Updating Your Readmission Reduction Strategy for 2015
(And Making Sure You Have One!)

Spring Conference & Trade Show
March 19, 2015

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REDUCING READMISSIONS – 2015 AND BEYOND

Strategies for Success in a Quickly Evolving Market

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Collaborative Healthcare Strategies
March 19 2015
Agenda

- Current hospital incentives and penalties
- How these incentives and penalties affect SNFs
- Lessons from successful strategies
- Recommendations
Objectives

• Describe the major policy & payment forces that driving major changes for hospitals and SNFs

• What are hospitals with hospital – wide results doing?

• How does that apply to SNFs as we are exposed to same / similar market forces?

• Identify 3 practical ways to expand your strategies to reduce readmissions
Accountable Care- What Does that Mean?
Accountable: only so many ways to dress it up

- **Lose** money for readmissions:
  - Hospital readmission penalties
- **Earn-back** withheld money
  - Medicare Value-Based Payment Program, SNF VBP
- **Not lose** money
  - Skirt the line of no loss, no gain
- Receive a **small bonus**
  - For quality/use/satisfaction targets
- **Share in savings** from reducing costs
  - with the payer, for reducing costs while maintaining quality
  - Upside only (small gain), or full risk (bigger gains, potential loss)
Who’s Accountable, and What Are They Doing?

• Hospitals
  • Magnitude of the penalty warrants either no investment, or internal shifting of capacity to deploy existing staff to address issue

• Accountable Care Organizations
  • Big difference in whether Hospital-led ACO or Physician-led ACO
  • Many ACOs to date are focused on capacity development, data
  • Big focus in 2014 has been on “networks,” expanding population base and post-acute utilization

• Bundled Payment for Episodes of Care
  • Hospitalization +/- or Post-Acute Care + Follow up
  • 30, 60 or 90 day episodes
Map of Medicare Innovation Payment Programs

http://innovation.cms.gov/initiatives/map/
INCENTIVES AND PENALTIES

What’s here for hospitals, and coming for SNFs
Medicare Readmission Penalties

- Year 3: October 1 2014- September 30 2015

- Up to 3% reduction in all Medicare payments for hospitals with high 30-day readmissions for AMI, HF, PNA, COPD and hip/knee replacement

- Average penalty **DOUBLED** this year

- 2,160 hospitals penalized; **$480 MILLION**

- In MA, **80%** of all hospitals penalized = 55 hospitals
  - the average penalty in MA is 0.78%
  - 19 hospitals with >1% penalty this year
  - MA is #4 highest % of hospitals receiving penalty - behind NJ, DE, CT tied with NY
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<td>Lowell</td>
<td>MA</td>
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<tr>
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<tr>
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<td>Fall River</td>
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<tr>
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<td>MA</td>
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<td>0.75%</td>
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<td>0.30%</td>
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<td>0.73%</td>
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</tr>
<tr>
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<td>Palmer</td>
<td>MA</td>
<td>1069</td>
<td>Hampden</td>
<td>0.91%</td>
<td>1.35%</td>
<td>1.43%</td>
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January 26, 2015
High-Value Care: No Looking Back

<table>
<thead>
<tr>
<th>Year</th>
<th>% Medicare in Alternative Payment Models</th>
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<tr>
<td>2011</td>
<td>0</td>
</tr>
<tr>
<td>2014</td>
<td>20%</td>
</tr>
<tr>
<td>2016</td>
<td>30%</td>
</tr>
<tr>
<td>2018</td>
<td>50%</td>
</tr>
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</table>
Hospitals’ Value-Based Purchasing (VBP) payment will increasingly be based on their performance on outcomes/efficiency.

- **FY 2013**: 70% Clinical process, 30% Patient experience
- **FY 2014**: 45% Clinical process, 25% Patient experience, 30% Outcomes
- **FY 2015**: 30% Clinical process, 20% Patient experience, 30% Outcomes, 20% Efficiency
- **FY 2016**: 40% Clinical process, 25% Patient experience, 25% Outcomes, 10% Efficiency

Source: Bruce Spurlock, MD, Cynosure Health
Quality, Outcomes, Experience …..+ Efficiency!

Medicare Spending Per Beneficiary

- New “Efficiency Measure” for hospitals
- Medicare Part A + B spending per beneficiary
- Looks at total 3 days prior to through 30 days post-discharge
- Adjusted for age and severity of illness

- Ratio: Hospital Medicare Spending per Beneficiary
  National Median Spending per Beneficiary

Medicare Spending Per Beneficiary

- Effectively exposes all hospitals into a “bundle” payment
  - Hospitals must find ways to reduce cost of care overall

- CMS will provide cost broken down by:
  - 3 days before hospitalization
  - Cost of hospitalization
  - Cost 30-days post discharge
  - Overall by: inpatient, outpatient, home health, SNF, hospice, DME

- Hospitals judged by both performance and improvement
“Potential for efficiency improvements in post acute care utilization…..”

