a medical home*
3. Care coordination at hospital discharge
   - Hospitalized patients with new Rx: Medications were reviewed at discharge*
   - Heart failure patients received written instructions at discharge
   - Follow-up within 30 days after hospitalization for mental health disorder
4. Nursing homes: hospital admissions and readmissions
5. Home health: hospital admissions

* Indicator was not updated due to lack of data. Baseline figures from 2006 Scorecard are presented.

Adults with an Accessible Primary Care Provider

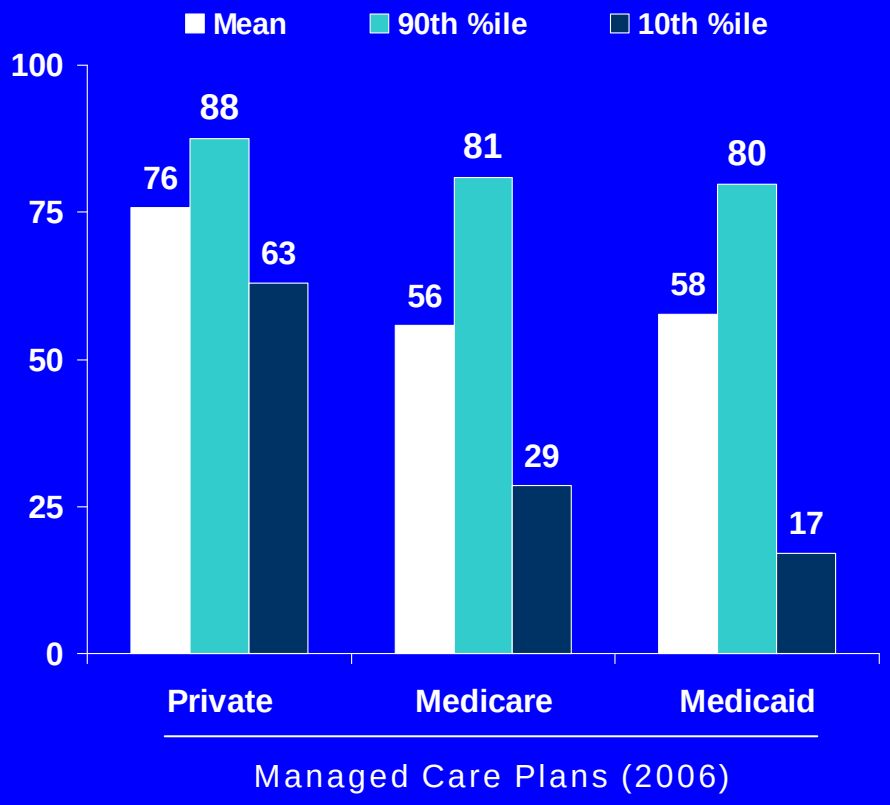
Percent of adults ages 19–64 with an accessible primary care provider*

