# Health Care Reform and Care Transitions


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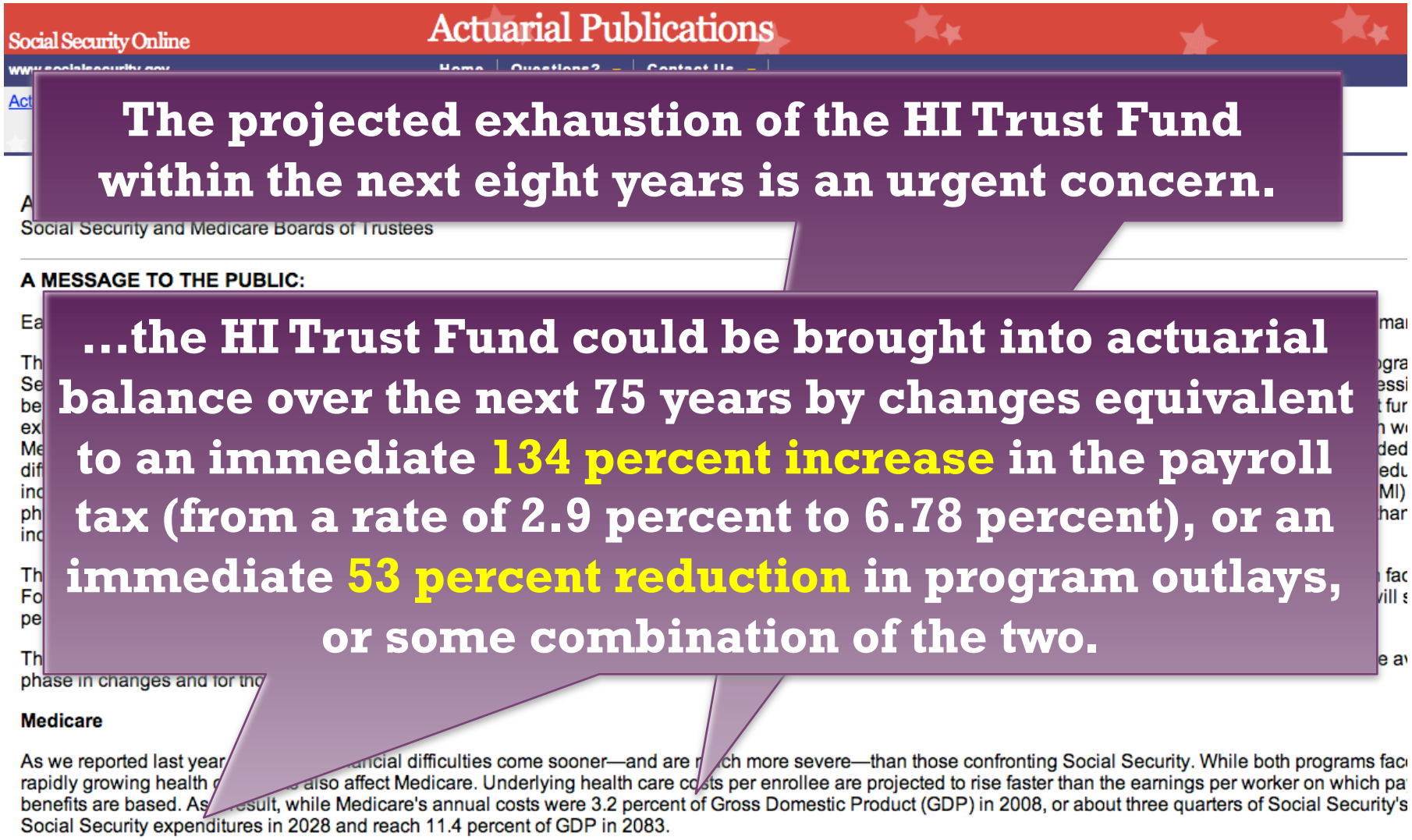
NORTHWESTERN UNIVERSITY

FEINBERG SCHOOL OF MEDICINE

Northwestern Memorial Hospital

# A Problem for a long time

- Rosenthal, J. M. and D. B. Miller "Providers have failed to work for continuity." Hospitals 53(10): 79-83. 1979
- Continuity of patient care between different health care settings has been advocated for nearly 20 years, but little has been done to affect it. The study described here emphasizes the current lack of effort by health care providers in hospitals and nursing homes to find a workable solution.


