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STRATEGIES TO DECREASE THE FINANCIAL IMPACT OF READMISSIONS

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FACULTY

Toni G. Cesta, Ph.D., RN, FAAN is a founding partner of Case Management Concepts, LLC, a consulting company that assists institutions in designing, implementing and evaluating case management models, new documentation systems, and other strategies for improving care and reducing cost. Dr. Cesta is the author of eight books, a frequently sought-after speaker, lecturer and consultant and is considered one of the primary thought leaders in the field of case management. Dr. Cesta also writes a monthly column called "Case Management Insider" in AHC Media's Hospital Case Management newsletter in which she shares insights and information on current issues and trends in case management.

Dr. Cesta has been active in the research and development of case management for over 20 years. Her research in case management has included two funded studies measuring the effects of a case management model on congestive heart failure and fractured hip patient populations, with measures of patient satisfaction, quality of life, and short and long term clinical perceptions and outcomes.

Dr. Cesta has presented topics on case management at national and international conferences and workshops. She has published extensively including the fourth edition of her book, "Nursing Case Management: From Essentials to Advanced Practice Applications," the second edition of "The Case Manager's Survival Guide: Winning Strategies for Clinical Practice" which won the AJN Book of the Year award, "Survival Strategies for Nurses in Managed Care", and her newest book: "Core Skills for Hospital Case Managers".

Bev Cunningham, RN, MS is a founding partner of Case Management Concepts, LLC. She has a 25-year deep working knowledge of case management with specific expertise in denials management, patient flow and the role of the Case Manager and Social Worker in the Case Management process. She has served as a Commissioner on the Commission for Case Management Certification and is a fellow with the Advisory Board.

Bev is also former Vice President Resource Management at Medical City Dallas Hospital where she had responsibility for Case Management, Health Information Management, Patient Access, Physician Integration and Solid Organ Transplant. Prior to her position as Vice President, Bev served as Regional Director of Clinical Effectiveness for Mercy Health Partners, Toledo, Ohio. In this role she directed the Case Management, Quality Management, and Pre-Authorization Departments. She also served eight years as a consultant, assisting hospitals in implementing, evaluating and improving their case management programs. As a Clinical Assistant Professor for the Master of Nursing Program at the University of Oklahoma, she coached students in their clinical practicums. Bev continues to mentor students in a Master's of Healthcare Administration program.

Bev is a well-known speaker in the Case Management field. Her publications include a chapter CMSA's Core Curriculum for Case Management Certification and most recently, co-author of the book, Core Skills for Hospital Case Management. Bev has a BSN from Pittsburg State University, Pittsburg, Kansas and a Master of Science, Nursing Major, from the University of Oklahoma.

OBJECTIVES

- Identify the readmission penalties implemented by CMS while developing a strategy to decrease them.
- Identify tactics to improve the role of the ED case manager and social worker in managing readmissions.
- Explain new and revised case management standards, regulations, and laws put forth by CMS, TJC and the federal government.
- Evaluate case management protocols and penalties.

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READMISSIONS: THE HOSPITAL'S U-TURNS

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THE QUANDARY OF READMSSIONS THEN (2012)

- 1 in 5 Medicare beneficiaries readmitted within 30 days
- National cost estimated to be $17B to $41B
- Half of patients readmitted had no physician contact between discharge and readmission
- 70% of surgical readmits were for chronic medical conditions
- Potentially 40% of all readmissions are preventable

New England Journal of Medicine
Drs. Jencks, Williams and Coleman
(At the start of the readmission reduction program)

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READMISSIONS WHO?

- >55% of all readmissions are Medicare patients
- >58.2% of readmission costs are Medicare patients

AHRQ 2013 (from 2011 data)

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READMISSIONS---WHAT TOP CONDITIONS?

- Heart failure
- Septicemia
- Pneumonia
- COPD
- Cardiac dysrhythmias

AHRQ 2013 (from 2011 data)

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READMISSIONS WHY?