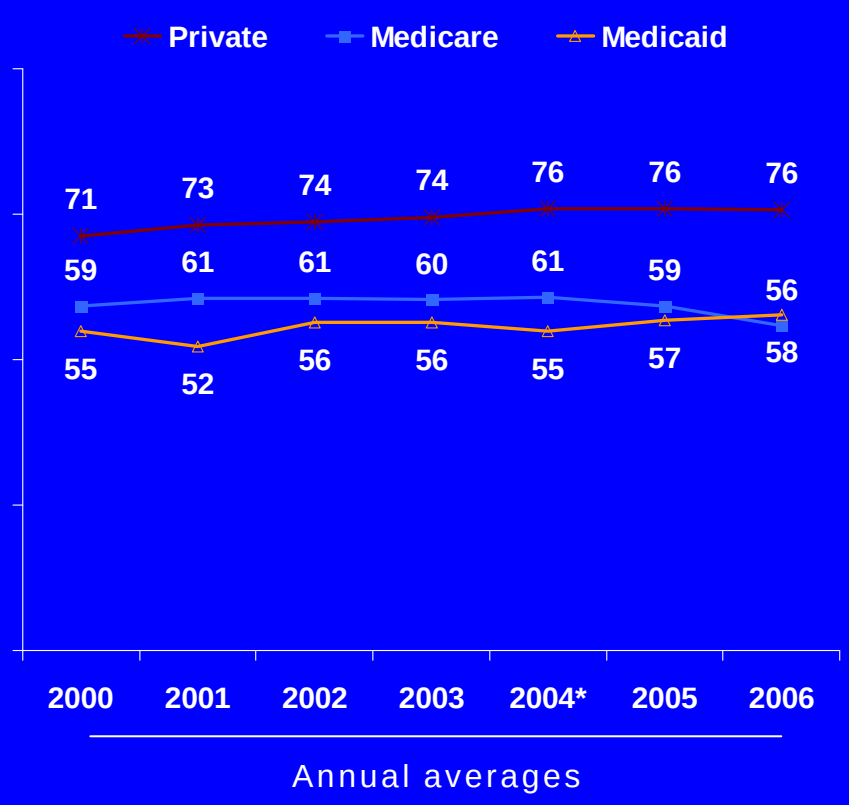


* An accessible primary care provider is defined as a usual source of care who provides preventive care, care for new and ongoing health problems, referrals, and who is easy to get to.
Data: B. Mahato, Columbia University analysis of Medical Expenditure Panel Survey.

Managed Care Health Plans: 30-Day Follow-Up After Hospitalization for Mental Illness

Percent of health plan members (ages >6) who received inpatient treatment for a mental health disorder and had follow-up within 30 days after hospital discharge