“Conditions for which post acute care accounts for a large percent of episode payments provide hospitals with a stronger incentive to efficiently manage post acute services.”
SNF Utilization Patterns are Increasingly Visible

- CMS is developing a SNF 30-day all cause readmission policy

- Office of the Inspector General’s November 2013 report analyzed hospitalizations from SNFs SNF by SNF

- Area of active research in academics, payers, state/federal agencies

  - Pressure on SNFs, Pressure on Hospitals
Department of Health and Human Services
OFFICE OF
INSPECTOR GENERAL

MEDICARE NURSING HOME
RESIDENT HOSPITALIZATION
RATES MERIT ADDITIONAL
MONITORING

Daniel R. Levinson
Inspector General
November 2013
OEI-06-11-00040
EXEcutivE SUMMARY: Medicare Nursing Home Resident Hospitalization Rates Merit Additional Monitoring
OEI-06-11-00040

WHY WE DID THIS STUDY

Nursing homes hospitalize residents when physicians and nursing staff determine that residents require acute-level care. Such transfers to hospitals provide residents with access to needed acute-care services. However, hospitalizations are costly to Medicare, and research indicates that transfers between settings increase the risk of residents’ experiencing harm and other negative care outcomes. High rates of hospitalizations by individual nursing homes could signal quality problems within those homes.

HOW WE DID THIS STUDY

We used administrative and billing data both for nursing homes and hospitals to identify all Medicare residents in Medicare- or Medicaid-certified nursing homes who experienced hospitalizations—i.e., transfers to hospitals for inpatient stays—in fiscal year (FY) 2011. We included all Medicare nursing home residents—those in Medicare-paid skilled nursing and rehabilitative (referred to as “SNF”) stays and those in nursing home stays not paid for by Medicare, which include long-term care (LTC) stays—in our analysis. We calculated the percentage of Medicare nursing home residents that each nursing home hospitalized. We identified the diagnoses associated with these hospitalizations, calculated Medicare reimbursements for the hospital stays, and calculated the rates and costs of hospitalizations of nursing home residents. We also examined the extent to which annual rates of resident hospitalizations varied among individual nursing homes.

WHAT WE FOUND

In FY 2011, nursing homes transferred one quarter of their Medicare residents to hospitals for inpatient admissions, and Medicare spent $14.3 billion on these hospitalizations. Nursing home residents went to hospitals for a wide range of conditions, with sepsis the most common. Annual rates of Medicare resident hospitalizations varied widely across nursing homes. Nursing homes with the following characteristics had the highest annual rates of resident hospitalizations: homes located in Arkansas, Louisiana, Mississippi, or Oklahoma and homes with one, two, or three stars in the Centers for Medicare & Medicaid Services’ (CMS) Five-Star Quality Rating System.

WHAT WE RECOMMEND

In its comments on the draft report, CMS concurred with both of our recommendations to: (1) develop a quality measure that describes nursing home resident hospitalization rates and (2) instruct State survey agencies to review the proposed quality measure as part of the survey and certification process.

Facility-by-facility analysis – SNF and LTC; rates, diagnoses, and $$ analyzed variation across facilities

“when physicians and nursing staff determine…require acute care”

1 in 4 residents hospitalized
>$14 Billion
Range of diagnoses, sepsis #1
Wide variation across facilities

Measure NH hospitalizations; surveyors to focus on this
<table>
<thead>
<tr>
<th>State</th>
<th>Rate</th>
<th>State</th>
<th>Rate</th>
<th>State</th>
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<td>Louisiana</td>
<td>38.3%</td>
<td>Maryland</td>
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<td>20.9%</td>
</tr>
<tr>
<td>Mississippi</td>
<td>35.7%</td>
<td>Indiana</td>
<td>24.9%</td>
<td>New Mexico</td>
<td>19.5%</td>
</tr>
<tr>
<td>Arkansas</td>
<td>31.7%</td>
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<td>Oklahoma</td>
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</tr>
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<td>Kentucky</td>
<td>29.2%</td>
<td>Virginia</td>
<td>24.8%</td>
<td>Washington</td>
<td>18.6%</td>
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<td>Illinois</td>
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<td>Connecticut</td>
<td>24.7%</td>
<td>Wisconsin</td>
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<td>Tennessee</td>
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<td>California</td>
<td>24.2%</td>
<td>Vermont</td>
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<td>New Jersey</td>
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<td>Texas</td>
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<td>Maine</td>
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</tr>
<tr>
<td>Missouri</td>
<td>27.9%</td>
<td>Pennsylvania</td>
<td>23.4%</td>
<td>Montana</td>
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<td>Kansas</td>
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</tr>
<tr>
<td>New York</td>
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<td>Arizona</td>
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<td>Alabama</td>
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<td>Iowa</td>
<td>22.9%</td>
<td>Minnesota</td>
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<td>West Virginia</td>
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<td>District Of Columbia</td>
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<td>South Carolina</td>
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<td>North Dakota</td>
<td>21.4%</td>
<td>Hawaii</td>
<td>10.6%</td>
</tr>
</tbody>
</table>
SNF- hospitalizations cost more than average

