“Clinically Specific Conditions and Considerations for Tracking Readmissions”
National Consensus Conference on Readmissions
Sponsored by NAHDO funded by AHRQ
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Professor
Texas Tech University Health Science Center
Special Thanks!

Clinical Panel Participants

Clinicians

• Dr. Adrian Hernandez
• Dr. Don Kennerly

Methodologists

• Dr. Norbert Goldfield
• Dr. Michael Pine
Scope of the Problem

Medicare Expenditures for Readmissions

- 18-20% (1/5th) of Medicare Beneficiaries readmit within 30 days of discharge
- 33% (1/3rd) readmit within 90 days
- Readmissions have a 0.6 day longer LOS than other patients in the same DRG
- Medical causes dominate readmissions
- Estimated cost to Medicare: $15 to $18.3 billion in annual spending


What is CMS’s “Game Plan”?

System of Care Issue

Hospitals

P4P
“Value-based Purchasing”

Home Health  Skilled Nursing Facilities

Other important considerations:
• Beneficiary responsibility
• Fee-for-service providers

Two Stage Process:
1) Public disclosure of readmissions rates
2) Follow with payment changes

Readmissions is a National Conversation

• A growing interest in developing methods for public reporting and readmissions analysis for:
  - *Quality and safety analysis*
  - *Pay for performance (cost reductions)*

• Adequate methods and measures are still under development but standardization is important to:
  - *P4P*
  - *Use of data to improve care*
  - *State and national public reporting*
What is a readmission?

• “Readmissions are not primarily about people being rehospitalized because of mistakes made in the hospital.

• Readmissions is about making transitions effectively.

• Taking care of people with ongoing problems or chronic illnesses and frailty.

• Transitions of care not done well,…evidence suggests they wind up back in the hospital.”

Stephen Jencks, M.D., a former senior clinical adviser to CMS
Clinical Consensus:
What is a readmission?

• May be a “Failure of the system”

• May be the best and safest course of treatment for the patient

• Planned versus unplanned (potentially avoidable)

• Reflective of process of care and an outcome
Clinical Consensus: What is a readmission?

• A readmission is a component of care within an overall context of patient care that is reflective of:
  - Medical vulnerability relating to chronic illness
  - Social needs of the patient
  - Provider system

• All factors which can be estimated as we measure readmissions

“Clinically Specific Conditions and Considerations for Tracking Readmissions”
Clear Consensus:
A Costly proposition,…
## Hospital Readmission Rates

Hospital readmission rates for Medicare Beneficiaries

<table>
<thead>
<tr>
<th></th>
<th>7 days</th>
<th>15 days</th>
<th>30 days</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td>6.2%</td>
<td>11.3%</td>
<td>17.6%</td>
</tr>
<tr>
<td><strong>Non-ESRD</strong></td>
<td>6.0%</td>
<td>10.8%</td>
<td>16.9%</td>
</tr>
<tr>
<td><strong>ESRD</strong></td>
<td>11.2%</td>
<td>20.4%</td>
<td>31.6%</td>
</tr>
</tbody>
</table>

Note: ESRD: end stage renal disease

### Potentially preventable hospital readmission rates

Patients readmitted to hospital within:

<table>
<thead>
<tr>
<th></th>
<th>7 days</th>
<th>15 days</th>
<th>30 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate of potentially preventable readmissions</td>
<td>5.2%</td>
<td>8.8%</td>
<td>13.3%</td>
</tr>
<tr>
<td>Spending on potentially preventable readmissions</td>
<td>$5 billion</td>
<td>$8 billion</td>
<td>$12 billion</td>
</tr>
</tbody>
</table>

Source:

“Biggest Bang For the Buck”
The BIG QUESTION:

How do we define readmissions and discern the readmissions that are preventable or should be preventable, and allow readmissions that are important for the safety of the patient?
Clinical Considerations for Examining Readmissions

- Not all admissions are avoidable.
- Starting with a specific patient population may present a good “test-bed” for development with added considerations at later dates.
- Clinical specificity may be important in outlining goals in terms of trying to prevent readmissions, or define policies that would incentivize hospitals for addressing readmissions.
- Targeting improvements with clinical specificity (e.g. heart failure) may not take into consideration the patient’s other comorbid illnesses, such as mental illness or substance abuse that might impact a readmission.
- As we consider chains of readmission, measuring “the right” readmission to impact positive results may be challenging.
- Transitions of care in relation to the clinical domain or specificity may be very important, particularly as we consider chronic conditions such as heart failure.

