

Preventable Readmissions

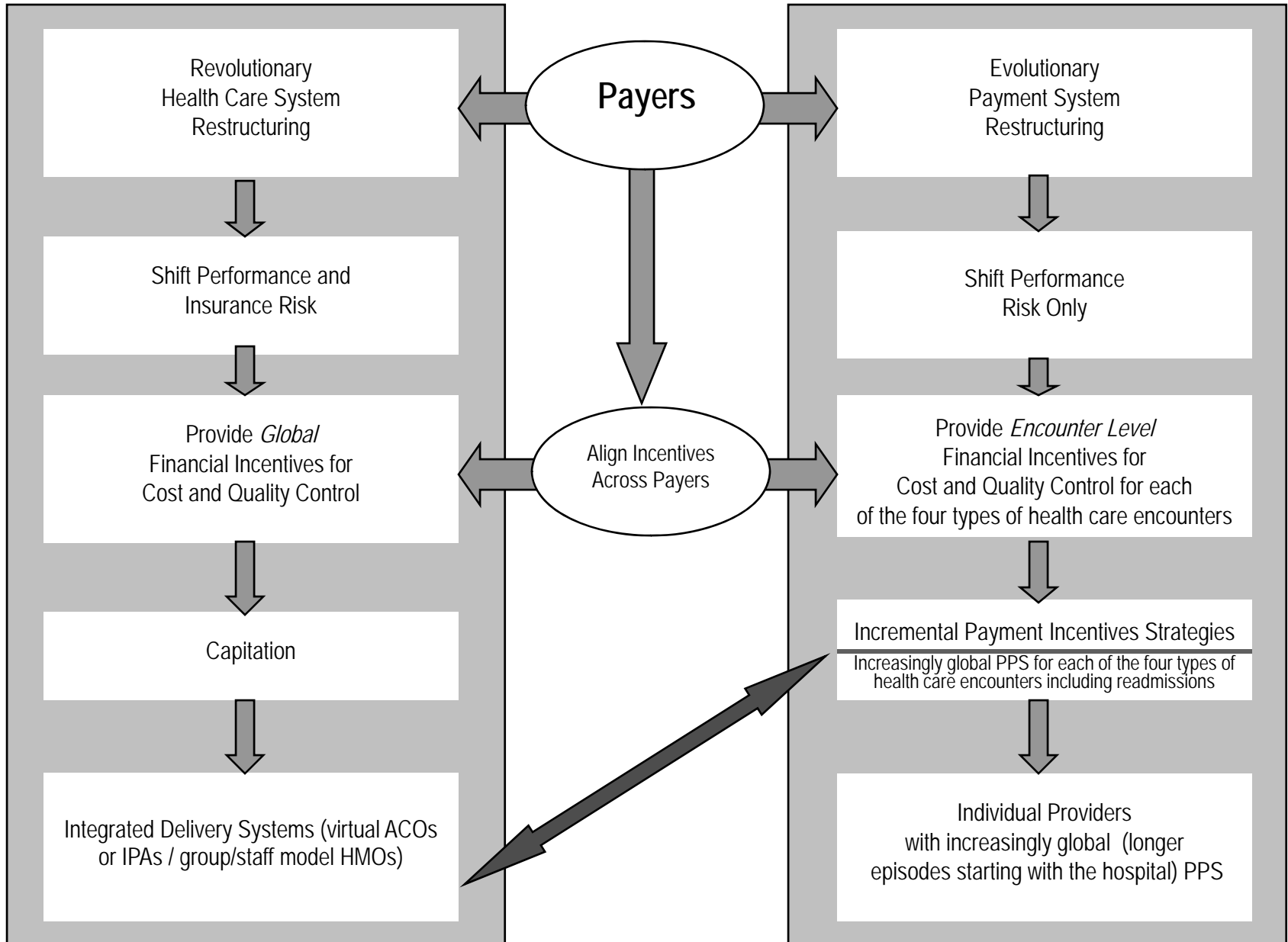


3M HIS Clinical Research Experience

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
- Together with the State of Maryland and JHU/U of Maryland developing new payment system for inpatient mental health services with NIMH grant