Social Security Online
Actuarial Publications
The projected exhaustion of the HI Trust Fund within the next eight years is an urgent concern.
Social Security and Medicare Boards of Trustees
A MESSAGE TO THE PUBLIC:
...the HI Trust Fund could be brought into actuarial balance over the next 75 years by changes equivalent to an immediate 134 percent increase in the payroll tax (from a rate of 2.9 percent to 6.78 percent), or an immediate 53 percent reduction in program outlays, or some combination of the two.
Medicare
As we reported last year
rapidly growing health
benefits are based. As
Social Security expenditures in 2028 and reach 11.4 percent of GDP in 2083.

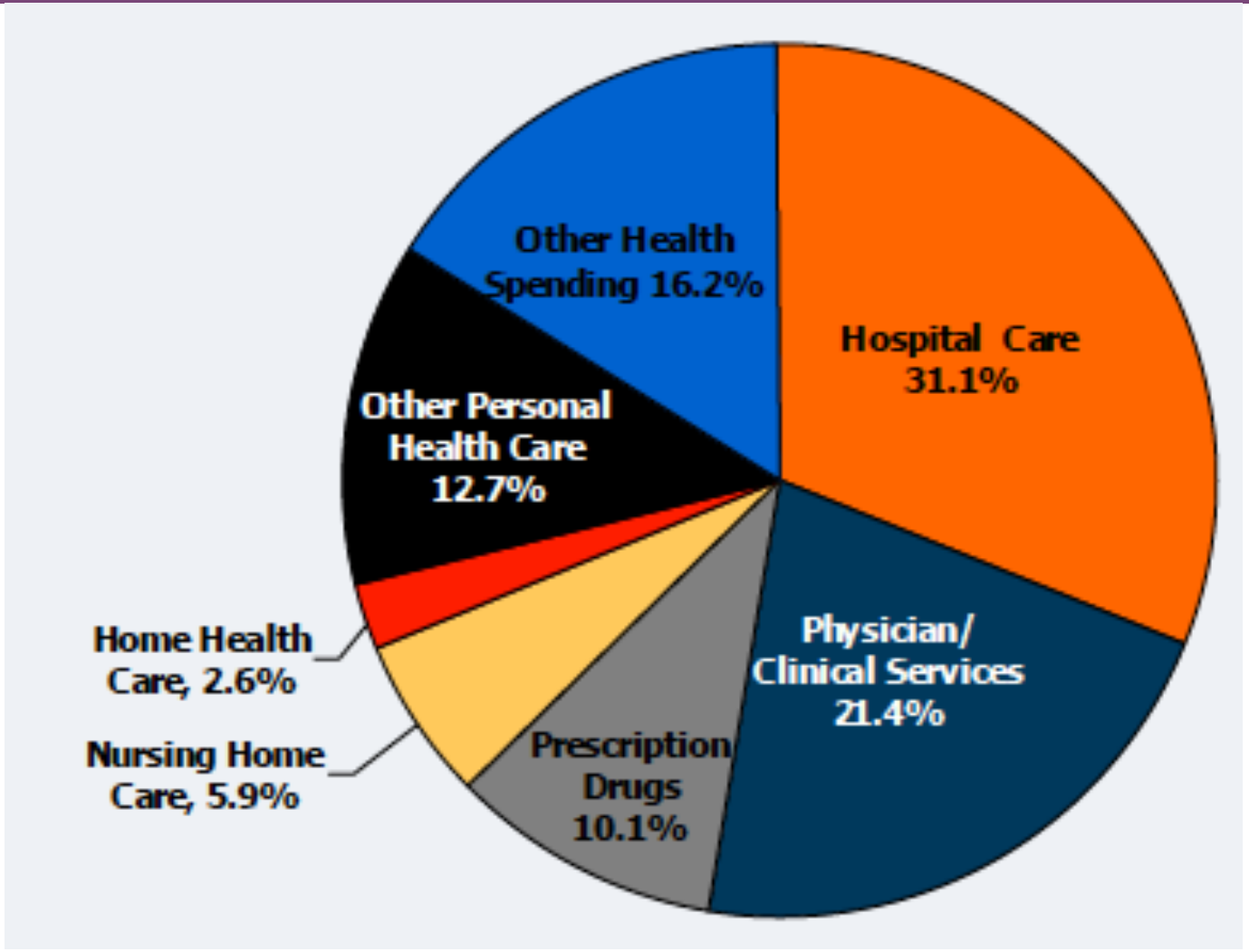
# Reform – It's here!

