Population Health Considerations for Connecticut’s Healthcare Systems

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Impact of health disparities, reflected in higher health care spending, lost productivity and premature death, is approximately $309 billion annually in direct and indirect costs.

Joint Center for Political and Economic Studies. The Economic Burden of Health Inequalities in the United States

Black infants are almost four times as likely to die from complications related to low birth weight.

U.S. Department of Health and Human Services. HIS Fact Sheets

Members of racial and ethnic populations, even among insured populations, are less likely to receive preventive health services than are members of the majority population.

Institute of Medicine. Challenges and successes in reducing health disparities

Patients are 29% more likely to be hospitalized if they have limited health literacy skills.

Joint Commission. Improving Health Literacy

More than 50% of healthcare costs are attributed to 5% of the population

National Institute for Healthcare Management Foundation Data Brief July 2011
Chronic Disease Forecast

• Predicted chronic obstructive lung disease to be #3 cause of death by 2020
  • According to CDC milestone hit April 2011
• Patients >65 years will increase 73% by 2025
  • Over 80M baby boomers
• 20-27% primary MD shortage by 2025
  • Allergists, gerantologists, anesthesiologists
• Over 100M Americans have chronic health condition

Healthcare Disparities Spectrum

- Cardiovascular Disease
- Obesity
- Cancers
- Diabetes
- SIDS
- Asthma
- Early Hospital Readmissions
- HIV/AIDS
- Preterm Delivery
- Sexually Transmitted Infections
- Infant Mortality
- Chronic Renal Disease
- Oral Health Outcomes
U.S. Hospital Readmission Challenge

4 PILLARS OF TRANSITIONAL CARE: LOWERING READMISSION COSTS

- $26 BILLION PER YEAR: COST OF READMISSIONS FOR MEDICARE PATIENTS ALONE
- $17 BILLION PER YEAR: COST OF PREVENTABLE READMISSIONS FOR MEDICARE PATIENTS ALONE

- COMPREHENSIVE CARE COORDINATION: 56% OF NON-FEDERAL ACUTE CARE HOSPITALS AND 31% OF PRIMARY CARE PHYSICIANS DO NOT USE EHRs
- MEDICATION MANAGEMENT: 66% OF PREVENTABLE MEDICATION ERRORS HAPPEN DURING TRANSITIONS IN CARE
- IMPROVED HAND-OFFS: 2X PATIENTS WERE TWICE AS LIKELY TO REPORT A PROBLEM IF THEIR PRIMARY CARE PROVIDER WAS UNAWARE OF THE HOSPITALIZATION
- POST-DISCHARGE FOLLOW-UP: 25% DECREASE IN PATIENT SATISFACTION WHEN THEY DID NOT RECEIVE A FOLLOW-UP PHONE CALL ABOUT THEIR MEDICATION INSTRUCTIONS

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Glossary of Key Terms

- **Health Disparities**
  - Particular health difference closely linked with social, economic, environmental, exclusion disadvantage
  - Preventable or avoidable factors

- **Healthcare Disparities**
  - Difference in quality of care when there is equal access and same preference and need for treatment
  - What we may “own” as healthcare systems
Determinants of Population Health

- Genes & Biology
- Health Behaviors
- Medical Care
- Total Ecology
- Social/Societal Characteristics

http://www.cdc.gov/socialdeterminants/FAQ.html

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Healthcare Disparities

- No simple cause or solution
  - Societal, behavioral biologic factors
  - Barriers encounters in health systems
  - Quality and access to care

- Latest healthcare systems challenges
  - Alternative value based payment models
  - Population health approach
  - Provider-patient centricity
  - Policy and health system prioritization
  - Stakeholder alignment
## Changing Healthcare Paradigm

<table>
<thead>
<tr>
<th>Traditional focus</th>
<th>Transformational Focus</th>
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<tr>
<td><strong>Immediate Clinical needs</strong></td>
<td><strong>Comprehensive needs of the whole person</strong></td>
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<td><em>Patients are the recipients of care and the focus of the care team</em></td>
<td><em>Pts and family members are essential and active members of the care team.</em></td>
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<tr>
<td><em>Variety of different teams</em></td>
<td><em>Cross continuum Team with a focus on the pts experience over time</em></td>
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[www.ihi.org/knowledge/pages/audio and video/ihi approach to reducing avoidable rehospitalizations.aspx](http://www.ihi.org/knowledge/pages/audio and video/ihi approach to reducing avoidable rehospitalizations.aspx)
Early Hospital Readmissions

