Care Transitions: Where We Are and Where We Need to Be

HCAF Annual Conference
July 23, 2013

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Care Transitions

Today’s Objectives

• Know the difference between hospital readmission rates for Florida and the nation.
• Understand the impact of readmission for patients and the healthcare system.
• Examine the common root causes of readmissions.
• Learn strategies to improve transitions from acute care to home.
• Learn about state and national initiatives to reduce acute-care readmissions.
Definition of “Readmission”

“…in the case of an individual who is discharged from an applicable hospital, the admission of the individual to the same or another applicable hospital within a time period specified by the Secretary (30 days) from the date of such discharge.”

Source: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html

Florida and National Readmission Statistics

- Medicare Fee-For-Service (FFS) Admissions July 2011 - June 2012
- Nationally:
  - 10,791,833 patient admissions
  - 1,972,000 patient readmissions
    - 30-day readmission rate: 18.27%
- Florida:
  - 517,924 patient admissions
  - 99,653 patient readmissions
    - 30-day readmission rate: 19.21%

Source: Medicare Fee-For-Service Inpatient Claims 2011-2012
United States Readmission Rankings (All Discharges)

US Rate = 18.8%

Florida ranks 44th in the nation.

Data source: Rates are calculated by Colorado Foundation for Medicare (CFMC) from Medicare fee-for-service claims for inpatient discharges October 1, 2010–September 30, 2012.

Hospital Readmissions for Discharges to Home Health Agencies (HHA)

All-Cause Readmission Rates

Data Source: HCPCS Quarterly Scorecard: January 1, 2009 - December 31, 2012; June 1, 2013. Rates are calculated from the National inpatient file by Colorado Foundation for Medicare (CFMC) for fee-for-service beneficiaries. June 1, 2009 - December 31, 2012. Rates are not seasonally adjusted. Discharge status to HHA is identified by the hospital claim status value of '10C' on the index hospitalization (first admission) claim.
### Medicare FFS Readmission Rates by Diagnosis and Setting

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Florida</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute MI</td>
<td>20.45%</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>24.54%</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>17.78%</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Discharge Setting</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Home</td>
<td>17.70%</td>
</tr>
<tr>
<td>Home with Home Health</td>
<td>21.64%</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>23.41%</td>
</tr>
</tbody>
</table>

- **Patients readmitted before receiving care from a provider**: 53.76%
- **Patients readmitted within 14 days of hospital discharge**: 60.7%

Source: Medicare Fee-For-Service Inpatient Claims July 1, 2011 – June 30, 2012

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### Readmissions Impact Multiple Areas

![Diagram showing the impact of readmissions on cost, quality, and patient experience.](chart.png)
Patient Impact of Readmission

- Re-hospitalization places patient/family under significant physical and emotional distress.
- The patient is at risk for potential medical errors, falls, and infections.
- The patient is exposed to Post-Hospital Syndrome:
  - "During hospitalization, patients are commonly deprived of sleep, experience disruption of normal circadian rhythms, are nourished poorly, have pain and discomfort, confront a baffling array of mentally challenging situations, receive medications that can alter cognition and physical function, and become deconditioned by bed rest or inactivity..."

Health System Impact of Readmissions

Readmissions of Florida Medicare Fee-for-Service (FFS) beneficiaries discharged in 2012:
- Florida discharges to home with Home Care: 145,205
- Home Care patient readmissions to acute care within 30 days: 31,136 (21.4%)
- CMS estimated cost per inpatient hospitalization: $9,600

Estimated Cost of Florida Home Care readmissions in 2012: $289,905,600
Timeline for Quality Initiatives

- Hospital Medicare readmission penalties
- Hospital value-based purchasing program penalties
- NH Value-based purchasing demo (ends June 2012)
- Reduce avoidable hospitalizations among nursing facility residents (ends August 2016)
- Community-based care transitions program
- Expansion of pilot programs to evaluate bundling payment for an episode of care
- QAPI demonstration project (ends August 2013)


CMS Readmissions Reduction Program

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. The regulations that implement this provision are in subpart I of 42 CFR part 412 (§412.150 through §412.154).

