Federal Fiscal Year

• Oct 1, 2012, start of Federal Fiscal Year
• Begins Medicare’s largest effort yet at pay-for-performance
• Targeting Readmissions and Quality
Reducing Hospital Readmissions

• The **Patient Protection and Affordable Care Act (PPACA)** is a **United States federal statute** signed into law by **President Barack Obama** on March 23, 2010

• Enacted in the Affordable Care Act is the Hospital Readmission Reduction Program (HRRP)
Reducing Hospital Readmissions

• The Hospital Readmission Reduction Program (HRRP)

• Started October 1, 2012, FY 2013, Medicare will penalize hospitals for higher-than-expected rates of readmissions.

• Penalties are being applied to encourage hospitals to enact improved follow up and other procedures to reduce preventative readmits to Medicare patients.
Hospital Readmission Reductions Program

- Hospitals that report higher than average 30-day readmission rate with:
  - Acute myocardial infarction
  - Heart Failure
  - Pneumonia
- Financial penalties will be imposed
  - 1% in fiscal year 2013
  - 2% in 2014
  - 3% in 2015
- HRRP is expanding the list of relevant health conditions
- Hospital reductions based on data from July 1, 2008 - June 31, 2011
- HRRP goal is to drive quality of care improvements while saving Medicare $710 million each year.
19.6% of the 11.8 million rehospitalizations occurred within 30 days

53% of those discharged were rehospitalized or died within the first year

50.2% of the rehospitalized patients had no MD office visit between admissions

Readmissions have a .6 day longer LOS

The cost of unplanned rehospitalizations in 2004 was 17.4 billion

Kaiser Family Foundation Study found, nearly 40% of NH patients are admitted to hosp. annually

And, that 25% of these may be preventable

A congressional panel estimated 14% of patients D/C from the Hosp to the NH are sent back to the Hosp

The panel believes 14% of these readmissions are preventable
Reducing Hospital Readmissions

• CMS website, Hospital Compare, displays the rates of readmissions for any reason following hospitalization for one of three common conditions,
  – Heart Attack
  – Heart Failure
  – Pneumonia
Reducing Hospital Readmissions

• Two-thirds of hospitals will experience penalties
• Or, 76% of our nations hospitals, averaging – $125,000
• 33%, will experience no penalty, due to not having enough cases
• In aggregate, penalties equal .24 percent of all inpatient payments in 2013

*http://www.Fiercehealthcare.com
Reducing Hospital Readmissions

• A little bad math is going to cost the Hospitals
• CMS announced Oct 3, 2012 errors in the initial calculations
• CMS August Final Rule included Medicare claims before the set period of June 30, 2008- July 1, 2011
• “Technical Errors” now corrected
• Calculation is a change of two-hundreds of a percent of regular Medicare reimbursement
Reducing Hospital Readmissions

• America’s hospitals are committed to improving,
  • The safety they deliver
  • The quality of care
  • As well as working to reduce avoidable readmissions

• Some of the evidence-based care transition interventions funded by CMS and AoA,
  • The Care Transitions Intervention (CTI)
  • The Transitional Care Model (TCM)
  • Project Boost
  • Re-engineered Discharge (RED)
  • Transforming Care at the Beside (TCAB)

The Care Transitions Intervention (CTI)

• Developed by Eric Coleman, from University of Colorado

• 34 out of the 47 communities under the CMS Community-Based Care Transitions Program have adopted this model.
The Care Transitions Intervention (CTI)

- **The Four Pillars®**
  - **Medication self-management:** Patient is knowledgeable about medications and has a medication management system.
  - **Use of a dynamic patient-centered record:** Patient understands and utilizes the Personal Health Record (PHR)
  - **Primary Care and Specialist Follow-Up:** Patient schedules and completes follow-up visit.
  - **Knowledge of Red Flags:** Patient is knowledgeable about indications that their condition is worsening and how to respond.
The Transitional Care Model (TCM)

• Comprehensive in-hospital planning and home follow-up for chronically ill high-risk older adults hospitalized for common medical and surgical conditions.