- 69% noncompliance with meds
- 51% lacked knowledge of how to use therapy devices
- 45% inadequate knowledge of medications
- 42% unable to self manage care
- 37% no follow up with physician
- 31% developed infection post discharge

Webinar 2012
Greg Spratt, Kimberly Wiles, Becky Anderson

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UNDERSTANDING THE READMISSION PENALTY PROGRAM

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HOSPITAL READMISSIONS REDUCTION PROGRAM

- Section 3025 of the Patient Protection and Affordable Care Act added section 1886(q) to the Social Security Act, establishing this program
- Requires CMS to adjust payments to hospitals paid under Inpatient Prospective Payment System (IPPS) with excess unplanned readmissions
- Aims to
  - Improve quality of care, especially by improving communication, care coordination, and costs
  - Reduce variation among hospitals

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THE OLD WIVES TALE OF READMISSION PENALTIES

"YOU AREN'T PAID FOR ANY READMISSION WITHIN 30 DAYS OF DISCHARGE"

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READMISSIONS PUBLICLY REPORTED

- First reported on CMS's Hospital Compare in 2009
- Defined as better, worse, or no different than U.S. national rate
- Eventually added hospital-wide all-cause readmissions
- https://www.medicare.gov/hospitalcompare/

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INCLUSION CRITERIA

- Index admission to which readmission is attributed
  - Medicare fee-for-service or VA beneficiary (VA only applies to AMI, heart failure and pneumonia measures)
  - At least 65 at time of admission
  - Principal discharge diagnosis of condition at index admission
  - Discharged alive from non-federal acute care hospital or VA hospital
  - Not transferred out to another acute care facility (multiple contiguous hospitalization with readmission attributed to hospital discharging to non-acute care setting)
  - Enrolled in Medicare Part A and Part B for 12 months prior to date of index admission (need a full year of data for risk adjustment) and enrolled in Part A during index admission
- Unplanned readmission

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EXCLUSION CRITERIA

- Not enrolled in FFS Medicare at least 30 days post discharge (only to non-VA hospitals)
- Left against medical advice
- AMI only: Same-day discharges, as they are unlikely to have had a clinically significant AMI

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EXCLUDED READMISSIONS

- Planned readmissions
- Same day readmission to same hospital for same condition (CMS requires these two accounts to be combined to a single claim)
- Observation stay
- ED visit
- Admissions to facilities other than sort-term acute care hospitals, for example rehab, LTAC, psych hospital, hospice facilities, long-term care facility, SNF

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NO RISK ADJUSTMENT FOR SOME VARIABLES

- Complications of care
- Admission source
- Socioeconomic status
- Hospital size, specialty or location

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MEASURING EXCESS READMISSION RATES

- Predicted rate: adjusted actual readmissions
- Expected rate: number of expected readmission based on average performance, based on hospital's case mix
- Payment adjustment factor for each hospital updated annually in IPPS final rule

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THE QUANDARY OF READMISSION PENALTIES NOW

- Higher fines, but close to the same number of hospitals fined (2,592)
- Total 2015 penalties estimated to be $420M ($290M in 2013 and $227M in 2014)
- Maximum penalty 3% (4 hospitals received maximum penalty—2 in KY, 1 in TN and 1 in LA)
- Average penalty for all hospitals 0.61%
- Why?
  - More medical conditions measured
  - Major teaching hospitals
  - Hospitals with higher shares of low-income beneficiaries

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HOW CALCULATION OF READMISSION PENALTY WORKS

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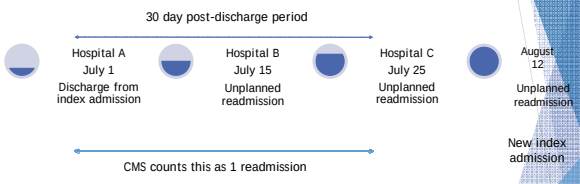
UNPLANNED READMISSIONS



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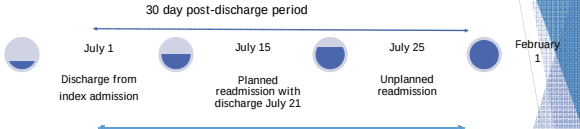
UNPLANNED READMISSIONS AFTER A PLANNED READMISSION



CMS does not count this as a readmission

Once a planned readmission occurs, the measure stops looking for unplanned readmissions during the remainder of the 30-day post-discharge period

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JUST REMEMBER……..

