Grounding the Frequent Fliers:
How Hospice Can Help Hospitals Meet the Readmissions Challenge

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Introduction & Background

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Objectives

- Describe the “readmissions challenge”
- Match hospice care services with partners’ need for help with readmissions
- Identify data points indicating hospitals vulnerable to high rates of readmissions
- Discuss interpretations of data to identify prospective partners and strategies
Why?

- Why readmissions?
  - 1 in 5 Medicare patients readmitted
  - $41.3 billion total; $24 billion Medicare $$ (2011)
  - Across all DRGs, median 27% readmissions preventable

Why?

- Why penalize?
  - Incentivize collaboration
    - Goal by 2018, 50% all payments made through alternative models
  - Extend responsibility into post-discharge
Penalties for 30-day readmissions

- Phased in since 2012
- Increasing # diagnoses, rate of penalty
  - Calculation is additive
- 2014–15:
  - Heart attack, heart failure, chronic lung problems, pneumonia, elective hip and knee
  - If readmission unplanned and related
  - Up to 3% reduction in Medicare payment rate for every Medicare patient
  - Patients on hospice included in measure if dc to hospice

Readmissions reduction FY2015

- 78% of hospitals get penalized
- 1.2% get maximum penalty
- Estimated total penalty $425 million
- *No adjustment for socio-economic factors*
How race and dual status affects readmissions

- **30-day readmission rates**

<table>
<thead>
<tr>
<th></th>
<th>White</th>
<th>Non-white</th>
<th>Non-Dual Eligible</th>
<th>Dual Eligible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Attack</td>
<td>19.3%</td>
<td>22.9%</td>
<td>18.7%</td>
<td>24.3%</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>17.7%</td>
<td>20.5%</td>
<td>17.3%</td>
<td>20.1%</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>24.1%</td>
<td>26.9%</td>
<td>23.7%</td>
<td>27.4%</td>
</tr>
</tbody>
</table>

Source: KNG Analysis of 2009 100% Medicare inpatient file and FY2011 Hospital IPPS final rule impact file.

Impact of dual eligibles

- As compared to traditional Medicare beneficiaries, dual eligibles are:
  - Much less likely to receive specific measures of preventive care, follow-up care or testing
  - 600% more likely to reside in a nursing facility
  - 250% more likely to have Alzheimer’s disease
  - 200% more likely to have a disability
  - 100% more likely to have heart disease
  - 50% more likely to have diabetes
  - 15% more likely to have a cognitive or mental impairment

Why do readmissions happen?

- Meta-analysis* of factors:
  - Premature discharge or inadequate post-discharge support
  - Insufficient follow up
  - Failed handoffs to PCP
  - Complications from procedures
  - Infections, pressure ulcers, and patient falls
  - Therapeutic errors, many involving medications


Why do readmissions happen?

- Other factors – based on case review
  - Couldn’t read the discharge form
  - Pharmacy wasn’t open/out of stock
  - Lack of transportation to follow up appts
  - No air conditioning or refrigerator to store meds
  - Late-in-the-day transfers
  - Equipment failures at home or in the post-acute setting
  - Sensory, social, or mobility (ADL) deficits
Why do readmissions happen?

- **Risk factors—clinical**
  - Use of “high-risk” medications
  - Polypharmacy
  - 6+ comorbid conditions
  - Specific conditions
- **Risk factors—demographic, logistic**
  - Prior hospitalization
  - Black race
  - Reduced social network indicators
  - Lower socioeconomic status
- **LACE index**

Source: Alper et al.

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Carolinias readmissions

- **2015 penalties**

<table>
<thead>
<tr>
<th></th>
<th># Hospitals Penalized</th>
<th>% All Hospitals Penalized</th>
<th>Average Penalty</th>
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</thead>
<tbody>
<tr>
<td>North Carolina</td>
<td>76</td>
<td>68</td>
<td>0.56%</td>
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<tr>
<td>South Carolina</td>
<td>47</td>
<td>75</td>
<td>0.57%</td>
</tr>
<tr>
<td>National</td>
<td>2592</td>
<td>54</td>
<td>0.61%</td>
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</tbody>
</table>


- **Initiatives:**
  - NC: Community Care of North Carolina
  - SC: Preventing Avoidable Readmissions Together (PART)
Exlore How Hospice/Palliative Care Can Help

What’s working to reduce readmissions?

