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READMISSION REDUCTION IN LTC
LEGAL AND RISK MANAGEMENT IMPLICATIONS

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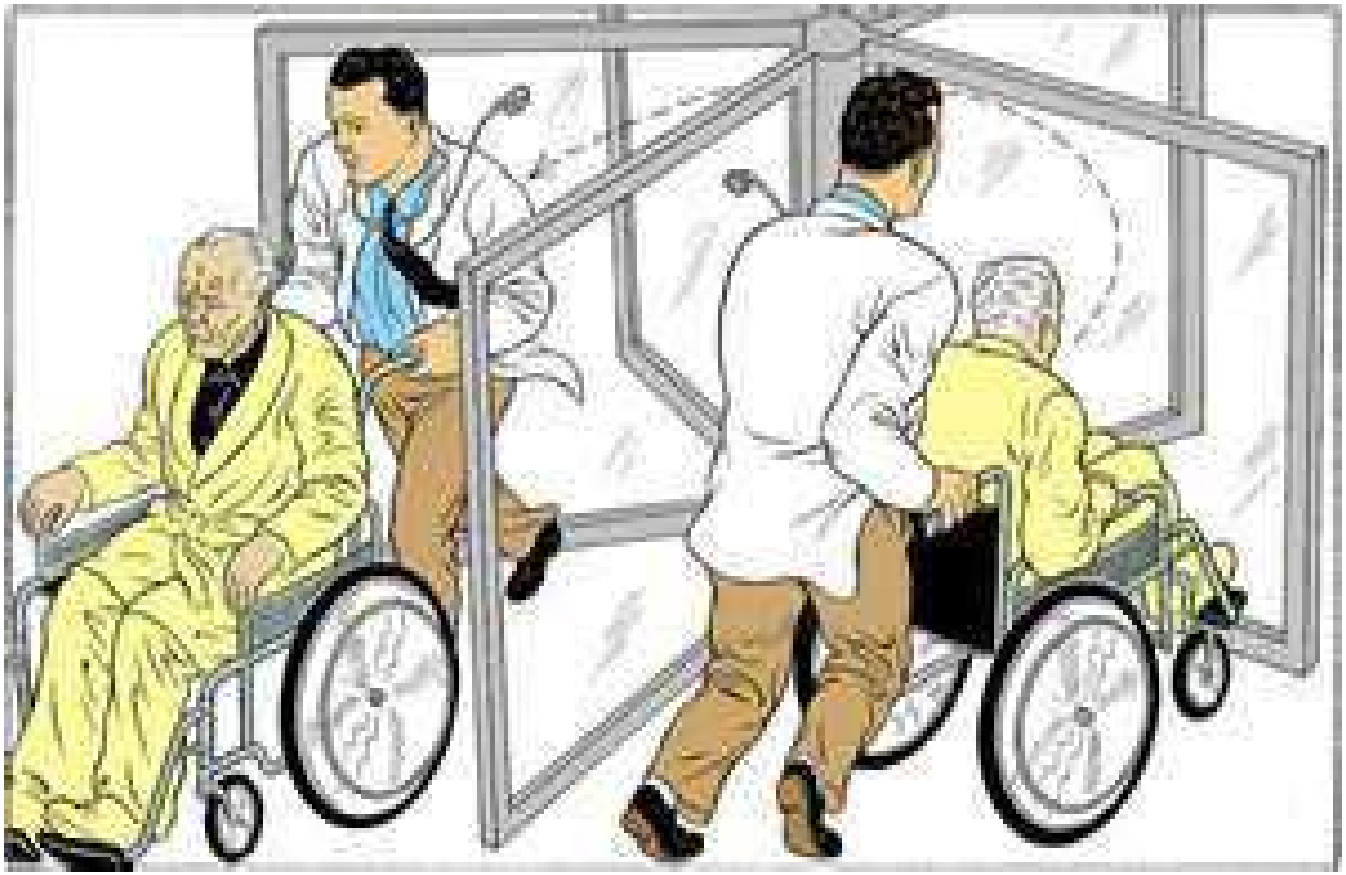
MARSH

Objectives

- Gain an understanding of the Patient Protection and Affordable Care Act as it relates to Readmissions and Long Term Care
- Discuss prevalence of Hospital Readmissions and the unintended consequences on the resident and the facility
- Discuss factors that influence Hospital Readmissions from long term care and the inherent legal vulnerabilities
- Identify potential key measures for monitoring Hospital Readmissions
- Describe strategies for reducing Hospital Readmissions from a long term care facility and mitigating strategies that reduce facility risk

READMISSIONS
What's the Big Deal?