A READMISSION IN ONE MEASURE MAY ALSO QUALIFY AS AN INDEX ADMISSION IN ANOTHER MEASURE

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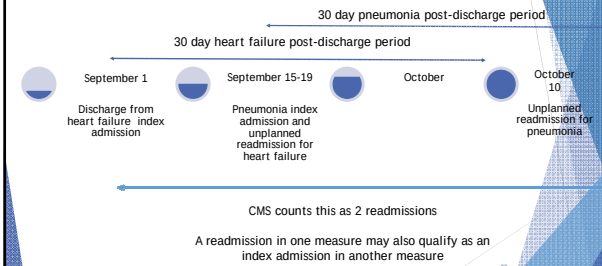
UNPLANNED READMISSIONS AFTER A PLANNED READMISSION



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SAY IT ISN'T SO!!!

A READMISSION TO THE SAME HOSPITAL FOR A DIFFERENT CONDITION-----IS A STILL A READMISSION

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TRANSFERRED PATIENTS AND READMISSIONS

- Readmission ultimately attributed to hospital that discharges patient to non-acute care stetting
- Second inpatient admission (transfer) must occur on same day or next calendar day following discharge from first inpatient admission at a short-term acute care hospital
- Principal discharge diagnosis for final hospitalization in transfer chain must meet measure cohort inclusion criteria for that measure

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HOSPICE PATIENTS AND READMISSIONS

- Hospice patients not excluded
- Measure does risk adjust for probability that these patients are sicker, or at the end of their lives
- Patient discharged from hospital and admitted to dedicated hospice facility within 30 days is not considered a readmission

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CONDITION-SPECIFIC READMISSION MEASURES

- AMI*
- COPD
- Heart Failure*
- Pneumonia*

* First condition-specific measures published and measured

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WHY THESE CONDITION-SPECIFIC MEASURES?

- Most common in Medicare population
- Associated with increased mortality and morbidity
- Impacts patient quality of life
- High burden on healthcare system
- Marked variation of performance on these measures across hospitals
- Ability to combine quality of care metrics with readmissions (core measures and efficiency of care)

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ADDING IN PROCEDURES: CABG AND TOTAL HIP AND KNEE ARTHROPLASY (THA/TKA)

- Common procedures in Medicare populations
- CABG
  - Also associated with increased morbidity, mortality and health care spending
  - Encourages early recognition and treatment of postoperative complications
  - Encourages improved coordination of perioperative care and discharge planning
- THA/TKA
  - Variation in readmission rates after elective procedures
  - Variation in quality of care at hospitals suggested by varied readmission rates
  - Encourages a focus on improving care and hardwiring care coordination

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CABG INCLUSION/EXCLUSION CRITERIA

INCLUSION CRITERIA

- Medicare fee-for-service
- At least 65 years old at admission
- Admitted for isolated CABG procedures, as defined by ICD-9 codes
- Discharged alive
- Enrolled in Medicare Part A and Part B for 12 months prior to date of index admission and Part A during index admission

EXCLUSION CRITERIA

- Did not have at least 30 days of post-discharge FFS Medicare enrollment
- Left AMA
- Had subsequent qualifying CABG procedures during measurement period

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WHY ONLY ISOLATED CARDIAC PROCEDURES?

- Isolated procedure definition: CABG procedure without concomitant valve or other major cardiac or vascular procedures
- Excluded:
  - Valve
  - Atrial and/or ventricular septal defects
  - Congenital anomalies
  - Other open cardiac procedures
  - Heart transplants
  - Aorta or other non-cardiac arterial bypass procedures
  - Head, neck and/or intracranial vascular procedures
- Represent a higher risk population

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TRANSFERRED PATIENTS WITH CABG

- Included in the measure
- Readmission attributed to hospital performing first (index) CABG procedure—even if it is not the discharging hospital

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TRANSFERRED PATIENTS WITH CABG Scenario #1

- Patient has CABG at hospital A and is transferred to hospital B
- Hospital B discharges patient
- Patient readmitted within 30 days of discharge from hospital B
- Readmission attributed to hospital A
- 30 day readmission measurement time frame begins with day of discharge from hospital B