- 30% Medicare hospitalizations are followed by early or within 30 days readmission
- 90% appear to be unplanned and result from clinical deterioration
- 75% preventable, $12B yearly to Medicare costs according to MedPAC
- Only 50% rehospitalized had MD visit before readmission
  - Unclear if lack of MD visit causes readmissions
  - Lack continuity of care key for chronically ill
Early Hospital Readmissions

- Data suggests many rehospitalizations are preventable
  - Many rehospitalized before seeing MD
  - Interhospital and interstate variations
  - Randomized clinical trials and pilot interventions
  - Ethnic, racial and population disparities
- Actual percentage truly “avoidable” not clear
- Likely hospitals, physician, longterm facility, pharmacy and community collaboration can prevent more readmissions than just hospitals alone
Hospital Readmission Reduction Program

- Legislative context shaped HRRP
  - 2010 Patient Protection and Affordable Care Act
    - Faced stiff opposition
    - To get passed programs inserted to reduce the total cost burden
- HRRP is one cost reduction program
- Estimated to reduce Medicare payments by $7.1B between 2013-2019

Hospital Readmission Reduction Program

HRRP reimbursement penalty for general acute care hospitals that have readmissions CMS deemed “excess”

- Began October 1, 2012
- Reduction 2% in 2014, 3% beyond 2015
- Sole community hospitals, Medicare-dependent small rural hospitals, and low volume conditions are exempt from penalties
- Reductions apply to total DRG reimbursement endorsed by the National Quality Foundation (NQF)
  - Acute Myocardial Infarction
  - Heart failure
  - Pneumonia


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HRPP Reimbursement Penalties

- 2,211 hospitals received penalties for high readmission rates in 2013
  - Forfeited about $280 million in Medicare funds
- According to Medicare, 2 out of 3 hospitals evaluated failed to meet new standards for preventing 30-day readmissions
- Penalty rate up to 1% x total Medicare reimbursement/year = lost revenue

Rehospitalizations in Medicare Fee-for-Service (FFS) Program

- One in five Medicare beneficiaries are readmitted within 30 days equating to 2.3M patients
- National cost of over $17B
- 50% of patients readmitted had physician contact
- 70% of surgical readmits were for chronic medical conditions
- Potentially up to 75% of all hospital readmissions are preventable

NEJM, Stephen F. Jencks, MD, MPH, Mark Williams, MD and Eric A Coleman, MD MPH
Avoidable Hospital Readmissions

- Readmissions are indicator of quality of care
- As facet of healthcare disparities
- Review 34 studies published between 1966-2010 of readmissions deemed avoidable
  - 24% were deemed avoidable
  - Adults received only 55% of recommended care

1. Carl Van Walraven, MD MSc, Carol Bennett, MSc, Alison Jennings, MA, Peter C. Austin, PhD, Alan Forster, MD MSc. Proportion of hospital readmissions deemed avoidable: a systematic review. April 19-11 vol183 no. 7 E391-E402

2. Elizabeth McGlynn, Steven Asch, John Adams, Joan Keesey, Jennifer Hicks, et al. The Quality of Health care delivered to adults in the united states. NEJM.
Hospital Readmission Factors

- 69% were noncompliant with medications
- 51% lacked knowledge of how to use therapy devices
- 45% inadequate knowledge of medications
- 42% unable to self manage care
- 37% had no follow up visit with physician
- 31% develop infection post discharge

AARC August 28-12 "Hospital to Home-efforts at Reducing Hospital Readmissions”. Greg Spratt BS, RRT; Kimberly Wiles BS, RRT; Becky Anderson RRT
Readmissions Not the Only Change

Moving away from fee-for-service

- Pay-for-Performance (P4P) and Value-Based Purchasing (VBP), alternative payment models
- Rewards physicians, hospitals, medical groups and other providers for certain performance measures for quality and efficiency and coordinated care
- Rewarding hospitals for the **quality** of care they provide to Medicare patients, not just the **quantity** of procedures they perform