• Hospitalization of patients from SNF/LTC averages $11,255

• Average Medicare hospitalization cost is $8,447

• 33% higher
Table 1: Primary Diagnoses on Claims of All Hospitalized Medicare Nursing Home Residents in FY 2011

<table>
<thead>
<tr>
<th>CCS Primary Diagnosis Category</th>
<th>Percentage of Hospitalizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fifteen Most Frequent CCS Categories</td>
<td></td>
</tr>
<tr>
<td>Septicemia</td>
<td>60.9%</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>13.4%</td>
</tr>
<tr>
<td>Congestive heart failure, nonhypertensive</td>
<td>7.0%</td>
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<tr>
<td>Urinary tract infections</td>
<td>5.8%</td>
</tr>
<tr>
<td>Aspiration pneumonitis, food/vomitus</td>
<td>5.3%</td>
</tr>
<tr>
<td>Acute renal failure</td>
<td>4.0%</td>
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<tr>
<td>Complication of device, implant, or graft</td>
<td>3.9%</td>
</tr>
<tr>
<td>Respiratory failure, insufficiency, or arrest</td>
<td>3.3%</td>
</tr>
<tr>
<td>Gastrointestinal hemorrhage</td>
<td>2.7%</td>
</tr>
<tr>
<td>Complications of surgical procedures or medical care</td>
<td>2.7%</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease (COPD) and bronchiectasis</td>
<td>2.4%</td>
</tr>
<tr>
<td>Delirium, dementia, and amnestic and other cognitive disorders</td>
<td>2.4%</td>
</tr>
<tr>
<td>Acute cerebrovascular disease</td>
<td>2.2%</td>
</tr>
<tr>
<td>Fluid and electrolyte disorders</td>
<td>2.1%</td>
</tr>
<tr>
<td>Fracture of neck of femur (hip)</td>
<td>2.0%</td>
</tr>
</tbody>
</table>
236 of 285 Diagnoses → Hospitalization from SNF

*There may be a few most frequent conditions, but don’t plan on narrowly focused efforts*
## Cost of Hospitalization from SNF

<table>
<thead>
<tr>
<th>Reason for Hospitalization</th>
<th>Total Cost</th>
<th>$ / Hospitalization</th>
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</thead>
<tbody>
<tr>
<td>Sepsis</td>
<td>$3 billion</td>
<td>$17,430</td>
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<tr>
<td>Pneumonia</td>
<td>$850 million</td>
<td>$9,500</td>
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<tr>
<td>CHF</td>
<td>$640 million</td>
<td>$8,700</td>
</tr>
<tr>
<td>Aspiration Pneumonia</td>
<td>$618 million</td>
<td>$12,200</td>
</tr>
<tr>
<td>Complications</td>
<td>$450 million</td>
<td>$14,600</td>
</tr>
</tbody>
</table>

OIG November 2013
Effect of Hospital-SNF Referral Linkages on Readmission

- “**Stronger** hospital-SNF linkages were found to reduce readmission rates”

- The **greater proportion** of discharges a hospital sends to a **single SNF, the lower** the rate of readmission”

- Specifically lower rates of **immediate bounce-backs** (days 0-3)

Rahman et al, December 2013
Return to Acute Care After SNF d/c to Home

- 55,980 Medicare d/c from 694 SNFs
- 67% d/c to home care after SNF
- 12,350 (22%) returned to acute care <30d
  - 10% returned to ED
  - 15% readmitted
  - ~50% of returns <30d occurred <10d!
- High Risks: male, black, history of HU, dual, comorbidities, cancer, respiratory
- Low Risks: fracture, longer SNF LOS, more LPN hours
- “indicates the need for interventions to improve transition from SNF to home”

Toles et al JAGS 2014
A.3 Long-Term Care and Home Health

In its 2013 report, the Commission noted that Massachusetts spent $771, or 72 percent, more per resident than the U.S. average on long-term care and home health in 2009 (Figure A.6). Here, we analyze drivers of higher expenditure levels and potential areas for improved efficiency, focusing primarily on care provided in nursing facilities and by home health agencies. In this section, we refer to nursing facilities to describe both include both skilled nursing facilities providing short-term post-acute care and nursing homes providing long-term supports and services, as 96 percent of nursing facility beds in Massachusetts are dually certified for both of these purposes. 