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TRANSFERRED PATIENTS WITH CABG Scenario #2

- Patient has admitted to hospital A and is transferred to hospital B, where CABG performed
- Hospital B discharges patient
- Patient readmitted within 30 days of discharge from hospital B
- Readmission attributed to hospital B where index CABG procedure performed
- 30 day readmission measurement time frame begins with day of discharge from hospital B

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TRANSFERRED PATIENTS WITH CABG Scenario #3

- Patient has admitted to hospital A where CABG performed and is transferred to hospital B, where subsequent CABG procedure performed
- Hospital B discharges patient
- Patient readmitted within 30 days of discharge from hospital B
- Readmission attributed to hospital A where index CABG procedure performed
- 30 day readmission measurement time frame begins with day of discharge from hospital B

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THA/TKA INCLUSION/EXCLUSION CRITERIA

INCLUSION CRITERIA

- Medicare fee-for-service
- At least 65 years old at admission
- Admitted for a qualifying THA/TKA procedure, as defined by ICD-9 codes 81.51 (THA) or 81.54 (TKA)
- Qualifying elective primary procedure, as defined by CMS
- Discharged alive
- Enrolled in Medicare Part A and Part B for 12 months prior to date of index admission and Part A during index admission

EXCLUSION CRITERIA

- Did not have at least 30 days of post-discharge FFS Medicare enrollment
- Left AMA
- Admitted for index procedure and transferred out to another acute care facility (attribution has been determined as difficult)
- Had more than two THA/TKA procedure codes during index admission (likely a coding error)

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HOSPITAL-WIDE ALL-CAUSE READMISSIONS (HWR)

INCLUSION CRITERIA

- Medicare fee-for-service
- At least 65 years old at admission
- Discharged from inpatient stay at non-federal short-term care hospital
- Discharged alive
- Not transferred to another acute care facility
- Enrolled in Medicare Part A and Part B for 12 months prior to date of index admission and Part A during index admission
- Patients admitted with cancer for non-cancer diagnosis or surgical treatment of cancer

EXCLUSION CRITERIA

- Admitted to PPS-exempt cancer hospital
- Did not have at least 30 days of post-discharge FFS Medicare enrollment
- Left AMA
- Admitted primary psych diagnoses or rehab
- Admitted for rehab
- Admitted for medical treatment of cancer

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HWR READMISSION MEASURE AND TRANSFERRED PATIENTS

- Readmission attributed to discharging hospital
- Planned readmissions do not count as readmissions

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INCLUSION IN THE READMISSION PENALTY PROGRAM

MEASURE	FY 13	FY 14	FY 15	FY 16	FY 17
Acute MI	X	X	X	X	X
Heart Failure	X	X	X	X	X
Pneumonia	X	X	X	X	X
COPD			X	X	X
Total Hip and Total Knee Arthroplasty			X	X	X
Coronary Artery Bypass Graft Surgery					X
Hospital-Wide All-Cause Readmissions					?

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THE FINANCIAL PENALTY

2013	1%
2014	2%
2015	3%
2016	3%
2017	3%

- Called the "payment adjustment"
- First effective beginning with federal fiscal year 2013
- Made after a review and correction period for the hospital—prior to public reporting
- Penalty adjustment
  - Annual
  - Applied if any of the conditions or procedures have a performance that is worse than the national average
  - Applies to all Medicare discharges for that year
  - Applies to a portion of the hospital's payment

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CURRENT READMISSION DATA SOURCES AND PERIOD

- Final Medicare claims for discharges between July 1, 2011 and June 30, 2014
- Subsequent admission 30 days after discharge for short-term acute care and critical access hospitals, including VA hospital
- Medicare inpatient, outpatient and physician claims used to identify comorbidities during index admission and in 12 months prior to index admission (hospital-wide readmission measure does not include outpatient claims)
- Demographic, enrollment and mortality information from Medicare Enrollment data base and Veterans Health Administration National Patient Care Database

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UNDERSTANDING READMISSION RULES AND THEIR FINANCIAL IMPLICATIONS HELPS YOU PLAN YOUR STRATEGIES

