

# **REDUCING READMISSIONS**

## **How Oregon Can Become a National Leader in Reducing Costs and Improving Quality**

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Network for Regional Healthcare Improvement  
and  
Executive Director  
Center for Healthcare Quality and Payment Reform

# Why All the Interest in Hospital Readmissions?

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- We started measuring them
  - You don't manage what you don't measure
  - You don't care about problems you don't know about
- It's a way to reduce costs without rationing
- High rates of readmissions mean there are significant savings opportunities if they can be reduced
- Readmissions affect most types of patients, so all payers are interested
- Some projects have shown significant reductions in readmissions can be achieved at low cost
- Savings can be achieved quickly

# A Good Formula for Healthcare Reform

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# However...

- Not all readmissions are preventable and we don't have good measures for which are and aren't
- A wide range of factors cause readmissions, so no single intervention can address them all
- Since multiple providers are involved, it's not clear who should be held accountable
- Current healthcare payment systems don't support or reward providers' efforts to reduce readmissions

# What is Currently Being Done to Reduce Readmissions?

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- Primary focus is on improving care transitions
  - Evidence that there are weaknesses in hospital discharge
  - Evidence that there is lack of coordination during transition
  - Evidence that patients aren't ready for discharge instructions while they're in the hospital
  - Easy to identify the patients
  - Several projects have reduced readmissions through relatively simple interventions focused on improving transitions from hospital to community

# Examples of Projects With Published Evidence of Success

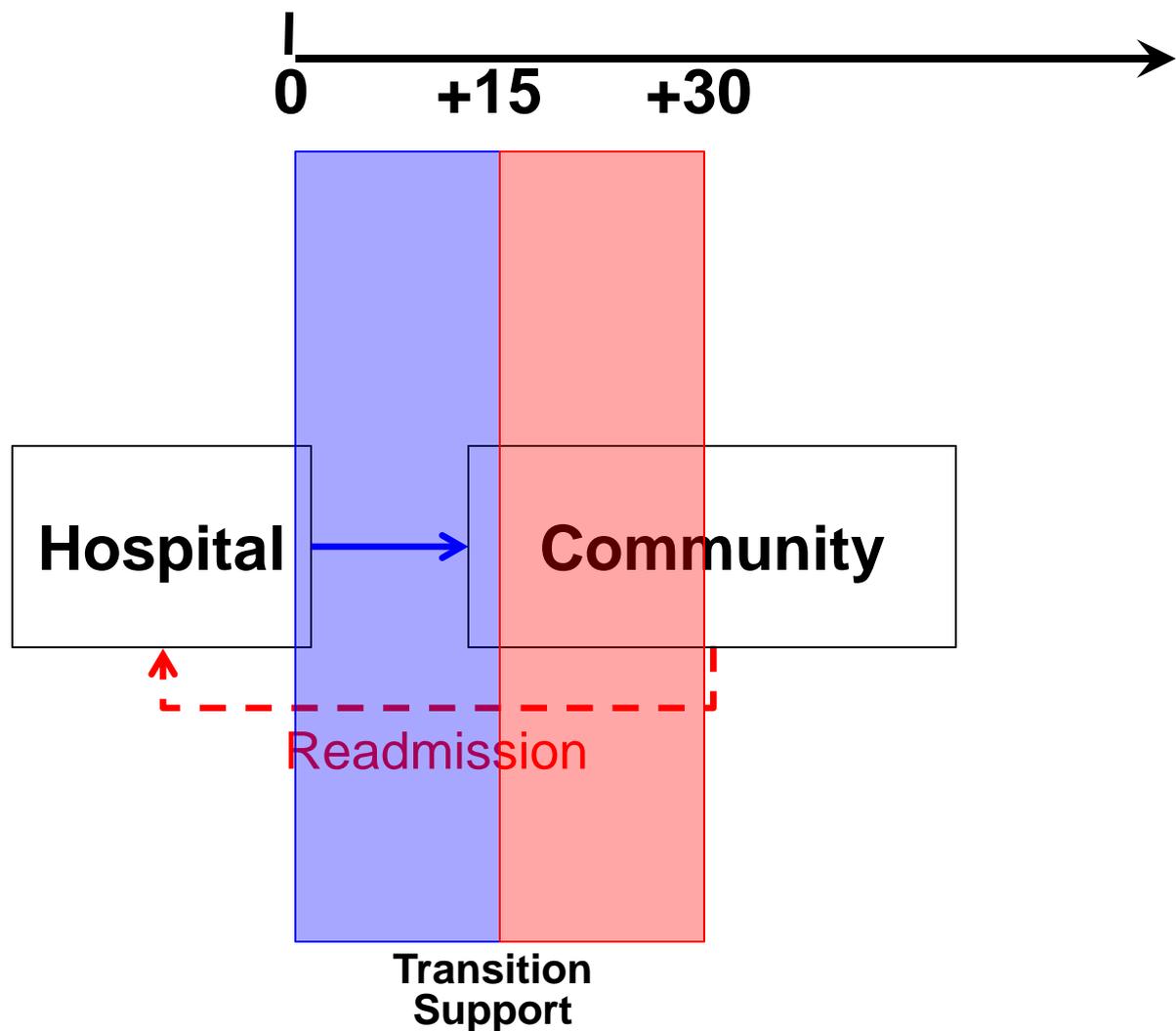
<b>PROJECT</b>	<b>WHEN</b>	<b>WHAT</b>	<b>HOW</b>	<b>WHO</b>	<b>WHICH</b>
Transitional Care (Naylor)	During stay + Post-Discharge (up to 12mo.)	Patient Education & Self-Mgt Support	Hospital visits + Home visits + Phone calls	Advanced Practice Nurse	65+ 65+ with CHF
Care Transitions (Coleman)	Pre-Discharge + 1 Mo. Post-Discharge	Self-Mgt Support	Hospital visit + Home visit + 3 phone calls	Nurses or Lay Coaches	All
Project RED (Jack)	Discharge + Immediate Post-Discharge	Patient Education + Medication Assistance	Hospital visit + Phone call	Nurse (or simulation) + Pharmacist	All

# Extensive Efforts at Replication Nationally

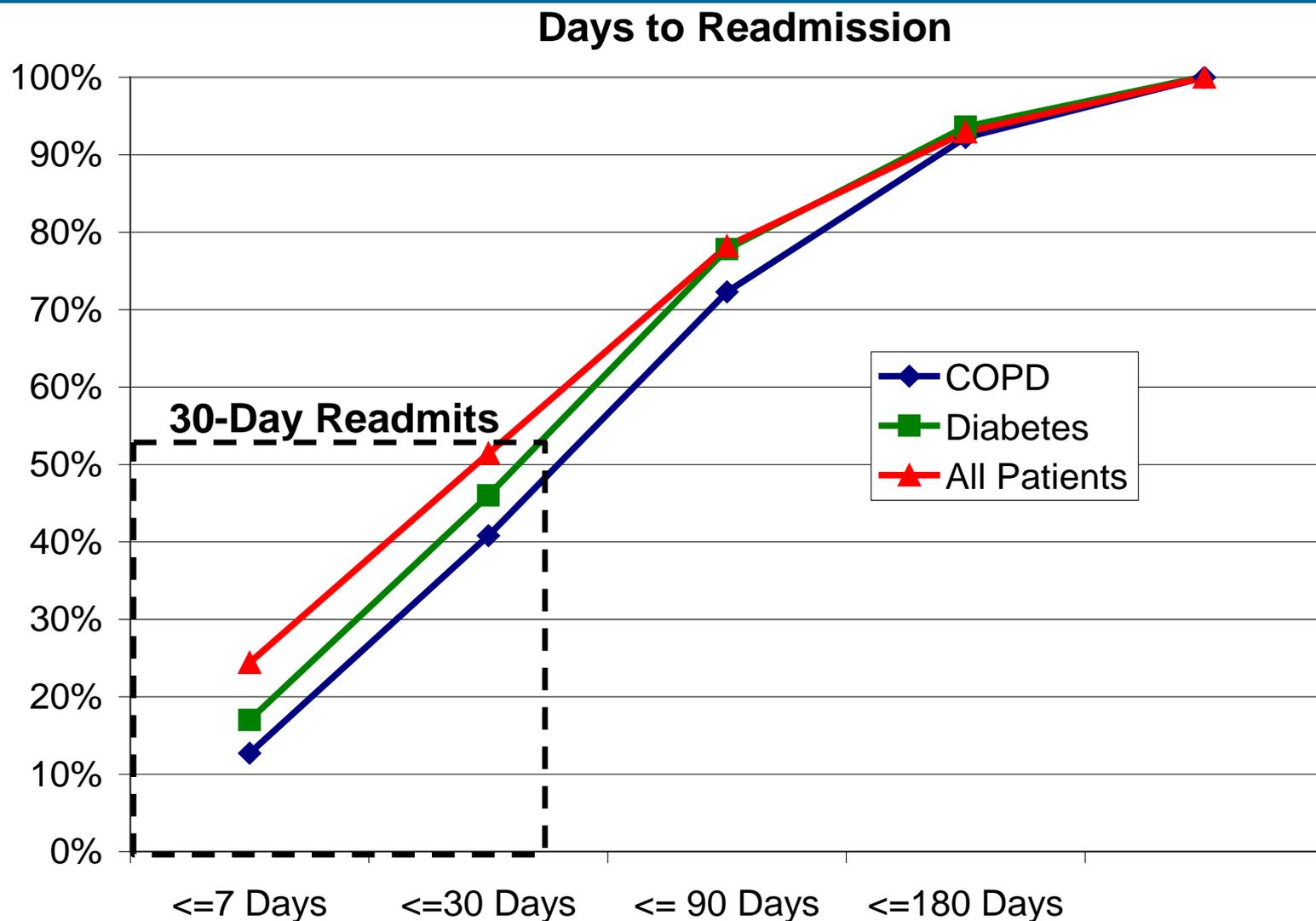
- Project BOOST (Better Outcomes for Older Adults through Safe Transitions)
  - Toolkit, training, and mentoring for improved discharge planning
  - [http://www.hospitalmedicine.org/ResourceRoomRedesign/RR\\_CareTransitions/html\\_CC/project\\_boost\\_background.cfm](http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/html_CC/project_boost_background.cfm)
- QIO Care Transitions Initiative for Medicare Beneficiaries
  - CMS project to improve transitions in 14 communities led by QIOs
- CMS Community-Based Care Transitions Program for High-Risk Medicare Beneficiaries
  - \$500 million, 5 year program
  - Partnerships of hospitals with high readmission rates and community based organizations delivering care transition services

*Most efforts are primarily focused on seniors/Medicare beneficiaries, even though high rates of readmissions occur at all ages*

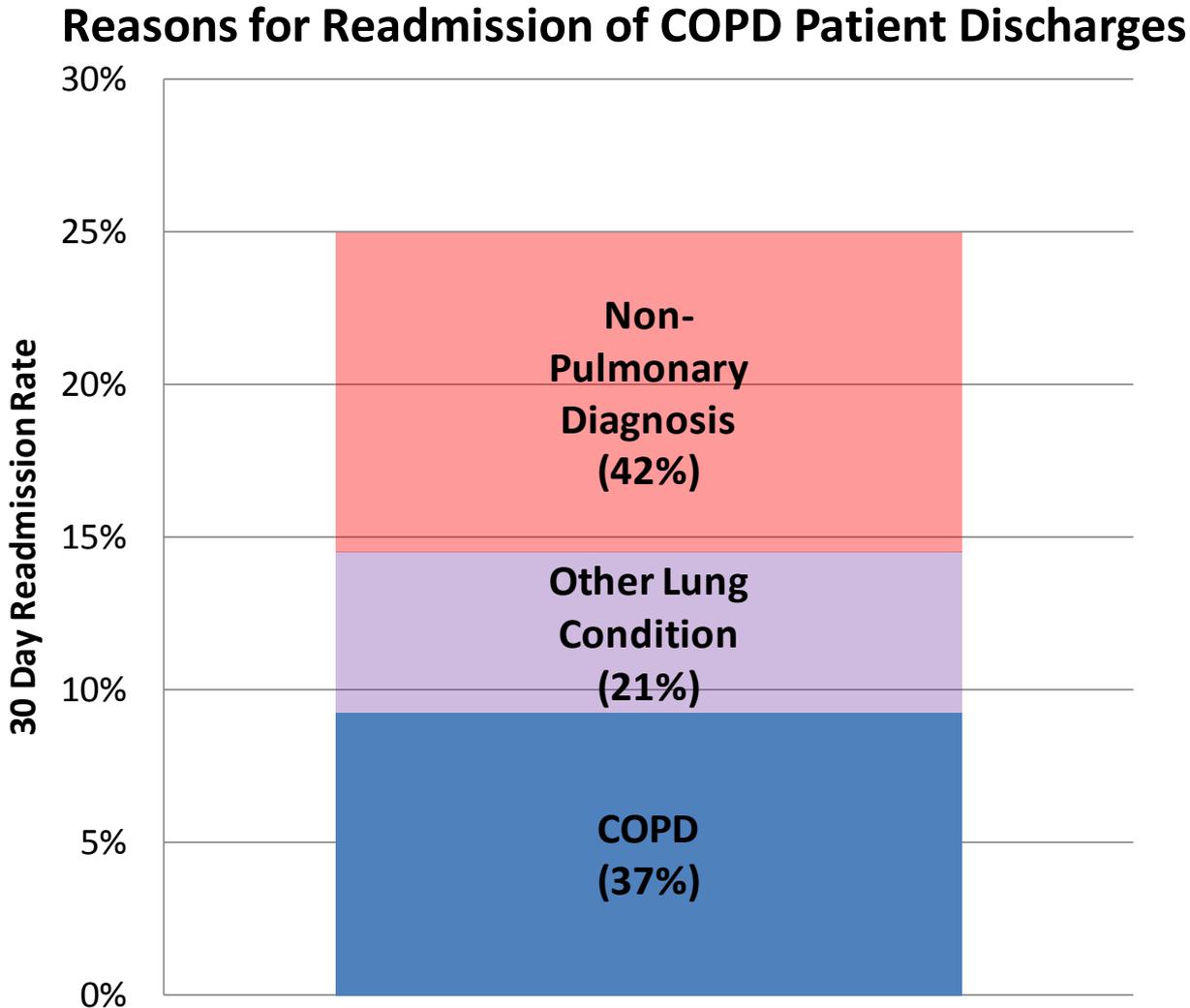
# Improving Transitions Seems Like It's Addressing The Problem...



# Except That Many Readmissions Occur Well After 30 Days...



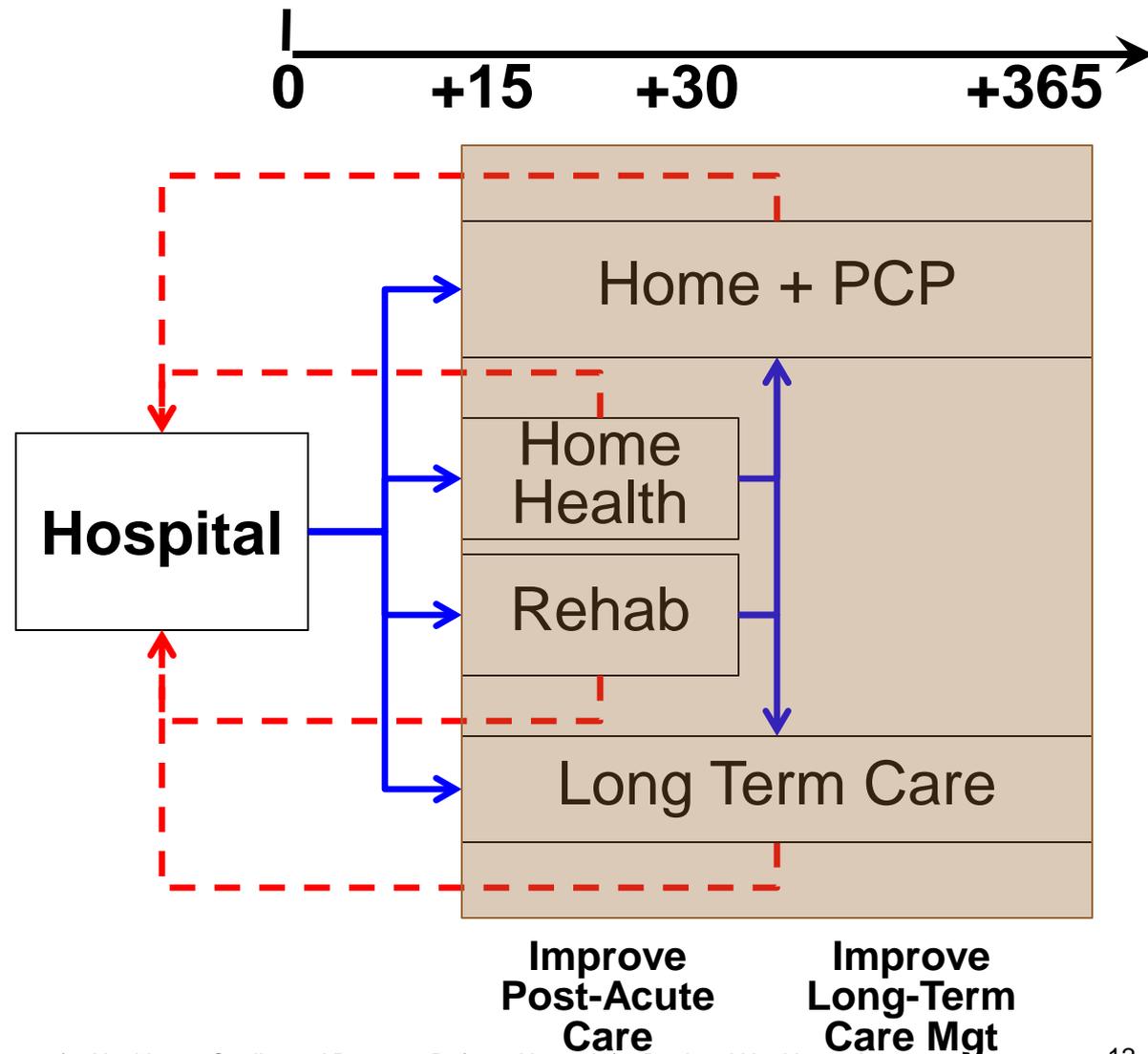
# ...Many Readmissions Are for Different Issues...