All classification tools including PPRs are developed jointly with NACHRI



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

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) – Episodes

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

Quality

Cost

Assumptions Underlying the Development of PPRs

- Not all readmissions are preventable
- Patients who have had a problem with the quality of inpatient care or outpatient care following discharge will be more likely to be readmitted
 - Discharged too sick, too quick
 - Poor discharge planning
 - Poor follow-up care
- A hospital with these types of quality problems will be more likely to have higher rates of readmissions
 - For certain types of patients
 - Across the board

Research Approach for Development of PPRs

- 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

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General Guidelines for PPRs

		Readmission	
Initial Discharge	Medical	Surgical	
Medical	PPR except if clearly unrelated acute events	Not PPR unless initial medical diagnosis clearly should have resulted in surgery	
Surgical	PPR except conditions clearly unrelated	PPR if related to complications of prior surgery	

PPRs Must Be Clinically Related To Prior Discharge – either the pdx and/or sdx

- Case 1: PPR
Initial discharge: Asthma
Readmission 8 days post discharge: Asthma
- Case 2: PPR
Initial discharge: Acute MI
Readmission 6 days post discharge with Diabetes Mellitus
- Case 3: Not a PPR
Initial discharge: Pneumonia
Readmission 4 days post discharge: Fractured femur & skull
sustained in motor vehicle accident
- Case 4: Not a PPR
Initial discharge: CHF
Readmission 6 days post discharge: Appendectomy
- Case 5: PPR
Initial discharge: Abdominal Pain
Readmission 2 days post discharge: Appendectomy

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Example of PPR Chains

Days between current admission & previous discharge	DRG SOI	Med Surg		Type of Admit
	304.2	S	DOR/LUMB FUS EXC CRV BCK	Initial discharge
13	721.2	M	POST-OP INFECTION	PPR
10	347.2	M	BACK PAIN	PPR
285	304.3	S	DOR/LUMB FUS EXC CRV BCK	New initial discharge
10	721.2	M	POST-OP INFECTION	PPR

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Discussion Issues

- Discharge severity of illness?
- Hospital MUST be able to replicate the data if we wish improvement.
- Readmission window of time
 - Fifteen day window for the hospital
 - Starting at day sixteen upside risk potential for increased funding of the medical home
- Readmission to same hospital or any hospital
- Outlier chains
- Computation of expected value for beneficiaries with mental illness and/or substance abuse disorders
- Age specific groups; other socioeconomic variables?
- Payment: based on rates (as proposed by Medpac) at the hospital level not on specific cases.

General Philosophical Approach

- 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 to reduce readmission but not to create a financial crisis
 - 1-3 percent of hospital Medicare payments

Challenge


- What has to change in American health care so that in 5 years, we're not having the same discussion about why health care isn't safer, more effective, and less costly than it is today

Today's Health Care Landscape

- Hospital CEOs are paid on the basis of financial results from DRG type system
- PCPs are paid on the basis of maximizing RVUs
- Payment based on outcomes quality minimal to none
- A continuous focus on magical or revolutionary solutions
- Shifting costs onto the consumer/little attention to valid consumer reports/low patient activation/empowerment

A Realistic Landscape – Five years from now

- Hospital CEO is paid on the basis of value (outcomes quality divided by payment) of bundled services that include:
 - 35% reduction in 15 day readmissions (outcomes quality measure)
 - payment for hospitalization and 30 days post discharge for both physician and hospital portion.
- Five years of relentless focus on a path to increased but realistic bundling of services that started on year 1 with readmissions.
- Consumers have much higher activation/empowerment index (a la Hibbard, Lorig or Wasson) in combination with consumer specific reports cards with no more consumer based tiering.
- PCP medical home payment “experiment” is a success largely due to income in part derived largely from decreased hospital admissions/readmissions rather than up front payments



“The hospitals who say they are penalized for doing the right thing are absolutely right,” said Dr. Robert Berenson. “If we can’t do this (readmissions), we can’t do much of anything in health reform.”

New York Times – Reed Abelson – 2 weeks ago