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REGULATORY INFLUENCES ON READMISSION PENALTIES

HOME CARE PROPOSED RULE

- 1.72% cut to standard episode 60-day home-care episode rate for 2016 and 2017: CMS reported lower-than-expected growth in severity for home care services
- Rule would slash Medicare home care costs by 350M next year
- Final rule due in November
- Kindred at Home disputing proposed rule: Patients have greater needs for ambulation, transferring, grooming and toilet in 2014

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REGULATORY INFLUENCES ON READMISSION PENALTIES

HOME CARE PROPOSED RULE IMPACT

- Might prevent HHA from taking more medically complex patients (rather than less complex)
- Reduce access to home care for some beneficiaries
- Shift complex patients to higher levels of care that are more expensive
- More HHAs closing
- Increase hospital readmission rates

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FINANCIAL INCENTIVES DRIVING READMISSION STRATEGIES

- Improve hospital care
- Improve assessment of readiness for discharge
- Facilitate transitions to outpatient status
- Continue to improve strategies with “noncompliant” patients

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READMISSION PARTNERSHIPS

- Partnership for Patients
- Community-based Care Transitions Program (CCTP)
- National Priorities Partnership (NPP)
- American College of Cardiology (ACC)
- State Action on Avoidable Rehospitalizations (STARR) initiative
- Commonwealth Fund
- The Society of Hospital Medicine (SHM)
- Project Red (Re-Engineered Discharge)

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PARTNERSHIP FOR PATIENTS

- Launched in 2011 by CMS
- Focus
  - Patient and family engagement
  - Partnership with care providers across continuum
  - Patient safety
- Goal regarding readmissions: 40% decrease in preventable hospital readmissions

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COMMUNITY-BASED CARE TRANSITIONS PROGRAM (CCTP)

- Part of Partnership for Patients
- Launched in 2012
- CMS allocates funds for qualified hospitals to pursue two-year renewable agreements aimed at
  - Testing models that improve care transitions from hospital to other settings
  - Reduce readmissions for high-risk Medicare beneficiaries
- $500M available 2011-2015 to community-based organizations partnering with hospital and other providers

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NATIONAL PRIORITIES PARTNERSHIPS (NPP)

- Founded in 2008 and part of National Quality Forum
- Partnership of 52 major national organizations that developed and implemented National Quality Strategy
- National blueprint for achieving a high-value healthcare system through effective communication and care coordination

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AMERICAN COLLEGE OF CARDIOLOGY (ACC)

- ACC and IHI developed Hospital to Home (H2H) national campaign
- Launched in 2010
- Aimed at reducing preventable readmissions for heart failure and AMI
  - Follow-up appointment schedule/cardiac rehab referral made within 7 days of hospital discharge
  - Optimal medical management for clinicians and patients
  - Activate patients to recognize early warning signs of complications with a plan to address them

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STATE ACTION ON AVOIDABLE REHOSPITALIZATIONS (STARR) INITIATIVE

- IHI conducted this program 2009-2013 with aim of reducing rehospitalizations
- Worked across organizations and across 4 states with 148 hospitals
- Engaged multiple stakeholders
- Provided technical assistance, coaching and teaching to providers on the front line working to improve transitions out of the hospital
- Improved patient transitions and receipts from hospitals and ED to SNF, rehab, home care and home, focusing on higher risk patients

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COMMONWEALTH FUND FOCUS ON READMISSIONS

- Launched in 2010 to focus on improved metric with readmission penalty
- Worked with John A. Hartford Foundation and Health Research & Education Trust (HRET) of American Hospital Association
- Produced Health Care Leader Action Guide to Reduce Avoidable Readmissions

www.commonwealthfund.org

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SOCIETY OF HOSPITAL MEDICINE (SHM)

- Launched readmission focus in 2008
- Project BOOST: Better Outcomes for Older Adults through Safe Transitions
- Goal to improve care of patients as they transition from hospital to home
  - Decrease readmissions
  - Decrease hospital LOS
  - Improve patient satisfaction
  - Improve transition of care between providers
- Target population: high-risk general medicine patients with focus on older adults

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SOCIETY OF HOSPITAL MEDICINE (SHM)

- Tools
  - Evidence-based clinical intervention tools
    - Risk assessment
    - Risk-specific patient and care give discharge preparation
    - Standardized forms and methods for transmitting information to primary care providers
    - Teach back training process