The “Revolving Door” Syndrome



What Is This All About?

- **Changes in Medicare Financing**
  - **Pay-for-Performance** (“P4P”)
  - No payment for certain complications; disincentives for avoidable hospitalizations
  - **Bundling of payments** for episodes of care
  - **Accountable Care Organizations** that include hospitals, physicians, home health agencies, and SNFs that are responsible for the care of a defined group of patients
- FY 2013 IPPS Final Rule: 30-day Unplanned Readmission Measures for Pneumonia, Heart Failure and AMI
- FY 2014 IPPS Proposed Measure: All-cause Unplanned Readmission Measure for 30 days Post Discharge from Long-Term Care Hospitals
- FY 2015 IPPS Proposed Measure: Hospital-Wide All-Cause Unplanned Readmission (HWR).

What Is This All About?

- Medicare beneficiaries account for a larger portion of the readmissions
  - May be linked to place of residence and health system providing care
- Patient Protection and Affordable Care Act's requirement for CMS to penalize hospitals with higher than expected readmission rates has increased both public and hospital attention to avoidable readmissions.
  - **Reductions in Medicare reimbursement began in October 2012** for more than 2,000 hospitals with high readmissions for pneumonia, congestive heart failure, and acute myocardial infarction.
  - **307 hospitals received the highest penalty** of a 1 percent reduction in base Medicare payments.
  - The maximum penalties increase to **2 percent in 2013 and 3 percent the following year.**
  - Many hospitals are actively engaged in efforts to reduce avoidable readmissions, but the success of their efforts and the effects on patient outcomes and overall health care costs are unknown.

What Is This All About?

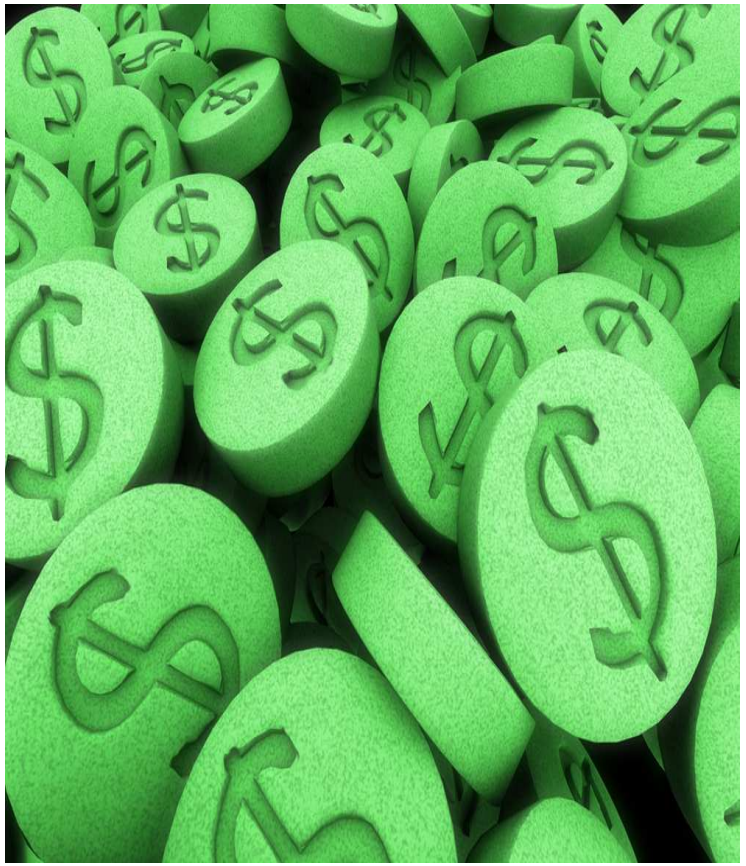
- Patient Protection and Affordable Care Act (March 23, 2010)
  - Creates financial penalties for hospitals with **excessive readmissions**
  - Includes initiatives to **prevent hospital readmission** through a comprehensive program for hospital discharge planning
  - Must develop **episode-of-care and post-acute care quality measures**
    - Law specifies the following episode-of-care quality measures
      - Functional status improvement
      - **Rates of avoidable hospital readmissions**
      - Rates of discharge to the community
      - **Rates of admission to an emergency department after a hospitalization**