Drivers of higher expenditures

Drivers of Massachusetts’ higher level of spending on long-term care include significant differences in demographics and input costs, but there are also large utilization differences not accounted for by demographics. For nursing facilities, Massachusetts spent 74 percent more per capita than the national average in 2009. The state’s older age profile explains 13 percentage points of this difference and its higher prices paid to nursing facilities (driven by wage levels) explain 23 percentage points of the difference. These two factors account for less than half of the 74 percentage points of higher spending on nursing facilities, suggesting a large utilization difference that is not driven by demographics. Similarly, for home health services, demographics and prices paid account for less than half of the higher levels of spending in Massachusetts relative to the national average.

Both nursing facilities and home health care agencies provide two types of care: post-acute care and long-term services and supports (LTSS). Post-acute care is delivered to support recovery after an acute hospitalization, while LTSS care supports those with significant cognitive or physical impairment in their activities of daily living (ADLs). Massachusetts’ higher use of nursing facilities and home health care agencies spans both post-acute care and LTSS uses. This is evident in higher spending both for Medicare, which pays for post-acute care services but not LTSS, and for MassHealth, which is the primary payer for LTSS (Figures A9 and A10). (Like Medicare, commercial payers typically pay for post-acute care, but not LTSS. As a result, most LTSS services provided for populations not covered by MassHealth are paid out-of-pocket. Long-term care insurance covers those long-term care needs, but has...
Spending Per Capita & Per Beneficiary in MA

Figure A.8: Total spending per capita on long-term care and home health
Dollars per capita, 2009

Figure A.9: Medicare spending per beneficiary on long-term care and home health
Dollars per beneficiary, 2009

SOURCE: Centers for Medicare & Medicaid Services; HPC analysis
Figure A.12: Relative likelihood of discharge to a nursing facility for post-acute care by hospital
Adjusted rate of selecting nursing facility as setting for post-acute care*†, 2012
SNF Readmission Penalties

Prepare now, don’t wait – this takes time to get good at!
SNF Readmission Penalty Timeline

- Passed in 2014
- All cause readmission measure defined (by October 2015)
- “Potentially preventable” adjusted rate (October 2016)
- Public reporting of SNF readmissions (October 2017)
- Ranked score provided to SNFs (October 2018)
- 2% withhold of SNF payments (October 2018)
  - 50-70% of the withhold will go to incentive payments to SNFs
  - 30-50% of the withhold will go to Medicare for savings
- Incentive/ penalty goes live (October 2018)
  - 40% of SNFs nationally will receive a penalty
- Estimated to save Medicare $2B over next 10 years
It’s Time to Get Serious……

COLLABORATIVE
Healthcare Strategies
THANK YOU CMS

6 game-changing messages from CMS policies……..
6 Very Important Messages from CMS

1. Readmission reduction “pays” – at least *inaction hurts*

2. Hospitals must *update & standardize* transitional care processes

3. Reducing readmissions is a *cross-continuum* effort

4. Attend to *non-clinical needs* for post-hospital supports & services

5. We will flood the market with all *best ideas* on our dime

1. Reducing readmissions requires *better data*
HOWEVER....

Powerful messages from powerful agencies can create blinders
CMS’ Focus Has Created Blinders

1. HF, AMI, PNA…COPD, hip/knee replacement
   • NOT the 5 most frequent diagnoses leading to readmissions
   • Obscures other meaningful categorizations s/a frequent utilizer, social complexity, BH, functional status, frailty, end-of-life

2. Driven a Medicare focus to the exclusion of other high risk patient groups

3. Driven a case-finding approach rather than improving standard care
   • Interventions often focused on Medicare FFS with few certain diagnosis

4. Preferred first move among hospitals: hire new staff
   • Not leveraging cross-setting providers as part of the solution (enough)
Let’s Run the Numbers:
*One Strategy Won’t Get Us There*

<table>
<thead>
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<th></th>
<th>Number</th>
<th>Rate</th>
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<tbody>
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<td>Medicare admits/year</td>
<td>5,000 admissions</td>
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<tr>
<td>Medicare RA rate</td>
<td></td>
<td>20%</td>
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<tr>
<td># Medicare RA /year</td>
<td>1,000 readmissions</td>
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<td>Pilot project</td>
<td>200 high risk patients</td>
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<td>Pilot group RA rate</td>
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<tr>
<td>Expected # RA pilot</td>
<td>50</td>
<td></td>
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<tr>
<td>Expected effect of pilot</td>
<td></td>
<td>20%</td>
</tr>
<tr>
<td># RA reduced by pilot</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td># Medicare RA/year</td>
<td>1000 - 10 = 990</td>
<td>1%</td>
</tr>
</tbody>
</table>