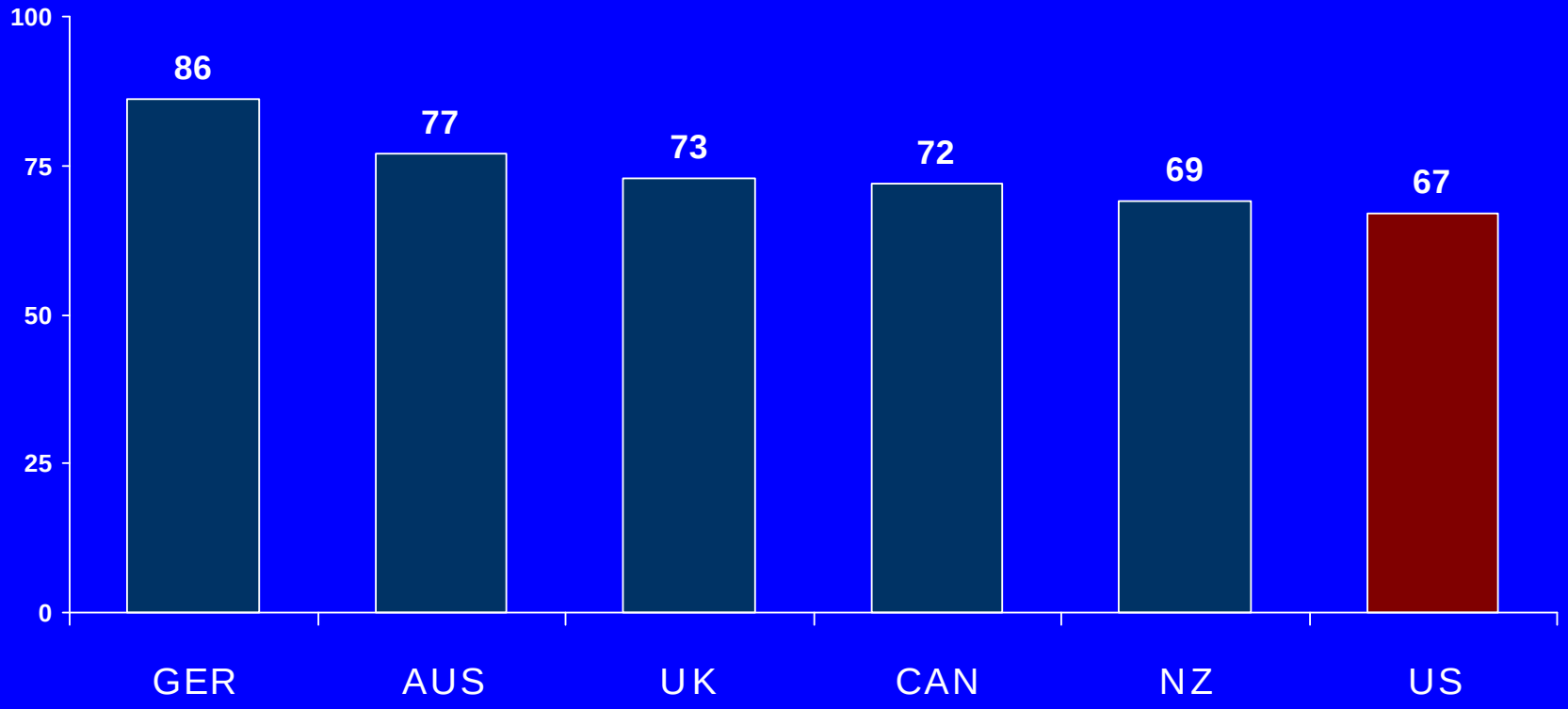




* Denotes baseline year.
Data: Healthcare Effectiveness Data and Information Set (NCQA 2007).

Medications Reviewed When Discharged from the Hospital, Among Sicker Adults

Percent of hospitalized patients with new prescription who reported prior medications were reviewed at discharge