Impact of Readmissions

- Nursing facility residents are subject to frequent avoidable inpatient hospitalizations.
  - expensive, disruptive, and disorienting
  - vulnerable to risks that accompany hospital stays and transitions between nursing facilities and hospitals.
- **2/3** of nursing facility residents are enrolled in Medicaid, and most are also enrolled in Medicare (Medicare-Medicaid enrollees).
- The unadjusted rate of readmission to LTCHs and IPPS hospitals in the 30 days after an LTCH discharge was about **26%** in 2010 and 2011
- **45%** of hospital admissions among Medicare-Medicare enrollees receiving Medicare skilled nursing or Medicaid nursing facility services could have been avoided (Walsh et. al, 2010).
  - 314,000 potentially avoidable hospitalizations
  - $2.6 billion in Medicare expenditures in 2005

Impact of Readmissions

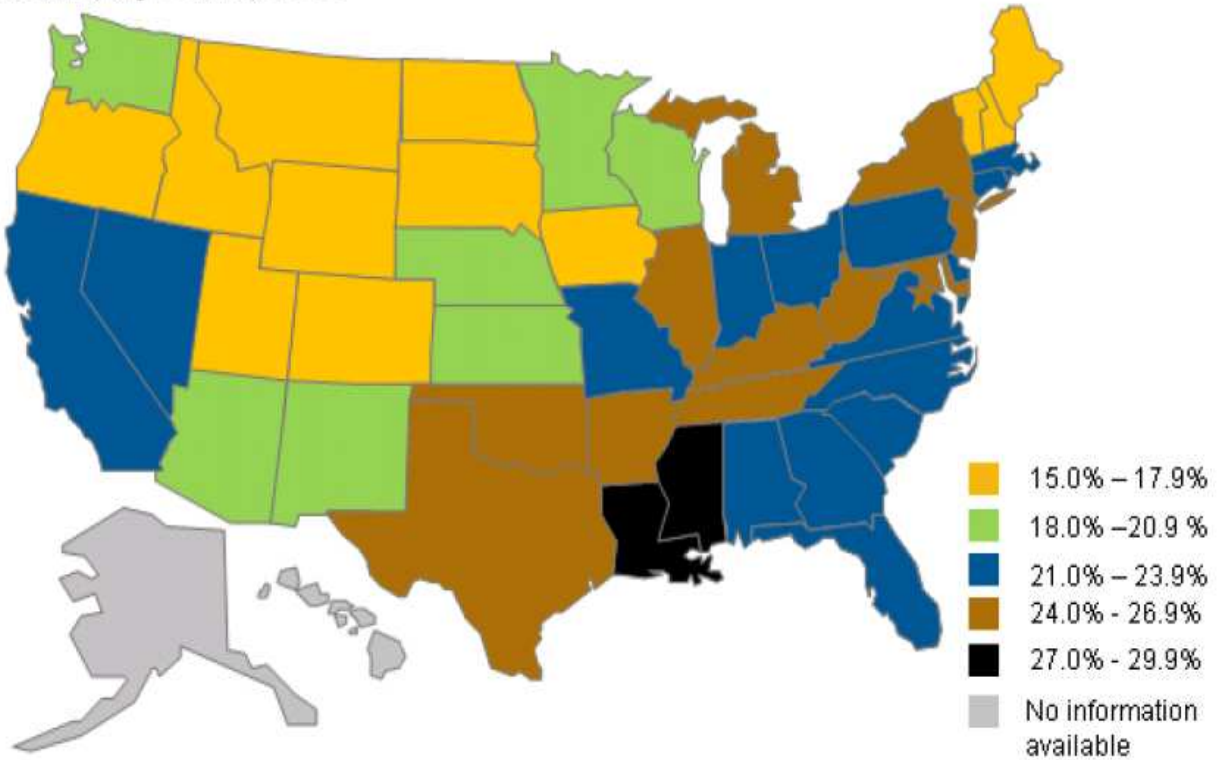
- The federal government has pegged the cost of readmissions for Medicare patients alone at $26 billion annually
- More than $17 billion of it pays for return trips that need not happen if patients get the right care.



Why Does It Matter?

1 in 4 patients admitted to an SNF are re-admitted to the hospital within 30 days at a cost of $4.3 billion

Figure 3: Frequency of Rehospitalization of Short-Stay Nursing Home Residents, by State, 2006