© Amy Boutwell 2014
Hospitals with hospital-wide results

- Know their data –
  Analyze, trend, track, display, share, post

- Broad concept of “readmission risk”
  Way beyond case finding for diagnoses

- Multifaceted strategy
  Improve standard care, collaborate across settings, enhanced care

- Use technology to make this better, quicker, automated
  Automated notifications, implementation tracking, dashboards
KNOW YOUR DATA

Using data to dispel assumptions, expand opportunities for focus
Top 10 Medicare Dx:
1. CHF
2. Sepsis
3. Pneumonia
4. COPD
5. Arrhythmia
6. UTI
7. Acute renal failure
8. AMI
9. Complication of device
10. Stroke

Top 10 Medicaid Dx:
1. Mood disorder
2. Schizophrenia
3. Diabetes complications
4. Comp. of pregnancy
5. Alcohol-related
6. Early labor
7. CHF
8. Sepsis
9. COPD
10. Substance-use related

Methods:
- Used CCS groupers
- Included OB
ASK YOUR PATIENTS “WHY”

Interview patients, caregivers for the “story behind the chief complaint”
Understand the “story behind the chief complaint”

- 86F in ED from SNF with “bad labs” from routine blood draw. Treated for hyperkalemia in the ED, repeat labs normal. Hospitalist called to admit because she is a “bounce-back” and “needs sorting out.”

- 70F in ED from SNF 4 hours after discharge from a different hospital to SNF now to our ED (we were closer).

- 80M in ED 3 days after d/c from 20 days in SNF with abdominal pain.

*Chart reviews and administrative analyses will NOT reveal what you need to know: you must talk to your patients, their families and caregivers, providers*
There is Never One Reason for Readmission…..

• KP team reviewed 523 readmissions across ~14 hospitals:
  • 250 (47%) deemed potentially preventable
  • Found an average *of 9 factors* contributed to each readmission

• Assessed factors related to 5 domains:
  • 73% - care transitions planning & care coordination
  • 80% - clinical care
  • 49% - logistics of follow up care
  • 41% - advanced care planning & end of life
  • 28% - medications

• 250 readmissions identified 1,867 factors!
Readmission Interviews

3 parts:
1. Brief basic chart review (10m)
2. Patient/caregiver interview (15m)
3. Provider interview (5m)

Tips:
- Chart review is just to get the basics to prep for patient interview
- Patient/caregiver interview is MOST IMPORTANT part
- Not “the” cause of the readmission, but “all” reasons leading to RA
- Use for patient-specific problem solving AND for generalized themes
- Experienced readmission teams do this for EVERY readmission
DESIGN A PORTFOLIO OF STRATEGIES

There is no single bullet; we are engaged in system transformation
Develop A Multifaceted Portfolio of Efforts

- Improve facility-based care processes for all patients
- Collaborate with cross-setting partners, including payers
- Provide enhanced services

Use data, analytics, flags, workflow prompts, automation, dashboards to support continuous improvement, ensure reliability, drive to results
Example Portfolio Strategy for Hospitals

Improve hospital-based transitional care processes for ALL patients

1. Flag discharge <30d in chart
2. ED-based efforts to treat & return
3. Broaden view of readmission risks; assess “whole-person” needs
4. Develop transitional care plans that consider needs over 30 days
5. Ask patients & support persons why they returned, if readmitted
6. Ask patient & support persons what help they need; share with them their needs/risk assessment
7. Use teach-back, target the appropriate “learner”
8. Customize information
9. Arrange for post-hospital follow up
10. Use a check-list for all patients

Collaborate with cross-setting partners

1. Use ADT notifications with medical and behavioral health providers
2. Ask community providers what they need and how they want to receive it
3. Collaborate to arrange timely follow up
4. Perform “warm” handoffs, and opportunity for clarification
5. Form a cross-continuum team that can access resources your staff are unaware of
6. Constantly refresh your awareness of social and behavioral health resources
7. Broaden partners to include Medicaid health plans and their care managers
8. Identify community partners with social work and behavioral health competencies

Provide enhanced services for high risk

1. Segment “high risk” – varying types of service & levels of intensity
2. Strategy for high utilizers
3. Strategy for navigating care
4. Strategy for accessing resources
5. Strategy for self-management
6. Strategy for frailty/medically complex
7. Strategy for end-of-life trajectory
8. Strategy for recurrent stable symptoms, etc individual care plans
Improve Standard Care for All: Standard Discharge

CMS Issued Updated Discharge Planning Conditions of Participation May 2013 that require hospitals demonstrate the following:

1. Have a process
2. Know your data; track rates & review readmissions
3. Assess & reassess patients for post-hospital needs
4. Engage patients and caregivers
5. Teach self-care to patients & caregivers
6. Provide a written discharge plan for all inpatients
7. Communicate effectively with “receiving” providers
8. Know the capabilities of area providers, including support services
9. Arrange for post-acute services, including support services