Source: [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html)
CMS Readmissions Reduction Program (continued)

• Hospital Excess Readmission penalties were applied to all Medicare FFS discharges beginning October 1, 2012.
• Initially, penalties are based on readmission rates for Congestive Heart Failure (CHF), Myocardial Infarction (MI), and Pneumonia occurring from 2008 – 2010.
• Readmission penalties can reach the following:
  o Fiscal year 2012: 1%
  o Fiscal year 2013: 2%
  o Fiscal year 2014: 3%

CMS Readmissions Reduction Program (continued)

• 2,217 hospitals were assessed a penalty ranging from 0.01% to 1% of Medicare revenue in FY 2013.
• In Florida, 39 hospitals received no readmission penalty, while 14 hospitals were assessed a 1% penalty.
CMS Readmissions Reduction Program (continued)

Great article that summarizes the program:
“Time to Get Serious About Hospital Readmissions” by Amy Boutwell:
http://healthaffairs.org/blog/2012/10/10/time-to-get-serious-about-hospital-readmissions/

Root Causes of Readmissions

- Poor communication between providers
- Medication-related issues
- Lack of access to care after discharge
- Poorly-defined transition processes
- Lack of patient engagement or knowledge to manage own condition
- Inconsistent access to community services

Source: Results from the fourteen Quality Improvement Organizations (QIOs) participating in the Care Transition demonstration project
August 2008 – July 2011
CCTP: Community-Based Care Transitions Project

- Created by Section 3026 of the Affordable Care Act, tests care delivery models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries.
- Goals of the CCTP are:
  - Improve transitions from inpatient hospital to other care settings;
  - Improve quality of care;
  - Reduce readmissions for high-risk Medicare beneficiaries; and
  - Document measurable savings to the Medicare program.

Care Transition Goals

Improving Care Transitions Goal: By the end of 2013, preventable complications during transition from one care setting to another would be decreased so that all hospital readmissions would be reduced by 20% compared to 2010.

Source: http://innovation.cms.gov/initiatives/Partnership-for-Patients/index.html
Improving Transitions in Home Care

- Home Health Quality Improvement (HHQI) National Campaign [www.homehealthquality.org/Home.aspx](http://www.homehealthquality.org/Home.aspx)
  - Dedicated to improving the quality of care provided to America’s home health patients
  - Best Practice Intervention Package
  - Quality data tracking
  - Home Health Compare public information

Strategies to Reduce Acute Care Readmissions

- “Frontload” visits for high-risk patients.
- Work with the patient, pharmacy, and the provider to confirm a single, accurate medication list.
- Ensure the patient has a follow-up visit with his/her care provider.
- Educate the patient and family using “teachback” to know the symptoms of a worsening of their illness and what to do if they see these changes.
- Agree to a structured communication process with the patient and family.
- Check in by phone on days with no visits.
Strategies for Agency Leaders

• Visit the Home Health Quality Improvement website and download the “Fundamentals of Reducing Acute Care Hospitalization” BPIP.

• Contact your acute care facilities and offer to meet with nursing or case managers to discuss transitions processes to decrease readmissions.

• Work with local physicians to encourage the appropriate use of home care in high-risk patients.

Transitional Care Management CPT Codes

• Medicare’s final 2013 physician fee schedule includes a new service for treating patients transitioning out of hospitals or SNFs. The new fee schedule recognizes the work done by physicians and their staff in the first 30 days after discharge. This includes medication adjustment, results tracking, and services referrals.

• Service may be provided by practice staff under the direction of the physician. The codes can be used only once in the 30 days after discharge.

Source: http://www.ama-assn.org/amednews/2012/11/12/gvl11112.htm
Transitional Care Management CPT Codes (continued)

Requirements for Care Coordination services are:

• High Complexity Medical Decision-Making (CPT 99496)
  - Direct, telephonic, or electronic contact with the patient or caregiver within two business days of discharge with documentation
  - Face-to-face patient visit with seven days of discharge with documentation

• Moderate Complexity Medical Decision-Making (CPT 99495)
  - Direct, telephonic, or electronic contact with the patient or caregiver within two business days of discharge with documentation
  - Face-to-face patient visit within fourteen days of discharge with documentation

Things to do by Tuesday…

• Share information from this presentation with your team and hospital leaders.
• Look at your HHA’s latest readmission rate.
• Join the No Place Like Home Campaign.
  www.noplacelikehomefl.com/
• Reach out to your key acute care and nursing facility partners to talk about care transitions.
The No Place Like Home Campaign offers a ready resource for taking action on your commitment to reduce avoidable readmissions, and engages providers at all levels of performance in rapid-cycle projects for collaborative learning and action that accelerate healthcare quality improvement.

For more information, please visit:  
www.noplaceilikethomefl.com

Medicare Quality Improvement Organizations encourage collaboration through utilizing technology to manage and freely share knowledge and tools for improving health quality, efficiency, and value.

HealthHub  
Your platform for sharing knowledge  
www.HealthHubFL.com
Medicare Quality Improvement Organizations engage providers at all levels of performance in rapid-cycle projects for collaborative learning and action that accelerate healthcare quality improvement.

Questions?

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This material was prepared by FMQAI, the Medicare Quality Improvement Organization for Florida, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the Department of Health and Human Services (HHS). The contents presented do not necessarily reflect CMS policy. FL-105OW-2013FLC804-6-1029