

October 2011

A Regional Call to Action
on Transitions of Care

Memphis, TN



Qsource.

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Project Description

Over the past several years, geographic analyses of healthcare claims data have demonstrated significant variations in utilization, cost and quality of hospital services. Pressure to reduce healthcare costs will continue to be a major focus of health reform. As purchasers and payers call for better integration of healthcare delivery, these same analyses also represent an opportunity to develop a systems-based approach to making healthcare service provision more coordinated, effective, and affordable. Regions that function together as a community are better able to deliver high value healthcare to residents, improving the health of the workforce and reducing healthcare costs to existing and potential employers.

Beginning in 2011, communities across the country will have the opportunity to form collaboratives to improve transitions of care. In response to these opportunities, Qsource, in its role as the Medicare Quality Improvement Organization (QIO) for Tennessee, is making proactive efforts to engage community stakeholders in identifying root causes of variations in care and sharing innovative approaches to improving care coordination.

National Scope of the Readmissions Problem

- 1 in 5 Medicare patients discharged from a hospital has a readmission within 30 days
- 3/4 are preventable = \$12 billion in annual Medicare spending
- 2 in 3 Medicare (FFS) medical discharges are readmitted or dead within a year
- 1 in 2 Medicare (FFS) surgical discharges are readmitted or dead within a year

Source: Medicare Payment Advisory Commission

Introduction

The breakdown in processes of care delivery that occur during a transition from hospital to the next source of care have major implications for health outcomes, cost of care and experience of the patient.

Under the concept of healthcare delivery system transformation, targets for improving transitions of care include: decreasing the deterioration of health conditions that can occur following discharge for all patients receiving hospital care, making sure that care delivery is responsive to both the clinical and social needs of all patients in a hospital service area, and reducing expenditures for unnecessary readmissions.

The problem of readmissions is not solely a hospital-based problem. It involves multiple providers across settings – primary care physicians and specialists, nursing home and home health staff, and non-clinical providers of supportive services in the community. In order to understand this complex problem, focus needs to be directed not only at what is going on within the four walls of the hospital but also what is going on after the patient re-enters the community that contributes to the readmission of the patients.

The Patient Experience

Mr. Jones had been admitted multiple times in the past year for the same set of conditions – congestive heart failure, hypertension and diabetes. During his last readmission episode, he reported high satisfaction with the hospital care and seemed to really understand his discharge instructions around medicines, diet and follow-up care. Mr. Jones was discharged to home under self-care and was able to return to usual daily activities without any problems. He has been successful with recommended dietary changes including avoiding fried foods, foods with high sodium content and sodas. For example, he eats baked chicken instead of fried but admits “slipping up” every now and then when he eats greens. The main issue was that Mr. Jones was taking 8 or 9 medications – no expensive brand name or genetically engineered drugs – drugs off the State formulary. Still the copays on those 8 or 9 prescriptions were unaffordable. So he would take the drugs until he ran out and wait to refill until his next check. Meanwhile, warning symptoms including stomach pain & swelling would start and he would suffer through it as long as possible, then return to the hospital. It was a cycle. He also did not have a regular doctor and though he was scheduled for a follow-up appointment during discharge, Mr. Jones did not have transportation. During his current admission, he felt anxious prior to discharge because it was going to be two weeks before his next check and he was worried about getting sick again.

Based on actual patient interview. The patient name is fictitious to protect patient confidentiality.

Methods

In order to expand accountability for readmissions from the hospital to all providers within the community involved in care transitions, a community rate of readmissions was developed that captures all causes of readmission for any condition to any facility. Medicare hospital claims and beneficiary enrollment file information for CY 2009 were used. The methodology for calculating a community rate of readmissions addresses multiple measurement issues that arise during the transition from a hospital-based measure of readmissions to a community-based measure of readmissions. Major issues include consideration of unit of analysis, definition of numerator and denominator, risk adjustment, inclusion and exclusion criteria, event counting and geographic boundaries.