- It depends . . .
How do Hospice/Palliative Care fit in?

- Almost 7% all Medicare pts dc alive die within 30 days; <2% dc are referred to hospice
- When dc to hospice, 6x less likely to readmit
- 78% hospitals NO readmissions from hospice
- When dc to hospice, cost savings ~$2300/pt
- Study: If pt received IPC consult,
  - Pts dc home with no services 3.73x more likely to be readmitted than other pts
  - Pts dc to SNFs were 4.97x more likely to be readmitted
- Our patients; we can help!


Message essential services

https://www.youtube.com/watch?v=0SDNl-dhPeM
Proactively approach partners

- **Hospitals**
  - Develop specialty areas in HF, COPD management
  - In-services on terminal criteria for HF, COPD
  - In-services on ACP for non-terminal pts
  - Seat on ethics committee
  - Educate how HPC can reduce readmissions (and $$)
  - Reach out to affiliated MD groups, referring specialists
  - Improve transfer processes and forms
  - Provide IPC consult service or partner with IPC team to identify appropriate pts
  - Contract for support of hospice residence
  - Financial support for community-based palliative care

- **Nursing facilities**
  - Help them reduce their readmissions, keep beds filled
  - In-services on terminal criteria
  - In-services on ACP for non-terminal pts
  - MD—MD meetings and collaboration
  - Improve transfer processes and forms
  - Assist with prognostication and assessing appropriateness for PC and hospice (Flacker scale)
  - Collaborate on hospice residence within SNF/NH
Proactively approach partners

- Hospital-SNF-Hospice collaboration
  - Regular “council” or “continuum” meetings to discuss readmissions factors, processes, progress
  - Case reviews, including interview of patients/families
  - Share data
  - Critique and improve processes
What do you need to know?

- Know your data (and your competitors’)
  - Referral sources
  - Diagnosis mix
  - ALOS/MLOS by dx
  - Availability of PC

What do you need to know?

- Know your partners’ data (hospital, SNF)
  - IPC services, utilization
  - ALOS/MLOS by dx
  - Admission/dc diagnosis mix
  - Readmissions rate by diagnosis
  - Deaths by diagnosis
  - Potential benefit in earlier dc to hospice
    - Hospital: ↓ Mortality, LOS, readmissions
    - SNF: Better pt care, readmissions
Sources of information

- Your data
- Hospice Analytics InfoMAX
- Hospice Analytics special reports
- Hospital Compare (Medicare Data sets: [https://data.medicare.gov/data/hospital-compare](https://data.medicare.gov/data/hospital-compare))
- Nursing Home Compare (Medicare Data sets: [https://data.medicare.gov/data/nursing-home-compare](https://data.medicare.gov/data/nursing-home-compare))

Interpret data/Identify Partners/Develop Approach
## Let’s pretend . . .

<table>
<thead>
<tr>
<th>Hospital</th>
<th>% All Admits</th>
<th>ALOS</th>
<th>% HF Died</th>
<th>% HF DC</th>
<th>% Re-admit</th>
<th>% All Admits</th>
<th>ALOS</th>
<th>% Died</th>
<th>% COPD DC</th>
<th>% Re-admit</th>
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<td>12.9</td>
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<td>13.4</td>
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<td>7</td>
<td>93</td>
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<td>Bigumpus Hospital</td>
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<td>10.3</td>
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<td>6.92</td>
<td>5</td>
<td>9.2</td>
<td>90.2</td>
<td>27.5</td>
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</tbody>
</table>

## References

Thank you

Please contact Cordt Kassner, PhD, at Hospice Analytics with any questions, comments, feedback, or for additional information:
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* Review the new National Hospice Locator at www.HospiceAnalytics.com – geo-maps and detailed information on every known hospice in the United States!