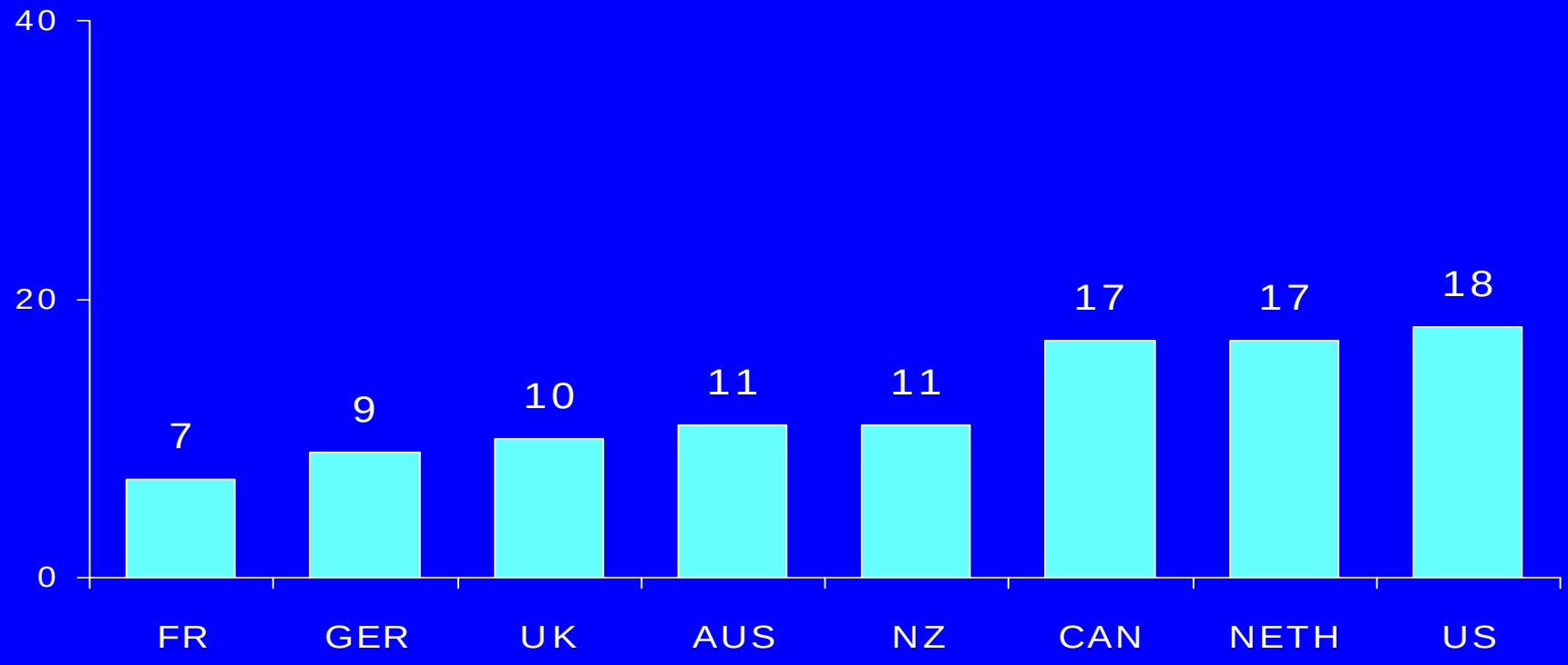


Note: Indicator was not updated due to lack of data. Baseline figures from Scorecard 2006 are presented.
AUS=Australia; CAN=Canada; GER=Germany; NZ=New Zealand; UK=United Kingdom; US=United States.
Data: 2005 Commonwealth Fund International Health Policy Survey.

Readmitted to Hospital or Went to ER From Complications During Recovery

Base: Adults with any chronic condition who were hospitalized

Percent



Source: 2008 Commonwealth Fund International Health Policy Survey of Chronically Ill Adults

Key Strategies for Change
Path to High Performance

Primary Drivers

Aim:
Reduce re-hospitalizations in states/regions

Will ←

Who
- Multi-stakeholder Coalitions
- Hospital Associations
- Integrated Health Care Systems
- Payers and Purchasers
- Communities
- Clinicians / Providers of Care

How
- Aligned incentives, Policy Change and Payment Reform
- Transparent State-wide Measurement

Outcome Measures:

1. All-cause 30 day re-hospitalization rates

1. Patient and family satisfaction with:

- Transition out of the hospital
- Coordination of care in community

Knowledge ←

- Optimizing the transitions in care after hospitalizations
- Providing enhancements / supplemental to routine care for patient s at high risk for re-hospitalization
- Engaging consumers and their family caregivers in their own care (and medication management)

Execution ←

- Micro-System Capability
- Customized Sequencing of Work
- Robust, timely, and actionable measurement
  - that can help to drive Improvement (provides feedback over time)
- Learning System
  - o collaborative learning
  - o local support for improvement

Source: Institute for Healthcare Improvement

Knowledge: Solutions for Action

- Evidence about what to do exists
- Boutwell A et al. "Effective Interventions to Reduce Rehospitalizations …" Cambridge, MA: IHI; 2009 includes 15 promising interventions to reduce hospital readmissions

STRENGTH OF EVIDENCE:		
… Strong evidence of impact	**… Very Good evidence of impact**	**… Need formal evaluation and/or currently under evaluation**
IMPORTANT ELEMENTS:		
e.g. Patient education, post-discharge care planning, and provider coordination	**e.g. Initiating reminder calls for preventive care, empowering nurse practitioners to work as care managers, and utilizing multidisciplinary clinical teams**	
CURRENT PROJECTS:		
• **Project Red (Re-engineered discharge; Jack)** • **Transitional Care Model (Naylor)** • **Care Transitions Program (Coleman)** • **Evercare Care Model**	• **Community Care North Carolina** • **Commonwealth Care Alliance Brightwood Clinic** • **Heart Failure Resource Center** • **Home Healthcare Telemedicine** • **Novant Physician Group Practice Demonstration Project** • **Kaiser Permanente Chronic Care Coordination** • **IHI Transitions for Patients with Heart Failure: St Luke's Hospital**	• **INTERACT** • **Project BOOST** • **Guided Care** • **Hospital at Home**