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PROJECT RED (RE-ENGINEERED DISCHARGE)

- Founded by AHRQ in 2003 at Boston University Medical Center
- Develops and tests strategies to improve hospital discharge process and ED visits
  - Promote patient safety
  - Reduce rehospitalization rates
  - Assign discharge advocate to ensure all components of project complete
- National Quality Forum adopted Red as a "safe practice"
- Results: Reduced ED visits and 30 day readmissions by 30%

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SOME HOSPITALS SELECT ONE PARTNERSHIP AS A STRATEGY

SOME HOSPITALS SELECT A BEST PRACTICE FROM SEVERAL PARTNERSHIPS

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STRATEGIES ARE ALSO IMPLEMENTED OUTSIDE THE HOSPITAL

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INTERVENTIONS TO REDUCE ACUTE CARE TRANSFERS (INTERACT)

- Launched in 2009
- CMS quality improvement program for long-term care facilities with
  - Clinical tools
  - Educational tools
- Goal to provide strategies to reduce frequency of transfers to the acute hospital
- Results
  - 3 nursing homes with high rates reduced hospitalizations by 50%
  - 36% reduction of potentially avoidable hospitalizations

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EVERCARE CARE MODEL

- Goal: reduce readmissions by customizing patient care and improving care coordination
- Implemented in 38 states
- Focuses on patients living in long-term care facilities
  - Medicare Part A and/or Part B
  - Dual eligible (Medicare and Medicaid)
  - Long-term or advanced illness
  - Older
  - Disabilities
- Advanced practice nurses and other care managers implement care plans
  - Coordinate multiple services
  - 4 levels of care provided (from minimal to extensive)
  - Uses transitions coaches
- Results
  - Hospitalization rate reduced by 45% with no increase in mortality
  - ED visits reduced by 50%
  - Decreased cost for care

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STATE-SPECIFIC PROJECT: OREGON'S MEDICAID CARE COORDINATED ORGANIZATION (COO)

- Launched in 2013
- Focus: Patient-centered primary care enrollment
- Results after first 9 months of 2013
  - ED visits and spending decreased
  - Lowered unnecessary hospitalizations for chronic conditions
  - Reduced hospital readmissions
  - Increased use of primary care

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YOUR BEST STRATEGY: RE-EVALUATE

- You've probably been implementing strategies, but are they working?
  - Increased fines
  - Increased conditions/procedures measured
- Re-evaluate the team
- Re-evaluate case management's involvement
- Re-evaluate the knowledge of all participants
- Re-evaluate the department's collaborative partners

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RE-EVALUATE CASE MANAGEMENT'S INVOLVEMENT IN THE READMISSION INITIATIVE: COLLABORATE, COLLABORATE, COLLABORATE

- Multidisciplinary rounds
- Walking rounds with patient involvement
- Effective discharge planning
- Home care for any patient needing medication reconciliation
- Coordinate across continuum
- Act now

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RE-EVALUATE CASE MANAGEMENT'S INVOLVEMENT IN THE READMISSION INITIATIVE: COLLABORATION BETWEEN HOSPITAL AND COMMUNITY PARTNERS

- Develop same next level of care strategies as Accountable Care Organizations and organizations with bundled payment initiatives
  - Identify next level of care providers with lowest readmission rates
  - Know star ratings of SNFs (1-5 stars)
  - Develop a mechanism to assure patient choice for home care and SNF, but also provide patient education regarding those SNFs and HHAs with high readmission rates
  - Use results from your case management software to understand next level of care provider acceptance and readmission rates
  - Meet at intervals with next level of care providers
    - Collaborate closely with case managements from next level of care providers
  - Expect the very best from your system's next level of care providers!