Methodology Highlights:

Unit of Analysis:	Health Referral Region (HRR)
Inclusion Criteria:	All Medicare beneficiaries 65+ with at least one hospital admission in the HRR of residence
Exclusion Criteria:	Planned readmissions, same day transfers, death
Numerator:	All admissions within 30 days of discharge to any hospital
Denominator:	Event rate per 1,000 Medicare beneficiaries
Risk Adjustment:	None
Geographic Boundaries:	Includes cross-state data within the HRR

A rate per 1,000 Medicare beneficiaries begins to look more like a community health indicator (i.e., mortality rates) or more specifically, a community healthcare indicator. It should be noted that multiple events for an individual beneficiary can still be captured in the numerator.

In a typical measure of readmission, the hospital is the unit of analysis. While some methodologies use complex statistical procedures to attribute a readmission to the hospital in which it occurs and subsequently to a geographic community, a simpler approach is used for this project. A readmission is attributed to the zip code in which the beneficiary resides. Since zip codes can be coterminous (e.g., share boundaries) with a geographic community, the zip code level data are aggregated to the hospital service area (HSA) and subsequently to the health referral region (HRR). HRRs and HSAs are based on Dartmouth Atlas of Health Care Project geography and reflect natural utilization patterns of Medicare beneficiaries. Project rates of readmission are reported both at the HSA and HRR levels.

Findings

Within the Memphis HRR, 182,646 total Medicare beneficiaries over 65 reside. Of these beneficiaries, 26,176 were admitted to the hospital during 2009. Approximately 20% (5,196) of all beneficiaries receiving inpatient care experienced one or more readmissions and accounted for a total of 7,815 readmissions. Within the Memphis HRR, \$71 million was spent by Medicare on readmissions in 2009 alone.

Figure 1. Rates of Readmissions Across Tennessee HRRs

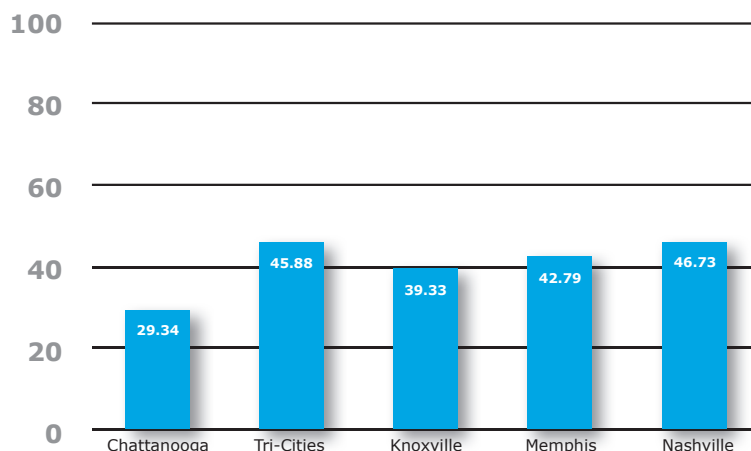


Figure 1 shows the community rates of readmission at the HRR level across the State. The rate is expressed per 1,000 Medicare beneficiaries based on enrollment file data in each region.

The lowest community rate of readmissions occurs in the Chattanooga area while the highest rate occurs in Nashville. In the Memphis HRR, there are approximately 43 readmission events per 1,000 Medicare beneficiaries. Furthermore, approximately 23% of all readmission events in the Memphis HRR involve subsequent admissions within 30 days to a different hospital than the index (first) admission occurred.

The top ten causes of readmissions account for 41% of all readmissions within the Memphis HRR (Table 1). Not surprisingly, heart failure is the leading cause of readmissions.

