

Advisor Live Executive Summary from June 17, 2010 program:

Healthcare Reform and Readmissions

Speakers:

- **Pam Phillips**, vice president of missions, Bon Secours DePaul Medical Center
- **Jim McMillen, M.D., F.A.C.P.**, medical director, Heartland Health
- **Jan McNeilly, R.N., B.S.N., FACHE**, director, clinical client management, Premier
- **Danielle Lloyd, M.P.H.**, senior director, reimbursement policy, Premier

Summary of presentations:

Danielle Lloyd, M.P.H., senior director of reimbursement policy, Premier

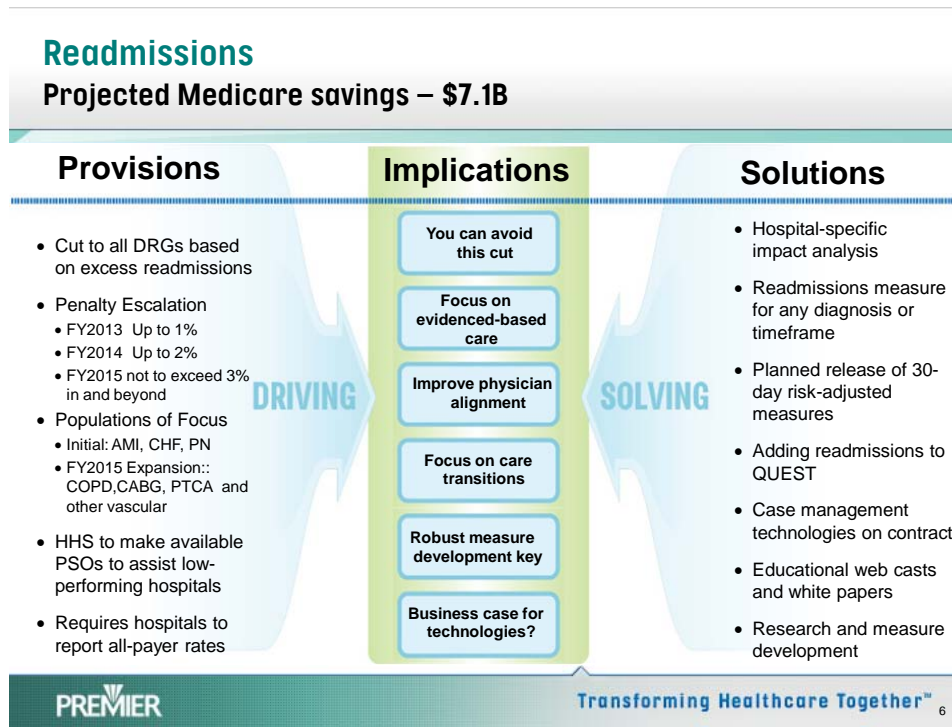


Illustration of readmission calculation problem

Subject	Elements	Results
Principal Diagnosis, Heart Failure	Total base payments	\$8,000,000
	Total cases	1,000
Re-admissions	Actual	200
	Expected	190
	Excess (200 - 190)	10
Re-admission Rates	Actual (200 / 1,000)	20%
	Expected (190 / 1,000)	19%
	Excess (10 / 1,000)	1%
	Statute calc. of excess = 20% / 19% - 1	5.3%
Medicare Payments & Penalties	Payment = 1% of \$8 million	\$80,000
	Intended penalty = payment*	(\$80,000)
	Statute penalty = 5.3% of \$8 million	(\$421,053)

Explanation

Penalty in statute =
*base payments * excess readmission rate*

Excess readmission rate in statute =
observed rate/expected rate - 1
(traditional quality metric)

Correct excess readmission rate =
observed rate - expected rate



Jan McNeilly, R.N., B.S.N., FACHE, director, clinical client management, Premier

Factors contributing to readmissions:

- Discharge instructions
 - Pre-printed/generic discharge instruction forms
 - Small font
 - Includes “just in case” information
 - Requires hand-written input (legibility)
 - Not written at a level understandable to people with below high school education
 - Often completed at the “last minute” to facilitate a timely discharge
 - Often do not include a scheduled follow-up appointment
 - Continuity
 - 12 hour nursing shifts = “part time” nursing staff
 - Multiple nursing units involved (ICU to telemetry to med/surg)
 - Physicians share coverage (both hospitalists and non-hospitalists)
- Medication reconciliation
 - More compliance-focused than patient-focused
- Discharge Summaries
 - Medical Staff Rules & Regulations - most not modified for decades specific to documentation requirements
 - Discharge summaries - 30 day window to dictate
 - Minimal content requirements