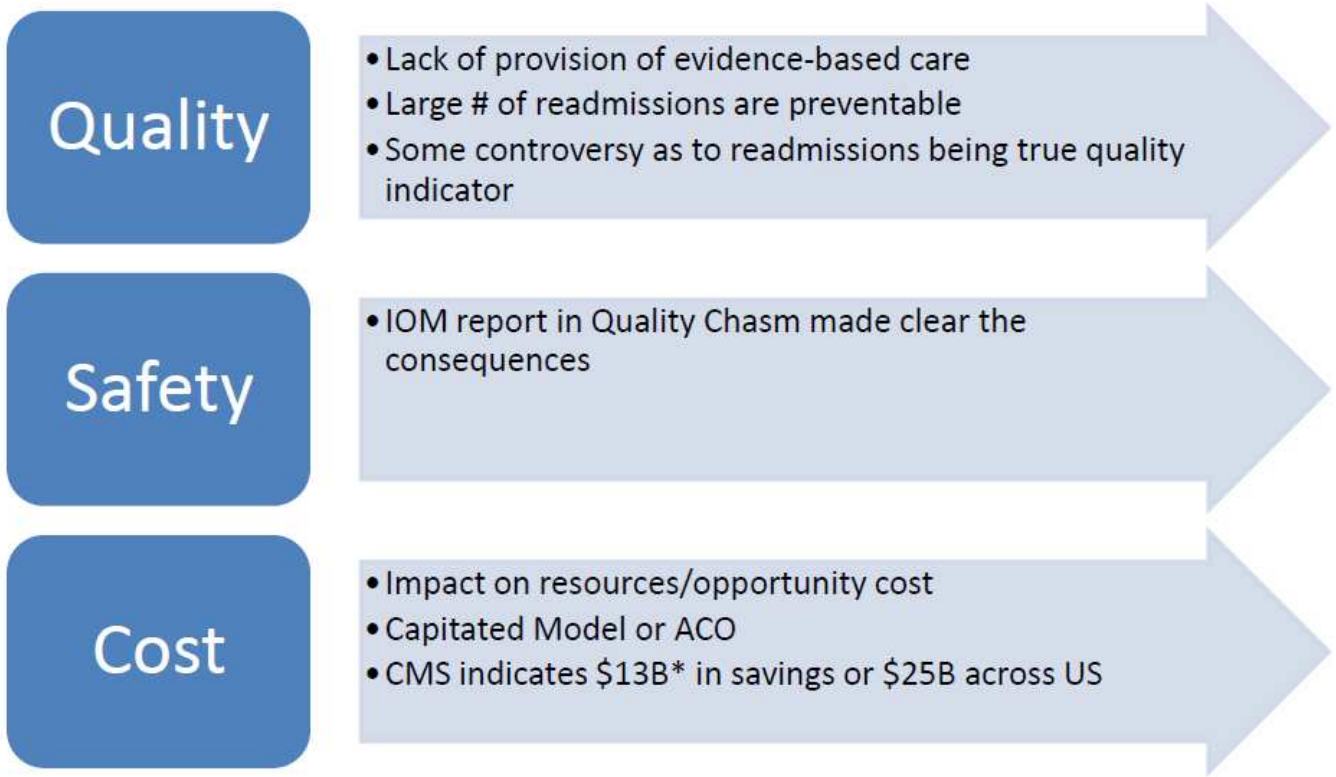
Source: Vincent Mor, et al. (2010) Medicare SNF Rehospitalizations: Implications for Medicare Payment Reform. Health Affairs.

Ouslander et al; J Amer Ger Soc 58:627-635, 2010

Why Does This Matter?

- A national perspective
  - Emergency room visits, observation stays hospitalizations, and readmissions of nursing home residents are:
    - ✓Common
    - ✓Result in complications
    - ✓Expensive
  - Some hospital transfers, ER visits, observation stays, hospital admissions, and readmissions are "**avoidable**", "**preventable**", or "**unnecessary**"
  - Avoidable hospital readmissions are being thought of "**indicators of poor care or missed opportunities to better coordinate care**"

Why Focus on Readmissions?



*MedPac 2007 Report to Congress; Promoting Greater Efficiency in Medicare. Chapter 5: Payment Policy for Inpatient Readmissions

Evidence that hospitalizations can be avoided

- Stem from multiple system failures:
  - Inadequate primary care, poor nursing facility quality of care, poor communication among providers, family preferences, and others.
  - Financing arrangements between Medicaid and Medicare are not well aligned.
- Widespread consensus that a high percentage of these hospitalizations are avoidable.
- Studies have estimated that **30% to 67%** of hospitalizations among nursing facility residents could be prevented with well-targeted interventions (Jacobson, et. al., 2010).

CMS Special Study in Georgia – Expert Ratings of Potentially Avoidable Hospitalizations

Based review of 200 hospitalizations from 20 NHs

	Was the Hospitalization Avoidable?	
	Definitely/Probably YES	Definitely/Probably NO
Medicare A	69%	31%
Other	65%	35%
HIGH Hospitalization Rate Homes	75%	25%
LOW Hospitalization Rate Homes	59%	41%
TOTAL	68%	32%

Ouslander et al; J Amer Ger Soc 58:627-635, 2010

Readmissions
So Why Are They Happening?