Creating the Will to "Organize" the Delivery "System" for High Performance

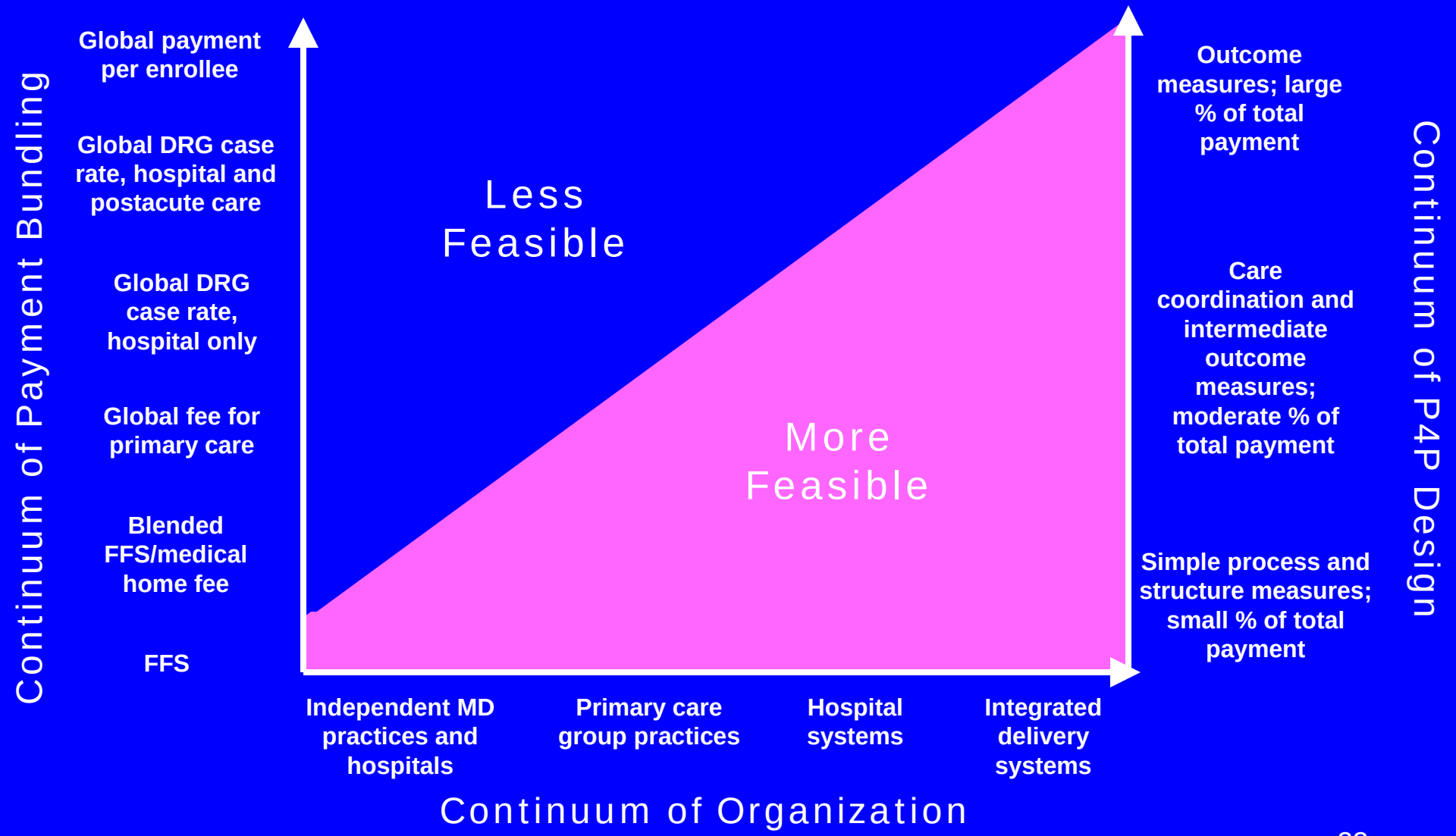
6 Attributes of a "System"