- H.R. 3590, the Patient Protection and Affordable Care Act
  - H.R. 4872 the Health Care and Education Reconciliation Act
- Paying for quality instead of quantity
- Demonstration projects

# Quality and Affordable

- 10 titles
- 3 contain "Quality" and 2 of these "Affordable"
- Title I: Quality, Affordable Health Care for All Americans
- Title III: Improving the Quality and Efficiency of Health Care
- Title X: Strengthening Quality, Affordable Health Care for All Americans

# Health Expenditures - 2007



# Eric Coleman, MD, MPH

- Director, Care Transitions Program
  University of Colorado Denver
- Reducing readmissions "jumps off the page as an area where we could see enormous savings in national health expenditures."
- "We're pretty good at identifying who's at risk of readmission, but it's harder to say who's at modifiable risk."

# Reducing Readmissions

- Financial penalties on hospitals for "excess" readmissions vs. "expected"
  - HF, AMI, Pneumonia
  - FY2013
  - Not supported by SHM
- Community Based Care Transitions Program
  - Starts Jan. 1, 2011

PERSPECTIVE | Annals of Internal Medicine

# Could Medicare Readmission Policy Exacerbate Health Care System Inequity?

Rohit Bhalla, MD, MPH, and Gary Kalkut, MD, MPH

The Centers for Medicare & Medicaid Services recently started publicly reporting hospital readmission rates. Health care reform proposals include readmission provisions as vehicles to promote care coordination and achieve savings. Current approaches ascribe variability in hospital readmission primarily to differences in patient medical risk and hospital performance. These approaches do not adequately account for the effect of patient sociodemographic and community factors that influence health care utilization and outcomes. The evidence base on cost-effective and generalizable care management techniques to reduce readmission is still evolving. Although readmission-related policies may prove to be a transformational force in health care reform, their incorrect application in facilities serving vulnerable communities may increase health care system inequity. Policy options can mitigate this potential.

*Ann Intern Med.* 2010;152:114-117. www.annals.org
For author affiliations, see end of text.
This article was published at www.annals.org on 1 December 2009.

- "Same" patient
  different environmental factors

# Readmission Reduction
## *CBO - $7.1 bil savings over 10 years*

- Hospital Quality & Performance Based Payments
- All DRG payment amounts in hospitals with excess readmission are reduced by a factor determined by the level of "excess, preventable readmissions"
  - Effective FY2013
  - Excess = ratio of actual to expected (risk-adj)
  - Reduction of up to 1%, 2%, 3% first 3 years

# Readmission Reduction Program

- NQF endorsed measures
  - Initially AMI, HF, pneumonia
  - Expand in 2015 to 4 more conditions
    - COPD, CABG, PTCA, Other Vascular
  - Measures must have exclusions for readmissions *unrelated* to prior discharge
    - e.g. transfers, planned readmissions
  - Readmission time window specified by Secretary
    - 30 days in NQF measures
- Report *all-payer* readmission rates publicly

# National Strategy for Quality Improvement

- Secretary shall establish a national strategy to improve:
  - Delivery of health care services
  - Patient health outcomes
  - Population Health
- Work in consultation with NQF
- Submit report to Congress Jan, 2011

# Measure Development

- Secretary will award grants for measure development in gap areas identified by HHS, CMS, AHRQ
  - Health outcomes / functional status
  - Coordination of care across episodes
  - Patient experience
  - Shared decision making
  - IOM's STEEP especially Efficiency and Equity
  - Meaningful use of HIT

# June 2007 MedPAC Report

- Medicare pays for ALL admissions regardless
  - Initial stay or readmission for same condition
- 17.6% of admissions result in re-admissions within 30 days (6% in 7 days)
  - = $15 billion in spending
- Future
  - "CMS proposes to require that all general acute hospitals conduct a CARE assessment on every Medicare beneficiary being discharged."
    - Continuity Assessment Record and Evaluation
  - Public Disclosure of readmission rates
  - Lower case payments for readmissions