Sound Familiar???

A nurse in New York said that hospitals are pressured to release patients to LTC when they still need significant care.

The problem she sees is that these facilities usually lack trained staff and resources to care for an ill or recovering patient. The result is that the patient returns to the hospital a few days later.

The hospital-nursing home liaison sometimes have eyeballed the patient, they have maybe gone through the record…

Despite having been in and out four times, the nursing home says “Yes, we can handle this patient.”

And then a week later, they were back in the hospital …

Factors Driving Hospitalizations of Long Term Care Facility Residents

- Limited on-site capacity at the facility to deal with medical issues
  - long-term care facility staff often lack the skill and training needed to deal with medical issues
  - suboptimal nurse-resident ratio
  - delays in testing and diagnostics
- Physician preferences for care in an inpatient hospital setting
  - decision to hospitalize tends to rest with the facility's medical director or attending physician
  - "Culture of Hospitalization"
  - convenience for physicians
- Liability concerns for physicians, nurses, and facilities
  - fear lawsuits from families if they do not hospitalize a resident when a medical situation arises; family panics and push for hospitalization even when not necessary

Factors Driving Hospitalizations of Long Term Care Facility Residents

- Financial incentives for physicians and long-term care facilities
  - physicians get paid more, and more frequently, when they see their long-term care facility patients in the hospital (paid for each day)
  - facilities continue to receive payments (i.e., bed hold days or reserve bed days) while the resident is in the hospital
- Assisted living facilities are often less able than nursing homes to address medical needs on premises
  - preventable emergency room visits and hospitalizations may be more common among assisted living facility residents
  - may be limitations on the type and amount of medical care a facility can provide because of their license
- An unspoken preference for sending long-term care facility residents to the hospital to die

Factors Driving Hospitalizations of Long Term Care Facility Residents

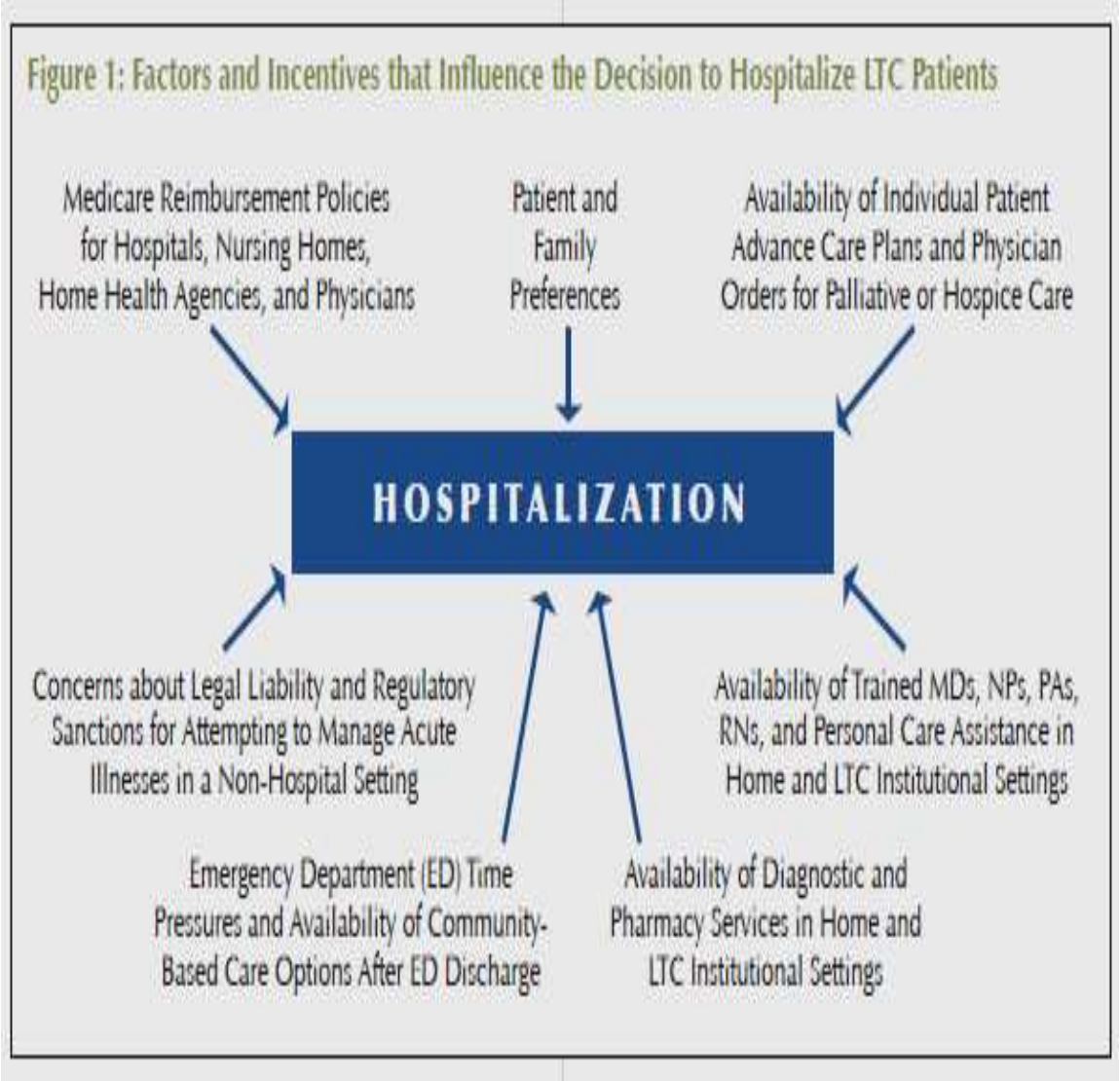
- Lack of a relationship between the facility staff, resident's physician, and the resident's family
  - feel it is "safer" to send the resident to the hospital
- Lack of advance care planning and failure to update care plans as medical needs change, resulting in confusion and panic
- Behavioral health issues
  - a frequent cause of hospitalizations is acting out or violence by residents due to dementia or behavioral health issues
- Reluctance of family members to intervene and second-guess decisions to hospitalize
  - Tend to defer to the facility and trust their judgment – not wanting to deny their loved one needed medical care, even if they think it is, or might be, futile
  - Anxious over resident's display of symptoms