Table 1. Top 10 Causes of Readmissions in the Memphis HRR

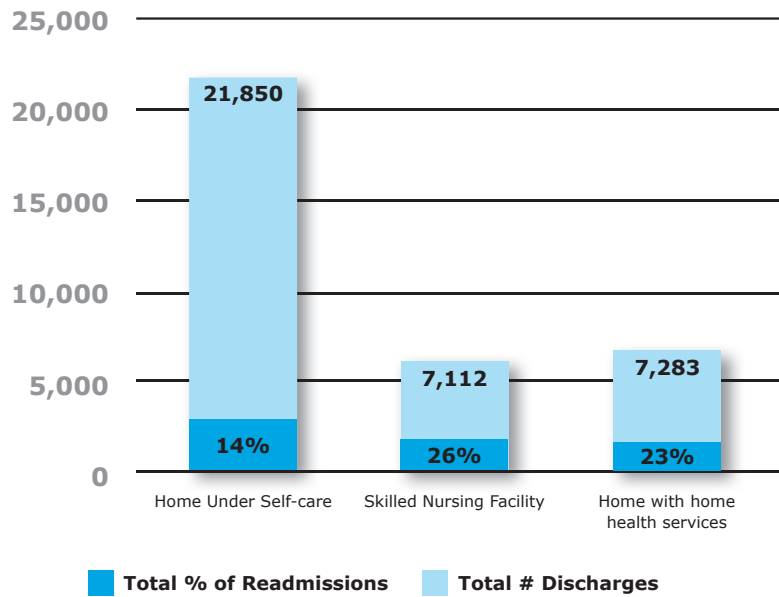
Condition by DRG	# Readmissions	% Total Readmissions
Heart failure & shock w/MCC	900	11.5
Septicemia w/o MV 96+ hours	382	4.9
Chronic Obstructive Pulmonary Disease	345	4.4
Nutritional & misc metabolic disorders	326	4.2
Kidney & urinary tract infections	301	3.9
Simple pneumonia & pleurisy	249	3.2
Renal failure	236	3.0
G.I. hemorrhage	207	2.6
Esophagitis, gastroent & misc digest disorders	138	1.8
Syncope & collapse	104	1.3

Figure 2 shows the proportion of readmissions to the total volume of discharges for the three locations accounting for the majority of discharges. The discharge location pertains to the discharge status from the index admission (e.g., admission prior to readmission).

Of all discharge events occurring in the Memphis HRR 51% are discharged to home under self-care and approximately 17% are discharged to both skilled nursing facilities and home with home health services (not shown). The remaining 15% of admissions are discharged to a variety of less frequent locations (i.e., hospice, psychiatric hospital, etc.).

As shown in Figure 2, one quarter of all discharges to either a skilled nursing facility or home with home health services result in a readmission. Home under selfcare has the lowest rate of readmissions (14%) among the most frequent discharge locations. Although the lowest proportion of readmissions come from home under selfcare, this setting accounts for the highest number of readmissions due to the volume of discharges.

Figure 2. Proportion of discharges and associated percentage readmitted by common discharge locations across the Memphis HRR



The distribution of expenditures shown in Figure 3 approximates the 80/20 principle of healthcare economics wherein the majority of expenditures are born by relatively few members of the population. Approximately 80% of beneficiaries receiving inpatient care had no readmissions (area 'A' on the chart), leaving 20% of the population that accounts for all readmission expenses. Individuals with one readmission accounted for nearly half of the readmission spending (area 'B'). Of great interest is the fact that less than 1% of beneficiaries receiving inpatient care (218 patients) went on to have four or more readmissions and account for 13% of the total inpatient expenditures. Casting the net a bit wider to those with 3 or more readmissions per year ($\approx 2\%$ of the total population) has the potential to effect savings of nearly \$20 million in unnecessary spending

Figure 3. Readmissions Expenditures within the Memphis Health Referral Region

One to three readmissions (areas B through D) represent opportunities for system level changes (i.e., electronic flow of information) that can impact all patients. Simultaneously allocating scarce resources toward individuals with 4+ readmissions (area E) targets high needs patients for whom the current delivery system works least well.