Improved Standard Care For All: “SNF Circle Back”

• Multi-hospital system in North Carolina (Carolinas Healthcare System)
• Pilot in one hospital; commitment to spread system-wide if effective
• Problem: early readmissions from SNF
• Test:
  • warm handoffs to SNF
  • Call back to SNF 3-24 hours after transfer to answer questions
• Details:
  • RCA revealed SNF-readmission patterns
  • Hospital readmission champion met with SNFs to discuss shared goals
  • Hospital (with some leadership effort) asked SNF to participate in this communication
  • RN calls nurse at SNF
  • SW or care coordinator calls for follow up clarification 3-24 hours after transfer
  • Daily workflow (with some modifications for weekends, done next business day)
  • Follow up calls are scripted and documented in Allscripts system
  • Pilot on paper with 1 RN and 1 SW
  • Pilot expanded to RN call report to SNF
  • Pilot expanded to add follow up calls
  • Pilot expanded to build questions into Allscripts
• Expand to all; new standard of practice

Source: Emily Skinner, Carolinas Healthcare System
SNF Circle Back – Warm Handoffs

SNF Circle Back Questions (Hospital calls back SNF 3-24h after d/c)

1. Did the patient arrive safely?
2. Did you find admission packet in order?
3. Were the medication orders correct?
4. Does the patient’s presentation reflect the information you received?
5. Is patient and/or family satisfied with the transition from the hospital to your facility?
6. Have we provided you everything you need to provide excellent care to the patient?

Insights

- Transitions are a PROCESS (forms are useful, but only a tool to achieve intent)
- Best done ITERATIVELY with COMMUNICATION

Source: Emily Skinner, Carolinas Healthcare System
Collaborate Across the Continuum:  
*Mass General “3 day waiver” Experience*

- “Warm follow-up” [patient directly admitted to SNF]

- Process with SNFs:
  - Warm handoff from ED to SNF clinician-clinician; joint decision
  - Support staff were available to facilitate
  - Telephonic “card flipping” between MGH team & SNF

- Key lessons:
  - Took a while to develop collaborative rapport v. “in-charge”
  - No substitute for verbal communication and problem solving
Collaborate Across the Continuum: *Emerging Practices from ACOs & Bundles*

- ACO or Bundle clinical coordinator
- Physical rounds in SNF
  - RN / NP to see patient, discuss plan with SNF staff
  - Respond to changes in clinical status to manage in setting
- Virtual care management rounds with SNF
  - Weekly telephonic rounds ACO/bundle coordinator and SNF
  - LOS, progress toward discharge goals, discharge planning
- Tele-medicine consults in SNF for follow up
  - Tele-evals for change in clinical status
- Direct admit to SNF from home if need escalated care
Delivered Enhanced Services

*Keswick SNF Transition to Home Program*

- 68 subacute beds, 174 LTC bed facility in Maryland
- 55-80 admissions per month
- “Home and Healthy Program”
- Comprehensive discharge planning: appointments, services made
- Reviews all information with resident, family, caregiver
- Direct contact after SNF discharge
  - Phone call next day
  - Once a week for a month
  - Once a month for 3 months
Let’s Run the Numbers:

*Three-part strategy*

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<thead>
<tr>
<th></th>
<th>Number</th>
<th>Rate</th>
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<tbody>
<tr>
<td>Medicare admits/year</td>
<td>5,000 admissions</td>
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<td>Medicare RA rate</td>
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<td>20%</td>
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<tr>
<td># Medicare RA/year</td>
<td>1,000 readmissions</td>
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<tr>
<td>1. Improve standard care</td>
<td>5,000 admissions (20% RA rate)</td>
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<tr>
<td>Expected effect</td>
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<td>10%</td>
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<td>Expected # RA reduction</td>
<td>100 RA avoided</td>
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<td>2. Collaborate with receivers</td>
<td>1650 admissions (1/3 total) (30% RA rate)</td>
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<tr>
<td>Expected effect</td>
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<td>20%</td>
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<tr>
<td>Expected # RA reduction</td>
<td>99 RA avoided</td>
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<td>3. Enhanced Service for Pilot</td>
<td>200 admissions (25% RA rate)</td>
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<tr>
<td>Expected effect</td>
<td></td>
<td>20%</td>
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<tr>
<td>Expected # RA reduction</td>
<td>10 RA avoided</td>
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<tr>
<td><strong>Total (illustative)</strong></td>
<td><strong>209 RA avoided</strong></td>
<td><strong>209/1000 = 20% overall</strong></td>
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46-study Meta-Analysis: What Works?