• Emphasizes coordination and continuity of care, prevention and avoidance of complications, and close clinical treatment and management

• Designed by Mary Naylor and the University of Pennsylvania
The Transitional Care Model (TCM)

• **TCM is built on the following key components:**
  
  – **Focus on Patient and Caregiver Understanding,** Patients often retain little of what they are taught while hospitalized. A great deal of information is communicated to patients and family members during hospital stays, but often the patient and caregivers are unable to absorb that information because being in the hospital is such a stressful and vulnerable experience.

  – **Helping Patients Manage Health Issues and Prevent Decline,** Recognizing that home follow up under TCM extends one- to three-months, a significant part of the TCN's role is to facilitate each patient's and family caregiver's ability to manage his/her care at home.

  – **Medication Reconciliation and Management,** During the patient's hospitalization, the TCN also reviews the medication plan with all providers, including the hospital pharmacist, to reduce the overall number of medications and eliminate contraindications and unsafe interactions.

  – **Transitional Care, Not Ongoing Case Management,** The Model is designed to fill an important gap in health care delivery, helping patients make an important transition from the hospital to the home, minimizing declines in health status. The purpose of the evidence-based model is not to provide ongoing care to patients but to optimize patient outcomes throughout and following an acute episode of illness.
Project Boost

- Project BOOST (Better Outcomes for Older Adults through Safe Transitions)
- Led by Society of Hospital Medicine (SHM)
- Initiative to improve practices in transition care and reduce readmission rates
- The project’s utilizes a toolkit, mentoring program, and national advocacy efforts.
- Combines multidisciplinary leaders and existing models for transitional care
Project RED (RED)

- **Project Re-Engineered Discharge**, known as **Project RED**,
- Developed by Brian Jack, M.D., Associate Professor of Family Medicine at Boston University and Timothy Bickmore, Ph.D., Assistant Professor in the College of Computer and Information Science at Northeastern University, through a Partnerships in Implementing Patient Safety grant from the Agency for Healthcare Research and Quality.
- The project is designed to re-engineer the hospital workflow process and improve patient safety by using a nurse discharge advocate who follows 11 discrete, mutually reinforcing action steps shown to improve the discharge process and decrease hospital readmissions.
- Patients who have a clear understanding of their after-hospital care instructions, including how to take their medicines and when to make follow-up appointments with their doctors, are 30 percent less likely to be readmitted or visit the emergency department than patients who lack this information,
- **February 3, 2009, Annals of Internal Medicine**
Transforming Care at the Beside (TCAB)

• National program that was developed by the Robert Wood Johnson Foundation (RWJF) and the Institute for Healthcare Improvement (IHI).

• The program goal is to engage front-line hospital nurses and leaders at all levels to:
  – Improve the quality and safety of patient care on medical and surgical units.
  – Increase the vitality and retention of nurses.
  – Engage and improve the patient's and family members' experience of care.
  – Improve the effectiveness of the entire care team.

Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents

- This initiative is possible through the collaboration of the CMS Innovation Center and the CMS Medicare-Medicaid Coordination Office.

- A new federal program aimed at the reduction of hospitalization among nursing home residents, especially dual eligibles, announced seven health system participants with 145 nursing facilities.

- By providing on-site services and support, participants “toward more seamless beneficiary transitions of care, and leverage use of emerging technologies, among many other activities.” One goal is to reduce hospitalization rates among dual eligibles, with CMS noting that “45% of hospitalizations among Medicare-Medicaid enrollees receiving either Medicare skilled nursing facility services or Medicaid nursing facility services could have been avoided.”

- The organizations and states are: the Alabama Quality Assurance Foundation (Alabama); Alegent Health (Nebraska); Curators of the University of Missouri (Missouri); Greater New York Hospital Foundation (New York); HealthInsight of Nevada (Nevada); Indiana University (Indiana); and UPMC Community Provider Services (Pennsylvania).

- [http://innovation.cms.gov/initiatives/rahnfr](http://innovation.cms.gov/initiatives/rahnfr)
National Center for Assisted Living

• The initiative is intended to be the assisted living counterpart to the American Health Care Association’s nursing home quality improvement program that launched on February.

