Data Analysis to Support Hospital Efforts in STAAR

Rehospitalization Data 201, Lecture A.

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Known Major Issues

- Exclusions from “counting” as a rehospitalization.
- Available measures of rehospitalization rates.
- Dealing with rehospitalizations at other hospitals.
- Data from patients and families.
- Tracking change.

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Exclusions from “counting” as a rehospitalization.

- “Planned” rehospitalizations may be wasteful, unnecessary, or system-gaming, but they are not best dealt with through better transition management. Counting may distort practice. Exclusion, even excessive exclusion may be OK.
- “Unpreventable” and are subjective and exclusion seems problematic.
- “Unrelated” are rare and often subjective. Exclusion is a lot of work for little gain.

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Available measures of rehospitalization rates:

- Do not produce the same results.
- Do not produce the same hospital rankings.
- Are important for payment, for inter-hospital comparisons, and perhaps for benchmarking.

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Available measures of rehospitalization rates: Hospital Compare (CMS)

- Will likely be basis for Medicare penalties starting next year.
- Limited to Medicare FFS discharges for heart attack, heart failure, and pneumonia.
- Sophisticated risk adjustment but requires ambulatory claims data.
- No exclusions for scheduled rehospitalizations.
- Can only change slowly with time (sample size).
- NQF endorsed.

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Available measures: Potentially Preventable Readmissions (3M)

- Under consideration or adopted in several states.
- Produces rates about half of CMS and UHC.
- Many exclusions but no explicit criteria for them and many seem debatable.
- Proprietary, and the major market is hospitals, not payers or public agencies.
- NQF declined to endorse.

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Available measures of rehospitalization rates: UHC

- The simplest model.
- Almost no exclusions.
- Produces overall rates similar to CMS.
- Not in broad use, but is very similar to NEJM paper.
- NQF endorsed.

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Dealing with rehospitalizations at other hospitals.

- A quarter of 30-day rehospitalizations occur at a hospital that did not discharge the patient.
- That fraction varies a lot among hospitals.
- A hospital must depend on a statewide or national data source for this information.
- The data source cannot give you patient names but can generally provide both patterns and names of hospitals rehospitalizing many of your patients.
- This issue should be pursued in parallel with or after understanding same-hospital rehospitalizations.

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Data from patients and families.

- Patients and families know more than anybody else about what happened and where care was fragmented.
- Non-scientific sampling of rehospitalized patients is a good starting point.
- Your hospital likely has some survey data from discharged patients/families.

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Tracking change

- Consider using volume of rehospitalization rather than rates to track progress.
- Rates are informative if admission volume remains constant, but if admission volume remains constant you already have a strong suspicion that things are not improving.

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DISCUSSION

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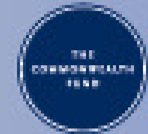
STate Action on Avoidable Rehospitalizations



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