# nrhi ...And Many Readmissions Aren't Caused by Problems in Transitions

- 88 Year Old Woman Admitted to Hospital for UTI/Sepsis (7/2)
  - IV antibiotics and fluids administered, rapid improvement
  - Kept in hospital 4 days, deconditioned, admitted to rehab facility (7/6)
  - Discharged and returned to assisted living facility (7/17)
- Rehospitalized in 14 days with another UTI (7/20)
  - Administered antibiotics and fluids, good improvement
  - Kept in hospital for 3 days, returned to rehab facility (7/23)
  - Developed UTI in rehab facility; nurse practitioner said policy was not to treat “asymptomatic UTIs”
  - Developed sepsis and taken to ER (8/11)
- Rehospitalized in 19 days with UTI/Sepsis (8/11)
  - Administered IV antibiotics; slow improvement
  - Family demanded that hospital develop plan for preventing UTIs
  - Physician prescribed ongoing prophylactic antibiotic regime
  - Kept in hospital for 6 days; discharged to new rehab facility (8/17)
  - No longer able to walk independently; returned home in wheelchair (9/9)
- No Further Readmissions for 14 months

# nrhi Post-Discharge Care Also Needed

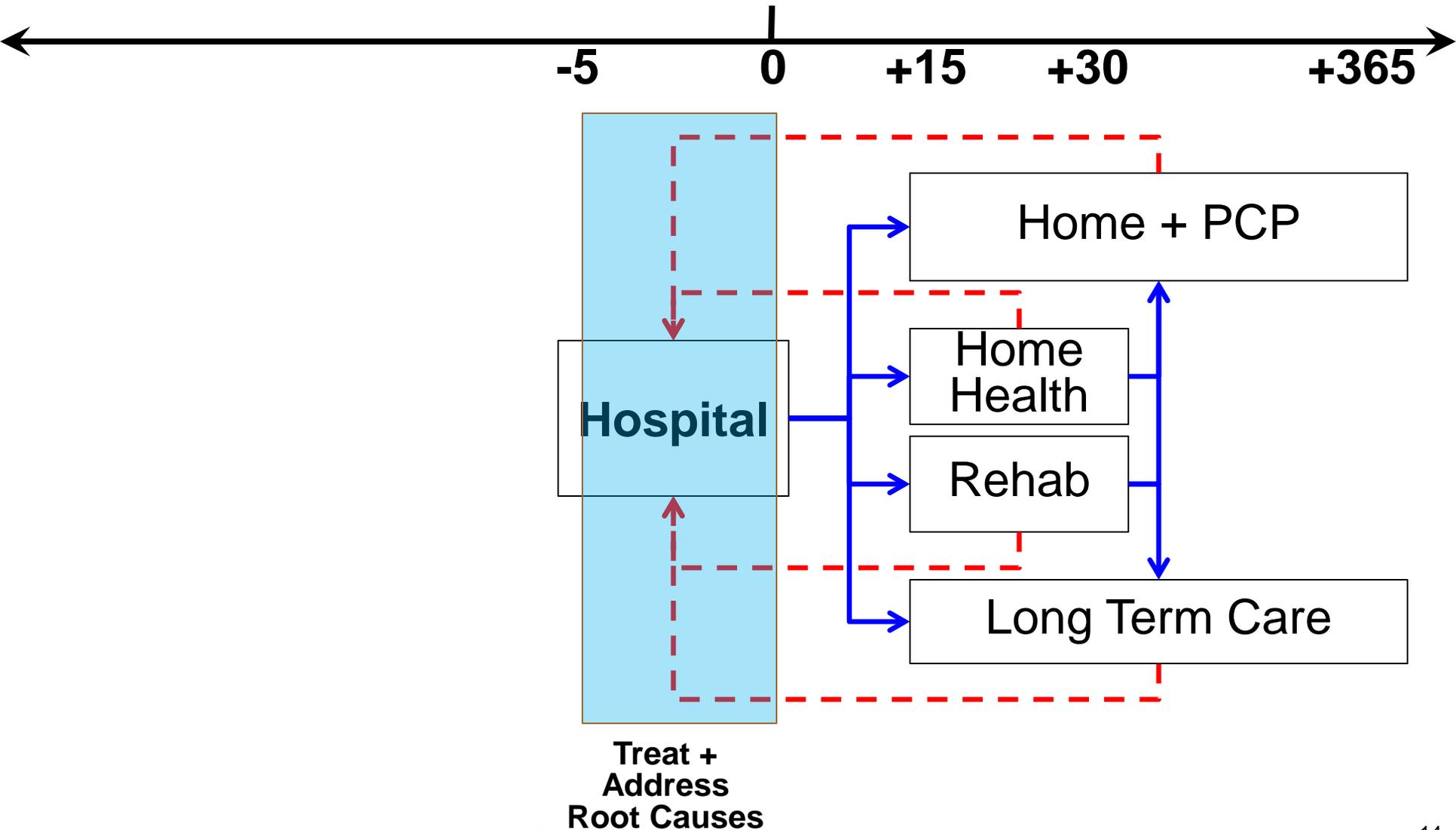


# Some Initiatives Focusing on Changing Post-Acute Care

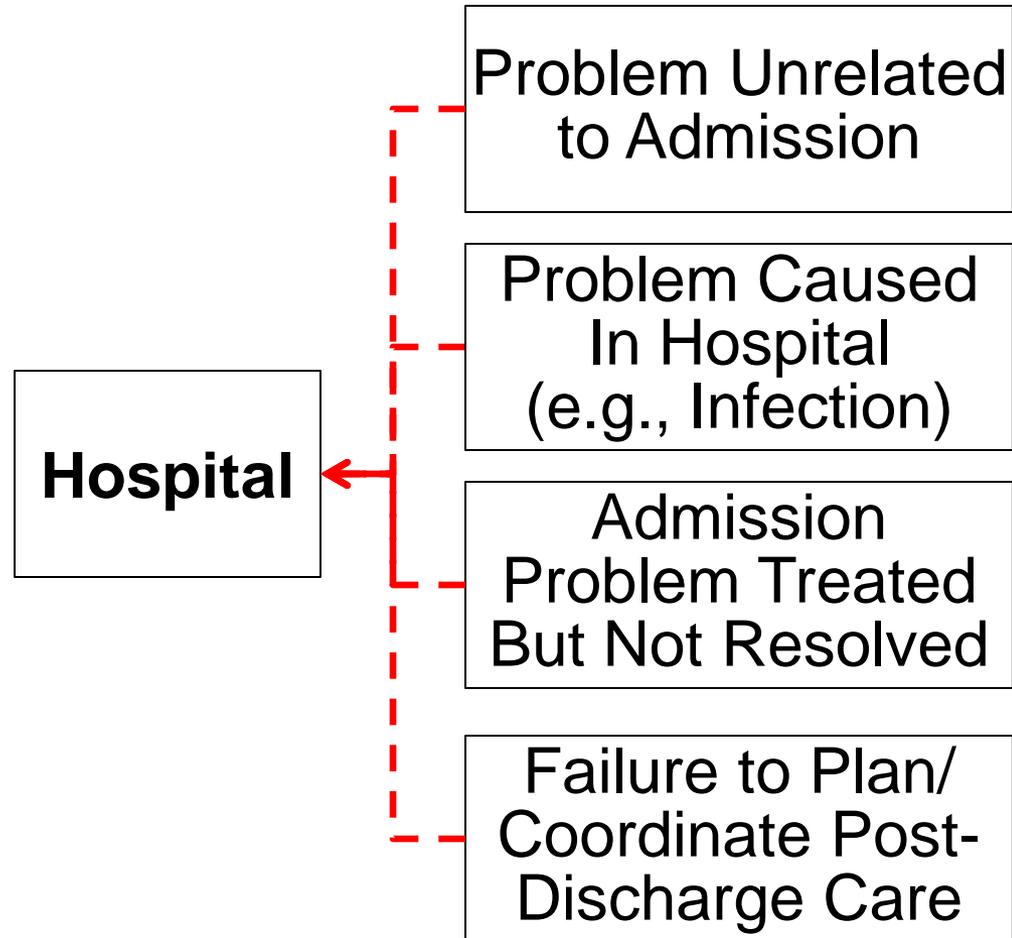
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- INTERACT (Interventions to Reduce Acute Care Transfers)
  - Developed by Georgia Medical Care Foundation (QIO)
  - Provides tools for nursing homes/long term care facilities to use to monitor and redesign care to reduce readmissions
  - <http://interact2.net/>

# Hospitals Need to Address Root Causes of Readmits If Possible

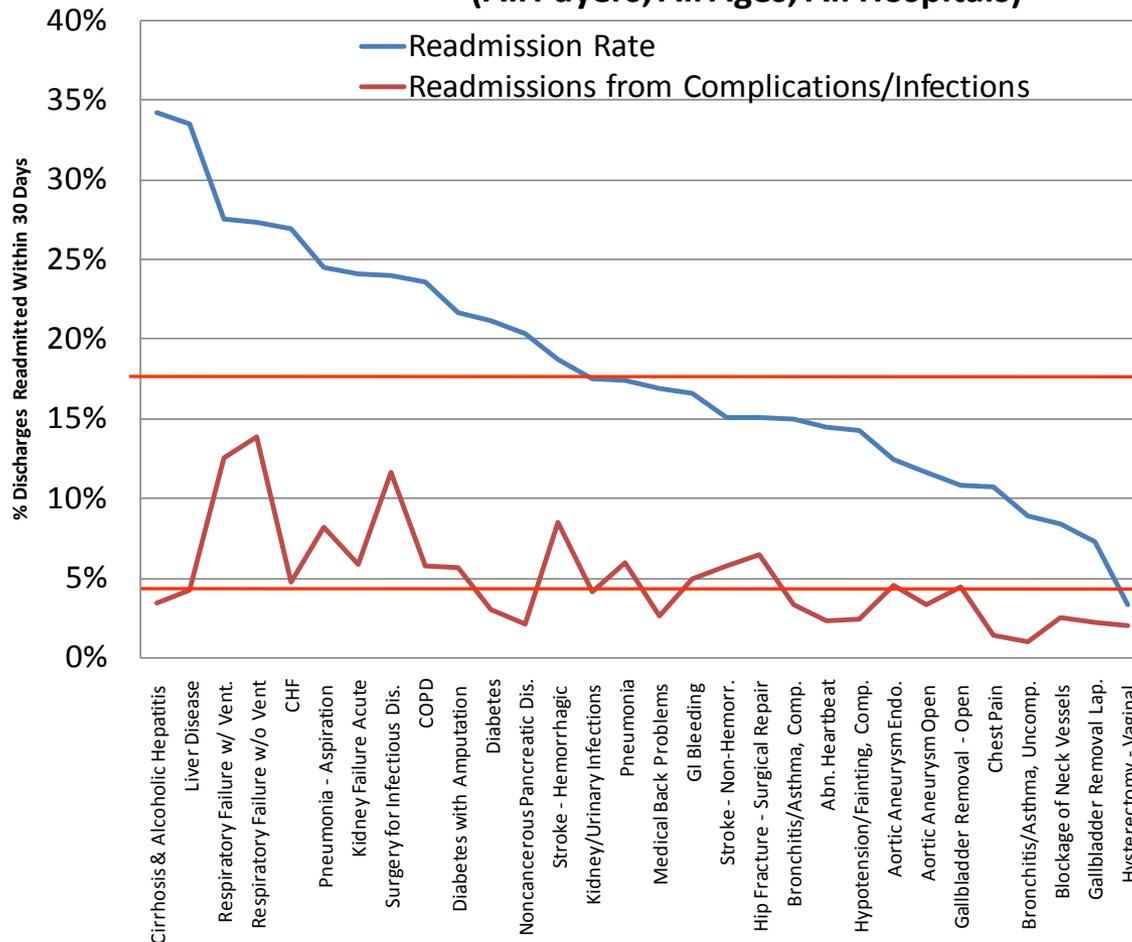


# Different Causes for Readmission



# Most Readmissions Are Not A Hospital-Caused “Problem”

Readmissions in Western Pennsylvania, 2007  
(All Payers, All Ages, All Hospitals)



Average  
Readmission Rate: 18%

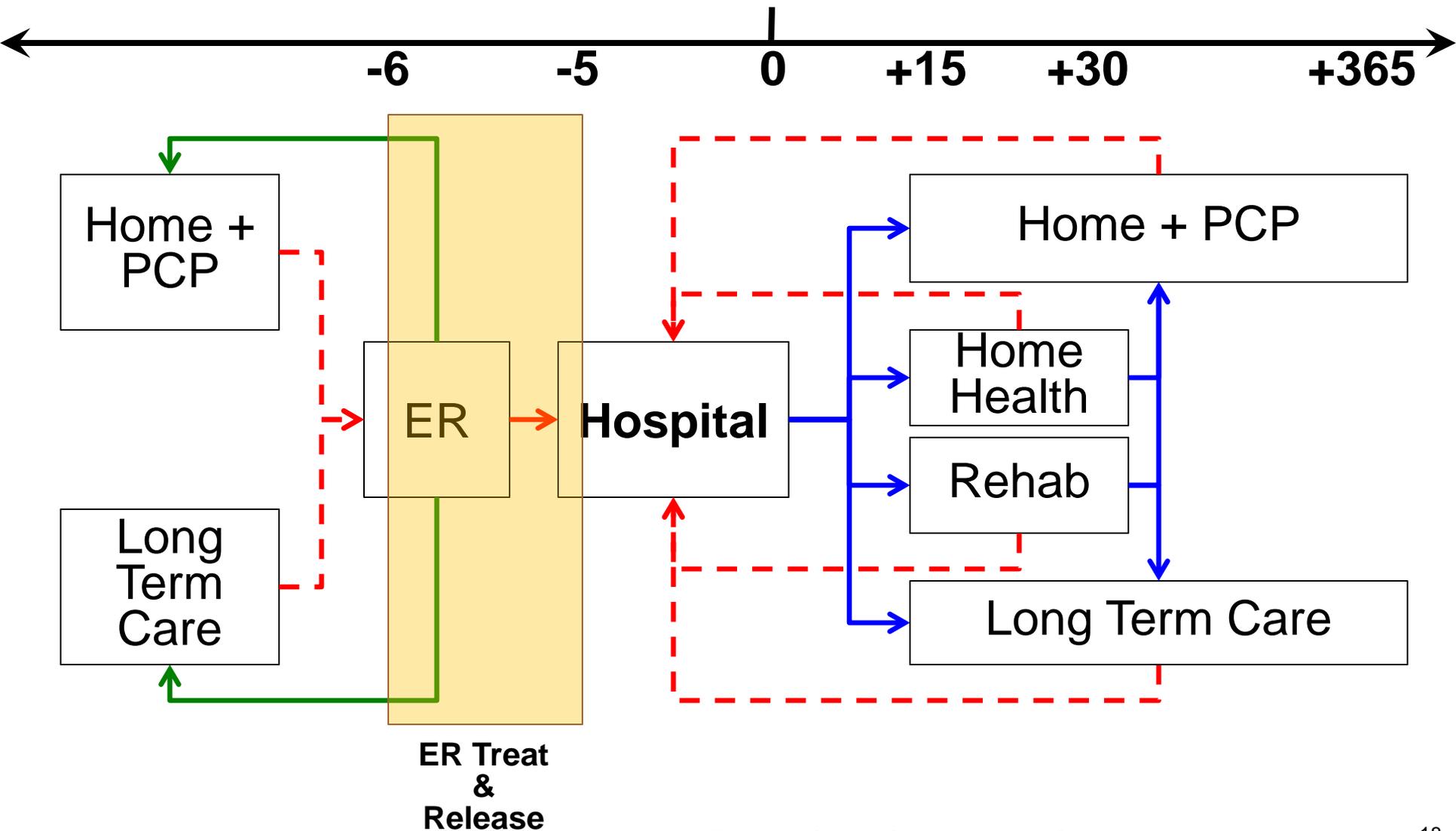
24% of Readmissions  
Due to Complications  
or Infections