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RE-EVALUATE CASE MANAGEMENT'S INVOLVEMENT IN THE READMISSION INITIATIVE: OPTIMIZE CASE MANAGEMENT SPECIALTY POSITIONS

- Complex Discharge Planning Specialist
  - Patients seen by this case manager are often at high risk for readmission
  - Optimize next level of care placement for patients at high risk for readmission
- Transition Case Manager
  - Follows high risk patients while in the hospital and during the first thirty days after discharge in the community
  - Community patients followed telephonically
  - If community case manager available, interfaces with the CM as well as the primary care provider, home care, etc.
  - Assesses patients for high risk criteria
    - Frequent readmissions
    - Specific diagnoses – particularly chronic conditions
- Perioperative Case Manager
  - Inpatient only patient sent home the day of surgery and admitted the next day……..is a readmission
  - Observe IP only patients who may be at risk for readmission—they may need to stay over night

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RE-EVALUATE CASE MANAGEMENT'S INVOLVEMENT IN THE READMISSION INITIATIVE: OPTIMIZE CASE MANAGEMENT SPECIALTY POSITIONS

- ED Case Manager and Social Worker
  - ED visits are on the rise
  - Case management strategies
    - Assistance with 2 midnight rule to assure only appropriate patients are admitted
    - Redirection of patients who can be placed elsewhere
    - SNF placement for patients discharged within past 30 days
    - Initiate assessment and discharge planning for inpatients being held in the ED
    - Collaborate with specific case managers in the community

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RE-EVALUATE CASE MANAGEMENT'S INVOLVEMENT IN THE READMISSION INITIATIVE

Assure order on chart matches what is actually billed so you don't have readmissions counted by accident (especially if you aren't completely electronic with your medical record)

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POPULATION HEALTH AS A READMISSION STRATEGY

- Approximately half of Americans report poor coordination of care
- Patients do not always understand where to turn for urgent, not emergent care

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POPULATION HEALTH AS A READMISSION STRATEGY

- Accountable Care Organizations (ACO), patient centered medical homes and bundled payment pilot projects promote coordination of care
- Critical element of population health—care provided through acute care services, and the 60 days post hospital discharge
- Successful ACOs decreased hospitalizations
  - Focus on patients coming to the ED to provide non-urgent care
  - Transition patients with psychiatric conditions to a psychiatric ED
  - Identify high risk, high cost patients and develop strategies to keep them out of the hospital
  - Increase use of alternative care practitioners
  - Improve technology for care across continuum

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COMMUNITY CASE MANAGER - RN

- Follows clinically high risk patients with a maximum caseload of 75 patients.
- Works with patient, doctors, and nurses involved with patient care to promote adherence to medical care plan.
- Works with patient and various community providers, determined by patient's psychosocial needs, to address non-medical needs that may impede adherence to medical care plan.
- When necessary, the RN Case Manager will deploy a Community Outreach Worker to provide home/community based support to further enhance the patient's compliance to the medical care plan (e.g.- assistance getting to/from appointments, obtaining medications from pharmacy, etc.) or engage patients who do not respond to contact attempts.
- Will use the patient registry to monitor patients' compliance with medical/lab appointments and reach out prior to appointments, when necessary, to remind patients to attend.
- When appointments are missed, the RN Case Manager will assist with rescheduling and maintaining the future appointments.

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COMMUNITY CASE MANAGERS: RN AND SOCIAL WORKER

- Follows psychosocially complex, behavioral health or substance abuse patients with a maximum caseload of 75 patients.
- Works with patient, doctors, and nurses involved with Pt care to promote adherence to medical care plan.
- Works with patient and various community providers, determined by patient's psychosocial needs, to address non-medical needs that may impede adherence to medical care plan.
- When necessary, the will deploy a Community Outreach Worker to provide home/community based support to further enhance the patient's compliance to the medical care plan (e.g. assistance getting to/from appointments, obtaining medications from pharmacy, etc.) or engage patients who do not respond to contact attempts.
- Will use the patient registry to monitor patients' compliance with medical/lab appointments and reach out prior to appointments, when necessary, to remind patients to attend.
- When appointments are missed, the will assist with rescheduling and maintaining the future appointments.

