Remington's Think Tank Leadership Exchange

Establishing Referral Partnerships Through Readmission Management

Business Intelligence for Strategic Development

Presented by:
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and Publisher, The Remington Report

June 6, 2024

Meet Lisa Remington

Lisa Remington, President
Remington's Think Tank Leadership Exchange and The Remington Report

Celebrating 30 Years As A Trusted Advisor

Lisa is a growth and strategy advisor with extensive knowledge across the care continuum for three decades. She has earned a trusted industry voice for her ability to navigate through disruption, identify new growth and revenue opportunities, position and expand home care's future, and define collaborative partnerships between hospitals, health systems, ACOs, payers, physicians, and home and community-based organizations.

As the publisher of The Remington Report, and president of the Think Tank Leadership Exchange, Lisa has led C-suite education to over 10,000 organizations through a variety of platforms, including think tanks, strategic improvement programs, consulting, board retreats, executive leadership programs, and peer-to-peer networking groups.

Lisa has personally authored thousands of healthcare articles, forecasting reports, special industry market reports, and has maintained a track record of 100% accuracy in predicting emerging healthcare trends and value-based solutions. Her healthcare career began in hospital business operations and as a turn-around specialist in home care.

Readmissions

Market Intelligence to Improve Readmissions

1

Hospital Readmissions

What is Changing?

2

Readmission Intervals

Is 30-Days The Right Interval?

3

Readmission Tools

Readmission Indicators, Key Metrics, and Management Tools

4

Readmission Discussions

Discussion Questions for Strategic Action

Your Value Proposition

With annual costs reaching $41.3 billion for patients readmitted within 30 days after discharge, readmission is one of the costliest episodes to treat in the United States

In 2018, there were 3.8 million 30-day all-cause hospital readmissions, with a 14% readmission rate and an average readmission cost of $15,200.00

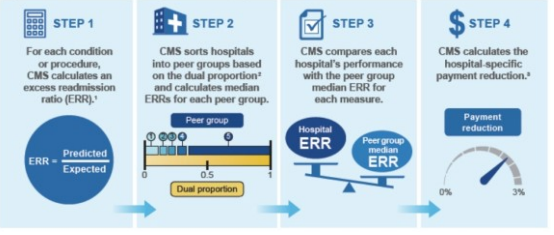
01

What's Changing About Readmissions?

Hospital Readmission Penalties: Targeted Conditions

RECAP: CMS includes the following 6 conditions/procedure-specific 30-day risk standardized unplanned readmission measures in the HRRP:

1. Acute myocardial infarction (AMI)
2. Chronic obstructive pulmonary disease (COPD)
3. Heart failure (HF)
4. Pneumonia (suppressed from payment reduction calculations for FY 2023)
5. Coronary artery bypass graft (CABG) surgery
6. Elective primary total hip arthroplasty and/or total knee arthroplasty (THA/TKA)



Dual Eligibles Readmission Penalties

Requires Medicare to consider social risk factors when calculating hospital penalties under the HRRP

Mandated by the 21st Century Cures Act

- Hospital performance - hospitals within the same peer group according to their dual-eligible inpatient stay ratio.
- Stratified into five peer groups, or quintiles, based on the proportion of dual-eligible stays.
- A hospital's dual proportion: Medicare fee-for-service (FFS) and Medicare Advantage stays where the patient was dually eligible for Medicare and full-benefit Medicaid.

Quintile #1 includes hospitals with fewer than 14% of its Medicare patients having dual coverage with Medicaid.

Quintile #5 includes hospitals with more than 31% of its Medicare patients having dual coverage with Medicaid.

Dual-Eligibles: Managing High-Need, High-Cost Patients

Readmissions

- The average all-cause 30-day readmission rate was four to eight times higher for high-need patients than for other patients.
- High-need, high-cost patients were more likely to be admitted for medical conditions rather than surgical or other types of conditions

Chronic Conditions

- Common chronic and acute conditions, such as congestive heart failure and septicemia, were among the 10 most common principal diagnoses for hospitalized high-need, high-cost across all payers.