# But The Hospital Could Also Address Other Root Causes

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- Earlier transition to post-discharge medications
- Better patient education about post-discharge medications
- Testing alternative medications to address problematic side effects or affordability
- Better education, physical therapy, occupational therapy, etc. to support better self-care and condition management after discharge

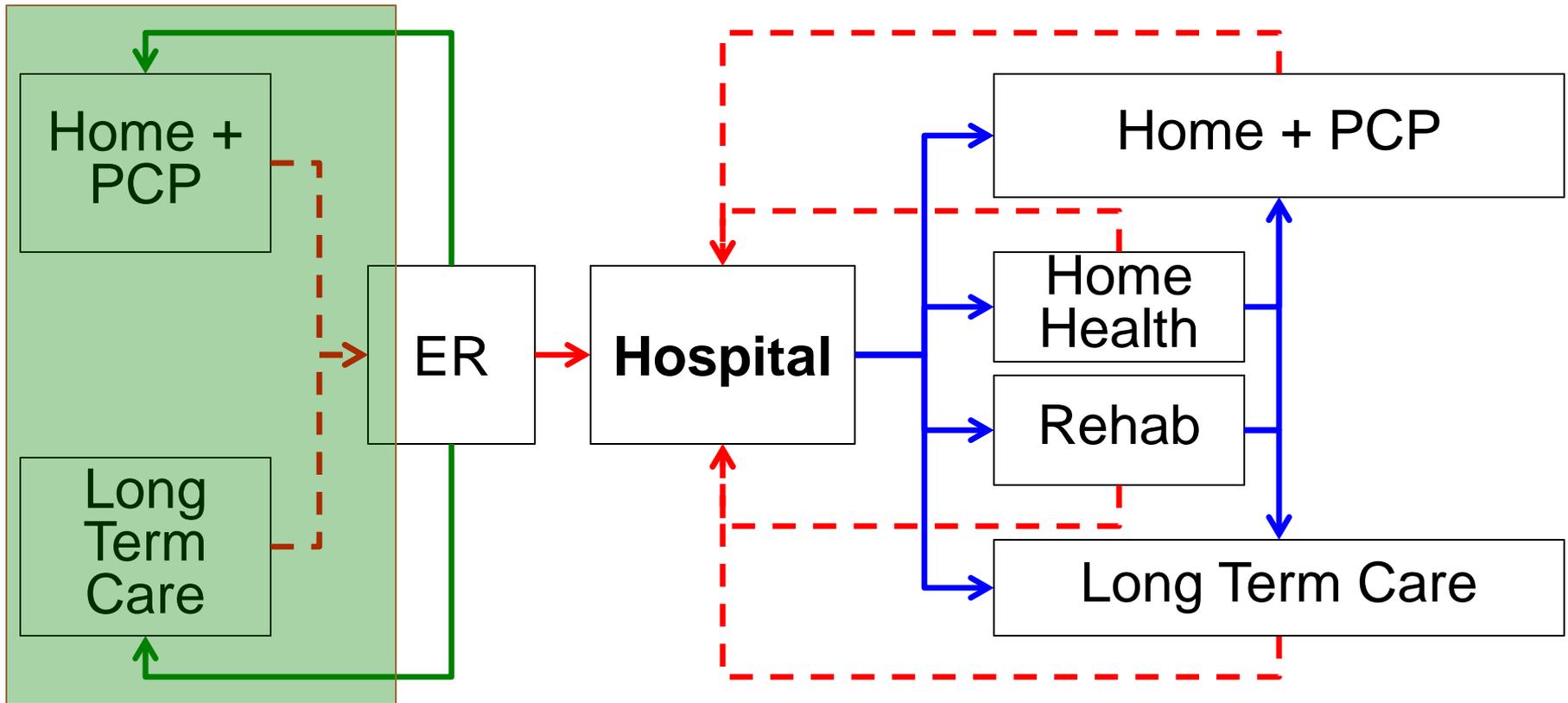
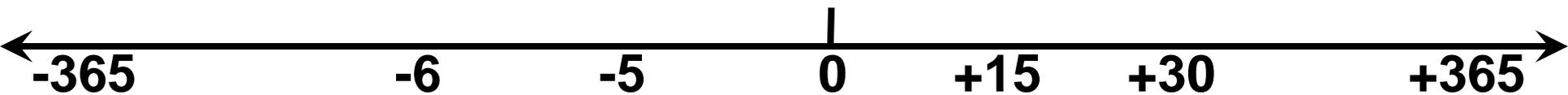
# Improving Ability of ERs to Treat and Release, Not Admit



# “Asthma Lounge”

- Highland Hospital in Alameda California created an "asthma lounge" within its emergency department.
- Nurses in the ER immediately move patients experiencing asthma exacerbations to the asthma lounge, which is staffed 24 hours a day by nurses and respiratory therapists who follow treatment protocols to expedite care, stabilize patients, and provide education on their condition.
- Nurses phone patients within 48 hours of ER discharge to check on them and reinforce the educational information.
- Since the lounge opened, waiting times and the frequency of return visits decreased significantly among asthma patients, while patient satisfaction levels have increased.

# Don't Wait for Hospitalization: nrhi PCMH To Prevent Initial Admission



**Prevention +  
Proactive  
Intervention**

# Significant Reduction in Rate of Hospitalizations Possible

## Examples:

- 40% reduction in hospital admissions, 41% reduction in ER visits for exacerbations of COPD using in-home & phone patient education by nurses or respiratory therapists

J. Bourbeau, M. Julien, et al, "Reduction of Hospital Utilization in Patients with Chronic Obstructive Pulmonary Disease: A Disease-Specific Self-Management Intervention," *Archives of Internal Medicine* 163(5), 2003

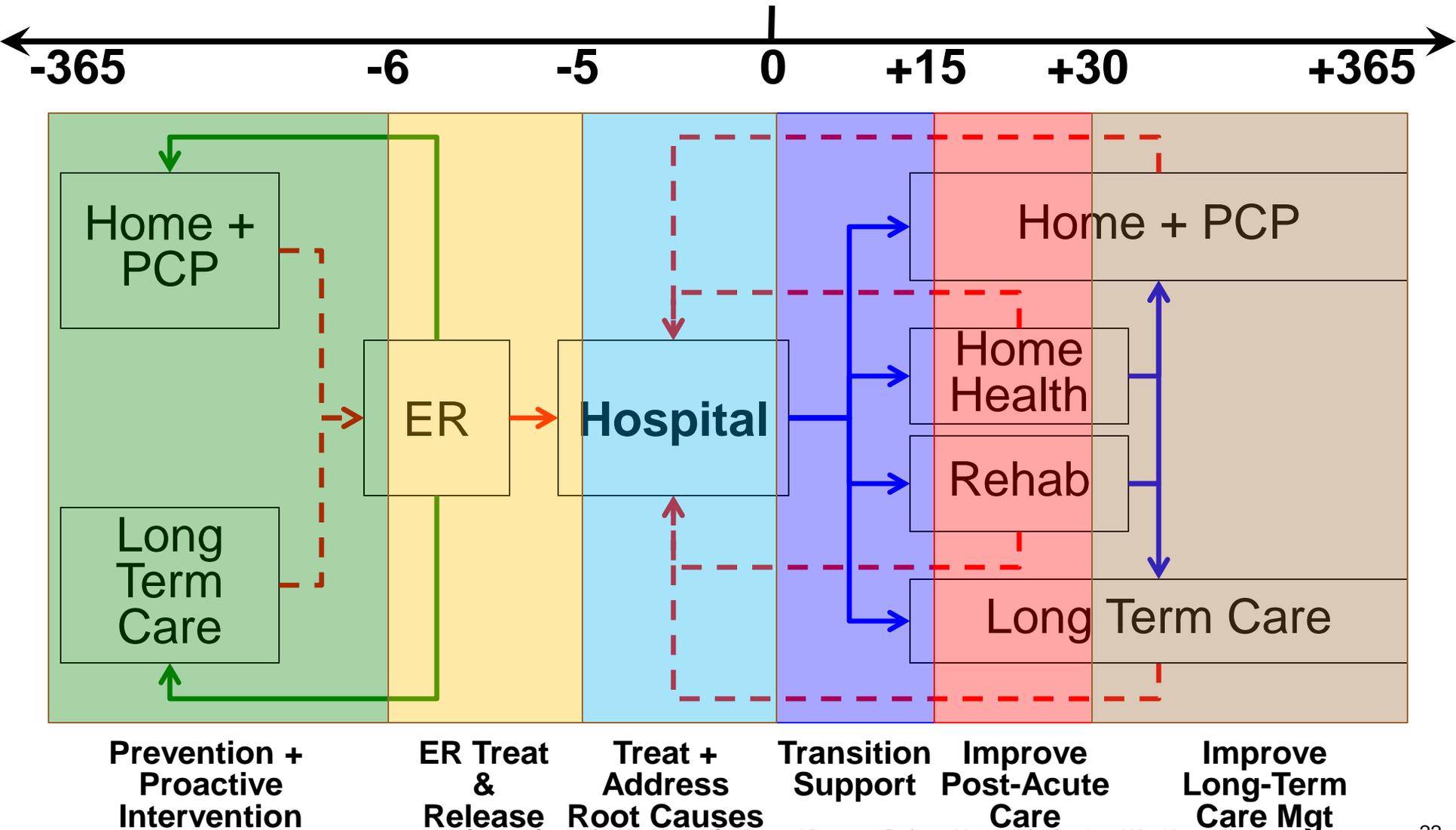
- 66% reduction in hospitalizations for CHF patients using home-based telemonitoring

M.E. Cordisco, A. Benjaminovitz, et al, "Use of Telemonitoring to Decrease the Rate of Hospitalization in Patients With Severe Congestive Heart Failure," *American Journal of Cardiology* 84(7), 1999

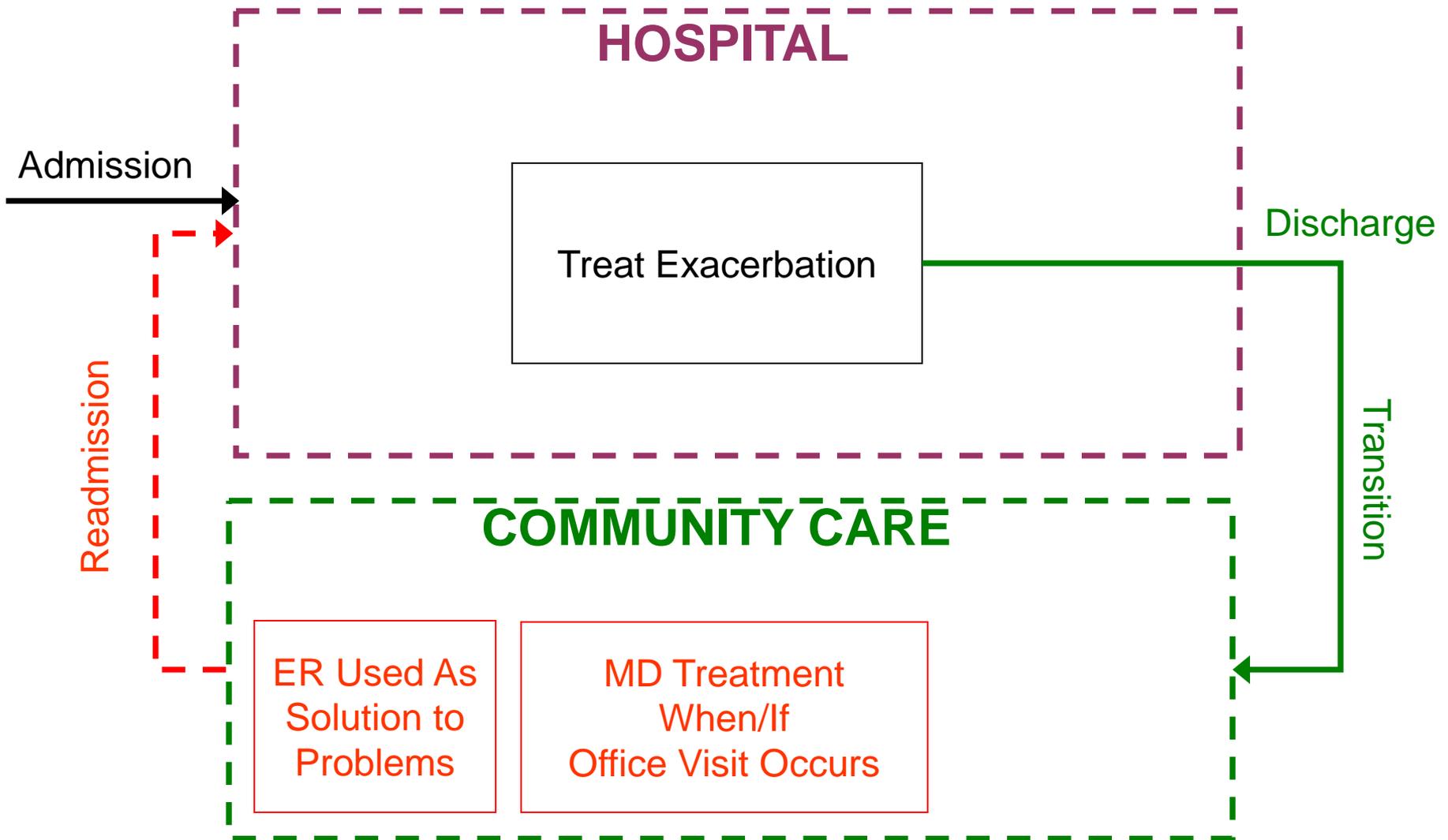
- 27% reduction in hospital admissions, 21% reduction in ER visits for COPD through self-management education

M.A. Gadoury, K. Schwartzman, et al, "Self-Management Reduces Both Short- and Long-Term Hospitalisation in COPD," *European Respiratory Journal* 26(5), 2005