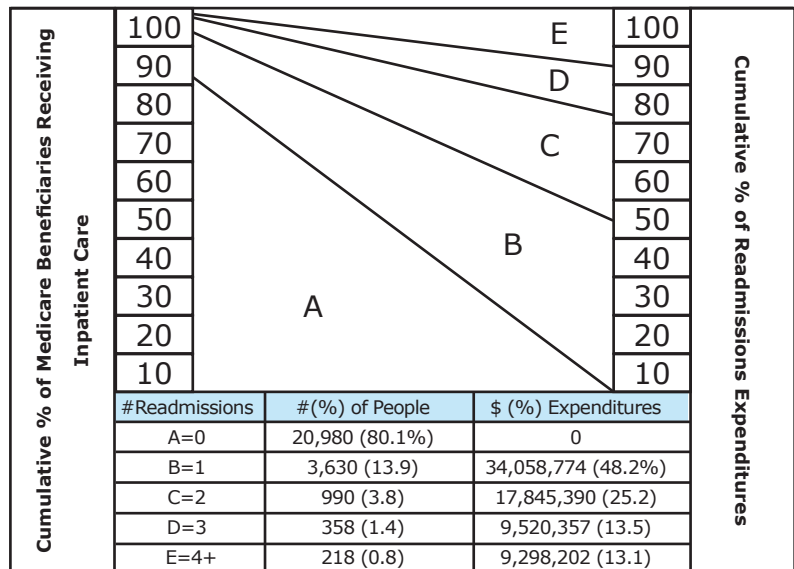
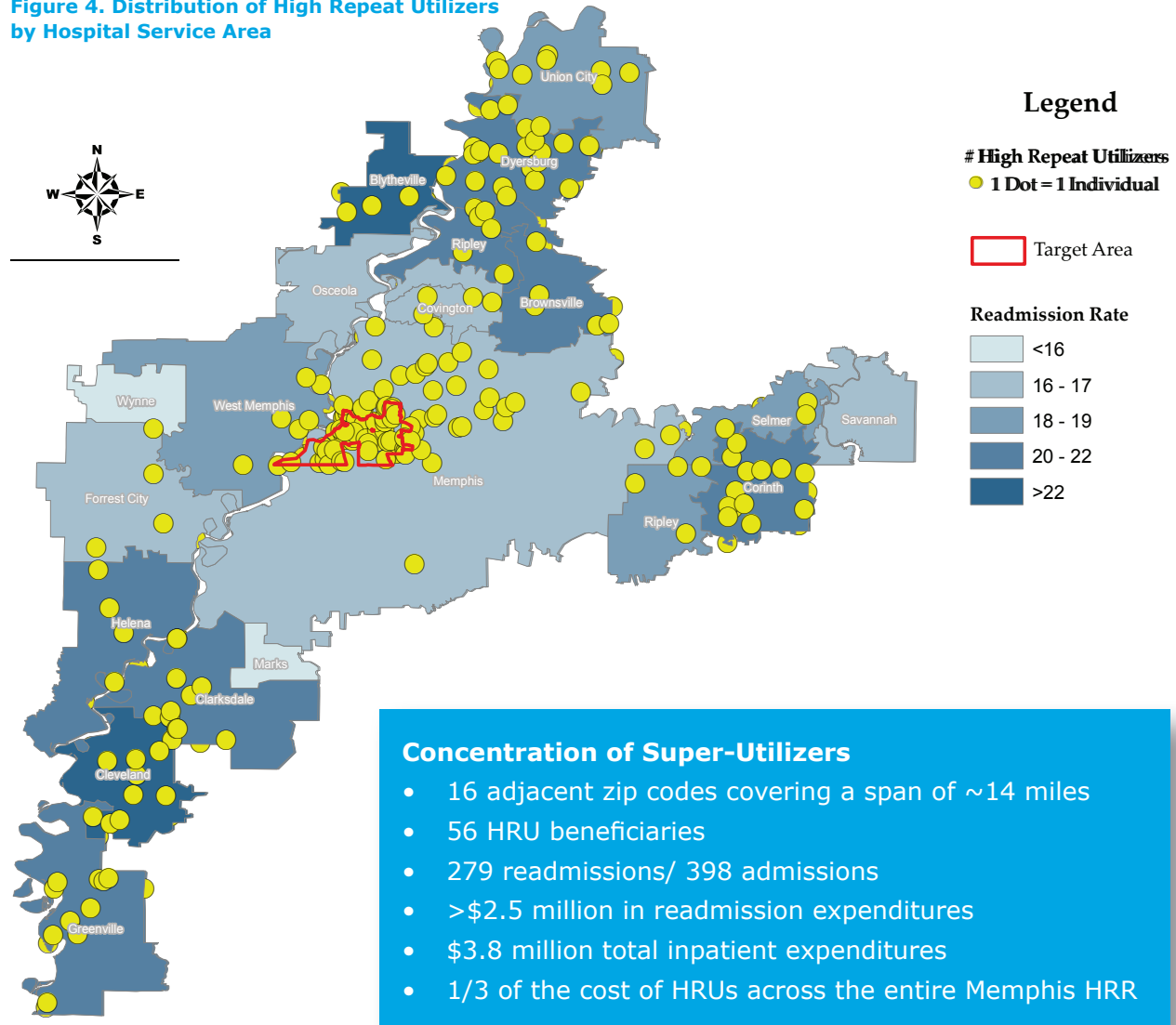