Mental Health

- Mental health and substance use disorders were among the top 10 principal diagnoses for high-need, high-cost aged 1 to 64 years regardless of payer.

Readmissions: Who Is Excluded?

- Critical access hospitals
- Rehabilitation hospitals and units
- Long-term care hospitals
- Psychiatric hospitals and units
- Children's hospitals
- Prospective Payment System-exempt cancer hospitals
- Veterans Affairs hospitals
- Short-term acute care hospitals in U.S. territories (that is, American Samoa, Guam, Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands)
- Religious non-medical health care institutions

2024 Hospital Penalties

Readmission penalties are expected to increase in 2024

- Trend from 2023 will be changing.
- CMS has also resumed use of its pneumonia readmissions measure.
- Overall, 70.1% of hospitals will receive penalties of less than 1% of their readmissions in FY 2024.
- For FY 2024, average penalty increasing.

Where to Find Readmission Rates

Where can you find readmission rates for your referral sources?

Hospital Care Compare website
https://www.medicare.gov/care-compare/

The average all-cause hospital-wide readmission rate for U.S. hospitals is 15.5%, with rates ranging from 11.5% to 21.2%, according to data from 4,100 hospitals

Discussion Questions

- Do you know the readmission rates for each of your referrals?
- Do you have clinical programs aligned to the six conditions involved with penalties?
- How are you communicating your readmissions scores to your referrals?
- What tools are being used to reduce readmissions?

02

Is 30-Days the Right Interval for Readmissions?

Four Key Findings: 30-Day Readmissions

1. Hospital-level readmissions were low at the thirty-day cutoff.

2. Readmissions were higher within the first several days after discharge reaching the lowest point around seven days.

3. The hospital quality signal is higher in the first five days after discharge than at longer time periods, such as thirty days.

4. The optimal interval for capturing hospital-level variation in the risk of readmission appears to vary across conditions.

For example, the acute myocardial infarction patients had the greatest increase in hospital-level variation after the tenth post-discharge day.

30-days: Lowest readmissions

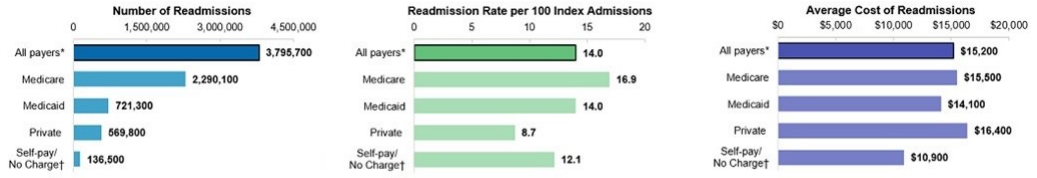
2-7 days: Highest readmissions

10-days: Myocardial infarction

After 7-days: social and community factors (SDOH)

DataPoint: Readmissions By Payer

Data Sharing: Number of Readmissions, Readmission Rates, and Average Cost of Readmissions
Three sets of statistics, overall and by expected payer, on 30-day all-cause adult hospital readmissions: the number of readmissions, the readmission rate, and the average cost of readmissions



Is 30-Days the Right Interval to Use for Readmissions?

