TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER
Anita Thigpen Perry School *of* Nursing™

"Clinically Specific Conditions and Considerations for Tracking Readmissions"
National Consensus Conference on Readmissions

Sponsored by NAHDO funded by AHRQ

October 29, 2009

June 18, 2009

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Professor

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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

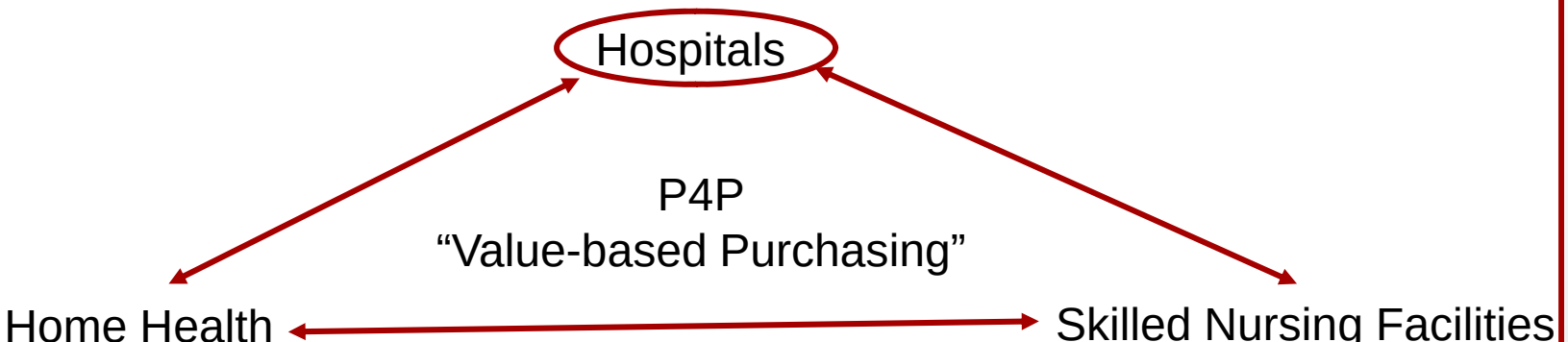
- 18-20% (1/5th) of Medicare Beneficiaries readmit within 30 days of discharge
- 33% (1/3rd) readmit within 90 days
- Readmissions have a 0.6 day longer LOS than other patients in the same DRG
- Medical causes dominate readmissions
- Estimated cost to Medicare: $15 to $18.3 billion in annual spending

Jencks SF et al. Rehospitalizations among patients in the Medicare fee-for-service program. *N Engl J Med* 2009 Apr 2; 360:1418.

Medpac (June 2007). “Report to the Congress: Promoting Greater Efficiency in Medicare”, pp 103-120.

What is CMS's "Game Plan"?

System of Care Issue



Other important considerations:

- Beneficiary responsibility
- Fee-for-service providers

Two Stage Process:

1) Public disclosure of readmissions rates
2) Follow with payment changes

Medpac (June 2007). *"Report to the Congress: Promoting Greater Efficiency in Medicare"*, p 105.

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

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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

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Clear Consensus:

A Costly proposition,…

Hospital Readmission Rates

Hospital readmission rates for Medicare Beneficiaries

	Percent of patients readmitted to hospital within:		
	7 days	15 days	30 days
Total	6.2%	11.3%	17.6%
Non-ESRD	6.0%	10.8%	16.9%
ESRD	11.2%	20.4%	31.6%

Note: ESRD: end stage renal disease

Source: Recreated from table within: Medpac (June 2007). *"Report to the Congress: Promoting Greater Efficiency in Medicare"*, p 107.

Potentially preventable hospital readmission rates

Potentially preventable hospital readmission rates

"Biggest Bang For the Buck"

	Patients readmitted to hospital within:		
	7 days	15 days	30 days
Rate of potentially preventable readmissions	5.2%	8.8%	13.3%
Spending on potentially preventable readmissions	$5 billion	$8 billion	$12 billion

Source:

Recreated from table within: Medpac (June 2007). *"Report to the Congress: Promoting Greater Efficiency in Medicare"*, p 107, from 3M analysis of 2005 Medicare discharge claims.

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?

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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.

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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*
  - *Behavorial Health & Substance Abuse*
  - ***Concensus: Purpose of the initiative should drive inclusion/exclusion criteria***
- Age Groups
  - *Pediatrics readmissions are different than adult chronic illness*

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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.

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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 is occurs
- Staged procedures should be examined
- Linkage methods (if necessary)
  - Deterministic versus Probabilistic
  - Data Quality across states
  - Software available for linkage

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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 publically 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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