Figure 4. Distribution of High Repeat Utilizers by Hospital Service Area



In the map above of geographic variation in readmission rate among hospital service areas, the community readmission rate expression is similar to more familiar rates of hospital readmissions (Figure 4). Color shading shows variation in rates between hospital service areas within the Memphis HRR. In addition, a dot density overlay shows the location by zip code of high repeat utilizers, or individuals with four or more 30-day readmissions in one year. Although the Memphis HSA has a lower readmission rate compared to the majority of smaller surrounding HSAs, there is a high concentration area of high repeat utilizers in the northwest section of the Memphis HSA (outlined in red).

The red outlined area of the map shows 16 adjacent zip codes covering a span of approximately 14 miles (205 square mile area). Within this relatively small geographic area, there are 56 beneficiaries that account for a total of 279 readmissions and 398 admissions in one calendar year. Total cost of readmissions in this area is over \$2.5 million dollars, nearly one-third of the total readmission cost from high repeat utilization across the entire Memphis Health Referral Region. Furthermore, total inpatient costs in this area are approximately \$3.8 million dollars.

Summary & Call to Action

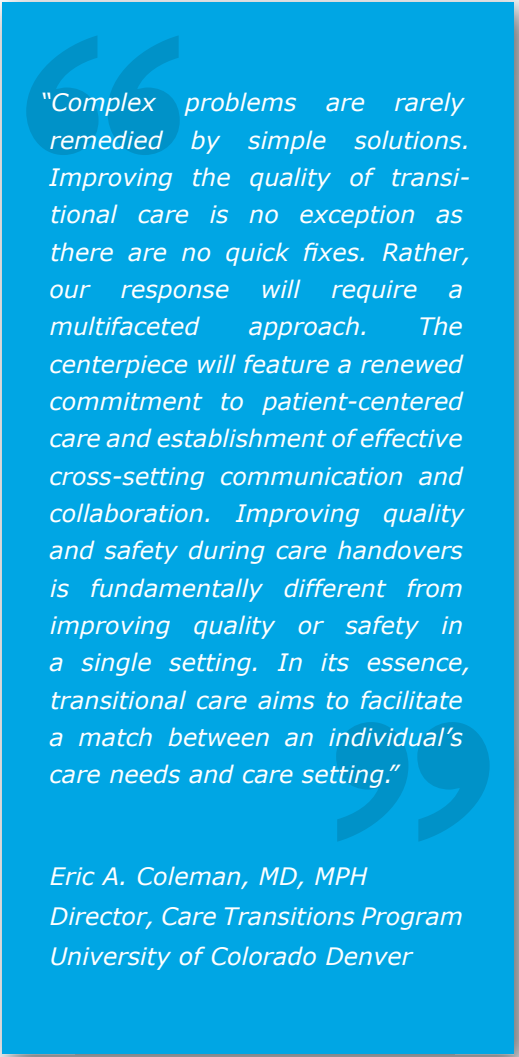
The movement toward integrated healthcare delivery will necessitate improving care transitions across multiple providers and settings. Refocusing the problem of readmissions to be inclusive of not only hospital care processes but also care provided in the community is a first step toward integration. This approach provides the potential for payment reform that can support needed changes to the healthcare delivery system.