• The primary goals of the NCAL quality improvement program are:
  • Safely reduce hospital readmissions by 15% by March of 2015,
  • Keep nursing staff turnover below 30% each year until at least March 2015,
  • Maintain the number of customers who would recommend the community to others at or above 90% by March 2015,
  • Reduce off-label antipsychotic use by 15% by December 2013.

• http://www.ahcancal.org/ncal/quality/qualityinitiative/Pages/default.aspx/.
Care Transitions

• The term “Care Transitions” refers to the movement patients make between health care practitioners and settings as their condition and care needs change during the course of a chronic or acute illness.

  – Dr. Eric Coleman, University of Colorado at Denver Health Sciences Center
Care Transitions

• Patients with serious or complex illnesses, have been prone to errors, transitions in setting of care
• One in five Medicare patients discharged from the hospital is readmitted within 30 days
• Translates- 2.6 million seniors at a cost of $26 billion every year
• Readmission rates are also high for your Dual-eligible patient

*http://www.healthcare.gov/compare/partnership-for-patients/safety/transitions.html
Chronic Disease Management

• More than 40% of the U.S. population has one or more chronic condition
• The prevalence of chronic diseases is increasing in both the elderly and non-elderly populations
• Increased spending on chronic diseases in Medicare is a significant driver of the overall increase in Medicare spending over the last twenty years
Chronic Disease Management

• Elements of a program may include
  – a treatment plan with regular monitoring,
  – coordination of care between multiple providers and/or settings,
  – medication management,
  – evidence-based care,
  – measuring care quality and outcomes,
  – And support for patient self-management through education or tools

• Chronic disease management is also frequently an element of medical homes

Federal Fiscal Year

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Value Based Purchasing

• October 1, 2012, Medicare started withholding 1 % of regular hospital reimbursements
• The Patient Protection and Affordable Care Act of 2010 requires the establishment of VBP program to pay hospitals for performance on quality measures rather than just reporting of these measures.
Changing Times

• 2010- Health Care Recovery Act of 2010
  – Established Value Based Purchasing, also referred to as “Pay for Performance”
  – Since introduced, VBP has been implemented with unprecedented momentum
  – Deficit Reduction Act of 2005 established “Pay for Reporting”
    • 2007 Pay for Reporting effective (Core Measures)
      – Health Care Reform Act of 2010 established VBP = Pay for Performance
        » FY 2013 Initial VBP; Clinical Process and Patient Experience
        » FY 2014 VBP expanded to include Outcomes
        » FY 2015 VBP expanded to include Medicare Spending Per Beneficiary
Value Based Purchasing

• Pay for Performance = Value Based Purchasing

• “A system that is transforming from one that rewards volume of service to one that rewards efficient, effective care and reduces delivery fragmentation.”
Value Based Purchasing

• The first definition of VBP was finalized April 2011, and since has quickly evolved.
• The VBP score will be based on performance domains.
• Funding for the VBP program is generated by withholding a percentage of all inpatient PPS Medicare MS-DRG payments.
Value Based Purchasing

• Medicare estimates about $850 million will be reallocated
• Some hospitals will get some money back
• Others will break even
• Some will end up getting extra
• Money will be returned based on
  – Clinical Guidelines
  – Patient Satisfaction Surveys
Phased in VBP Domains and Withholdings

**Domains**

- Patient Experience (HCAHPS)
- Outcomes (Morality in FY 2014)
- Efficiency (Medicare Pending)
- Clinical Process (Core Measures)

**FY2013 (Withhold 1.0%)**
- 70% (Patient Experience)
- 30% (Efficiency)

**FY2014 (Withhold 1.25%)**
- 45% (Patient Experience)
- 25% (Outcomes)
- 30% (Efficiency)

**FY2015 (Withhold 1.5%)**
- 20% (Patient Experience)
- 20% (Outcomes)
- 30% (Efficiency)
- 30% (Clinical Process)
Medicare Spending per Beneficiary National Breakdown by Claim Type

- Inpatient: 60%
- Carrier: 15%
- Skilled Nursing: 16%
- Home Health: 4%
- Outpatient: 3%
- Hospice: 1%
- DME: 1%