Find article in my favorites: Readmission 2012 and it has CMS and frequently asked questions.
Patient Satisfaction - HCAHPS

20 Key Performance Measures

- Nurse communication
- Cleanliness and quiet
- Doctor communication
- Responsiveness of hospital staff
- Pain management
- Discharge information
- Communication about medications
- Overall rating of hospital

Compare Your Hospital

Medicare.gov
The Official U.S. Government Site for Medicare

Hospital Compare

Find a Hospital

Required Search:
Location - ZIP Code or City, State or State
Example: 21244 or Baltimore, MD or Maryland

Optional Search:

Hospital Spotlight

- Hospital Compare has new measures related to:
  - Emergency Department Timing
  - Outpatient Health Information Technology
  - Surgical Site Infections
  - Linking Quality To Payment - Get data on the Hospital Readmissions Reduction

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Opportunities to Prevent Readmissions

Improve Quality Of Inpatient Care

Education

- Identify a champion
- Customize patient education approach
- Use teach back regularly
  - Especially understanding discharge instructions
- Teach patient self-managed care
- Involve different disciplines to teach

Average of 8 minutes spent on patient education in hospital

- **No** reimbursement for readmission education

Opportunities to Prevent Readmissions

Improve Quality Of Inpatient Care

Multidisciplinary rounds
  o Scheduled times to discuss patient as a team
  o Set up a discharge plan that is looked at and signed off across disciplines

Coordination rehabilitation facilities
  o Within 1-3 days of discharge
  o Teach and explain medications and lifestyle changes, exercise

Establish follow-up plan before discharge
  o Provide patient medications at discharge
  o Have a dedicated advocate or healthcoach at discharge and beyond
Opportunities to Prevent Readmissions

Early post discharge follow-up
  - Remote monitoring, telehealth, sensors
  - Reconciliation of medications, coordination with pharmacy and community entities

Proactive rather than reactive
  - Overall lack of preventative healthcare
  - Population health and care in context

Socioeconomic Determinants of Health
  - Education, housing, transportation, costs
  - Health equity, implicit biases in medicine

Collaborative Care and Hospital Readmissions

- Reducing Early Hospital Readmissions
  - Need for improved community care and education
  - Implementing Medical Home /Chronic Care Model
  - Chronic care requires different payment structures
  - Changes in Payment for primary and chronic care
  - Lower readmissions provides return on investment (ROI) of chronic care and preventative care investment
  - Impact healthcare disparities and improve population health outcomes
Prioritization and Involvement

- Address proactively
  - What projects can be championed? What committee meetings do you need to be represented
  - Infection Prevention - delegate attendance to multidisciplinary meetings to trusted and respected front line staff

- Reach beyond comfort zone
  - Coordinate nursing, finance, materials management to identify most effective evidence-based models and practices

- Racial and ethnic disparities in readmission rates at Connecticut’s hospitals
Common Systems Misalignments

- Lack of transfer of information to patient
  - Understanding of how to use medications after hospital discharge
  - Lack of understanding warning signs that warrant an emergency call to their physician

- Lack of transfer of information to ambulatory caregivers
  - Hospital to long care facility staff
  - Hospital to primary care physician
  - Lack of clarity on end of life care preferences
Common Systems Misalignments

- Lack of timely post-discharge physician visit
  - PCC unaware of hospitalization
  - Patient has no transportation to PCC
  - Patient has no PCC
- Lack of patient knowledge and nondisclosure of current drug therapy or inadequate medication reconciliation may yield drug therapy duplication or interaction
- Often patients unlikely to ascribe adverse effects to causes, might not ask for change in drug therapy
Health Policy Rationale for Readmission Prioritization

- Early hospital readmissions are increasingly costly, frequent and often avoidable
- U.S. ethnic and racial profile has changed
- Indicator of quality of care
- Public and child health implications
- CMS Hospital Readmission Reduction Program (HRRP)
- Professionalism and ACGME medical education core competency
- Health system sustainability and market advantage
Systems Readmission Strategic Goals

- Significant ethnic and racial disparities across Connecticut can be reduced
- Patient versus task-centered
- Outcomes, evidence-based approach
- Coordination and continuum of care
- Action beyond individual providers
  - Physician groups, patients, community, payers, researchers, funders, government and other stakeholders
Question and Comments?