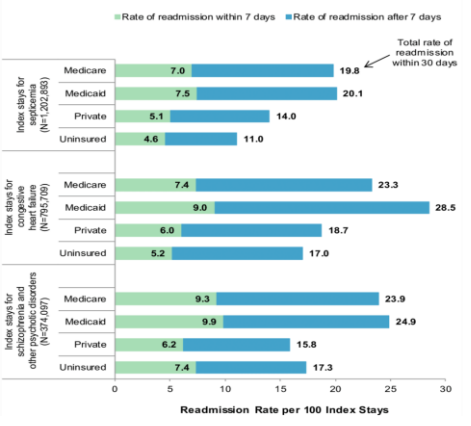
Readmissions by Payor

All Payors

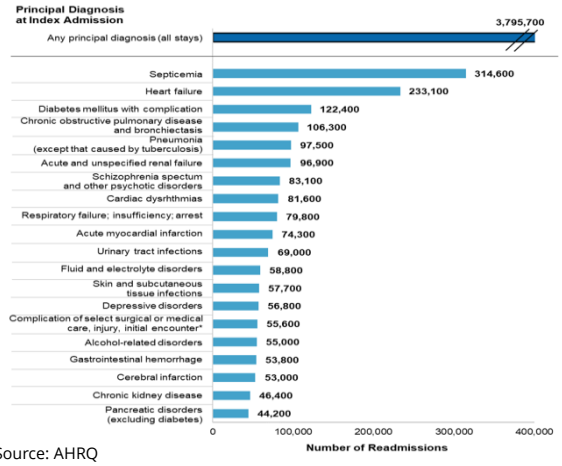
- For both 7-day and 30-day readmissions, the rate of readmission was highest among patients with Medicare, followed by patients with Medicaid, no insurance, and private insurance.

Medicaid

- Among Medicaid patients who were discharged with congestive heart failure or schizophrenia at the index stay, nearly 1 in 10 stays resulted in readmission within 7 days.



Top 20 principal diagnoses with the highest number of 30-day all-cause adult hospital readmissions, 2018



Source: AHRQ

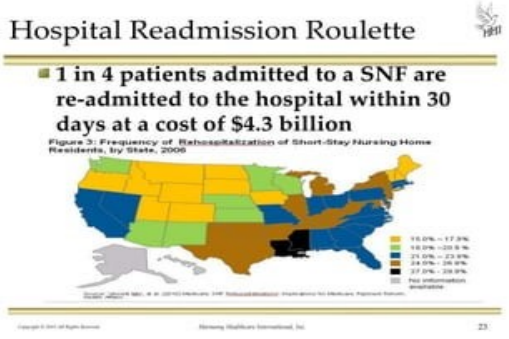
In 2018, 20 percent of adult hospital readmissions were associated with four conditions at index admission:

•Septicemia,
•Heart failure,
•Diabetes, and
•Chronic obstructive pulmonary disease (COPD)

Hospital stays for septicemia at index admission had the highest number of 30-day all-cause readmissions in 2018 (314,600), accounting for 8.3 percent of all readmissions.

The top four principal diagnoses at index admission—septicemia, heart failure, diabetes, and COPD—combined accounted for one in five readmissions.

Skilled Nursing Facilities



SNF Readmissions

- Journal of the American Medical Directors Association, features Medicare claims data collected from more than 67,000 heart failure hospitalizations in which patients where discharged to a SNF then to home.

The research includes several key data points:

- 24.2% of patients discharged from SNF to home were readmitted to a hospital within 30 days of SNF discharge
- The risk of readmission was highest in the first two days after SNF discharge
- Readmission risk declined with longer SNF length of stay

Falls & Readmissions

- Fall-related injuries are a leading diagnoses for hospital readmissions, particularly for at-risk older adults discharged home.
- Falls were the leading reason for readmission among patients whose initial hospital was fall-related and who were discharged to home, even with home health care.

A University of Michigan study found that in people 65 or older, fall-related injuries within a month of hospital discharge ranked as high as the third-leading diagnosis for readmission and the second-leading diagnosis at readmission for patients with cognitive impairment and whose initial hospitalization was fall-related.

- Among patients initially hospitalized with a fall-related injury who were discharged home or to home healthcare, a repeat fall-related injury ranked as the leading cause of readmission (12.3% and 11.8% respectively).
- The overall readmission rate was 14 percent. It was a bit higher for those with cognitive impairment (16 percent), but a bit lower for those with a previous fall injury (13 percent).