CareCoordinationManagement, LLC 2012
The New “LINK” between providers

- CMS is moving toward managing the delivery of health care by linking the multiple settings of the post acute care arena to the Medicare Spending Per Beneficiary “episode of care”
The New “LINK” between providers

- Medicare Spending Per Beneficiary= Measure of Hospital Performance
- Includes all Part A and Part B Beneficiary spending during a period of time that spans 3 days prior to a hospital admission, through 30 days after the patient is discharged
- Anticipated Outcome: Encourage hospitals to provide high quality care to Medicare beneficiaries at a lower cost
- Anticipated Outcome: To promote greater efficiencies across care settings and the US health care system in general
The New “LINK” between providers

• Understand the 3 components of the “episode of care” begins to make it clearer for the steps that are necessary for post acute providers to be viewed as a valued partner to the acute hospital

• This addition of the MSPB measure to Medicare reimbursement, makes the post acute provider now more then ever in a position to influence the acute care hospital
The New “LINK” between providers

• As noted on the previous graph, more than 1/3 of spending in a health care episode is outside of the acute care hospital, yet the hospital is being held accountable.

• This is the opportunity for post-acute providers
Current position of Hospitals

• Now aligning with Post-Acute providers that are
  – Proficient
  – Clinically competent in managing these disease states
  – Demonstrate the ability to pick up on subtle changes before they become crisis situations
  – Institute competent interventions when there is a patient decline
Post-Acute Providers

• Need to implement best practice approach towards
  – Review of organizational readiness
  – Strategic alliances
  – Proactive review of system processes
  – And Outcomes management for AMI, CHF, and pneumonia
Physicians Updates

• Physicians by 2015,
  – Budget Neutral Payment System, will adjust Medicare payments based on quality and cost of care phased in over two year period.

• Important for us to walk the walk and talk the talk,
  – Is the practice part of a Medical Home? What is their patient population? How are they using technology? What is their Continuum of Care approach?
Physicians PQRI Measures
www.cms.hhs.gov/PQRI

• Measures impacting CHRONIC CONDITIONS (chronic kidney disease, diabetes mellitus, heart failure, hypertension and musculoskeletal)
• Measures involving care coordination or transitions of care across settings
• Measures applicable across care settings- for example outpatient, inpatient and nursing facilities.
• Outcomes measures, including intermediate outcome measures of functional status
• Measures conducive to leveraging capabilities of an electronic health record (EHR)
Value Based Compositions Across Health Sectors

1. Redefining healthcare models around medical conditions= Chronic Care management
2. Providers need to choose a range and type of services offered= specialization
3. Providers align themselves around medically integrated services= Medical Homes, ACOs Continuum of Care, Bundled Payments
4. Providers must measure results, experience, methods and patient outcomes by service= Accountability and Standardization
5. Providers must market their services based on excellence, uniqueness and results= Customer Excellence, Patient Satisfaction and Quality Outcomes.
Staying Alive

• 2010- Patient Protection and Affordable Care Act (PPACA)-HEALTH CARE REFORM

— Opportunities
• Pay-for-Performance
• Population Health Management
• Independence at Home
• Hospital Re-Admission Reduction
• Community Based Care Transitions
• Bundled Payments
• Patient-Centered Medical Home
• Chronic Disease Management
• Employer Wellness
Thank you
5 WAYS HEALTH PLANS ARE REDUCING READMISSION 
AND ER VISITS

• Examples of the types of programs and services that health plans have 
implemented to reduce preventable hospital admissions, readmissions and 
emergency room visits.

1. Expanding patient access to urgent care centers, after-hours care, and nurse help lines give 
patients safe alternatives to emergency rooms for non-emergency care.

2. Arranging for phone calls and, in some cases, in-home visits by nurses and other professionals to 
make sure that follow-up appointments are kept, medications are being taken safely, care plans are 
being followed, medical equipment is delivered, and home health care is being received.

3. Offering intensive case management to help patients at high risk of hospitalization access the 
medical, behavioral health, and social services they need.

4. Arranging for home visits by multidisciplinary teams of clinicians, who provide comprehensive 
care, teach patients and their caregivers how to take medications correctly, and link families with 
needed community resources.