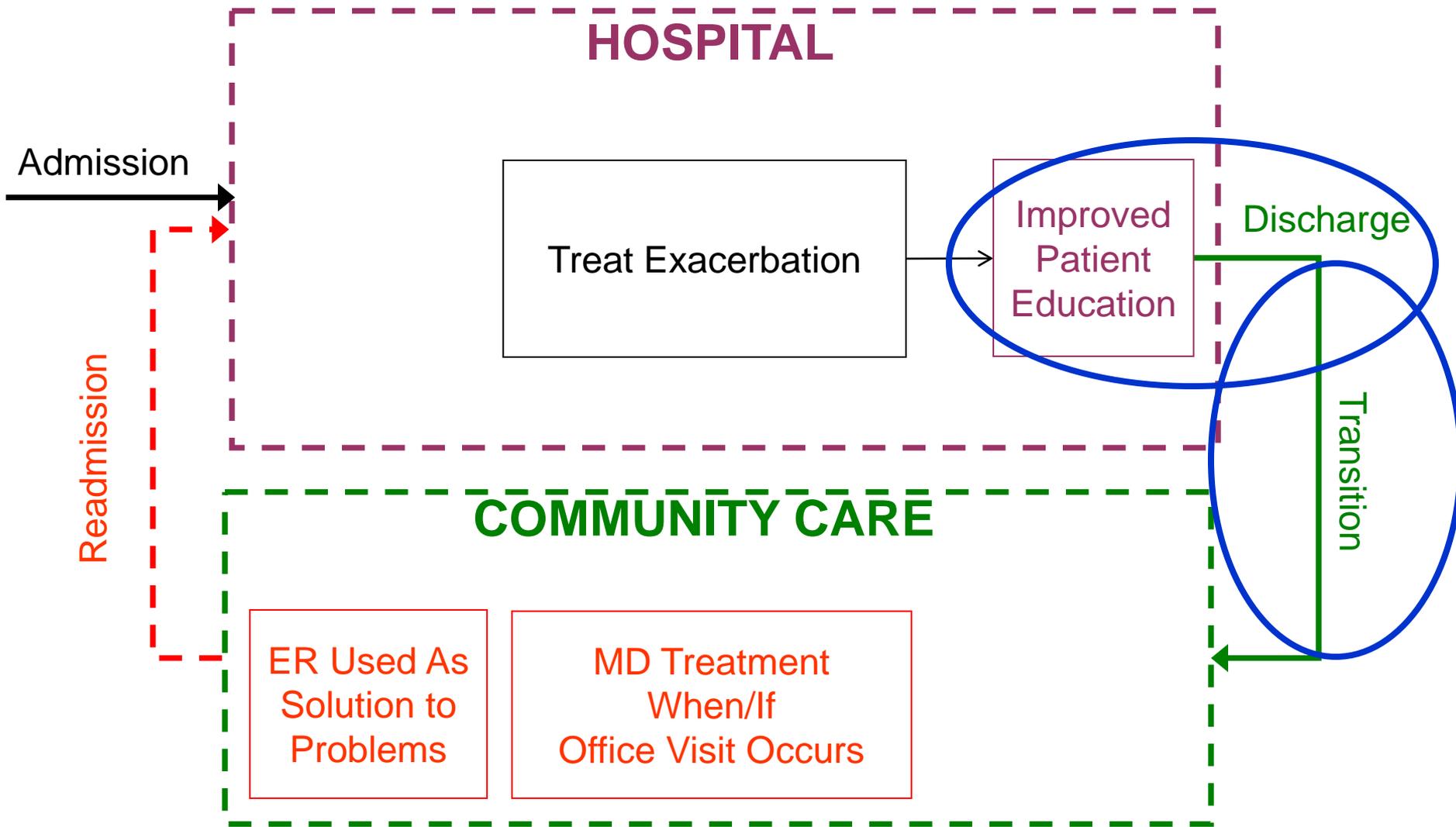
# A Truly Comprehensive Solution



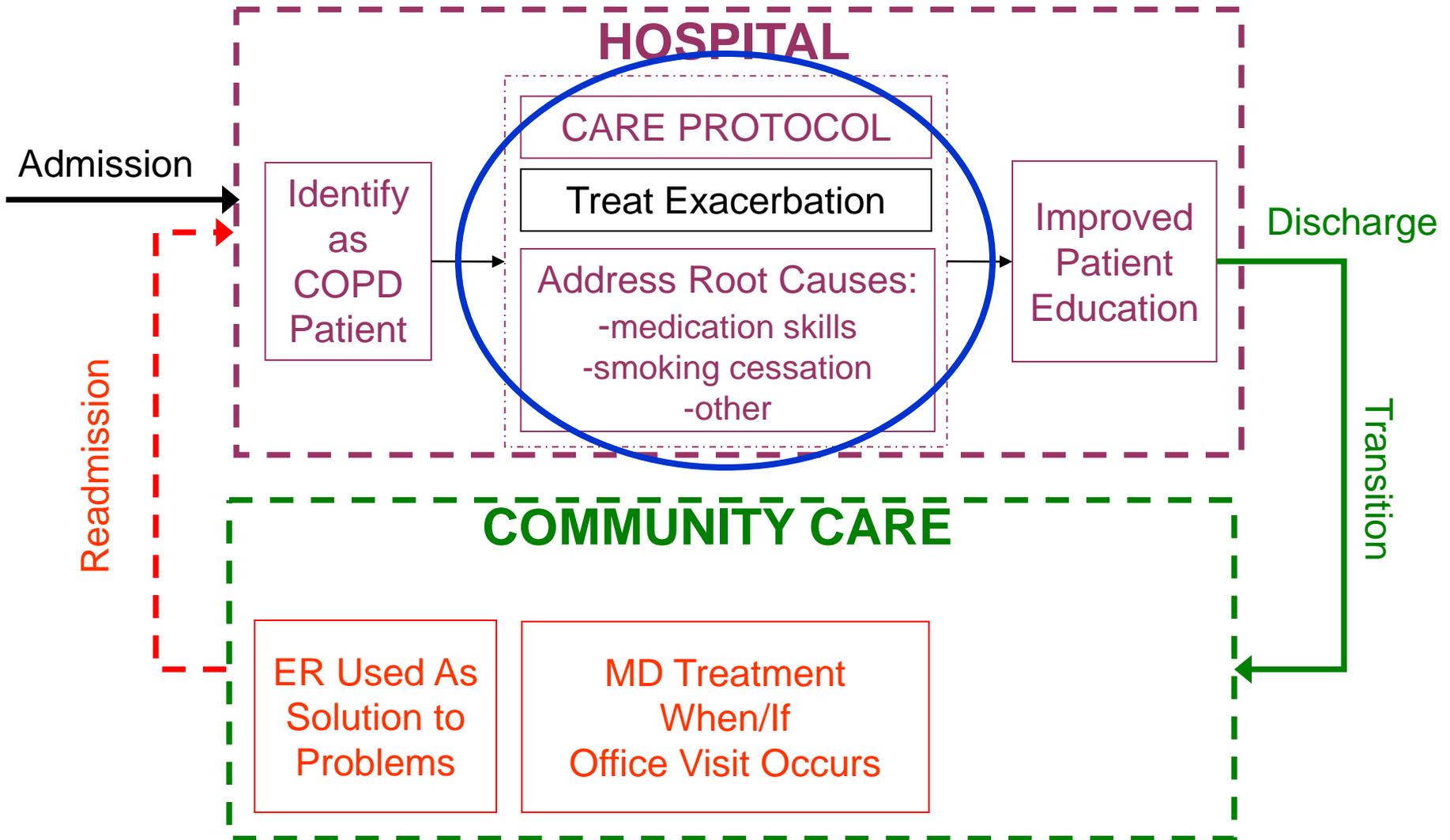
# nrhi Pittsburgh Regional Health Initiative



# nrhi Better Discharge/Transition PLUS..

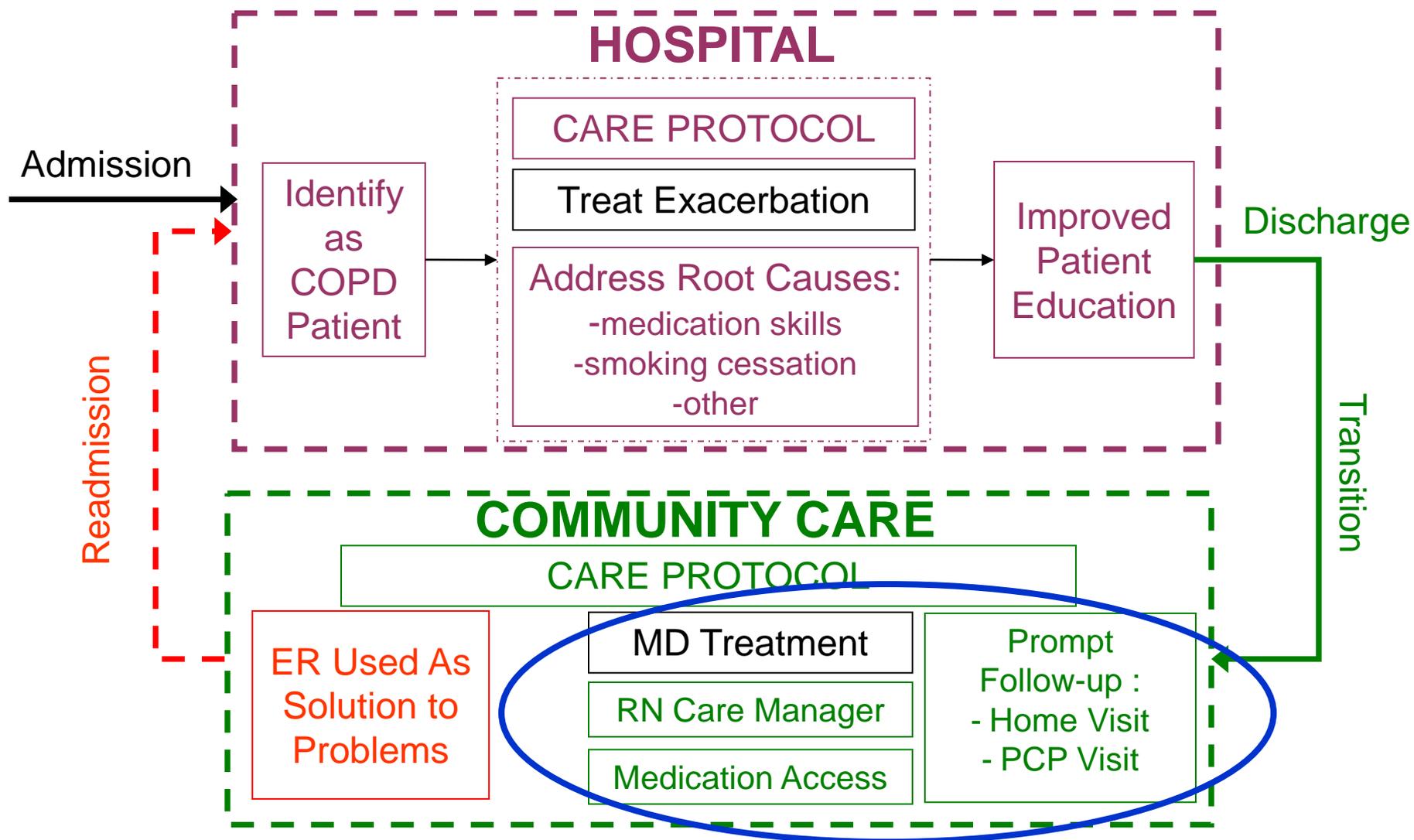


# What We Tried to Fix: Improved Care in Hospital



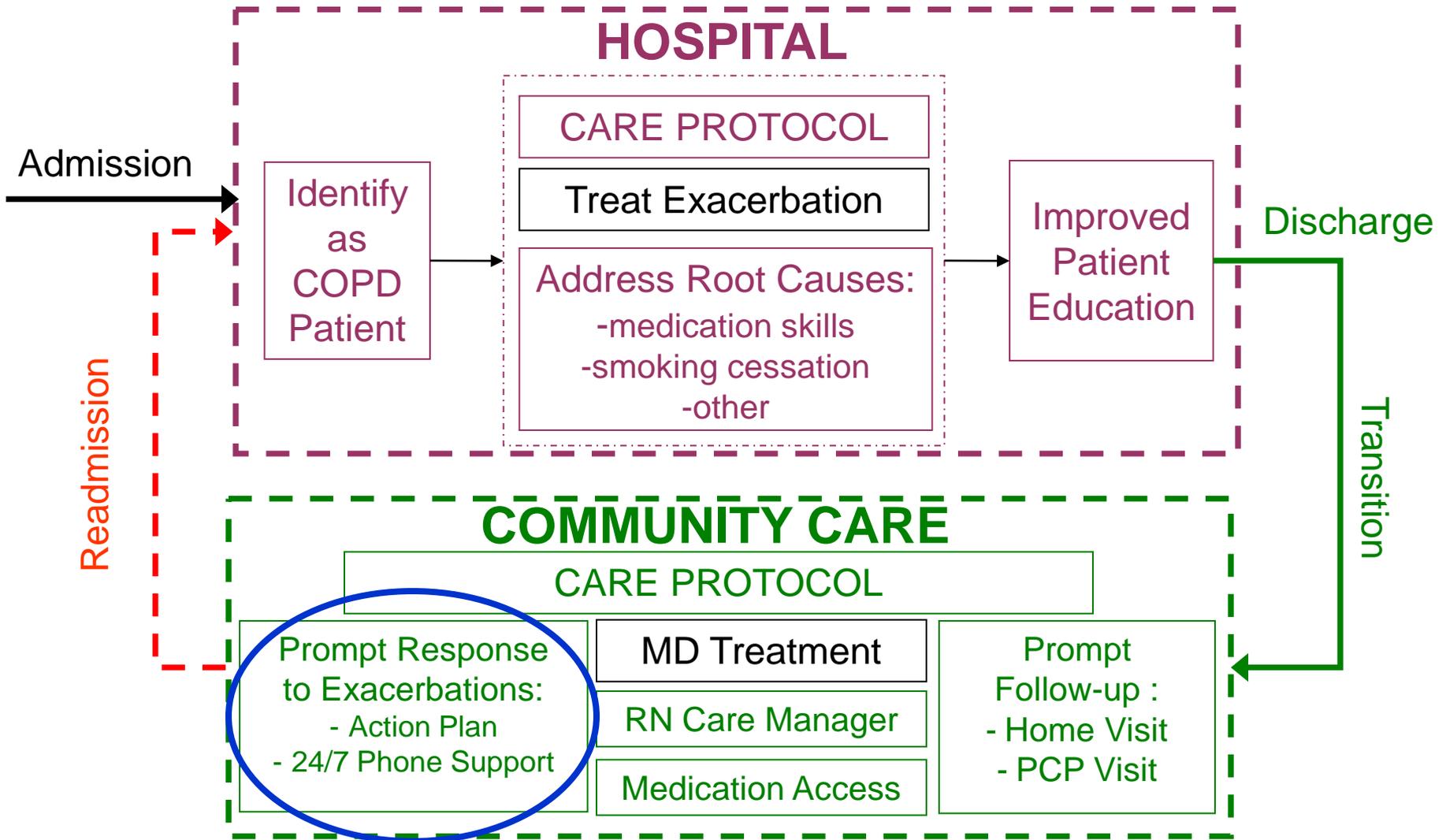
# What We Tried to Fix:

## Expanded PCP/Care Mgr Support

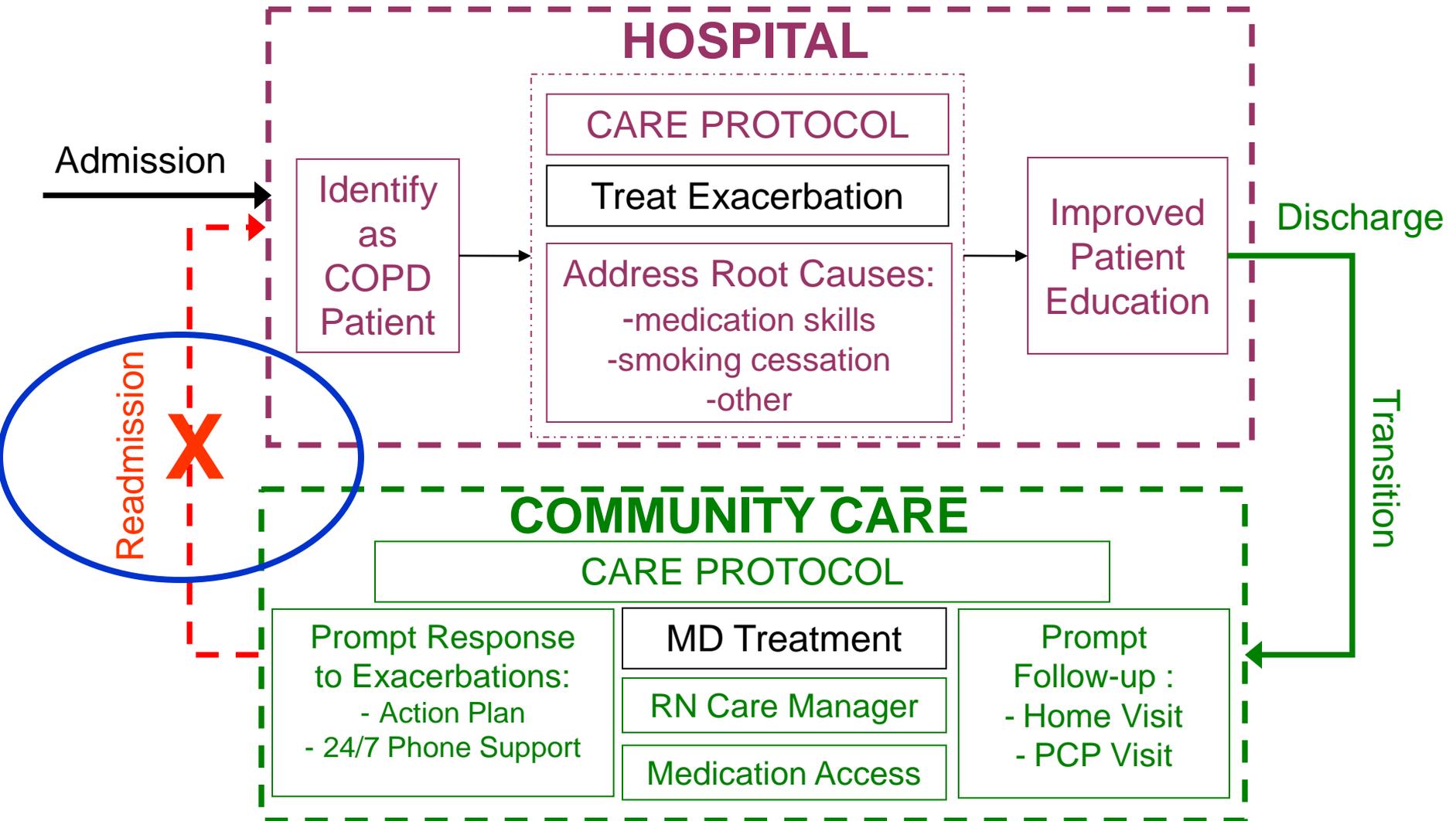


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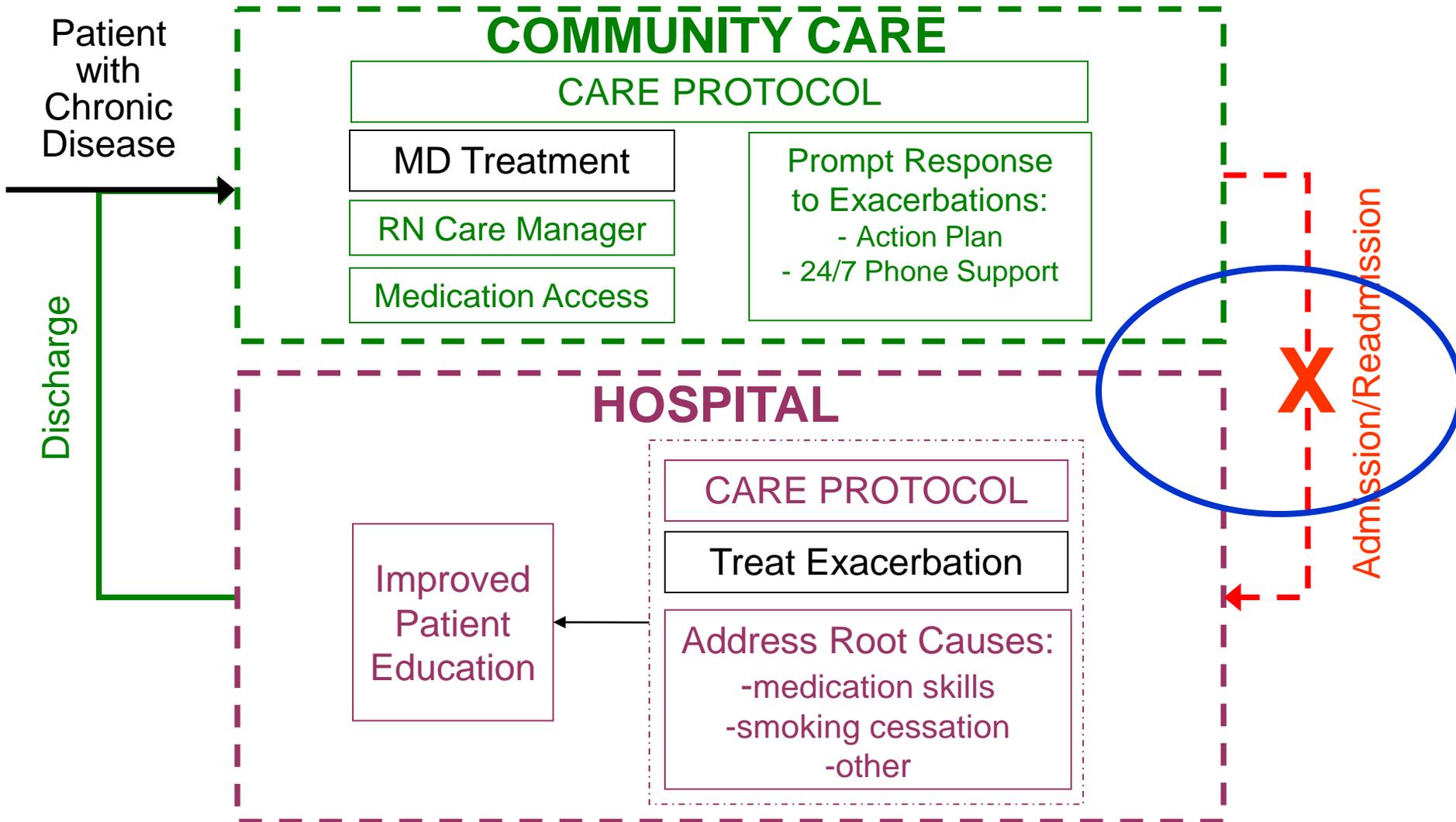
## nrhi Non-Hospital Solution to Problems