- Poor quality
 - No diagnostic test results – (33-63%)
 - No hospital course/treatment (7-22%)
 - No discharge meds (2-40%)
 - Pending tests no listed (65%)
 - Lack of follow-up plan (2-43%)
 - Kripalani, JAMA 2007 Feb 28;297(8)831-41
- Communication with post-discharge providers doesn't happen
- No process to ensure discharge summaries are provided

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- Pending test results
 - 41% of patients discharged with pending test results
 - 9.4% could require action
 - Of the 9.4%
 - 37% “actionable” (change in plan of care needed)
 - 12.6% “urgent” action required
 - MD's unaware 61% of the time

- Outpatient follow-up post discharge
 - 25% of discharged patients need outpatient management
 - 35.9% not done
 - Timely follow-up appointment key

Camden-Clark Memorial Hospital – newborn readmissions:

- High readmission rate for newborns when compared to a peer group
- Analysis showed a higher readmission rate for babies born following elective inductions, especially when prior to 39 weeks gestation
- Practice modified including no elective inductions prior to 39 weeks
- Results – reduced readmission rate

Pam Phillips, vice president of missions, Bon Secours DePaul Medical Center

Life Coach Model – Best Practice:

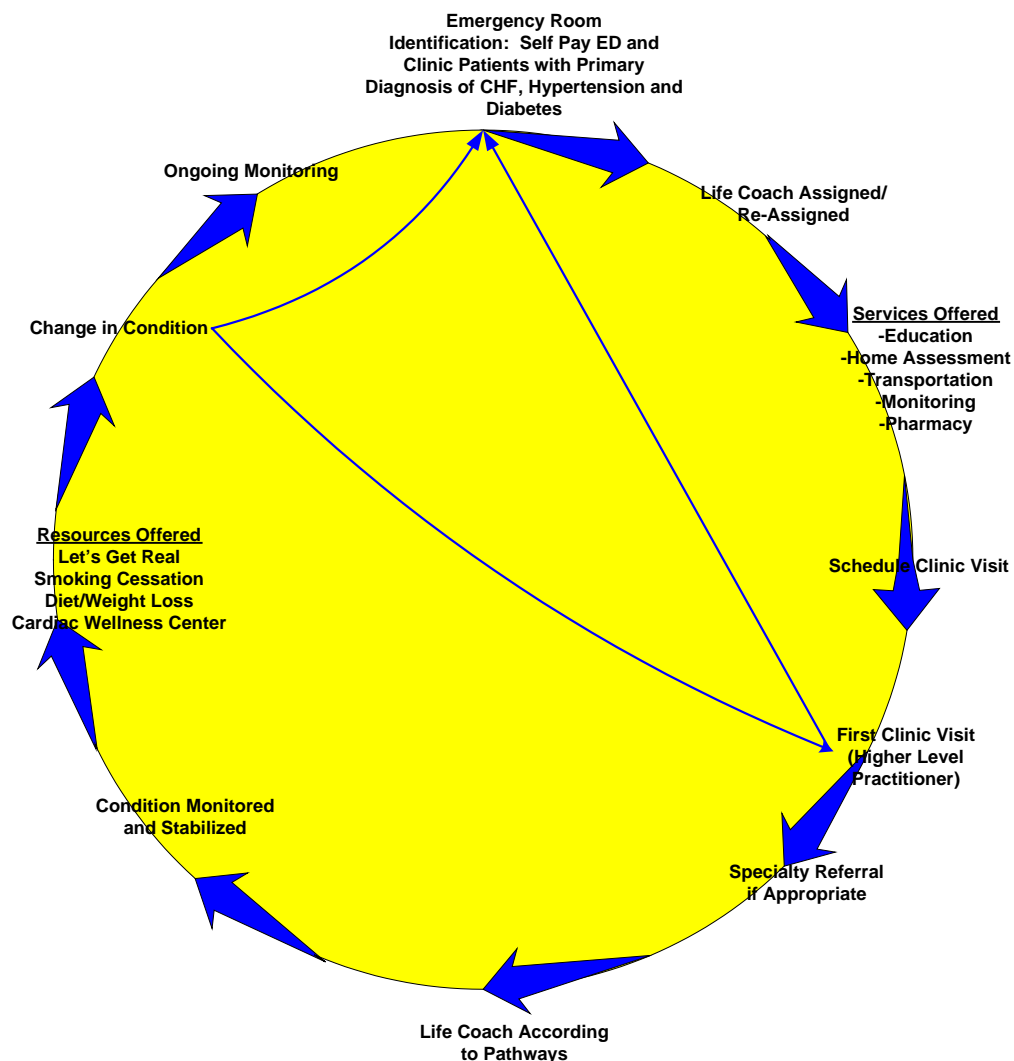
Project goal: To develop and implement community partnerships to better serve the economically poor with respect and dignity and to improve access to primary care.