Preventing 30-Day Hospital Readmissions
A Systematic Review and Meta-analysis of Randomized Trials
Leppin et al; JAMA Internal Medicine (online first) May 12 2014

- Review of 42 published studies of discharge interventions

- Found that *multi-faceted interventions* were 1.4 times more effective
  - Many components
  - More people
  - Support patient self-care

- Interventions published more recently had fewer components are were found to be less effective

Proposed Portfolio Strategy for SNFs

Improve facility-based transitional care processes for ALL patients

1. Embrace “shared expectations”
2. Develop transitional care plans that consider needs over 30 days
3. Ask resident & support persons what help they need; share with them their needs/risk assessment
4. Use teach-back, target the appropriate “learner”
5. Customize information – no stacks of printed handouts – focus on what they need to know about their specific plan
6. 100% MOLST for all residents
7. Medication optimization during SNF
8. Review whether residents will be able to afford and obtain medications at home; consider providing 3 days supply on hand
9. Arrange for post-discharge follow up with all relevant providers
10. Use a discharge check-list and “discharge time out” to ensure completion

Collaborate with cross-setting partners

1. Use ADT notifications to better track individuals’ utilization patterns over time
2. Ask community providers what they need and how they want to receive it
3. Collaborate to arrange timely follow up
4. Perform “warm” handoffs, and opportunity for clarification to Home Health
5. Form a cross-continuum team that can access resources your staff are unaware of
6. Constantly refresh your awareness of social and behavioral health resources
7. Broaden partners to include health plans PCMH/ACO/Duals care managers
8. Track services provided, resident outcomes, share upstream with hospitals and downstream with home health, ASAPS to inform and strengthen value of “shared expectations” across continuum
9. Collaborate with Accountable Organizations’ efforts to actively manage care across settings

Provide enhanced services for high risk

1. Post-SNF transitional care follow up to ensure services and follow up are in place
2 HOSPITALS’ PORTFOLIO STRATEGIES

Valley Baptist Medical Center, Harlingen TX
Frederick Memorial Hospital, Frederick MD
Valley Baptist Medical Center’s Portfolio of Strategies

- Palliative Care / Hospice
- Project Red – Appt. w/PCP or Clinic and FU Calls
- CCTP – CTI Coach and PAC Program
- Discharge Assessment within 24 hour of admission
- Walgreen’s Well Transition Program
- Registration Identifying Possible Readmissions in the ED
- Transitional CM

Courtesy of Angela Blackford, VBMC
Valley Baptist Medical Center - Results

All-cause readmissions

Medicare Penalty

• FY 2011: 28%
• FY 2013: 21% 0.8% (of possible 1%)
• FY2014: 14% 0.2% (of possible 2%)
• FY 2014: 0.04% (of possible 3%)

By the way, that’s a 50% readmission reduction!!!
Frederick Memorial Hospital - Portfolio

- **Improve Standard Hospital-based Processes**
  - ED-based SW/CM – identify patients at point of entry
  - CM screen for all patients – move from 8B to “behavioral interview”

- **Collaborate with Providers**
  - 25-member cross continuum team, meets monthly
  - Track and trend H-SNF readmissions, review each, INTERACT
  - Track and trend H-HH patients, weekly “co-management” virtual rounds (move up the continuum from HH to direct SNF if needed)
  - Warm handoffs, points of contact with community BH provider
  - Use off-site urgent care center for post-d/c appointments if needed

- **Provide Enhanced Services to High Risk**
  - CM refer via order entry to Care Transitions Team
  - Multi-disciplinary team “works the case” x 30+ days
  - Cardiology NP “Heart Bridge Clinic”
Frederick Memorial Dashboard