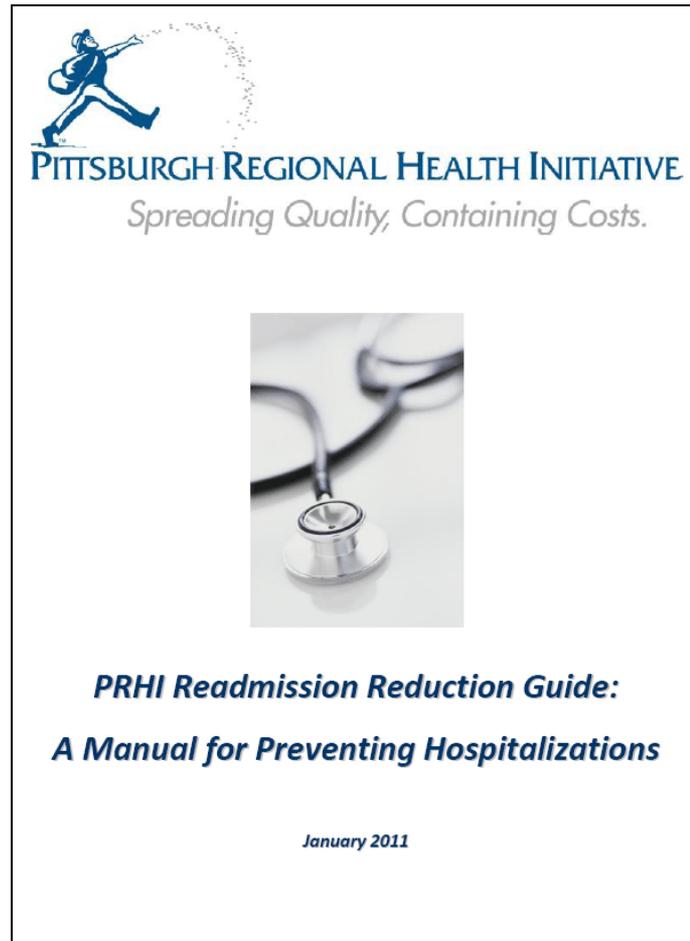
# Goal: To Prevent Readmissions, But Also...



# ... Ultimately to Prevent *Initial* Admissions



# More on the Pittsburgh Readmission Reduction Project



[www.PaymentReform.org](http://www.PaymentReform.org)

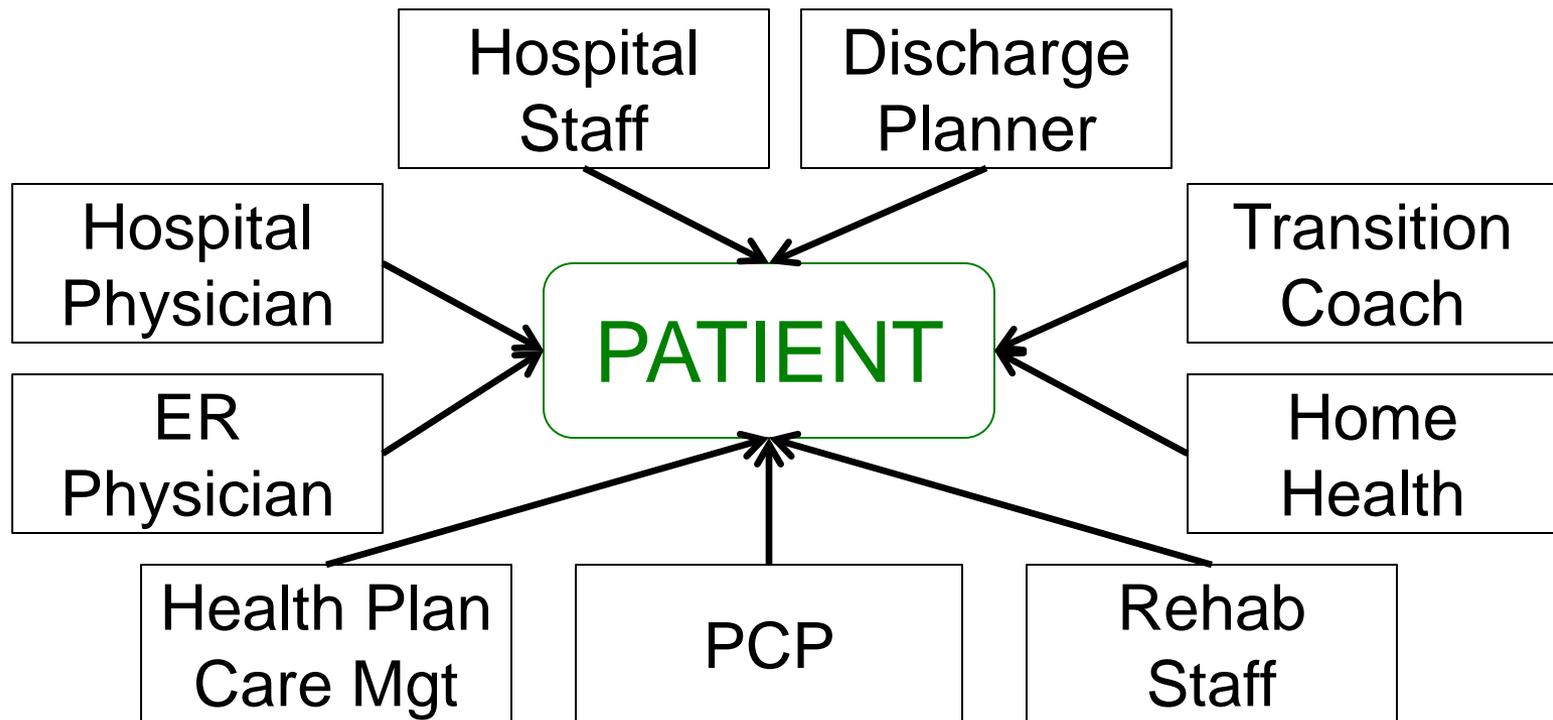
[www.PRHI.org](http://www.PRHI.org)

# Common Elements of Most Readmission Reduction Initiatives

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- **Provider Coordination**
  - e.g., medication reconciliation, fax or EHR connection
- **Patient Education**
  - e.g., why/how to take medications, proper wound care
- **Self-Management Support**
  - e.g., coaching, smoking cessation, R<sub>x</sub> financial assistance
- **Reactive Intervention**
  - e.g., support hotline, same-day appointment scheduling, on-site non-hospital care (e.g., in home or nursing home)
- **Proactive Intervention**
  - e.g., home visits, phone calls, remote monitoring

# Will This Be Patient-Centered, Coordinated Care?



# How Do We Coordinate Multiple Efforts?

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- Option 1: Everybody Works for the Same Corporation

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  - Yeah, right, like that ensures coordination...

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- Option 1: Everybody Works for the Same Corporation
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  - Data analysis to identify where problems exist
  - Mechanisms to coordinate multiple programs
  - Information exchange about individual patients
  - Real-time feedback on performance

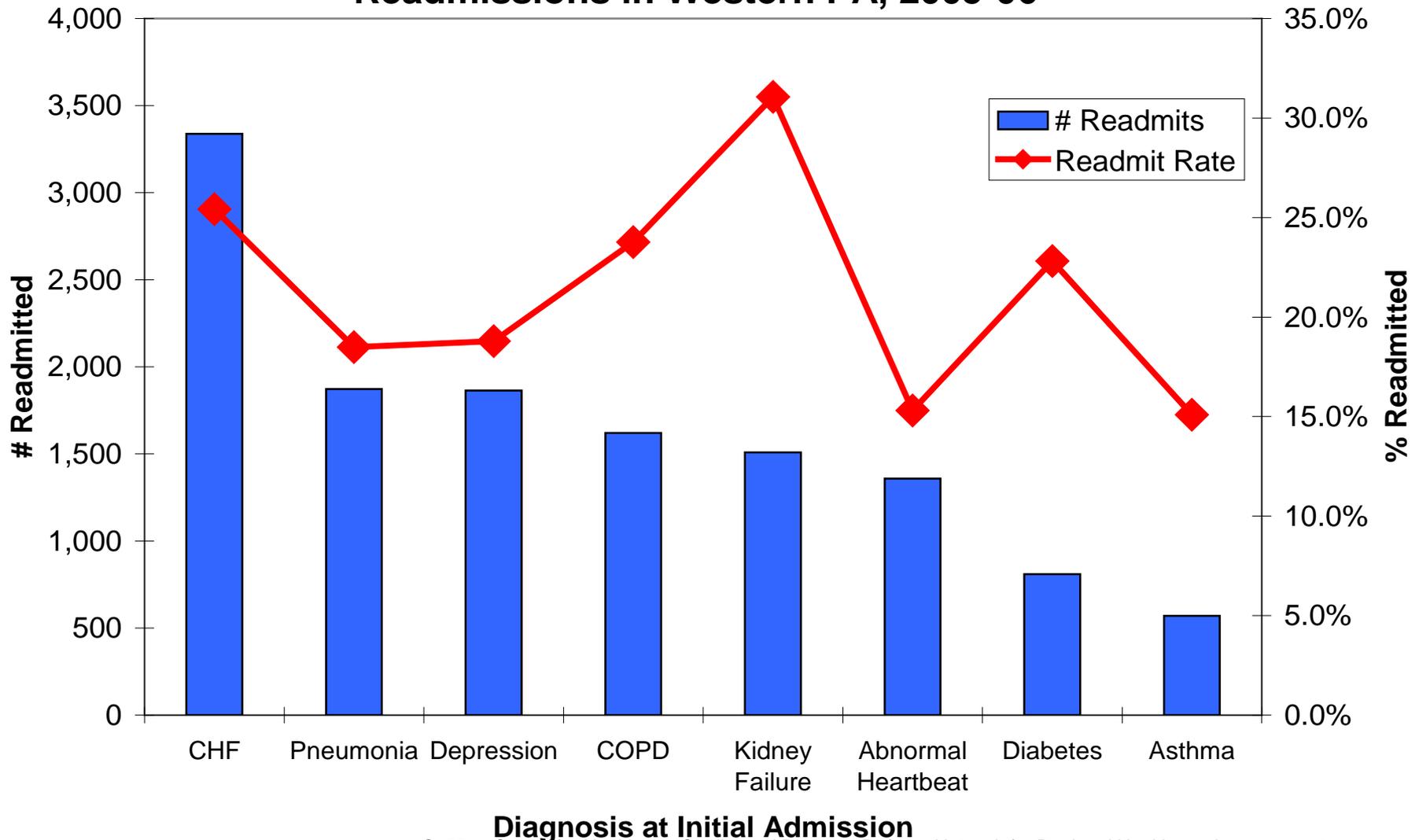
# How Do We Coordinate All Of This?

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- Option 1: Everybody Works for the Same Corporation
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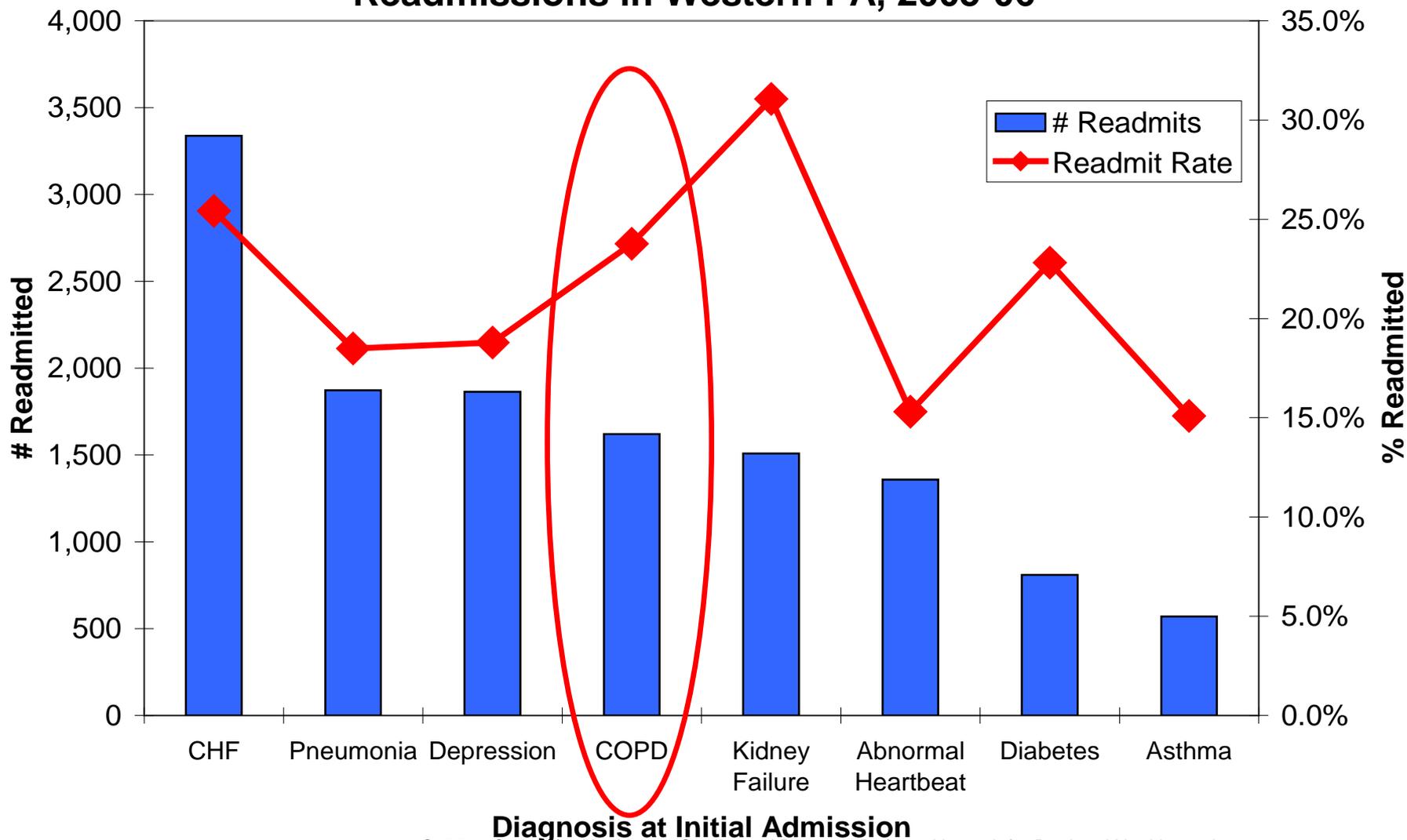
# Chronic Diseases Are Largest Categories of Readmissions