Five Actionable Data: Be Sure to Slice and Dice Data

1. By patient populations
2. By patient conditions
3. By payor
4. By referral
5. By 7-day vs 30-day readmissions

03

Data: Readmission Indicators, Key Metrics & Assessment Tools

Readmission Assessment Screening

- The 8P risk assessment screening tool is used to identify which patients have the highest risk for readmission. The 8P risk assessment is completed on the first day of admission for each new patient and is documented in the EMR. Patients with three or more of the following indicators are identified as high risk for readmission:
- Polypharmacy, defined as taking more than ten medications.
- Psychological problems, such as depression.
- Principle diagnosis of chronic conditions such as cancer, previous stroke, HF, or diabetes.
- Physical limitations, such as malnutrition or deconditioning.
- Poor health literacy, including language barriers or poor reading skills.
- Patient support is lacking, such as being homeless, social isolation, or having no primary care provider.
- Prior hospitalization, defined as non-elective admission within the past six months.
- Potential for palliative care, as indicated by advanced or progressive, serious illness.

Readmission Risk Stratification Tools

- Lace Index
- Krumholz/Yale Model
- Philbin Tool
- PARR Algorithm
- Boost
- Patient Activation Measure

L.A.C.E. Is a tool that was introduced to Millbrook Nursing and Rehabilitation Center by Methodist Hospital as **a best practice to reduce re-hospitalization.** L.A.C.E. is an Acronym for (L= Length patient Stay in the hospital, A= Acuity of Admission of patient in the hospital, C= Comorbidity and E= Emergency Visit

Best Practice: Patient Engagement Tools

Disengagement and non-compliance are the top causes of preventable readmissions

Disengagement refers to a patient's disinterest or unwillingness to participate in their care, and non-compliance means they are not following their treatment plan

Tool: Patient Activation Measures

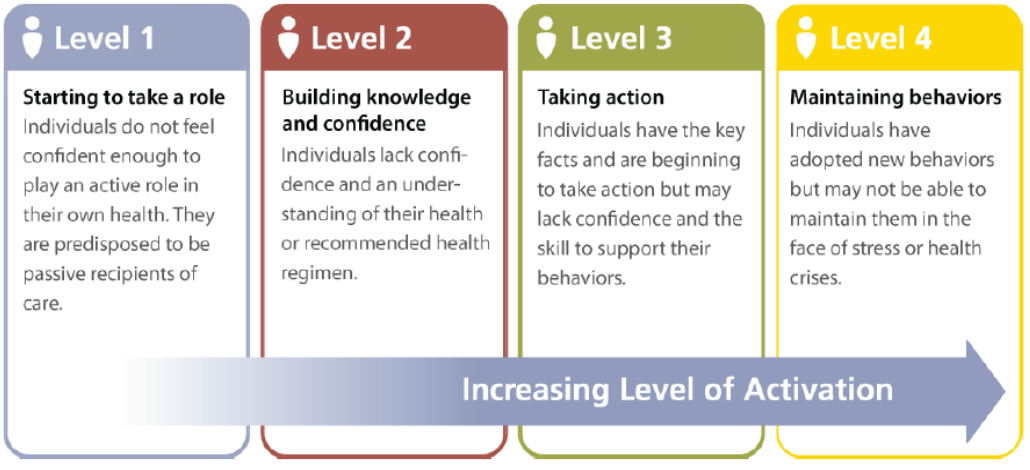
- Patient Activation Measure (PAM)
- Links activation levels to health outcomes, costs, and patients' experiences of care.
- A series of answers to questions—that gauges a person's self-concept as a manager of his or her health and health care. The measure is scored on a 0–100 scale, and people are categorized into four levels of activation, with level 1 the least activated and level 4 the most activated.
- Predicts future ER visits, hospital admissions and readmissions, medication adherence.