Additional Factors

- Discharge disposition seems to matter
  - Rehabilitation hospital vs skilled nursing facility vs assisted living facility vs home with home health vs home with family/caregiver vs home alone
- The causes of avoidable hospital readmissions are complex and multifaceted
  - patient illness level;
  - communication with other providers, patients and families;
  - reconciliation of medications;
  - coordination with community clinicians and non-acute care facilities; and
  - availability of longitudinal post-hospital care that can recognize problems early and work towards their resolution. While all of these factors can affect patient outcomes and readmissions, the relative importance of each is not known.

Factors Influencing Hospitalization

- Defining “Preventable”, “Avoidable”, “Unnecessary” hospitalizations is challenging
- Numerous factors and incentives influence the decision to hospitalize
- Risk adjustment is very complicated



•Maslow, K and , Ouslander, JG: Measurement of Potentially Preventable Hospitalizations. White Paper prepared for the Long Term Quality Alliance, 2012.

Readmission Impact

- The hospital is the most directly impacted organization
  - Financial impact for readmissions
  - responsible for discharge process

HOWEVER

- Nursing homes should act now to prevent readmissions
  - Demonstrate ability to help prevent avoidable readmissions
  - Ability to successfully and effectively managing resident care
  - Ability to work as a member of the ‘team’ to provide most effective care for resident/patient
  - **Future financial reimbursement impact for LTCH (CMS IPPS Proposed Rule FY 2014)**

Measures and Monitors: Knowing Where You Are

Types and Focus of Measures

- Tendency to focus on a single specific quality measure, such as the readmission rate
- Systems of Care approach may provide more meaningful data
  - Discharge planning
  - Care Coordination
  - Handoff Communication
  - Utilization Patterns in ED (site of routine care vs. emergent care)

Importance of the ‘quality’ process

- Collect your data
- Analyze your data
- Analyze each readmission for opportunities for improvement – which of the five focus areas contributed to the readmission?
- Analyze your care for each of the five focus areas
- Begin quality improvement projects to reduce readmissions and include your community partners – hospital, pharmacy, etc.

