Preventing Unnecessary Readmissions

Measuring Care Coordination Across the Continuum

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Readmissions (target pic)

- **Alliance for Home Health Quality and Innovation (AHHQI)** finds that hospital readmissions more than double the cost of providing care to a patient, and those readmissions become more likely when a patient suffers a chronic condition.
- 2009 Public Reporting of Hospital Readmission rates on the CMS Hospital Compare website
- Section 3025 of the Affordable Care Act added section 1886(q) to the Social Security Act establishing the Hospital Readmissions Reduction Program, which requires CMS to reduce payments to IPPS hospitals with excess readmissions, effective for discharges beginning on October 1, 2012.
Care Coordination

Value = Quality

Avoidable Readmissions

Cost
The EUHM Story

EUHM 30-Day Related & Unrelated Readmission Rate

*GHA HEN 1.0
CTC Direct Referrals
CTC Expansion
RROC

CTC Program

Month and Ending Month (for Rolling 12 Month Average Data)

RROC
Readmission Reduction Efforts

- GHA Hospital Engagement Network 1.0
- Community Care Transitions Program – Atlanta Regional Commission
- Care Transition Coordinator Program
- Readmission Reduction Oversight Committee
GHA HEN 1.0

- Readmission Reduction Target 20% All cause readmissions
- Population Focused
- EUHM
  - Renal
  - Sickle Cell
Renal Population

30-day Readmission Rate (UHC)
EUHM Unit 52/62 Readmission Rate

- Correspondence Center (transmitting DC summary)
- GHA HEN
- Teach back
- SNF collaboration
- CCDA
- SIBR

2012: CQ3, CQ4
2013: CQ1, CQ2, CQ3, CQ4
2014: CQ1, CQ2, CQ3, CQ4
2015: CQ1, CQ2

- 30-day Readmission Rate (UHC)
- Target

- 2012: 16.96%
- 2013: 20.35%
- 2014: 20.21%
- 2015: 17.22%

- 2012: 20.90%
- 2013: 20.83%
- 2014: 21.45%
- 2015: 16.57%

- 2012: 15.24%
- 2013: 16.89%
- 2014: 18.13%
- 2015: 17.22%

- 2012: 18.90%
- 2013: 17.16%
- 2014: 16.89%
- 2015: 16.57%
Sickle Cell Population

30-day Readmission Rate (UHC)
Sickle Cell Disease

- Stakeholder Engagement
- Support Group
- PFA Rounding
- New volume
- CTC 71

Q1 2013: 22%
Q2 2013: 26.7%
Q3 2013: 32.8%
Q4 2013: 40.1%
Q1 2014: 20.6%
Q2 2014: 25.0%
Q3 2014: 29.5%
Q4 2014: 30.9%
Q1 2015: 34.5%
New Model:
RN Care Transitions Coordinator (CTC)

- Performs risk stratification to identify patients at high risk for readmission
- Assists in coordinating and providing quality patient care of patients assigned to specific units or populations
- Works closely with the Interdisciplinary Team (IDT) to ensure care is appropriate and timely
- Helps team to manage patients’ length of stay (LOS)
  • Including tracking barriers to discharge
## Additional Challenges/Barriers

### Challenge/Barrier
- CTC role confusion
- House staff education and turnover
- Lengthy patient selection process
- Discharging patients without all care needs

### Solutions
- Unit/clinic based education on CTC Program
- Dyad teams established (CTC and SW)
- Medical Director of Care Coordination and unit / clinic champions assigned
- Education of CTC role in physician orientation
- Social Worker hired for department
- Early identification and procurement of home services
CTC Program Outcomes

• Significant reduction in readmission rate year over year
• Reduction of CMS readmission penalty to approximately $100,000
• Improved care coordination by the IDT (meeting Length of Stay goals)
• Improved employee engagement
• Case in Point Platinum Award for Best Transitions of Care Program
Care Coordination across the continuum

The Community-Based Care Transitions Program (CCTP, ACA Section 3026)

GOALS:
• Improve transitions of beneficiaries from the inpatient hospital setting to home or other care settings
• Improve quality of care
• Reduce readmissions for high risk beneficiaries
• Document measureable savings to the Medicare program

For more information, visit: http://innovations.cms.gov/initiatives/Partnership-for-Patients/CCTP
EUHM CCTP Partnership
Q3 2012 – Q1 2015
2376 enrolled; 155 readmitted *
Readmission rate = 6.5% (below programmatic overall readmission rate)
Partnership Summary
Feb 2012 - Mar 2015
Total enrolled – 9936;  Total readmitted – 890 *
Readmission rate – 9%

- EUHM: 2376 enrolled, 155 readmitted (6.5%)
- GMC: 1769 enrolled, 169 readmitted (9.6%)
- Kennestone: 1673 enrolled, 147 readmitted (8.8%)
- Piedmont: 1578 enrolled, 183 readmitted (11.6%)
- SRMC: 1311 enrolled, 121 readmitted (9.2%)
- Cobb: 1229 enrolled, 115 readmitted (9.4%)

*Readmission rate is calculated as the number of readmissions divided by the total number of enrollees.
## EUHM/CCTP

**Medicare Cost Saving Summary**  
**June, 2012 – February, 2015**

<table>
<thead>
<tr>
<th>Total Enrolled</th>
<th>2376</th>
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<tbody>
<tr>
<td>Total Readmissions</td>
<td>155**</td>
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<tr>
<td>Readmission Rate</td>
<td>6.5%</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Medicare Cost Savings *</th>
<th>$2,985,600 &gt; 974,946</th>
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### Calculating Reduced Medicare Spending

\[
\text{Reduced Medicare Spending} = \sum \text{Avoided Medicare Payments} > \sum \text{CCTP Payments}
\]

Sum of Avoided Readmissions = \(0.196 \times 2376\) = 466 - 155 = 311  
Avoided Medicare Payments = 311 \times $9600 = $2,984,960  
Sum of CCTP Payments = $974,946

### Avoided Medicare Payments

\[
\text{Avoided Medicare Payments} = \text{Avoided Readmissions} \times \text{Average Medicare Hospital Payments for CCTP eligible ($9600)}
\]

*Where*

\[
\text{Avoided Readmission} = (\text{Baseline readmission rate for CCTP} \times \# \text{ of CCTP enrollees}) - \# \text{ of readmissions for CCTP enrollees}
\]
RROC

- Readmissions Reduction Oversight Committee
- Unit/Service Line Teams presenting
- Improving Observation Admissions
- Increasing Home Health Utilization
- Communication & Coordination of Early Discharge Planning
Next Steps

• Application of CCTP model beyond Medicare Patients
• Palliative Care Referrals
• Care More Model for Medicare Beneficiaries