The NEW ENGLAND JOURNAL of MEDICINE

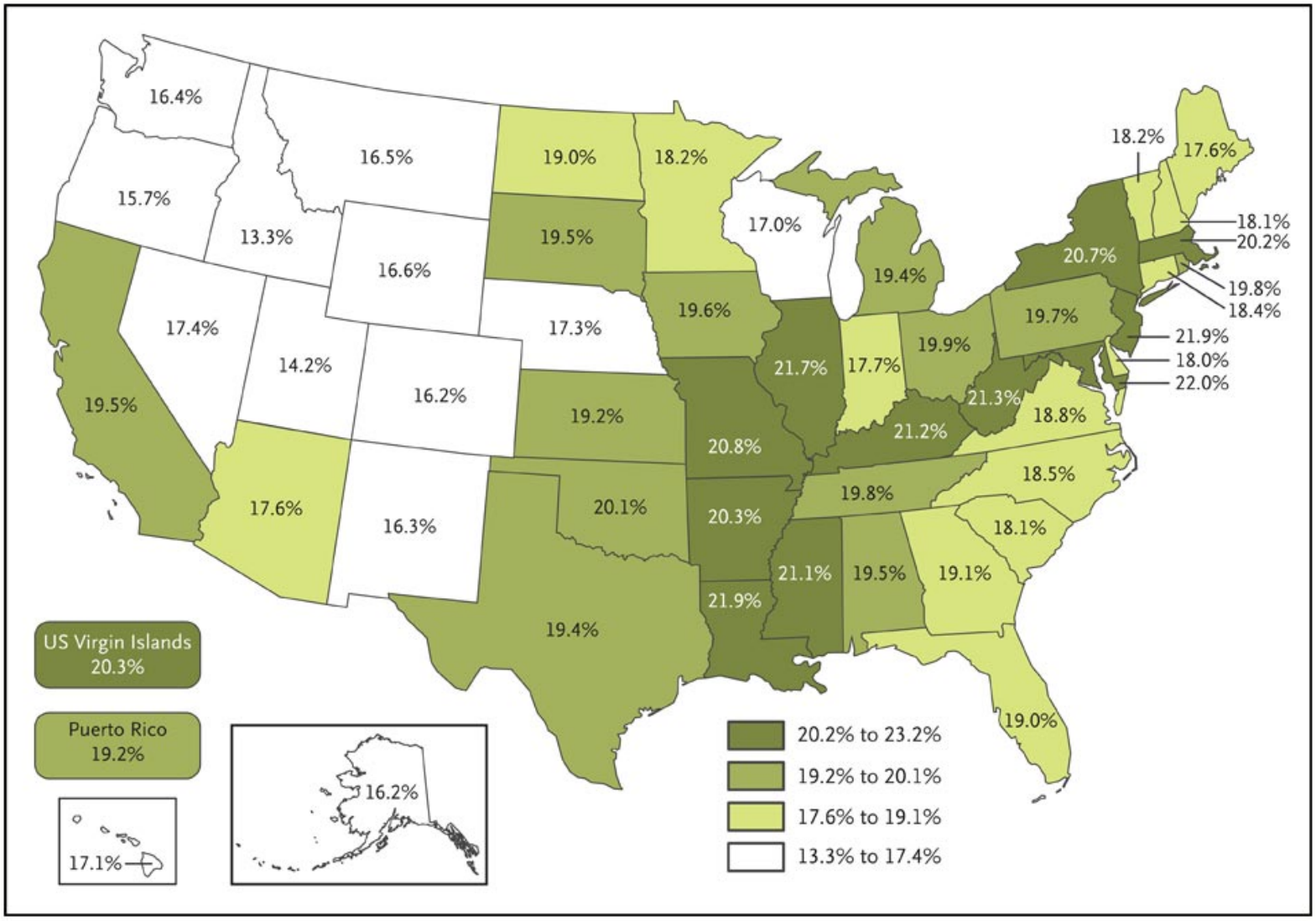
SPECIAL ARTICLE

# Rehospitalizations among Patients in the Medicare Fee-for-Service Program

Stephen F. Jencks, M.D., M.P.H., Mark V. Williams, M.D., and Eric A. Coleman, M.D., M.P.H.

- 1 in 5 Medicare patients rehospitalized in 30 days
- Half never saw outpatient doc
- 70% of surgical readmissions–chronic medical conditions
- Costs $17.4 billion

# Rates of Rehospitalization within 30 Days after Hospital Discharge




**Jencks S, Williams MV, Coleman EA. N Engl J Med 2009;360:1418-1428**

The NEW ENGLAND JOURNAL of MEDICINE

Health Affairs 2010; 29:57-64

By Vincent Mor, Oma Intrator, Zhanlian Feng, and David C. Grabowski

# The Revolving Door Of Rehospitalization From Skilled Nursing Facilities

ABSTRACT Almost one-fourth of Medicare beneficiaries discharged from the hospital to a skilled nursing facility were readmitted to the hospital within thirty days; this cost Medicare $4.34 billion in 2006. Especially in an elderly population, cycling into and out of hospitals can be emotionally upsetting and can increase the likelihood of medical errors related to care coordination. Payment incentives in Medicare do not encourage providers to coordinate beneficiaries' care. Revising these incentives could achieve major savings for providers and improved quality of life for beneficiaries.