This project supports accountability for health outcomes and expenditures at a system level through community-based measurement of readmissions. Project data demonstrates a potential to recapture \$71 million annually in Medicare spending on readmissions within the Memphis HRR. While only 20% of the Medicare patient population accounts for all readmission expenditures, a mere handful of the entire patient population (< 600 individuals) account for over one-quarter of this spending. In order to optimize impact on spending, system level interventions that improve care transitions for all patients can be coupled with allocation of resources targeted toward needs of those who account for disproportionate spending.

The data presented in this report is merely the tip of the iceberg in understanding a multi-faceted, complex problem. Further exploration of the local healthcare delivery system and patient needs is warranted. Community stakeholders with multiple perspectives of the problem of readmissions are uniquely positioned to identify opportunities for improvement that responds to local needs for healthcare delivery change. As a crucial part of the community, the value of patient perspective on breakdowns in care should not be underestimated. Particularly within the high-cost/high-need patient population, identifying barriers to care is essential to integrating appropriate mental health, social and other supportive services into care delivery.

As a partner for healthcare quality, Qsource will support community efforts to improve care transitions. Although regional information relating to the magnitude and scope of the readmissions is presented, community stakeholders are encouraged to further identify local challenges and opportunities for improvement. Additional support to communities may include identifying evidence-based models for improved care delivery that can be implemented to meet local challenges, assistance in seeking funding to support quality improvement initiatives and ongoing provision of data to assess community change. Finally, leveraging common resources for health information exchange and learning and action networks (LANs) will be part of the ongoing project efforts.

This presentation and related material was prepared by Qsource under a contract with the Centers for Medicare and Medicaid Services (CMS). Contents do not necessarily reflect CMS policy. Qsource-TN-110IC-2011-01



"Complex problems are rarely remedied by simple solutions. Improving the quality of transitional care is no exception as there are no quick fixes. Rather, our response will require a multifaceted approach. The centerpiece will feature a renewed commitment to patient-centered care and establishment of effective cross-setting communication and collaboration. Improving quality and safety during care handovers is fundamentally different from improving quality or safety in a single setting. In its essence, transitional care aims to facilitate a match between an individual's care needs and care setting."

*Eric A. Coleman, MD, MPH
Director, Care Transitions Program
University of Colorado Denver*



Qsource, is a nonprofit healthcare quality improvement and information technology consultancy headquartered in Tennessee, with offices in Memphis, Nashville, Knoxville and in Little Rock, AR.

Under a contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services, the organization focuses on three primary aims: better patient care, better population health, and lower healthcare costs through improvement.

This project was produced in collaboration with The University of Tennessee Health Science Center.



The methodology used to calculate the readmissions rates in this report is based on a compilation of methodologies with adjustments made to address issues that affect healthcare delivery in Tennessee. The results are not intended to reproduce rates previously reported on Tennessee hospitals on CMS's Hospital Compare website.

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