- ***Information Continuity*** Patients' clinically relevant information is available to all providers at the point of care and to patients through electronic health record (EHR) systems.
- ***Care Coordination and Transitions*** Patient care is coordinated among multiple providers, and transitions across care settings are actively managed.
- ***System Accountability*** There is clear accountability for the total care of patients. (We have grouped this attribute with care coordination since one supports the other.)
- ***Peer Review and Teamwork for High Value Care*** Providers (including nurses and other members of care teams) both within and across settings have accountability to each other, review each other's work, and collaborate to reliably deliver high-quality, high-value care.
- ***Continuous Innovation*** The system is continuously innovating and learning in order to improve the quality, value, and patients' experiences of health care delivery.
- ***Easy Access to Appropriate Care*** Patients have easy access to appropriate care and information at all hours, there are multiple points of entry to the system, and providers are culturally competent and responsive to patients' needs.

Creating the Will to "Organize" the Delivery System for High Performance

- The regulatory environment should be modified to facilitate clinical integration among providers
- Provider payment reform offers the opportunity to stimulate greater organization as well as higher performance
- Accreditation programs should be aligned in their focus on the six attributes of an ideal delivery system
- Patients should be given incentives and information to choose to receive care from high-quality, high-value delivery systems
- Provider training programs should focus on systems-based skills and competencies and include clinical training in organized delivery systems
- Regional Extension Centers or "innovations diffusion networks" could be funded with public/private dollars to provide services to practices as they transform towards greater care integration. Models are emerging in area of HIT and could be broadened.
  - For example, providers would be required to implement and utilize certified electronic health records that meet functionality, interoperability, and security standards and to participate in health information exchange across providers

“Integration” and Payment Methods



Note: DRG is diagnosis-related group. FFS is fee-for-service.
Source: The Commonwealth Fund, 2008

STAAR: State Action to Avoid Re-hospitalizations: A Multi-State Initiative

The initiative, a partnership between the Institute for Healthcare Improvement, and the Commonwealth Fund has three main goals that target “execution” and “will”:

1. System redesign - execution
2. Measurement, reporting and tracking of readmissions rates
3. Payment and regulatory reform - incentive

Reducing Hospital Readmissions: System Redesign

1. System redesign

- Targets transitions of care to encompass hospital and post-hospital settings where patients will receive ongoing care:
  - Home, rehabilitation center
  - Nursing home
  - Primary ambulatory care
- Intersects with Patient Centered Primary Care Medical Home demonstrations
- Intersects with Advancing Excellence in Nursing Home Campaign
- First phase will engage multi-stakeholder coalitions in three states – MA, MI, WA
  - Hospital Associations
  - Integrated Health Care Systems
  - Payers and Purchasers
  - Communities
  - Clinicians / Providers of Care
- While hospitals are implementing new models of care, payers and policymakers are also exploring payment and regulatory mechanisms to remove barriers and foster improvement infrastructure

Reducing Hospital Readmissions: Public Reporting and Payment Reform

Workgroups of national and state leaders will contribute to national health reform debates about public reporting and payment reform