Readmissions in Western PA, 2005-06



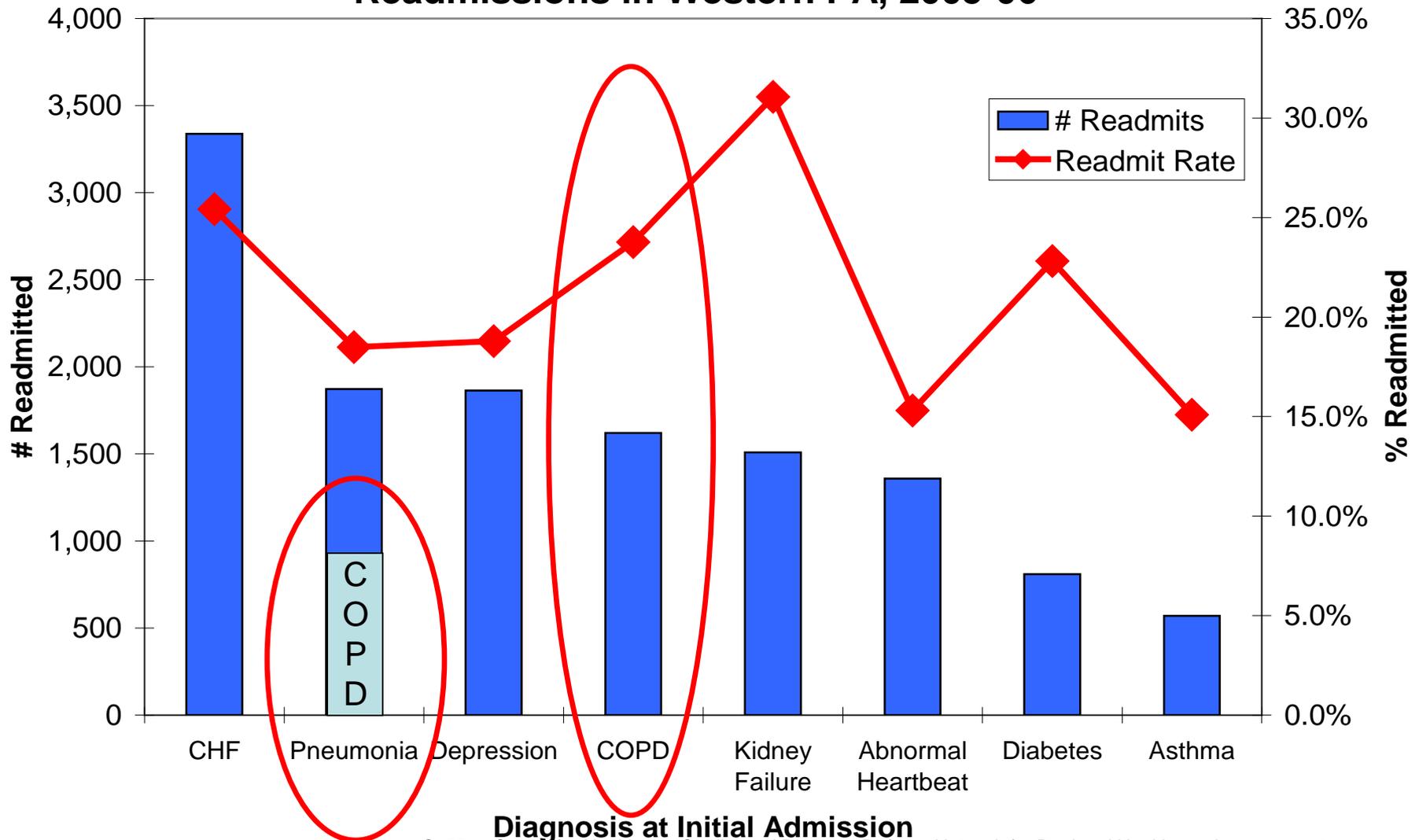
# Initial Focus: COPD is 4<sup>th</sup> Highest Volume & 25% Readmission Rate

Readmissions in Western PA, 2005-06



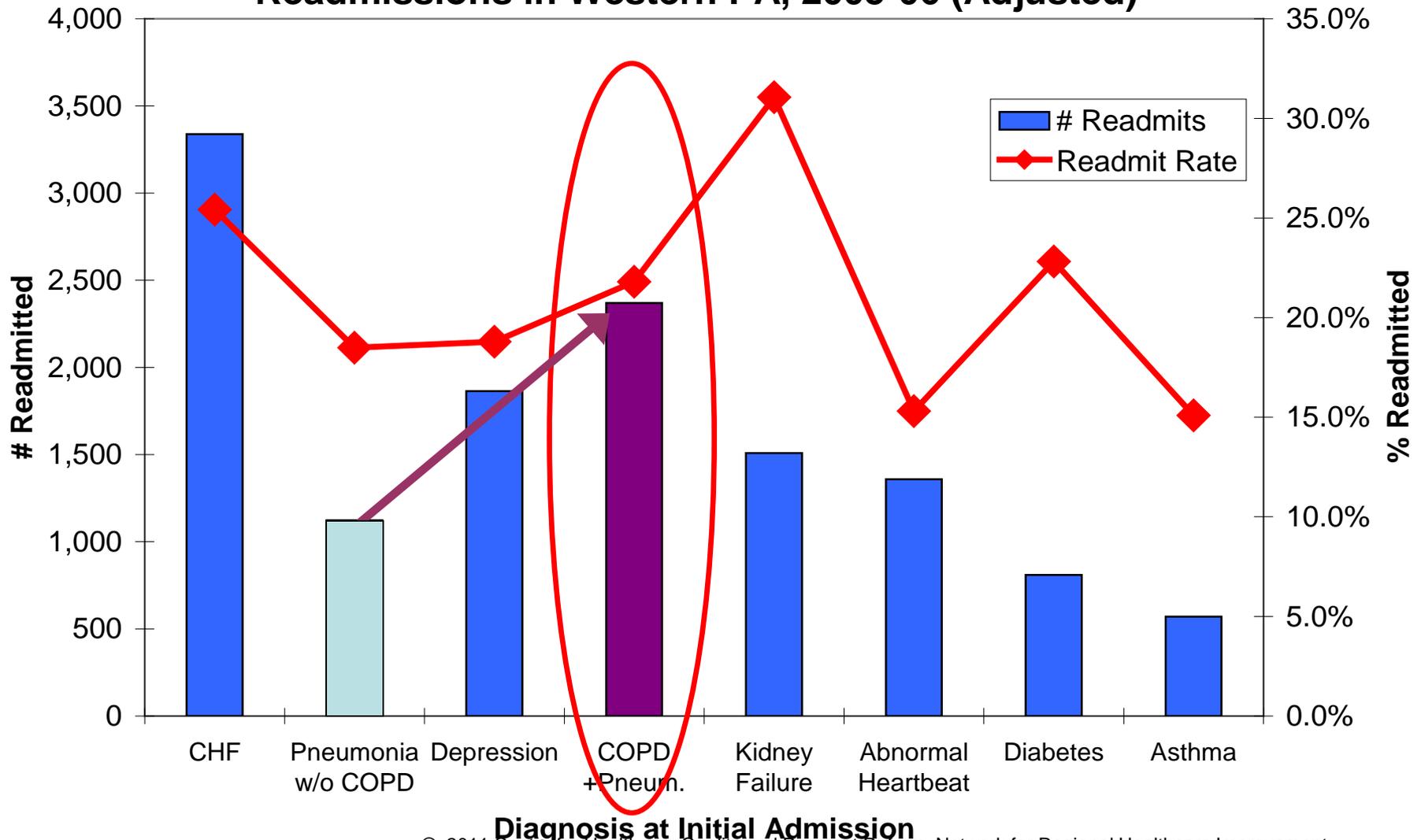
# Analysis Showed 40% of Pneumonia Readmits Had COPD

Readmissions in Western PA, 2005-06



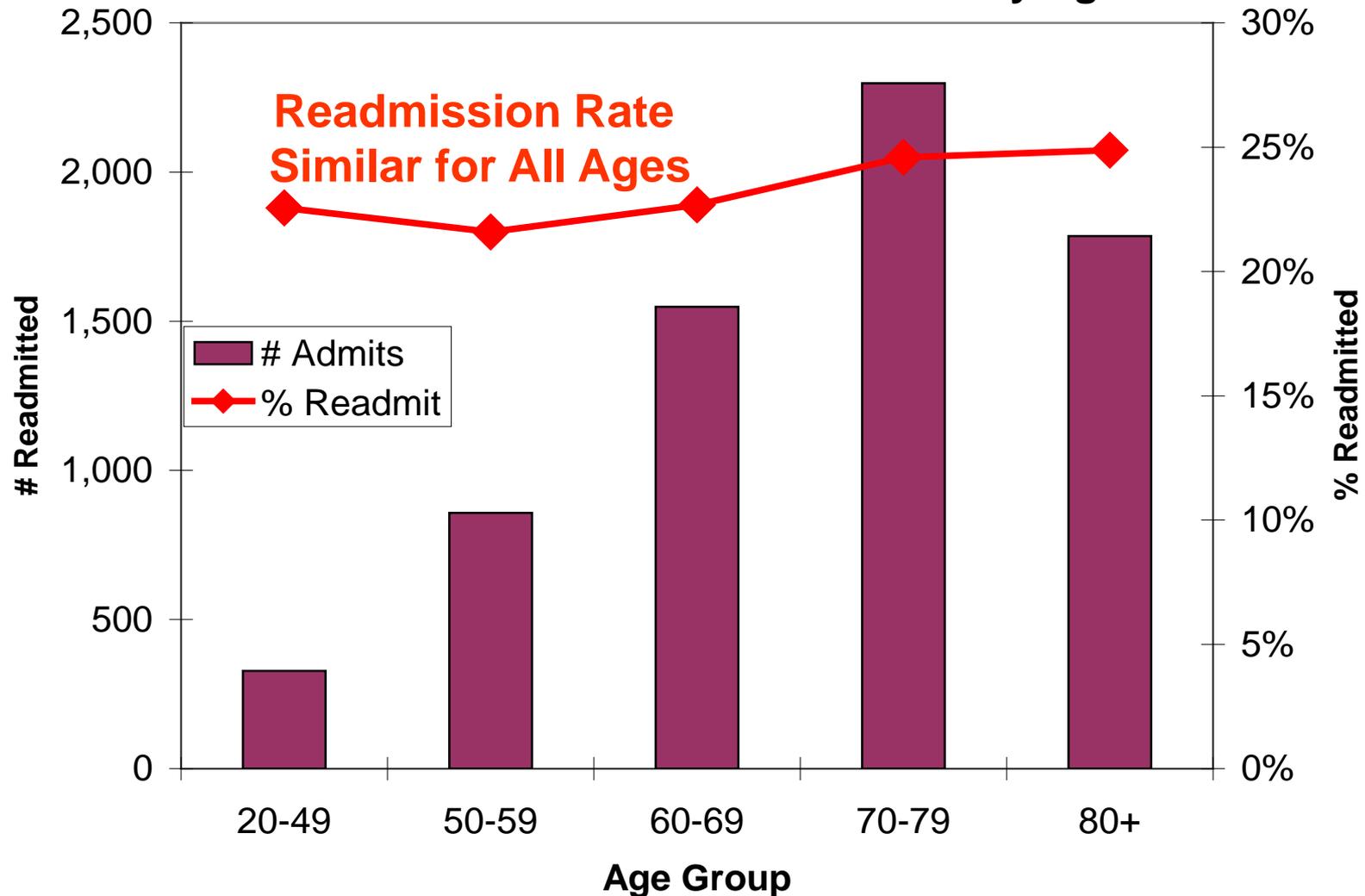
# So COPD Patients are 2<sup>nd</sup> Highest Volume of Readmits

Readmissions in Western PA, 2005-06 (Adjusted)



# COPD Readmissions Affected Commercial/Medicaid, Too

## COPD Admissions/Readmissions by Age



# How Do We Coordinate All Of This?

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    - A neutral convener, e.g., Q-Corp
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  - Information exchange about individual patients
    - Protocols to transfer information or an HIE
  - Real-time feedback on performance
    - “Real time” reports on readmissions and root cause analysis (claims data is too slow)

# Examples of Techniques Used in Pittsburgh's Project

- **Outcome Measurement:**
  - Monthly hospital-generated reports on readmission rates
    - All-payer claims data indicated that for these hospitals, 80-90% of readmissions return to the same hospital
  - Tracking of individual patients in registry by Care Manager
- **Causal Analysis:**
  - Special questionnaire in hospital to all readmitted patients
  - Care manager recorded reasons for hospitalization and identified any weaknesses in community support
- **Chart Review:**
  - Assessment of whether all recommended elements of care were actually delivered

# Are Readmission Reduction Projects Sustainable?

- We don't pay for things that we know will reduce readmissions
  - E.g., care transitions coaches to assist patients returning home after a hospitalization
  - E.g., having a nurse care manager visit chronic disease patients to provide education and self-management support
  - E.g., using telemonitoring to identify patient problems before admissions are necessary
  - E.g., having a physician answer a phone call with a patient who is confused about their treatment plan or experiencing a potential problem

# Will Hospitals Provide Ongoing Financial Support?

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  - E.g., having a nurse care manager visit chronic disease patients to provide education and self-management support
  - E.g., using telemonitoring to identify patient problems before admissions are necessary
  - E.g., having a physician answer a phone call with a patient who is confused about their treatment plan or experiencing a potential problem
- Hospitals and doctors lose money if they reduce readmissions
  - Hospitals are paid based on the number of times they admit patients
  - Physicians are paid based on the number of times they see patients and they see patients more often when patients are in the hospital

# Five Basic Approaches to Payment Reform

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1. Don't pay providers (hospitals and/or docs) for readmissions
2. Pay a provider more to implement programs believed to reduce readmissions
3. Pay providers bonuses/penalties based on readmission rates
4. Pay for care with a limited warranty from the provider (i.e., provider does not charge for readmissions meeting specific criteria)
5. Make a comprehensive care (global) payment to a provider for all care a patient needs (regardless of how many hospitalizations or readmissions are needed)

# A Blunt Approach:

## Don't Pay for Readmissions at All

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# Refusing to Pay for Readmissions Has Undesirable Consequences

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- The hospital and/or physicians could legitimately refuse to treat the patient needing readmission, if the payer won't pay for their services
- The patient may be readmitted to a hospital other than the one where the initial care was given, or the patient may be treated by physicians other than the ones which provided the care on the initial admission
- Hospitals/physicians may refuse to admit patients in the first place if they feel the patients are at high risk for readmission after discharge
- Not all readmissions may be preventable

# A More Positive Approach: Paying for What Works

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# Two Dilemmas

- **Dilemma #1: Who to Pay?**
  - Hospitals, PCPs, Nursing Homes, Home Health Agencies, Area Agencies on Aging, etc., could all implement programs that could reduce readmissions
  - Funding them all will reduce the return on investment
- **Dilemma #2: No Guarantee of Results**
  - Although it's been demonstrated that many different types of programs have been able to reduce readmissions, none of them are *guaranteed* to work, and those who want to replicate them aren't guaranteeing results
  - So how does the payer (Medicare, Medicaid, or a commercial health plan) know that providing additional funding for a program will reduce readmissions by more than the cost of the program, or even reduce readmissions at all?
  - Result: payers are reluctant to fund such programs on a broad scale

# Creating Incentives for Performance

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# P4P Programs Don't Offset the Underlying FFS Incentives

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- **Example:** A pay-for-performance (P4P) program that reduces a hospital's payment rate by 5% if its readmission rate is higher than average
- **Scenario:** Hospital has 25% readmission rate for a particular condition; the average for all hospitals is 18%

Initial Admits	Readmit Rate	Total Admits	Payment Per Admit	Revenues
500	25%	625	\$5,000	\$3,125,000

# P4P Hurts the Hospital If It Doesn't Reduce Readmissions

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Initial Admits	Readmit Rate	Total Admits	Payment Per Admit	Revenues	Change
500	25%	625	\$5,000	\$3,125,000	
500	25%	625	\$4,750 (-5%)	\$2,968,750	(\$156,250)

# But the Hospital May Be Hurt More If It Does Reduce Readmits

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500	25%	625	\$4,750 (-5%)	\$2,968,750	(\$156,250)
500	18%	590	\$5,000	\$2,950,000	(\$175,000)

*The P4P penalty actually costs the hospital less than reducing readmissions, particularly if additional costs must be incurred for readmission reduction programs*

# The Problems With P4P Bonuses/Penalties Alone

- The P4P penalty has to be very large to overcome the very large underlying disincentive in the DRG/FFS payment system against reducing readmissions
- The P4P penalty has to be even larger if reducing readmissions means the hospital will need to incur extra costs for readmission reduction programs *in addition* to reducing its revenues
- The larger the P4P penalty, the closer it comes to looking like non-payment for readmissions, i.e., the hospital or physician may be deterred from admitting the patient in the first place if the patient is viewed as a high risk for readmission after discharge
- There is no incentive to do *better* than the performance standard which is set in the P4P program

# Medicare's Complex Workaround

- Hospital Readmissions Reduction Program ( 3025 of PPACA)
  - All DRG payments reduced up to 1% in 2013, 2% in 2014, 3% in 2015+
  - Actual reduction based on number of “excess” risk-adjusted readmissions for heart attack, heart failure, and pneumonia
  - Additional conditions to be added in 2015