CARE TRANSITIONS PERFORMANCE DASHBOARD

<table>
<thead>
<tr>
<th>Metric Description</th>
<th>FY 11</th>
<th>FY 12</th>
<th>Goal</th>
<th>July</th>
<th>August</th>
<th>September</th>
<th>October</th>
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<th>January</th>
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<th>May</th>
<th>June</th>
<th>YTD</th>
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<tbody>
<tr>
<td>Readmission Rate</td>
<td>11.5%</td>
<td>10.3%</td>
<td>No goal</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>8</td>
<td>5</td>
<td>6</td>
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<td>6</td>
<td>2</td>
<td>8</td>
<td>66</td>
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<tr>
<td>% Patients in CL for &gt; 30 days of DC</td>
<td>31 (24/65)</td>
<td>No goal</td>
<td>17</td>
<td>24</td>
<td>23</td>
<td>27</td>
<td>26</td>
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<td>25</td>
<td>15</td>
<td>33</td>
<td>13</td>
<td>83</td>
<td>252</td>
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<td>% of Patients for no readmission</td>
<td>90</td>
<td>86</td>
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<tr>
<td>% of patients with a physical consultation or history</td>
<td>72%</td>
<td>68%</td>
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<td>% of care transitions patients died with post acute services</td>
<td>11.9%</td>
<td>35.6%</td>
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<td>Follow up MD visit</td>
<td>100%</td>
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RA = Readmission
- At or above goal
- < 10% below the goal
- > 10% below the goal
<table>
<thead>
<tr>
<th>Source</th>
<th>FY 2012</th>
<th>Goal</th>
<th>July</th>
<th>August</th>
<th>September</th>
<th>October</th>
<th>November</th>
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<tr>
<td># Patients RA w/ FY 2011</td>
<td>1719</td>
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<tr>
<td>% of Patients RA</td>
<td>10.27%</td>
<td>8.60%</td>
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<td>9.83%</td>
<td>9.76%</td>
<td>8.20%</td>
<td>8.02%</td>
<td>7.88%</td>
<td>8.44%</td>
<td>8.88%</td>
<td>11.00%</td>
<td>8.86%</td>
<td>7.89%</td>
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<tr>
<td>Average # of days from DC to RA</td>
<td>14.2</td>
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<td>14.5</td>
<td>13.4</td>
<td>12.0</td>
<td>13.2</td>
<td>12.8</td>
<td>13.2</td>
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<td>13.7</td>
<td>14.0</td>
<td>13.4</td>
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**All Patient RA Rate:**

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<tr>
<th>BRG Payer Source</th>
<th>FY 2012</th>
<th>Goal</th>
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<th>August</th>
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<tr>
<td>All Patients:</td>
<td>10.27%</td>
<td>8.60%</td>
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<td>9.83%</td>
<td>9.76%</td>
<td>8.20%</td>
<td>8.02%</td>
<td>7.88%</td>
<td>8.44%</td>
<td>8.88%</td>
<td>11.00%</td>
<td>8.86%</td>
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<td>MCO/MC HMO:</td>
<td>18.73%</td>
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<td>MA/MA HMO:</td>
<td>16.79%</td>
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<td>Self Pay/No Charge:</td>
<td>8.86%</td>
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<td>Commerical/Other:</td>
<td>6.07%</td>
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**BRG Diagnosis:**

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<th>August</th>
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<tr>
<td>HF DRG 184:</td>
<td>26.00%</td>
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<td>COPD DRG 148:</td>
<td>22.70%</td>
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<td>Bypass DRG 778:</td>
<td>17.12%</td>
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<td>Diabetes DRG 423:</td>
<td>31.11%</td>
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<td>Renal Failure DRG 490:</td>
<td>18.49%</td>
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<td>Bht. Bipolar DRG 763/783:</td>
<td>8.29%</td>
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<td>Bht. All Other:</td>
<td>8.88%</td>
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**Physician RA all Patients:**

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<tr>
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<tbody>
<tr>
<td>Dr. Praveen Boluram</td>
<td>27.40%</td>
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<td>Dr. Hiren Shah</td>
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<td>Dr. Ronald Miller</td>
<td>21.16%</td>
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<td>Dr. Austin Pearse</td>
<td>17.60%</td>
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SNF Readmissions, Frederick Memorial

NH Readmission Rate by FY

Nursing Facility Readmission Rate by FY

- FY 2011: 24.99%
- FY 2012: 16.99%
- FY 2013: 16.71%
- FY 2014 YTD: 15.33%

Courtesy of Heather Kirby
3-year results, Frederick Memorial

All-payer all cause readmissions

FY 12  10.6%
FY 13  9%
FY 14  7.8%

That’s a 28% reduction
Recommendations for SNFs in 2015
Define Value in Accountable Providers’ Terms

• Data is your best business development tool
  • SHOW what service, for whom
  • TRACK what happens to your residents
  • TREND improvement over time (LOS, return to ED, readmission)
  • DEMONSTRATE consistency through standard processes
  • DESCRIBE services & outcomes in terms that hospitals recognize

• Embrace the business of reducing SNF utilization
  • HELP Accountable Care providers make better decisions about who needs SNF and who can receive services at home
Describe Value in Accountable Providers’ Terms

- Describe services in terms of what creates value for them
  - Fewer emergency room visits
  - Fewer hospitalizations
  - Fewer readmissions
  - Shortened hospital length of stay
  - Reduced skilled nursing facility days
  - Shorter home health episodes
  - [possibly] greater patient satisfaction with hospital or SNF
  - [possibly] greater system loyalty based on positive experience
Recommendations

• Know your data and your patients

• Adopt a broad concept of readmission risk
  • Capture all reasons, whole-person approach

• Develop a multifaceted strategy
  • Improve standard hospital-based care for ALL patients
  • Start in ED
  • Collaborate across settings with multi-sector partners
  • Provide enhanced services

• Use technologies to make work better, quicker, automated
THANK YOU

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Lexington, Massachusetts

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