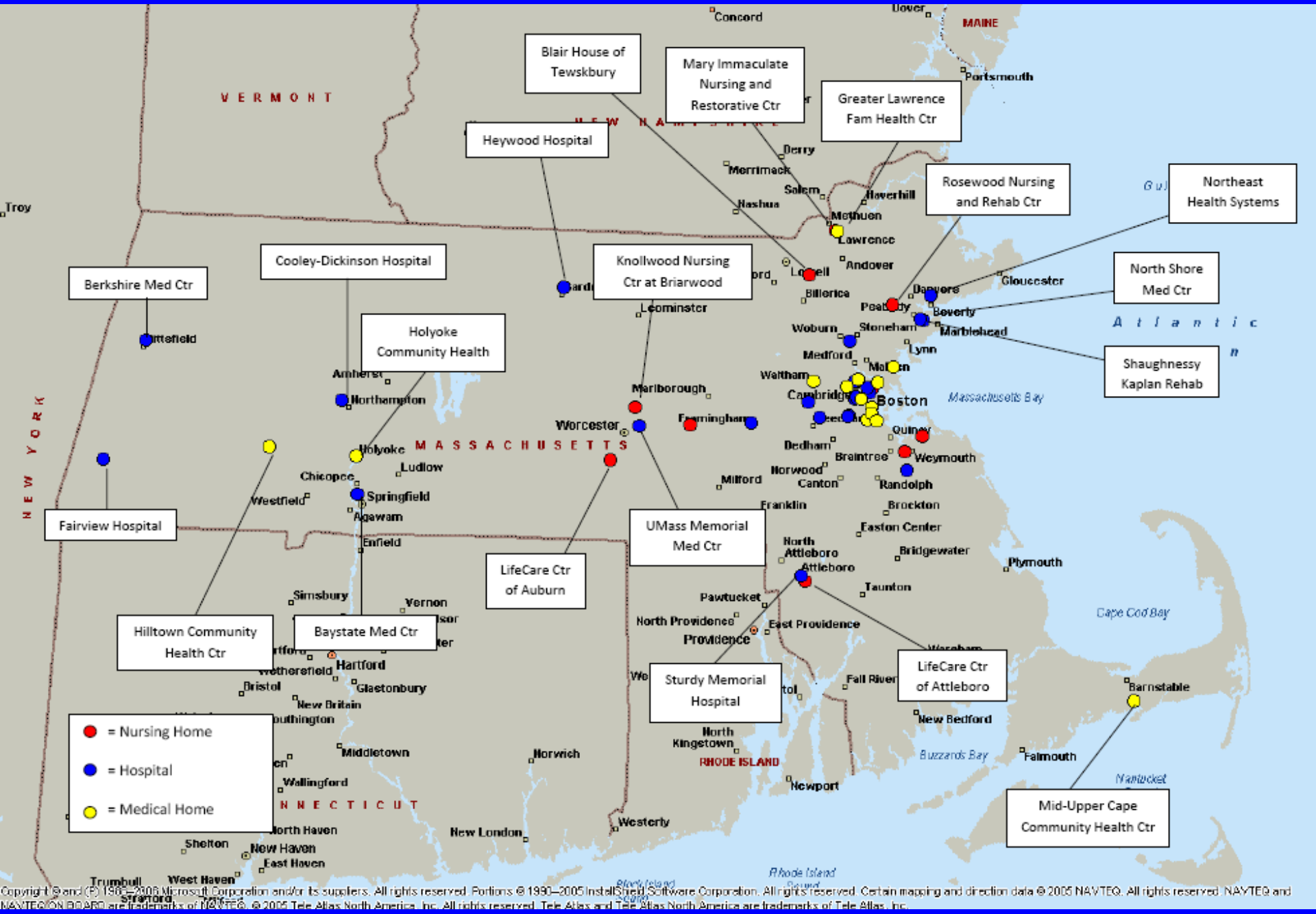
2. Public Reporting and Benchmarking at State and National Levels

- National Quality Forum Standard measure for hospital 30 day readmission do exist, but
- Access to data to profile at hospital and state level remains a challenge
  - Issues around access to population-based data that transcend site of care delivery
  - Data problems arising from fragmented payer market and Medicare and Medicaid policies

3. Payment and Regulatory Reform

- Develop solutions to remove financial disincentives (volume-revenue)
- Explore financial incentives, such as pay-for-performance contracts
- State Medicaid policies to reduce readmissions (e.g. Secretary Bigby in MA is leading with active development on a no-pay readmission policy)
- Sen. Michael Bennet (D-Colo.) Medicare Care Transitions Act of 2009 would create a nationwide network of community-based transitional "care coaches"

Community Level Opportunities to Reduce Re-hospitalizations



Resources

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