Types and Focus of Measures

- Applicable to all patient populations regardless of disease or risk categories
- Paired and address both the sending and receiving providers to promote shared accountability
- **Process measures** that evaluate the adequacy of the providers tracking vital information and acting on the information
  - Measures of accountability at the “care coordination hub” documenting appropriate and necessary care coordination activities
- **Process measures** that evaluate the timeliness and completeness of information transferred and received between care settings and/or providers
  - Measures of accountability that are applicable to the “sending” care provider confirming that key information (such as a medication list) has been sent to the intended “receiving” provider and the “hub”
  - Measures of accountability that are applicable to the intended “receiving” provider documenting attention to key information received

Types and Focus Of Measures

- Evaluate the adequacy of certain **structural elements** in the health care setting, especially those that promote safe transitions of care.
- **Outcome measures** that evaluate the adverse events occurring as a result of inadequate care transitions.
- **Efficiency measures** that evaluate the inappropriate utilization of resources, such as unnecessary readmissions and duplication of tests.
- **Patients' and providers' experience and perspectives** should also be measured

Hospital readmissions may be considered "sentinel" events

ACUTE CARE TRANSFER LOG

Facility Name _____ Month/Year _____/_____

Resident Room Number	Date of most recent admission to the facility	Admitted to the facility from* (circle)	Status at time of Transfer* (circle)	Date of Transfer	Time of Transfer (circle a.m. or p.m.)	Outcome of Transfer (check which applies)		Hospital Diagnosis for ED visit or admission
						ED visit only (returned to facility)	Admitted to the hospital	
	___/___/___	Hosp H O	S LT O	___/___/___	a.m. p.m.			
	___/___/___	Hosp H O	S LT O	___/___/___	a.m. p.m.			

The goal of this tool is to review transfers in order to identify opportunities to improve the identification, evaluation, and management of changes in resident condition and other situations that commonly result in transfers, and when feasible and safe, to prevent transfers to the hospital. This tool is intended to be completed retrospectively after the transfer to look back and identify opportunities for improvement in reducing preventable transfers.

Readmissions
What Is An Organization To Do?

Foundational Considerations

- The Affordable Care Act mandates that each facility have a Quality Assurance and Performance Improvement program ***("QAPI")***
  - Improving management of acute change in condition
    - Does your facility have a "rapid response" process for early assessment of a change in condition?
  - Reducing unnecessary hospital transfers
    - Who makes the decision to transfer? Was transfer 'unnecessary i.e., could the condition have been managed in the NH?
  - Ensuring effective communication processes
    - What is your process for handoffs at each touch point?
  - Improving advance care planning
    - Are palliative care services and resources readily available and shared with residents and families?

Strategies for Reducing Avoidable Hospitalizations of Long Term Care Facility Residents

- **Additional support and training for long-term care facility staff**
  - Focus on special challenges presented by residents with mental and behavioral health issues
  - what care can and should be provided in long term care facilities, rather than in a hospital setting
  - cost implications of frequent hospitalizations
- **More medical support to back up facility staff during late nights and weekends**
  - Minimize hospitalizations that result when staff members “panic” without sufficient access to physicians
- **Philosophy shift in the appropriateness of hospitalizations**
  - hospitalizations are often viewed as the “path of least resistance”

Strategies for Reducing Avoidable Hospitalizations of Long Term Care Facility Residents

- More ongoing advanced care planning and discussions among residents, families, physicians, and staff of long-term care facilities
- Improve capacity of assisted living facilities to deal with the medical needs of residents
  - predominant model for assisted living communities is a social model, not a medical model
- Review the financial incentives for physicians and facility staff
- Developed disease-specific discharge instruction forms
- Target patient populations at risk for high readmissions (“predictive modeling”)
- Provided discharge instructions in languages for non-English-speaking patients

Other Initiatives

- Discharge Management with Follow-up
  - Many models including LACE, BRIDGE,
- Patient Coaching
- Disease/Health Management
- Telehealth Services
- Patient Navigation
- Community Based Care Transitions Program (CMS)

Legal Vulnerability

- Communication failures
- Poor assessment and timely interventions
- Failure to recognize change in condition
- Competency and skill mix of staff
- Staffing plan
- Confusion regarding accountability
- Others???

Summary

- **Medicare readmissions are a target for financial reimbursement reductions**
- **The issue is on the providers' radar**
- **There are financial pressures to discharge as soon as possible**
- **Some hospitals are improving the discharge process and in-hospital experience to reduce readmissions**
- The quality of the individual provider may impact a readmission; Some providers are proactive, thinking ahead, and take steps to avoid a readmission

The issue of readmissions is NOT just a acute care hospital issue … it spans the entire continuum of care with significant implications regarding the provision of safe, quality care … regardless of the setting

Readmissions Information Resources & References

- **IHI (STAAR Initiative)**
  http://www.ihi.org/IHI/Programs/StrategicInitiatives/STateActiononAvoidableRehospitalizationsSTAAR.htm
- **IHI Transforming Care at the Bedside (TCAB)**
  http://www.ihi.org/IHI/Programs/StrategicInitiatives/TransformingCareAtTheBedside.htm
- **CMS** Affordable Care Act: Readmission payment reform
  http://www.govtrack.us/congress/bill.xpd?bill=h111-3590
- **Community Care Transitions Program (CCTP)**
  http://www.cfmc.org/caretransitions/files/rem_ja10-care_transitions.pdf
- **RARE Program**
  www.RAREreadmissions.org;
  http://www.rarereadmissions.org/resources/ltc.html