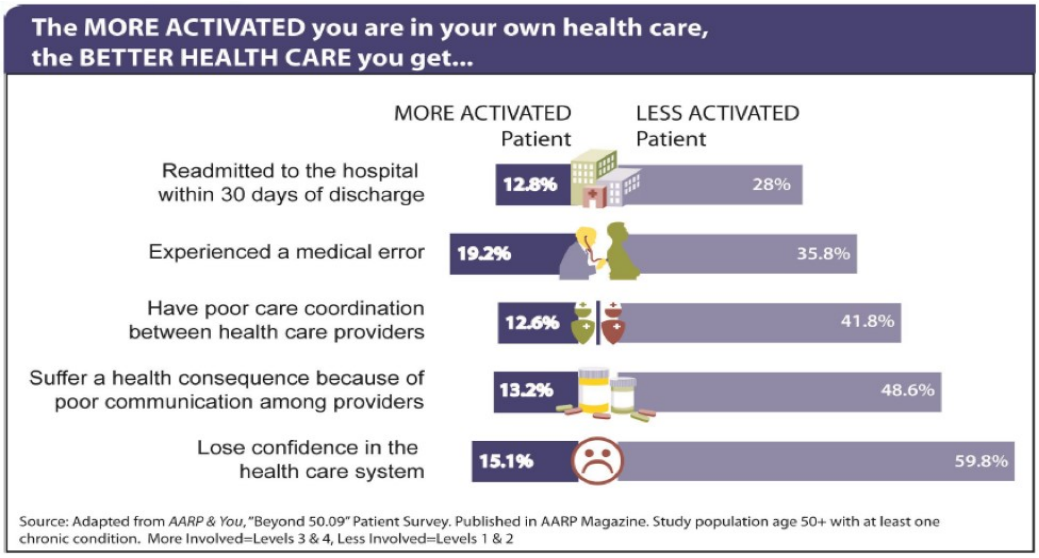
Insignia Health - Activate Your Population

The Patient Activation Measure

- Measures the patient's knowledge, skills and confidence essential to self management
- Stratifies patients into one of four activation levels
- Predicts healthcare outcomes including medication adherence, ER utilization and hospitalization
- Creates a universal language across care settings

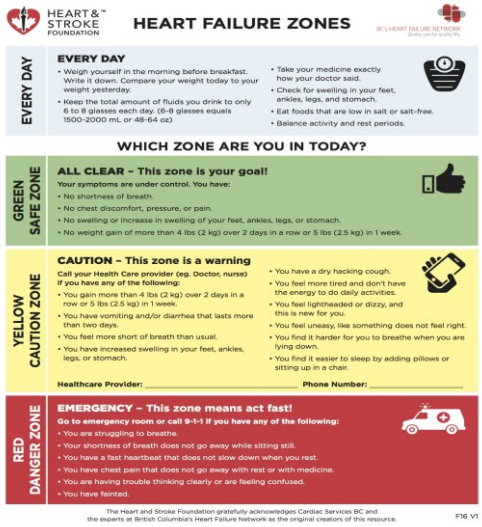
Levels of Activation





Discussion Questions

- **Screening Tools:** How is your organization monitoring patient compliance and engagement?
- What patient engagement tools help to decrease readmissions?
- How is your organization communicating in real-time patient's social determinants of health?