5. Revamping physician payment incentives to promote care coordination and improved health 
outcomes

CareCoordinationManagement,LLC2012
A federal demonstration program testing pay-for-performance incentives for nursing homes had mixed results, spelling uncertainty for the future of an Affordable Care Act provision, a recent report shows.

Under a pilot program, CMS rewarded nursing homes that met financial savings goals and improved quality of care. The program involved 182 skilled nursing facilities in Wisconsin, New York and Arizona, and made award determinations based on how well the facilities achieved financial savings through reduced avoidable hospitalizations and whether it met clinical quality measures, according to Kaiser Health News.

The first year of the three-year pilot program concluded on July 1 and CMS submitted a report detailing the results to Congress.

The program’s lead investigator, Harvard’s David Grabowski, Ph.D., said first year results were decidedly “mixed,” with Wisconsin SNFs attaining a fairly large savings, Arizona achieving modest savings, and New York SNFs netting no savings.

“The results are somewhat disconcerting,” Grabowski told Kaiser. “There does appear to be some opportunity for cost savings, but we don’t have a good sense yet as to whether this [demonstration project] will actually improve the quality of care.”
GOVERNMENT RELEASES ALZHEIMER’S TASKFORCE PLAN

- The National Institutes of Health will be required to collaborate with the Department of Health and Human Services and other federal agencies on Alzheimer’s disease-related issues, according to a new government plan.

The Congressional Task Force on Alzheimer’s disease released its first draft plan detailing specific strategies for increasing access to clinical trials, improving early diagnosis rates and broadening public outreach efforts. The draft plan calls for the NIH to develop a framework for expediting therapeutic outcomes for those with or at risk of Alzheimer’s disease. It will accomplish this by working with other federal agencies such as the Administration on Aging, the Centers for Medicare & Medicaid Services, the Food and Drug Administration and others.
The proportion of U.S. adults aged 45-64 with two or more chronic conditions increased 35% for whites, 31% for Hispanics and 20% for African Americans between 2000 and 2010, according to a report released by the Centers for Disease Control and Prevention.

An estimated 28% of African Americans aged 45-64 had multiple chronic conditions in 2010, compared with 21% of whites and 19% of Hispanics, based on data from the National Health Interview Survey, which looks at nine chronic conditions: hypertension, heart disease, diabetes, cancer, stroke, chronic bronchitis, emphysema, asthma and kidney disease. For adults aged 65 and over, the prevalence of multiple chronic conditions increased by 32% for Hispanics, 22% for whites and 18% for African Americans over the 10-year period. According to the report, the trend “presents a complex challenge to the U.S. health care system, both in terms of quality of life and expenditures from an aging population.”
A total of 19 participants have been selected for the Independence at Home Demonstration Program, CMS announced.

Three of the latest are:
• Innovative Primary Senior Care in Skokie, IL;
• Treasure Coast Healthcare in Stuart, FL;
• Virginia Commonwealth University Health System/Medical College of Virginia Hospitals and Physicians in Richmond, VA.

The consortia join 16 independent practices selected for the project in April, bringing total participants to 19. Authorized by the Patient Protection and Affordable Care Act, the three-year Medicare demonstration will evaluate whether primary care services delivered at home by multidisciplinary teams improve care and reduce costs for beneficiaries with chronic conditions. Participants must be available 24/7, use electronic health information systems, remote monitoring and mobile diagnostic technology. They will coordinate care across treatment settings for Medicare fee-for-service beneficiaries who have at least two chronic conditions, need assistance with at least two functional dependencies, and have had a non-elective hospital admission and received acute or sub-acute rehabilitation services within the past 12 months. The practices must serve at least 200 applicable beneficiaries each year of the demonstration and may share in savings if specified quality measures and savings targets are achieved.
CMS announced the Partnership to Improve Dementia Care, an initiative to prevent inappropriate use of antipsychotic medications for nursing home patients with dementia.