Readmissions Information Resources & References

- **Care Transitions Project -** Information and tools, including the Med Discrepancy Tool
  http://www.caretransitions.org/documents/checklist.pdf
- **Project Boost** –Robust info site with tools related to care transitions
  http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/CT_Home.cfm
  http://*www.caretransitions.org*
- **Project RED**
  http://www.bu.edu/fammed/projectred/toolkit
- The American Health Care Association and National Center for Assisted Living (AHCA/NCAL)
- **National Priorities Partnership** –7 key targets, incl “Continuity of Care”
  http://www.nationalprioritiespartnership.org

Readmissions Information Resources & References

- INTERACT – CMS project - clinical practice tools, strategies to implement them, and related educational resources http://interact.net
- Peikes D, Chen A, Schore J, and Brown R. Effects of care coordination on hospitalization, quality of care, and health care expenditures among Medicare beneficiaries. JAMA. 2009;301(6):603-618;
- Sylvia ML, Griswold M, Dunbar L, et al. Guided care: cost and utilization outcomes in a pilot study. Disease Management. 2008;11(1):29-36.
- Michael Perry, Julia Cummings, Gretchen Jacobson, Tricia Neuman, Juliette Cubanski. To Hospitalize or Not to Hospitalize? Medical Care for Long-Term Care Facility Residents. October 2010. The Henry J. Kaiser Family Foundation. www.kff.org.

READMISSIONS UPDATE eNEWSLETTER

Covering the Latest Developments in Medicare Readmissions Policy, Pilots, and Practice

VOLUME 3 - ISSUE 27
MAY 1, 2012

Welcome to the Medicare Readmissions Update eNewsletter

This issue sponsored by the Medicare Medicaid Payment Summit

READMISSIONS UPDATES

Gender as Risk Factor for 30 Days Post-discharge Hospital Utilization: A Secondary Data Analysis

A study by the Boston University School of Medicine, reported in the *British Medical Journal*, found that males in the study had a higher rate of readmissions, suggesting that gender is a factor to be considered in readmission reduction plans. Factors influencing the male readmissions were observed to be marital status (unmarried/divorced were more likely to be readmitted), employment status (e.g., retired), men suffering from depression and those having no PCP visits post-discharge. (BMJOpen, April 18, 2012)

NQF Endorses All-Cause Readmissions Measures

The National Quality Forum has endorsed two measures intended to reduce readmissions. The first measure, developed by the NCQA, counts the number of over 18 year-old inpatient stays that were followed by an acute readmission for any diagnosis within 30 days. The second measure is a CMS -- Yale tool that estimates the risk of unplanned readmissions based on conditions or procedures. (National Quality Forum, April 24, 2012)

Thirty-Day Readmissions -- Truth and Consequences

A study by the Harvard School of Public Health suggests that the ACA's incentives dilute attention paid to mortality in favor of a focus on those efforts that reduced 30-day readmissions. Readmission incentives form a larger percentage of incentive payments and penalties than do mortality rates. Ashish Jah, MD, MPH, an internist

FEATURED 2011 READMISSIONS SUMMIT STREAMING VIDEO

Reducing Readmissions by more than 20% through an ACO Model

Juan DaVilla
Senior Vice President, Network Management, Blue Shield of California

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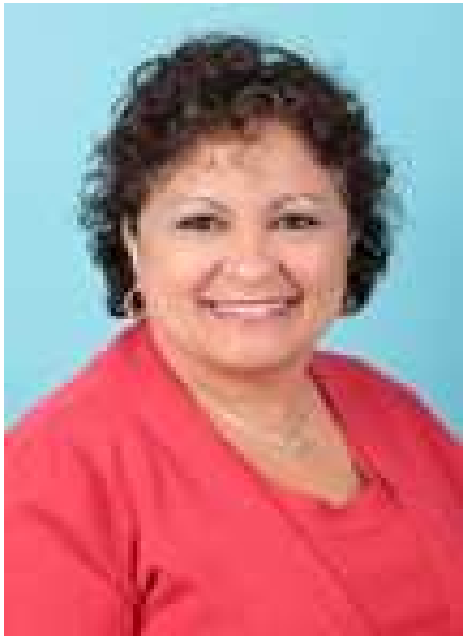
Questions?

See you this evening!



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