Key Readmission Metric Tracking

Metric Tracking: 30 Day

- 30-day readmission and 30-day ER return rate by payer and provider
- 30-day readmission and 30-day ER return rate by diagnosis
- 30-day readmission and 30-day ER return rate by timeframe
- 30-day readmission
- 30-day ER return rate by discharge place of service
- 30-day readmission and 30-day ER return rate by length of stay
- 30-day readmission and 30-day ER return rate by service type
- 30-day readmission and 30-day ER return rate by physician
- Track post-follow-up visit rate

DRG, CC, and MCC

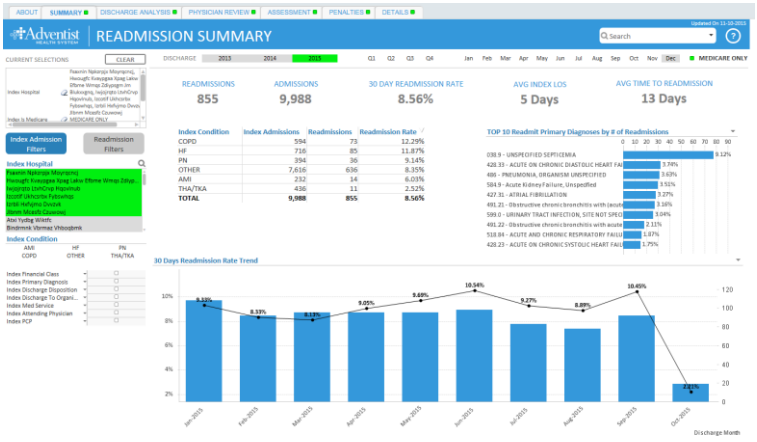
What is DRG and CC and MCC?

- 767 Medicare-Severity Diagnosis-Related Group (MS-DRG)
- Complication and Comorbidity (CC)
- Major Complication and Comorbidity (MCC): the presence of two or more chronic conditions in a single patient.

- Major comorbid conditions require more resources to treat than not-so-major comorbid conditions do. In cases like this, there may be three different DRGs, known as a DRG triplet:

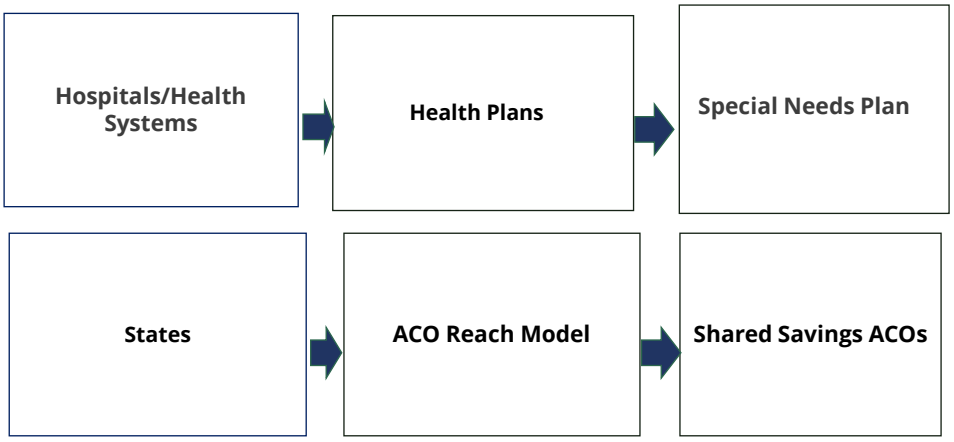
1. A lower-paying DRG for the principal diagnosis without any comorbid conditions or complications.
2. A medium-paying DRG for the principal diagnosis with a not-so-major comorbid condition. This is known as a DRG with a CC or a comorbid condition.
3. A higher-paying DRG for the principal diagnosis with a major comorbid condition, known as a DRG with an MCC or major comorbid condition.
4. A DRG title that includes “with MCC” or “with CC” means that, in addition to treating the principal diagnosis, the comorbid condition likely increased the resources the hospital had to use which is why the hospital was paid more than they would have received if you'd only had a single diagnosis and no comorbid conditions.