- Pilot began: March 2007 at DMC
- The Life Coaches:
 - Serve as liaison to Park Place Medical Center
 - Serve as a resource for patient education
 - Address social needs/issues

In FY09:

- Served over 1000 uninsured patients last year
- 12 pts. returned to the ED for primary care

Life Coach Continuum Program



Methodology:

- An average variable cost analysis was conducted utilizing inpatient discharge data
- March 2007 – December 2008 was the baseline period
- September 2008 – November 2009 was the current period
- Analysis was taken from the Premier ClinicalAdvisor[®] database
- ClinicalAdvisor contains inpatient and outpatient clinical and financial performance data for over 600 hospitals in the United States
- Analysis was filtered according to these parameters:
- Targeted APR-DRGs were reviewed for complications in all accounts
- Control group consisted of all accounts of the APR-DRG and Severity of Illness
- Evaluated LOS by Unit Type
- Reviewed Ventilator days by APR-DRG
- Compared actual variable cost per case to expected and historical cost per case
- Reviewed Readmission rates and mortality rates for the last two years

Conclusion:

- Improved quality of life for enrolled patients
- Uninsured patients have a medical home/physician
- High patient satisfaction
- Appropriate Emergency Room Utilization
 - Less wait time
 - Improved through-put/ patient flow
- Preventable Hospitalizations for Chronic Diseases
- Appropriate LOS for medically complex patients
- Decreased cost/case for medically complex patients
- Well established community partnerships
- The Life Coach Model of Care is the right thing to do for the community

Jim McMillen, M.D., F.A.C.P., medical director, Heartland Health



Interventions identified by CMS for avoiding hospital readmissions:

- Better, safer care during hospitalization
- Improved communication among providers and with the patient and caregivers
- Care planning that begins with assessment at admission
- Clear discharge instructions, with specific attention to medication management
- Shared accountability for care coordination, with attention to transitions and hand-offs
- Discharge to a proper setting of care
- Better, safer care in the post-acute setting
- Appropriate use of palliative care and the honest planning for the likely course
- Timely follow-up visits
- Active involvement of patients and their caregivers

*All are components of HRMC Pilot Program

Key aspects of pilot program:

- Inpatient Phase
- Transition Phase
 - 1st week post discharge
(Intense Case Management)
- Outpatient Phase
 - 2-4 weeks post discharge
(Less Intense Case Management)
 - After 4 weeks post discharge - graduation

(Ongoing Case Management)

Results:

- Overall Pilot Program readmission rate stands at 14.81% (through May 2010, ten months), compared to the expected readmission rate of 21.59%, and readmission rate baseline of 31.95%. Top decile performance indicates a readmission rate of 13.05%.

Conclusion:

- The CHF pilot is demonstrative of an ideal outpatient case management model for chronic illnesses, and demonstrates a positive impact on readmission rates for Stage C and D patients.

Questions:

Q: Do you have a document that states the definitions of the 2015 CMS Readmission Focus areas (COPD, Other Vascular, etc...)?

A: They have not been defined yet. The genesis of these conditions being chosen was a June 2008 MedPAC report that can be obtained at www.Medpac.gov that may provide a bit more information.

Q: Is the all-payer readmissions for all ages?

A: Yes, "all patient readmission rates" is specified in the legislation.

Q: Is it readmissions for the same diagnosis or any diagnosis (for measures that are part of the Medicare payment reduction)?

A: The 30-day, all cause can be any facility. "All cause" literally means any cause. However, there are requirements in the legislation for CMS to try and exclude some things, for example, planned readmissions. There is no code for CMS to determine planned readmissions yet. There will be a lot of opportunity for us to comment on this issue.

Q: The measurement period is federal fiscal year 2011 and the penalty will start in following year. How does that work?

A: It's likely that the measurement year will be calendar year 2011 and then payment for fiscal year 2013 which begins October 1, 2012. Hospitals should make changes by 2011. You can't wait to make these changes.

Q: What is the skill level for the Life Coaches at Bon Secours?

A: We use an LPN model because they can do patient education. We are adding a pharmacy technician because a lot of the community questions involve how to access pharmacy.

Q: When you stated that the financial impact would be across all DRGs did you mean literally all DRGs the facility files claims for or did you mean that the impact would be against all of the focus population DRGs?

A: Literally every single claim.

Link to presentation and video recording:

www.premierinc.com/advisorlive