“Clinically Specific Conditions and Considerations for Tracking Readmissions”
Measure considerations:

- Clinically specific conditions or all cause readmission rates
  - *Depends on purpose*
- Risk adjustment models versus categorical stratification methods
  - *Comparative reporting-risk adjustment*
  - *Improvement purposes-stratification is helpful*
- Should count begin with admission or discharge date?
  - *Consensus: discharge date*
- Timing: 14, 30, 60 or 90 day readmissions
  - *30 days*
- Inclusion and Exclusion criteria:
  - *Mortality*
  - *Oncology*
  - *Hospice/DNR*
  - *Behavioral Health & Substance Abuse*
  - *Consensus: Purpose of the initiative should drive inclusion/exclusion criteria*
- Age Groups
  - *Pediatrics readmissions are different than adult chronic illness*
Other measure considerations

- Objective criteria must be established to identify which admissions will be included in the population at risk and which of these will be designated as having had subsequent readmissions.
- Criteria must be specified in enough detail to ensure comparability of cases from all participating sites.
- Authoritative sources of data must be specified and care taken to ensure that data used for analyses fairly represent the performance of each institution and practitioner being evaluated.
- Rules to identify readmissions used to compute readmission rates also must be clear and appropriate to the proposed uses of the measurement.
- The maximum time between discharge and qualified readmission must be specified.
- When chains of readmission occur, rules for identifying index admissions and for counting subsequent admissions must be delineated.
Interpretation of Readmission Rates

- Interpretations of measures of clinical performance require an understanding of the context surrounding the measure.
- Designations of readmissions as elective, urgent or emergent are often inaccurate.
- “Planned readmissions” are scheduled prior to discharge.
- “Potentially preventable readmissions” characteristically result in significant differences in readmission rates after adjusting for patient factors beyond the providers control.
- “Unpreventable readmissions” can be improved only by advances in clinical practice beyond what is currently available, or by changes in the underlying risk factors of the population.
- Objective criteria must be established to identify which admissions will be included in the population at risk and which of these will be designated as having had subsequent readmissions.

“Clinically Specific Conditions and Considerations for Tracking Readmissions”
Other Important Considerations

- Definitions and criteria will be driven by intended purpose
- Within versus across hospital comparisons
- Readmission should be considered within the context of care in which it occurs
- Staged procedures should be examined
- Linkage methods (if necessary)
  - Deterministic versus Probabilistic
  - Data Quality across states
  - Software available for linkage
Final Comments by Panelists

• Development of methods to measure, interpret and apply risk-adjusted hospital readmission rates is in its infancy.

• Standards governing the creation and use of these measures should address only general issues.

• Diversity in approaches should be encouraged until a clear consensus is established about which methods and techniques are best suited to accomplish specific goals and objectives.

• Regardless of how analyses are performed and interpreted, clear and complete descriptions of methods and techniques employed should be publicly available.
Synopsis of Important Clinical Conclusions

- Distinctions must be made between readmissions that result from suboptimal care and readmissions necessary for quality of care.
- Transitional and ambulatory care are particularly useful to breakdown barriers.
- High quality data will be needed on readmissions and transitions of care.
- Sources of data and further methods development are critical to the industry’s success in improving readmissions.
- Precise definitions of populations at risk are important to reporting and improvement.
- Public reporting of readmission rates can raise public awareness and motivate providers.
Questions & Discussion

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