Readmissions: Hospital Dashboard



Social Determinants (SDOH)

Common Quality Measures



Z Codes: Document SDOH Factors

- Z codes are a set of ICD-10-CM codes used to report social, economic, and environmental determinants known to affect health and health-related outcomes.
- Z codes comprehensively identify non-medical factors affecting health and track progress toward addressing them

• Z codes are a tool for identifying a range of issues related – but not limited – to education and literacy, employment, housing, ability to obtain adequate amounts of food or safe drinking water, and occupational exposure to toxic agents, dust, or radiation

• Z codes can be used in any health setting (e.g., doctor's office, hospital, skilled nursing facility (SNF) and by any provider (e.g., physician, nurse practitioner).

Z Codes: Document SDOH Factors

Social determinants of health z codes are included in the following Z code categories:

- Z55 - Problems related to education and literacy
- Z56 – Problems related to employment and unemployment
- Z57 – Occupational exposure to risk factors
- Z58 – Problems related to physical environment
- Z59 – Problems related to housing and economic circumstances
- Z60 – Problems related to social environment
- Z62 – Problems related to upbringing
- Z63 – Other problems related to primary support group, including family circumstances
- Z64 – Problems related to certain psychosocial circumstances
- Z65 – Problems related to other psychosocial circumstances

- Z codes Z55-Z65 cannot be reported as the primary diagnosis.

- Z codes can be based on self-reported data and/or information. The information must be signed off by and incorporated into the medical record by the physician or clinician.

The 5 most utilized Z codes:
1. Z59.0 Homelessness
2. Z63.4 Disappearance and death of family member
3. Z60.2 Problems related to living alone
4. Z59.3 Problems related to living in a residential institution
5. Z63.0 Problems in relationship with spouse or partner

Discussion Questions

- **Patient Discharge**: Is Your Organization Asking Hospitals, SNFs, and Physicians for "Z" codes?
- What tools does your organization use to manage social determinants of health?
- How is your organization communicating in real-time patient's social determinants of health?

68%
of patients have at least one social determinant challenge

Discussion Questions

What Can Be Learned from Data?

1. Review your organization's data based upon our discussions.

2. Identify which readmissions are high? What's the root cause?

3. Evaluate readmissions by payer and clinical conditions

3. Evaluate readmissions by six conditions (hospital penalty program)
   - Acute myocardial infarction (AMI)
   - Chronic obstructive pulmonary disease (COPD)
   - Heart failure (HF)
   - Pneumonia
   - Coronary artery bypass graft (CABG) surgery
   - Elective primary total hip arthroplasty and/or total knee arthroplasty (THA/TKA)

4. Are your clinical programs tightly aligned with data analytics?

5. Do you have an effective dashboard to compare readmissions?

Remington Think Tank Leadership Exchange
Upcoming Master Classes

June 27, 2024 – Live. Also Will Be Available on-Demand
Chronic Care Management: Opportunities to Build Referral Relationships and Optimal Outcomes
Opportunities for Home Health, Hospice, Palliative Care, Private Duty, In-Home Care and Community-Based Organizations to Build Referral Relationships and Optimal Outcomes

July 18, 2024 – Live. Also Will Be Available on-Demand
Building Referral Partnerships with Payers and Medicare Advantage Plans
Opportunities for Home Health, Hospice, Palliative Care, Private Duty, and In-Home Care Providers to Implement Effective Strategies and Foster Relationships

Get the overview of all MasterClass Programs

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Live Recording Available
Building Referral Partnerships with ACOs
How Home Care Can Create Compelling Value Propositions for Establishing Strong Relationships and Team-Based Care
Received 5-Star Rating

Live Recording Available
Building Relationships with Physicians and Specialists
Opportunities for Home Health, Hospice, Palliative Care, Private Duty, and In-Home Care to Strengthen Clinical Relationships and Deliver Improved Outcomes
Received 5-Star Rating

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Additional Think Tank Resources

- Remington Report magazine
The Remington Report » Remington Report

- Remingtonreport.com: E-newsletter and Special Reports
https://remingtonreport.com/intelligence-resources/futurefocus/

- Email questions:
remington@remingtonreport.com

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