# It Will Provide Stronger Incentives Than Some P4P Programs...

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- Why this *theoretically* works “better” than other P4P programs:
  - Magnifies the penalty for high readmission rates for targeted conditions
  - Continues to pay (almost) the same for readmissions when they occur

# ...But That Doesn't Mean It's a Good Idea

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- Why this *theoretically* works “better” than other P4P programs:
  - Magnifies the penalty for high readmission rates for targeted conditions
  - Continues to pay (almost) the same for readmissions when they occur
- Why it's not good policy in *reality*:
  - Reduces the hospital's payment for *all* admissions to the hospital, regardless of whether there is any problem with other admissions
  - Creates the largest penalties for hospitals that have relatively few patients with the target conditions (since the penalty is a percentage of revenues for *all* patients, not just the patients with those conditions)
  - Creates no incentive to reduce readmissions for any other conditions or to reduce rates below average
  - Only affects the hospital, not physicians & not community programs

# A Better Idea: Paying for Care With a Warranty

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# Yes, a Health Care Provider Can Offer a *Warranty*

## **Geisinger Health System ProvenCare<sup>SM</sup>**

- A single payment for an ENTIRE 90 day period including:
  - ALL related pre-admission care
  - ALL inpatient physician and hospital services
  - ALL related post-acute care
  - ALL care for any related complications or readmissions
- Types of conditions/treatments currently offered:
  - Cardiac Bypass Surgery
  - Cardiac Stents
  - Cataract Surgery
  - Total Hip Replacement
  - Bariatric Surgery
  - Perinatal Care
  - Low Back Pain
  - Treatment of Chronic Kidney Disease

# Readmission Reduction: 44%

## ProvenCare<sup>®</sup> CABG Quality Clinical Outcomes - (18. mos)

	<i>Before ProvenCare (n=132)</i>	<i>With ProvenCare (n=181)</i>	<i>% Improvement/ (Reduction)</i>
In hospital mortality	1.5 %	0 %	
Patients with <u>any</u> complication (STS)	38 %	30 %	<b>21 %</b>
Patients with >1 complication	7.6 %	5.5 %	<b>28 %</b>
Atrial fibrillation	23 %	19 %	<b>17 %</b>
Neurologic complication	1.5 %	0.6 %	<b>60 %</b>
Any pulmonary complication	7 %	4 %	<b>43 %</b>
Blood products used	23 %	18 %	<b>22 %</b>
Re-operation for bleeding	3.8 %	1.7 %	<b>55 %</b>
Deep sternal wound infection	0.8 %	0.6 %	<b>25 %</b>
Readmission within 30 days	6.9 %	3.8 %	<b>44 %</b>

<b>Readmission within 30 days</b>	<b>6.9 %</b>	<b>3.8 %</b>	<b>44 %</b>
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# What a Single Physician and Hospital Can Do

- In 1987, an orthopedic surgeon in Lansing, MI and the local hospital, Ingham Medical Center, offered:
  - a fixed total price for surgical services for shoulder and knee problems
  - a warranty for any subsequent services needed for a two-year period, including repeat visits, imaging, rehospitalization and additional surgery
- Results:
  - Surgeon received over 80% more in payment than otherwise
  - Hospital received 13% more than otherwise, despite fewer rehospitalizations
  - Health insurer paid 40% less than otherwise
- Method:
  - Reducing unnecessary auxiliary services such as radiography and physical therapy
  - Reducing the length of stay in the hospital
  - Reducing complications and readmissions

# A Warranty is Not an Outcome Guarantee

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- Offering a warranty on care does not imply that you are guaranteeing a cure or a good outcome
- It merely means that you are agreeing to correct avoidable problems at no (additional) charge
- Most warranties are “limited warranties,” in the sense that they agree to pay to correct some problems, but not all

# Example: \$5,000 Procedure, 20% Readmission Rate

<b>Cost of Success</b>	<b>Added Cost of Readmit</b>	<b>Rate of Readmits</b>
\$5,000	\$5,000	20%

# Average Payment for Procedure is Higher than the Official “Price”

<b>Cost of Success</b>	<b>Added Cost of Readmit</b>	<b>Rate of Readmits</b>	<b>Average Total Cost</b>
\$5,000	\$5,000	20%	\$6,000

# Starting Point for Warranty Price: Actual Current Average Payment

Cost of Success	Added Cost of Readmit	Rate of Readmits	Average Total Cost	Price Charged	Net Margin
\$5,000	\$5,000	20%	\$6,000	<b>\$6,000</b>	\$ 0

# Limited Warranty Gives Financial Incentive to Improve Quality

Cost of Success	Added Cost of Readmit	Rate of Readmits	Average Total Cost	Price Charged	Net Margin
\$5,000	\$5,000	20%	\$6,000	\$6,000	\$ 0
\$5,000	\$5,000	<b>15%</b>	<b>\$5,750</b>	\$6,000	<b>\$250</b>

Reducing Adverse Events...

...Reduces Costs...

...Improves The Bottom Line

# Higher-Quality Provider Can Charge Less, Attract Patients

Cost of Success	Added Cost of Readmit	Rate of Readmits	Average Total Cost	Price Charged	Net Margin
\$5,000	\$5,000	20%	\$6,000	\$6,000	\$ 0
\$5,000	\$5,000	15%	\$5,750	\$6,000	\$250
\$5,000	\$5,000	15%	\$5,750	\$5,900	\$ 150

Enables  
Lower  
Prices

Still With  
Better  
Margin

# A Virtuous Cycle of Quality Improvement & Cost Reduction

Cost of Success	Added Cost of Readmit	Rate of Readmits	Average Total Cost	Price Charged	Net Margin
\$5,000	\$5,000	20%	\$6,000	\$6,000	\$ 0
\$5,000	\$5,000	15%	\$5,750	\$6,000	\$250
\$5,000	\$5,000	15%	\$5,750	\$5,900	\$150
\$5,000	\$5,000	10%	\$5,500	\$5,900	\$400

Reducing Adverse Events...

...Reduces Costs...

...Improves The Bottom Line

# Win-Win-Win Through Appropriate Payment & Pricing

Cost of Success	Added Cost of Readmit	Rate of Readmits	Average Total Cost	Price Charged	Net Margin
\$5,000	\$5,000	20%	\$6,000	\$6,000	\$ 0
\$5,000	\$5,000	15%	\$5,750	\$6,000	\$250
\$5,000	\$5,000	15%	\$5,750	\$5,900	\$150
\$5,000	\$5,000	10%	\$5,500	\$5,900	\$400
\$5,000	\$5,000	10%	\$5,500	\$5,700	\$200
\$5,000	\$5,000	5%	\$5,250	\$5,700	\$450

**Quality is Better...**

**...Cost is Lower...**

**...Providers More Profitable**

# In Contrast, Non-Payment Alone Creates Financial Losses

Cost of Success	Added Cost of Readmit	Rate of Readmits	Average Total Cost	Payment	Net Margin
\$5,000	\$5,000	20%	\$6,000	\$6,000	\$ 0
\$5,000	\$5,000	20%	\$6,000	\$5,000	-\$1,000
\$5,000	\$5,000	10%	\$5,500	\$5,000	-\$ 500
\$5,000	\$5,000	0%	\$5,000	\$5,000	\$0

↑  
Non-Payment for Readmits

↑  
Causes Losses While Improving

# Warranty Pricing Should Capture Costs of New Programs

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# Warranty Pricing Should Capture Costs of New Programs

<b>Cost of Success</b>	<b>Added Cost of Readmit</b>	<b>Rate of Readmits</b>	<b>Average Total Cost</b>	<b>Warranty Price</b>	<b>Net Margin</b>
\$5,000	\$5,000	20%	\$6,000	\$6,000	\$0

# Provider Offering Warranty Must Focus on Cost & Performance

Cost of Success	Added Cost of Readmit	Rate of Readmits	Average Total Cost	Warranty Price	Net Margin
\$5,000	\$5,000	20%	\$6,000	\$6,000	\$0
\$5,200	\$5,200	16%	\$6,032	\$6,000	-\$32

Higher Cost to Reduce Readmits

Even If Somewhat Successful

Means Losses

# Option 1: Improve Performance Enough to Justify Higher Costs

Cost of Success	Added Cost of Readmit	Rate of Readmits	Average Total Cost	Warranty Price	Net Margin
\$5,000	\$5,000	20%	\$6,000	\$6,000	\$0
\$5,200	\$5,200	16%	\$6,032	\$6,000	-\$32
\$5,200	\$5,200	10%	\$5,720	\$6,000	+\$280

Better Results

Means Better Margins

# Option 2: Reduce Costs of Interventions

Cost of Success	Added Cost of Readmit	Rate of Readmits	Average Total Cost	Warranty Price	Net Margin
\$5,000	\$5,000	20%	\$6,000	\$6,000	\$0
\$5,200	\$5,200	16%	\$6,032	\$6,000	-\$32
\$5,200	\$5,200	10%	\$5,720	\$6,000	+\$280
\$5,050	\$5,050	16%	\$5,858	\$6,000	+\$ 142



Lower  
Program  
Costs



Means  
Better  
Margins

# Then Offer the Payer Some Savings

Cost of Success	Added Cost of Readmit	Rate of Readmits	Average Total Cost	Warranty Price	Net Margin
\$5,000	\$5,000	20%	\$6,000	\$6,000	\$0
\$5,200	\$5,200	16%	\$6,032	\$6,000	-\$32
\$5,200	\$5,200	10%	\$5,720	\$5,900	+\$180
\$5,050	\$5,050	16%	\$5,858	\$5,900	+\$42



Lower  
Price to  
Payer

# Warranty Enables the Right Balance of Cost & Performance

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- Providers have an incentive to reduce readmissions as much as possible
- Providers have an incentive to find the lowest cost way to do that

# To Make It Work: Shared, Trusted Data for Pricing

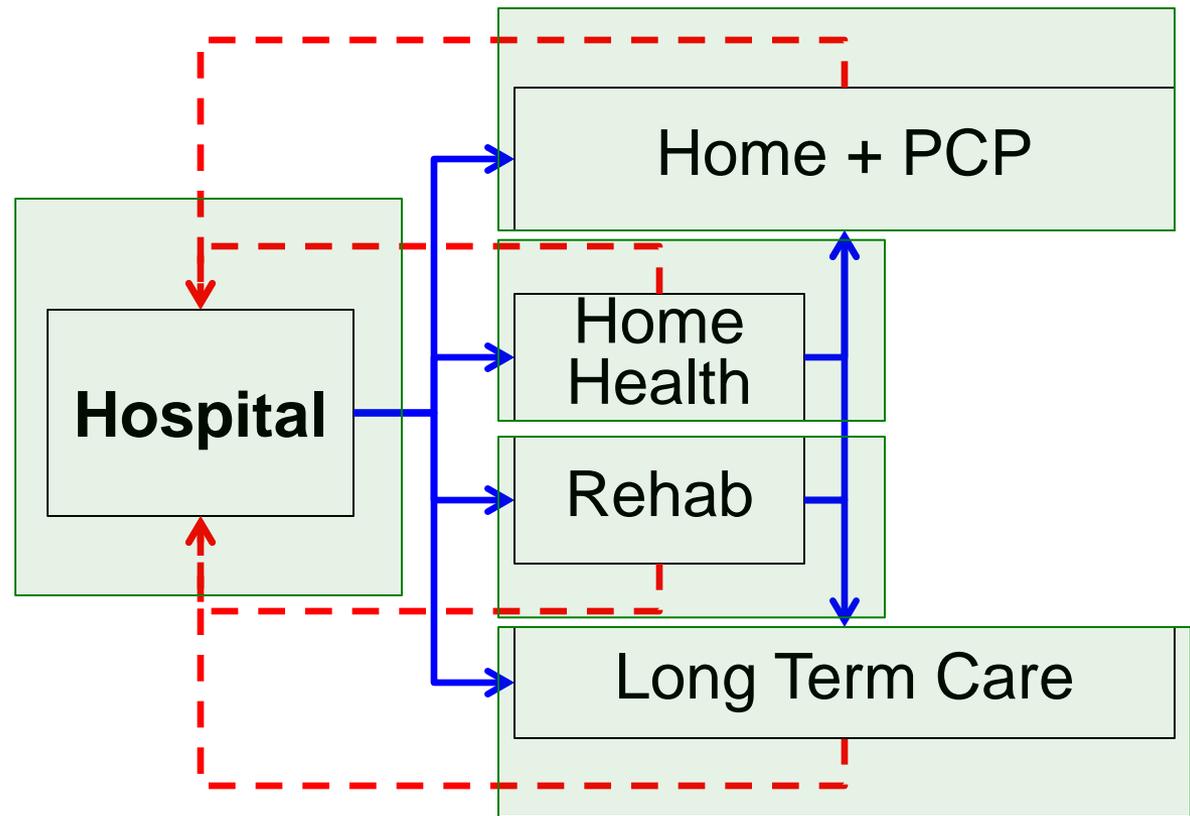
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- **Hospital/Health System** needs to know what its current readmission rates (or other complications) are and how many are preventable to know whether the warranty price will cover its costs of delivering care
- **Medicare/Health Plan** needs to know what its current readmission rates, preventable complication rates, etc. are to know whether the warranty price is a better deal than they have today
- **Both** sets of data have to match in order for both providers and payers to agree!

# Who Gives the Warranty?

- The Hospital?
- The PCP?
- The LTC Facility?

Which readmissions are they each taking accountability for?



# Comprehensive Payment for Comprehensive Services

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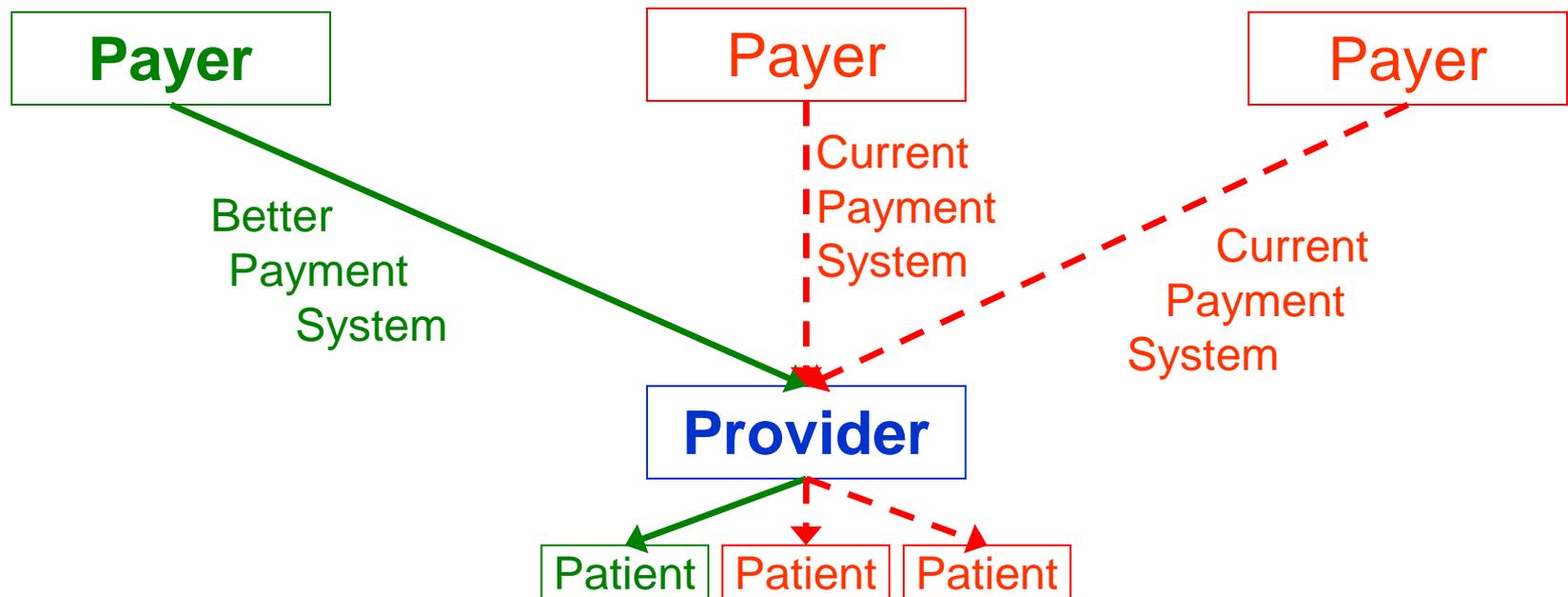
1. Don't pay providers (hospitals and/or docs) for readmissions
2. Pay a provider more to implement programs believed to reduce readmissions
3. Pay providers bonuses/penalties based on readmission rates
4. Pay for care with a limited warranty from the provider (i.e., provider does not charge for readmissions meeting specific criteria)
5. Make a comprehensive care (global) payment to a provider or group of providers for all care a patient needs (regardless of how many hospitalizations or readmissions are needed)