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NEXT STEPS IN CMS READMISSION REGULATIONS

- CMS concerned about "softening penalties"
- Risk-adjustment
  - Factors seem to show that hospital quality isn't the only indicator
  - MedPAC outlined ways to compare like hospitals
  - National Quality Forum recommending that some measures include adjustments for socioeconomic status
- Changing penalty process as some hospitals can improve readmission rate, but still be penalized
- Post-acute care provider penalties

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NEXT STEPS IN CMS READMISSION REGULATIONS

- CMS working with experts and other stakeholders to identify procedures and treatments that should be considered "planned"
- 2013 public reporting period expanded algorithm that identifies admissions typically planned
  - Examples: OB delivery, transplant surgery, maintenance chemotherapy/immunotherapy
  - Non-acute readmission for planned procedure
- Validation study by CMS enhanced the modifications of the algorithm for 2015 public reporting
- CMS stated "Admissions for acute illness or for complications of care are never planned"

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NEXT STEPS IN CMS READMISSION REGULATIONS AND STRATEGIES

- Bundled payment programs
  - Voluntary
  - Proposed mandatory
- CMS's Chronic Care Management Program
  - Payment for Patient Centered Medical Homes (PCMH) for payment for care coordination activities outside of office visits
  - PCMH challenges
    - Promoting increased patient engagement with the CMS-required comprehensive care plans
    - Encouraging hospitals and specialists to coordinate care with primary care physicians for patient benefit……..even if there is no financial benefit
    - Electronic health record alignment
    - Automating routine processes of chronic care so these patients don't overwhelm the PCMH

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RULE AND REGULATION CHANGES FOR OTHER LEVELS OF CARE

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PSYCHIATRIC HOSPITALS AND READMISSIONS

- FY 2016 IPPS final rules have 2 transition measures
  - Transition record with specified elements received by discharged patients
  - Timely transmission of transition record (to post care provider)
- Not related to any readmission penalty, but could be preparing these hospitals for future penalties

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MEDICARE PAYMENT ADVISORY COMMISSION (MedPAC) CONSIDERATIONS

- Changes in reimbursement for SNF, HHA, inpatient rehab and long term acute care hospitals
- Plan for one payment system as opposed to current payment system: payments for specific conditions instead of what kind of post-acute care setting hosts beneficiary
- 2013 Medicare hospital discharges
  - 20% to SNF
  - 17% to HHA
  - 4% to IP rehab
  - 1% to LTACH
- Post acute care spending doubled since 2001 (From $27B to $59B in 2013)
- MedPAC to submit report on this prototype by 6/30/16

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READMISSION RESEARCH, SURVEYS AND THE FUTURE

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COLLABORATION WITH HOSPITALS AND DRUG STORE CHAINS

Health Leaders, Beyond the Hospital; Another "Right" Place for Care, September 8, 2015

- Johns Hopkins Medicine and Walgreens
- Goals
  - Simplify and operationalize coordination for right care, right place, and right time
  - Clinical and economic research with development to create clinical pathways in Baltimore—that can be used and effective on a national scale
  - Reduce cost of care when possible
  - Route patients to most appropriate site for their condition
  - Move non-emergent patients out of ED and in to lower, more cost effective sties
  - Develop clinically novel programs

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COLLABORATION WITH HOSPITALS AND DRUG STORE CHAINS

Health Leaders, Beyond the Hospital; Another "Right" Place for Care, September 8, 2015

- Walgreens store and training site at Johns Hopkins Medicine campus
- First areas of focus
  - Rabies shots—moving initial and follow up shots outside of ED
  - STD treatment outside of ED
- Other examples being studies
  - Hepatitis C treatments
  - Computer technology for smoking cessation
- Utilizing nurse practitioners and pharmacists in more interactive and consultative manner
- Keeping patients out of the ED should help them develop better plans to manage health, rather than waiting til acutely ill to go to the ED—and end up as a readmission?????

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COMMUNITY PARAMEDIC (CP) PROGRAMS

- Concept: many 911 callers do not need hospital care
- 43 of 48 states surveyed*: actively planning or providing some sort of CP service
  - 29 already offer this
  - Both rural and urban areas
  - 94% working with hospital or health systems
  - 64% working with hospital on reimbursement strategies
- Nevada approved bill outlining certification for CPs

*Survey by National Association of State EMS Officers

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RESOURCES

- Quality Net www.qualitynet.org
- CMS http://cms.gov.Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html/
- Center for Healthcare Research and Transformation
- https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html

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Thank you for attending!

IT'S TIME FOR QUESTIONS

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