# Trends in Length of Stay and Short-term Outcomes Among Medicare Patients Hospitalized for Heart Failure, 1993-2006

Harlan M. Krumholz, MD, SM research group

Héctor Bueno; Joseph S. Ross; Yun Wang; et al.

*JAMA*. 2010;303(21):2141-2147 (doi:10.1001/jama.2010.748)

JAMA®

- Observational study of 6,955,461 Medicare FFS hospitalizations for HF; 1993 and 2006, with 30-day f/u.
  - Mean age = 80
  - 52% Htn, 38% DM, 37% COPD
- LOS 8.8 days down to 6.3
- In-hospital mortality declined from 8.5% to 4.3%
- 30-day mortality declined from 12.8% to 10.7%
- Discharges to SNF increased from 13% to 20%
  - Discharge to home decreased from 74% to 67%
- 30 day readmission increased from 17.2% to 20.1%
  - Post-discharge mortality increased from 4.3% to 6.4%

Journal of HOSPITAL MEDICINE www.journalofhospitalmedicine.com

HANDOFFS

# Transitions of Care Consensus Policy Statement: American College of Physicians, Society of General Internal Medicine, Society of Hospital Medicine, American Geriatrics Society, American College of Emergency Physicians, and Society for Academic Emergency Medicine

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The Transitions of Care Consensus Conference was funded by an unrestricted educational grant from Novo Nordisk as part of the American College of Physicians Diabetes Initiative and by the Agency for Healthcare Research and Quality. The funders had no input into the planning, structure, content, participants, or outcomes of the conference. This article is also being published by the Journal of General Internal Medicine [Vincenza Snow, Dennis Beck, Tina Budnitz, Doriane C. Miller, Jane Potter, Robert L. Wears, Kevin B. Weiss, Mark V. Williams. Transitions of Care Consensus Policy Statement American College of Physicians-Society of General Internal Medicine-Society of Hospital Medicine-American Geriatrics Society-American College of Emergency Physicians-Society of Academic Emergency Medicine]. *J Gen Intern Med* 2009 (online in advance of print).

# Principles

- Accountability
- Responsibility
- Coordination of Care
- Family Involvement
- Communication
- Timeliness
- National standards and metrics

## Consensus Principles and Standards for Managing Care Transitions

| Principle | Standards |
|---|---|
| 1. Accountability | All transitions must include records that contain minimum required elements†; ideal elements should also be included.†† |
| 2. Responsibility | At every point during care transition, patients (and their families) must know who is responsible for care and how to contact the caregiver.<br>Transition responsibility belongs to the sending clinicians and organizations until the receiving providers confirm assumption of responsibility. |
| 3. Coordination of care | As the hub of care, coordinating clinicians must provide timely communication to other care providers. |
| 4. Family involvement | Patients and families must be involved in and retain ownership of transition records, including information needed to identify patients' medical care homes and coordinating clinicians. |
| 5. Communication | Clinicians or institutions must provide a clear and direct communication infrastructure, including transition records, treatment plans, and follow-up expectations. |
| 6. Timeliness | Transition teams must provide information feedback and feed-forward (based on transition settings, patient circumstances, level of acuity, and transition responsibility). |
| 7. National standards and metrics | Standard communication formats for care transitions should be adopted, implemented, and used for accountability and continuous quality improvement.<br>Standardized methods of measuring outcomes should be implemented across healthcare settings. |

*†Minimum required information in the transition record:*
- *Principal diagnosis and problem list*
- *Medication list (reconciliation)*
- *Identification of the coordinating physician/institution and contact information*
- *Patient's cognitive status*
- *Test results and pending test results*

*††Ideal information in the transition record (plus all minimum required information):*
- *Emergency plan and contact person, including telephone number*
- *Treatment and diagnostic plan*
- *Prognosis and goals of care*
- *Advance directives, power of attorney, and consent*
- *Planned interventions and other medical needs (e.g., durable medical equipment, wound care)*

Journal WATCH

# IOM

"more to know,
more to do,
more to manage,
more to watch, and
more people
involved than ever before"