The agency said partners include federal and state agencies, nursing homes and other health care providers, advocacy groups and caregivers. “As part of this effort, our partnership has set an ambitious goal of reducing use of antipsychotics in nursing homes by 15% by the end of this year,” said CMS Acting Administrator Marilyn Tavenner. Among other actions, CMS plans to offer training for nursing homes and state and federal surveyors; begin posting facility-specific data on antipsychotic drug use to Nursing Home Compare in July; and emphasize non-pharmacological alternatives such as consistent staff assignments and increased exercise or other activities.
POST-OPERATIVE COMPLICATIONS DRIVE READMISSIONS AMONG SURGERY PATIENTS

• Postoperative complications are the most significant independent risk factor for hospital readmissions among general surgery patients, according to a new study published in the *Journal of the American College of Surgeons*.

Researchers reviewed data from 1,442 general surgery patients who were operated on between 2009 and 2011. They found that 163 patients, 11.3 percent, were readmitted within 30 days. Researchers found that specific surgical procedures, the number of postoperative complications each patient experienced, and the severity of complications were leading risk factors for readmission.

Pancreatectomy, colectomy, and liver resection procedures had a higher risk of readmission due to surgical complexity, researchers said. Gastrointestinal complications and surgical infections accounted for nearly half of all readmissions. Patients who had one or more complications after their operations were four times more likely to be readmitted than patients who had no complications, the study found.

Researchers said a better understanding of readmission predictors will help hospitals develop programs to decrease readmission rates.
CMS announced 17 sites selected to participate in the Community-based Care Transitions Program (CCTP). See example of programs.

Together with the first 30 participants, the CCTP now includes 200 acute care hospitals partnering with community-based organizations (CBOs) across 47 sites to provide care transitions services for an estimated nearly 185,800 Medicare beneficiaries annually residing in 21 states.

The CCTP is a five-year program created by the Affordable Care Act. Participants sign two-year program agreements with CMS, with the option to renew each year for the remainder of the program, based on their success. As of the date of this announcement, CMS continues to accept applications and approve participants on a rolling basis as long as funds remain available.
COMMUNITY-BASED CARE TRANSITION PROGRAM EXPANDS

• PENNSYLVANIA
  The Allegheny County Department of Human Services Area Agency on Aging will partner with four hospitals to deliver care transition services in Allegheny County, Pennsylvania. Allegheny will use the Care Transition Intervention Model to serve over 2,900 Medicare beneficiaries annually. The hospitals include: Allegheny General Hospital, Western Pennsylvania Hospital Forbes Regional Campus, Ohio Valley General Hospital, and Jefferson Regional Medical Center.

• http://www.innovations.cms.gov/initiatives/Partnership-for-Patients/CCTP/
CMS announced the selection of 500 primary care practices representing 2,000 providers in seven states (Arkansas, Colorado, New Jersey, Oregon, New York, Ohio, Kentucky, and Oklahoma) who will participate in a new partnership with CMS, state Medicaid agencies, commercial health plans, and self-insured employers.

Under the Comprehensive Primary Care Initiative—a four-year program administered by the CMS Innovation Center—CMS will pay a set care management fee ($20 on average) per beneficiary per month to primary care practices to support coordinated care management services for Medicare FFS beneficiaries.

Note: the practices were chosen based on several factors: use of health information technology (IT), ability to demonstrate recognition of advanced primary care delivery by leading clinical societies, service to patients covered by participating payers, efforts to transform their practice and improve their activities, and diversity of geography, practice size, and ownership structure.
CMS PROPOSES CARE COORDINATION PAYMENTS FOR RECENTLY DISCHARGED PATIENTS

• For the first time, CMS is proposing to pay community physicians for the care required to help a patient transition back to the community following discharge from a hospital.

Under the proposed rule, CMS would make a separate payment to a patient’s community physician to coordinate care during the first 30 days after a patient’s hospital stay. Research shows that patients who receive timely physician follow-up care after being discharged are significantly less likely to be readmitted. The proposed rule would increase payments for family physicians by 7 percent and other practitioners providing primary care services by 3 to 5 percent under the Medicare Physician Fee Schedule for 2013. The proposed rule, which appeared in the July 30 Federal Register, also seeks public comment on how Medicare can better recognize the services community physicians provide in office visits and in coordinating care outside of the office.