# New “Bundling” Initiatives From CMS Innovation Center

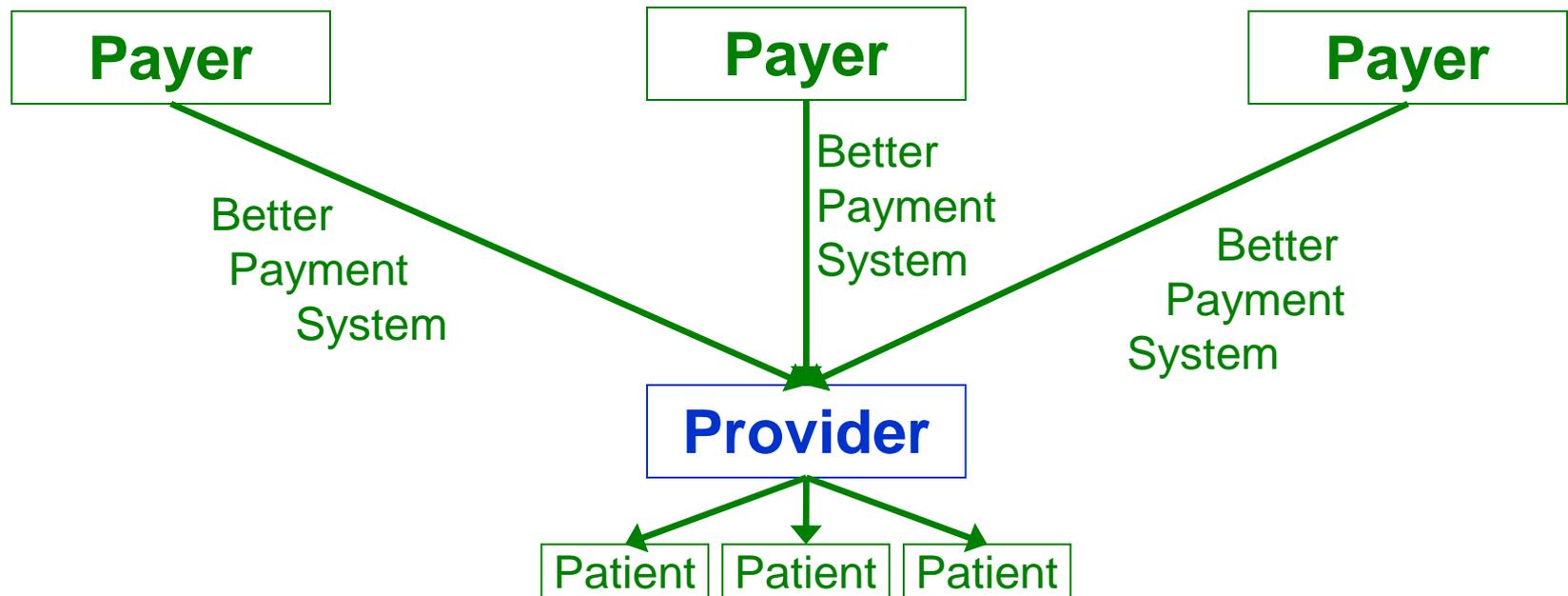
- **Model 1 (Inpatient Gainsharing)**
  - Hospitals can share savings with physicians
  - No actual change in the way Medicare payments are made
- **Model 2 (Virtual Episode Bundle + Warranty)**
  - Budget for Hospital+Physician+Post-Acute+Readmissions
  - Medicare pays bonus if actual cost < budget
  - Providers repay Medicare if actual cost > budget
- **Model 3 (Virtual Post-Acute Bundle + Warranty)**
  - Budget for Post-Acute Care+Physicians+Readmissions
  - Bonuses/penalties paid based on actual cost vs. budget
- **Model 4 (Inpatient Bundle, No Warranty)**
  - Single Hospital + Physician payment for inpatient care

# One Payer Changing Isn't Enough



***Provider is only compensated for changed practices for the subset of patients covered by participating payers***

# Payers Need to Align to Enable Providers to Transform



# A Simple Starting Point: Coordinate Payment Reform Silos

## SILO #1



Pay More to Physicians  
For Being Certified  
As a Medical Home  
With No Focus  
on Readmissions

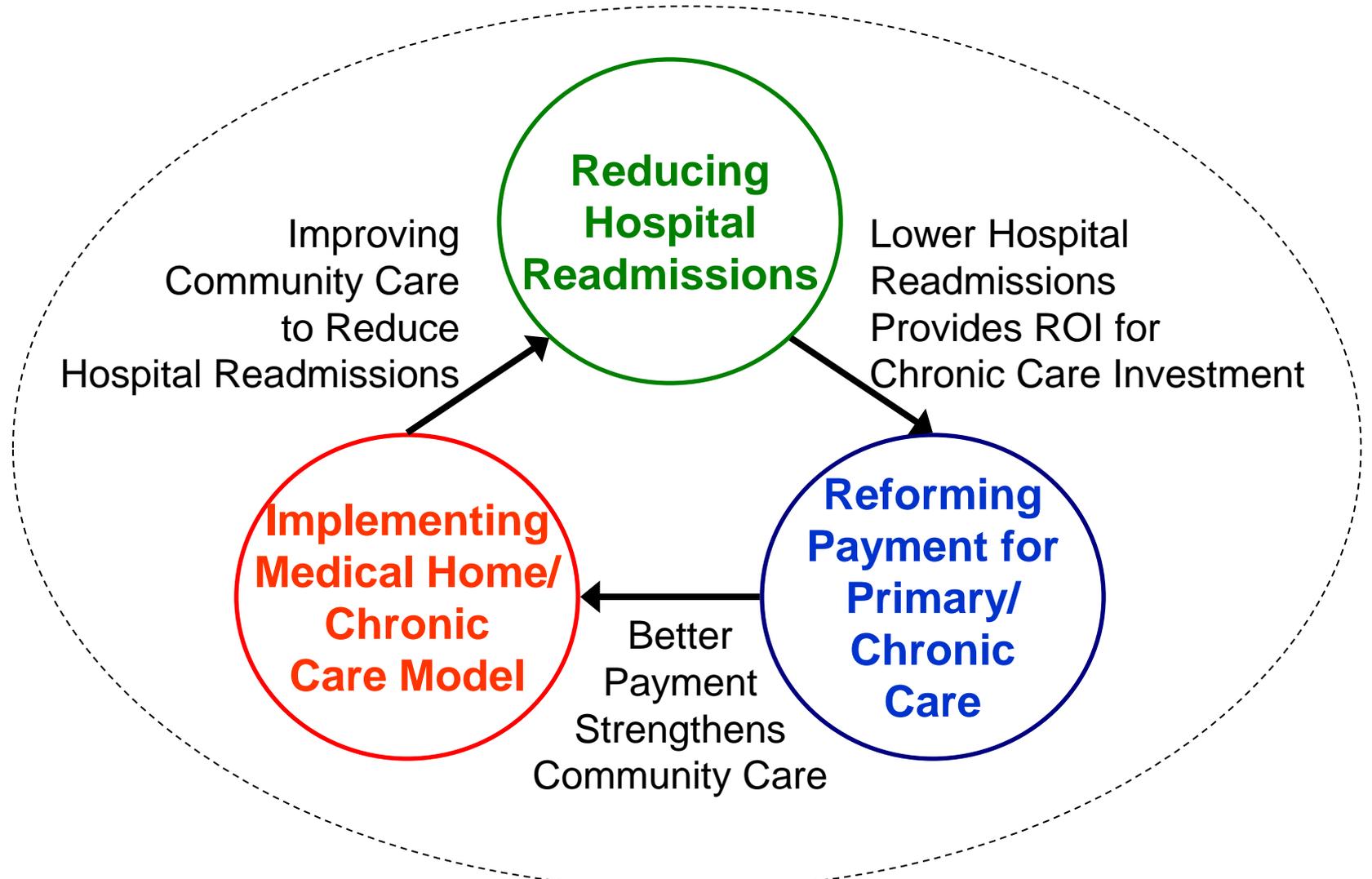


## SILO #2

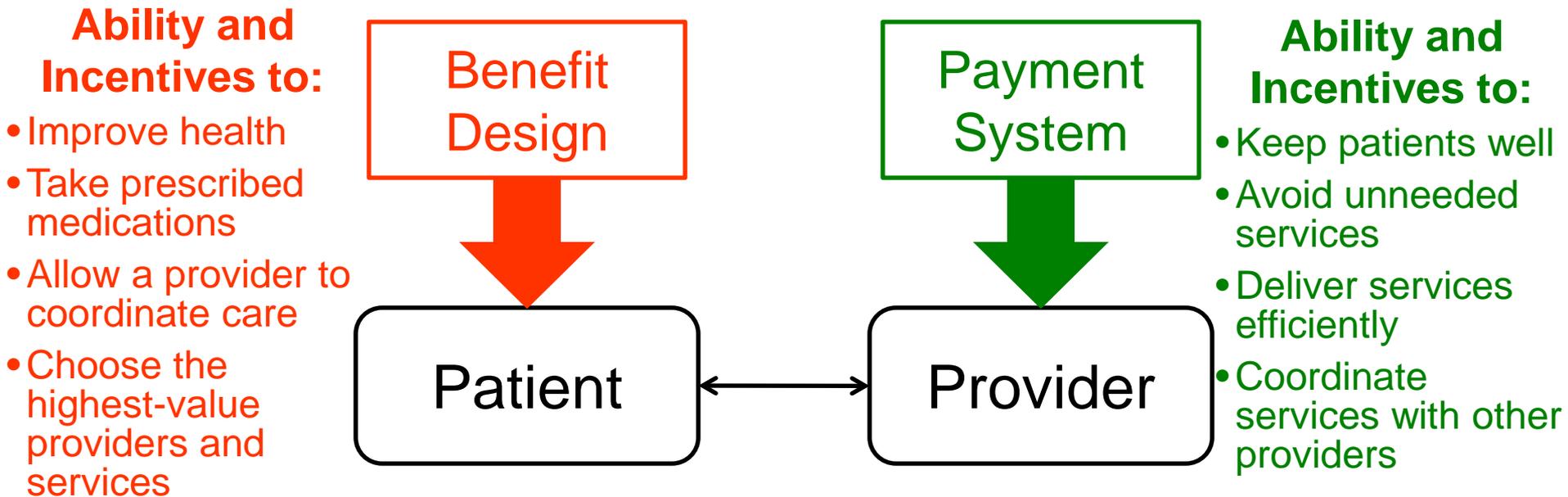


Penalize Hospitals for  
Readmissions Even  
If the Cause is  
Inadequate  
Primary Care

# Marrying the Medical Home and Hospital Readmissions

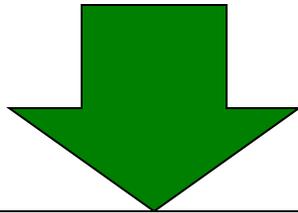


# Benefit Design Changes Are Also Critical to Success

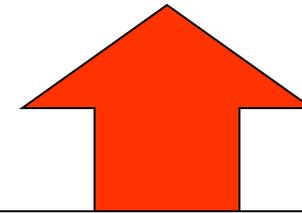


# Example: Coordinating Pharmacy & Medical Benefits

High copays & deductibles  
to reduce pharmacy spending...



...Are likely contributing to  
high rates of readmission



## Pharmacy Benefits

Drug  
Costs

- High copays for brand-names when no generic exists
- Doughnut holes & deductibles

*Principal treatment for most chronic diseases involves regular use of maintenance medication*

## Medical Benefits

Hospital  
Admissions

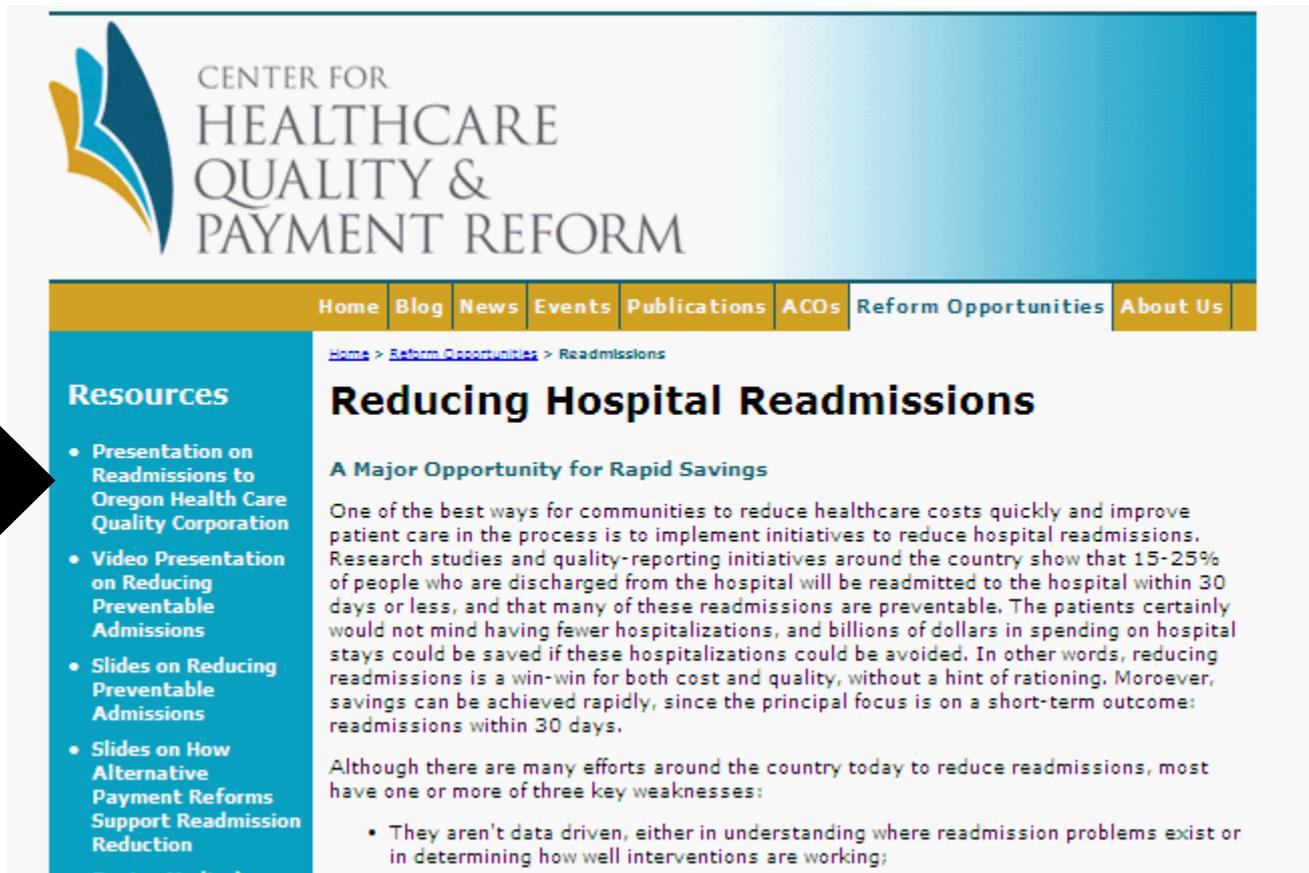
Hospital  
Readmissions

ER Visits

# A Comprehensive, Data-Driven Approach to Reducing Readmits

- **Analyze data to determine where your biggest opportunities for reducing readmissions exist**
  - Which conditions (e.g., CHF and COPD), which patients (age, geography, etc.), which settings (home, rehab, LTC)
- **Identify the (many) root causes of readmissions and redesign care in the settings where those root causes occur and/or can be most effectively addressed**
  - Transitional interventions should address the problems with transitions, not try to fix problems that should have been addressed earlier
  - Patients should not have to be hospitalized to get better ambulatory care; design/coordinate your efforts around a strong PCMH base
- **Create a business case to support sustainable funding**
  - Savings have to exceed costs – increase impact or reduce costs
  - Coordinate efforts to avoid duplication and gaps
- **Monitor performance and continuously adjust**
  - Just because it's “proven” in the literature doesn't mean it will automatically work well in your setting with your patients
  - Ask patients and family how well it's working, not yourselves!

# More Information, Including Today's Presentation



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QUALITY &  
PAYMENT REFORM

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Home > Reform Opportunities > Readmissions

## Resources

- Presentation on Readmissions to Oregon Health Care Quality Corporation
- Video Presentation on Reducing Preventable Admissions
- Slides on Reducing Preventable Admissions
- Slides on How Alternative Payment Reforms Support Readmission Reduction
- Design Medical

## Reducing Hospital Readmissions

### A Major Opportunity for Rapid Savings

One of the best ways for communities to reduce healthcare costs quickly and improve patient care in the process is to implement initiatives to reduce hospital readmissions. Research studies and quality-reporting initiatives around the country show that 15-25% of people who are discharged from the hospital will be readmitted to the hospital within 30 days or less, and that many of these readmissions are preventable. The patients certainly would not mind having fewer hospitalizations, and billions of dollars in spending on hospital stays could be saved if these hospitalizations could be avoided. In other words, reducing readmissions is a win-win for both cost and quality, without a hint of rationing. Moreover, savings can be achieved rapidly, since the principal focus is on a short-term outcome: readmissions within 30 days.

Although there are many efforts around the country today to reduce readmissions, most have one or more of three key weaknesses:

- They aren't data driven, either in understanding where readmission problems exist or in determining how well interventions are working;

<http://www.chqpr.org/readmissions.html>

# For More Information:

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