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The Financial Impact of Readmissions

A STAAR Initiative Webinar

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Agenda

- Discuss: Why do this analysis?
- Describe the approach of the “roadmap”
- Present key findings from 16 analyses
- Ask you to test the roadmap & share learning on 5/26/10 webinar

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Why do this analysis?

- Myths and back of the envelope calculations
  - "We stand to lose millions…" when Medicare stops paying….
  - "Readmissions are already a financial loser for hospitals…"
  - "Medicare doesn't pay for readmissions…"
  - "Hospitals will be able to replace low acuity readmissions with higher acuity admissions…"

Add data and dollar signs to conventional wisdom

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Why do this analysis?

- Cautionary tales from successful efforts in the past
  - Research efforts stopped after grant funding expired
  - Pilot programs ceased after start up funds spent
  - Cost-effective hospital based programs discontinued due to financial impact on hospital bottom-line
    - Both the invested human resources invested to provide better service AND
    - Reduced volume
- We work in an uncertain economic climate
  - A CFO noted that "when we hit our next financial rough spot, I know what FTEs I'll be looking to reduce."

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Why do this analysis?

The challenge:

"But even when hospitals find ways to greatly reduce the return trips, saving money for Medicare and other insurers, their efforts go unrewarded. In fact, because insurers typically pay hospitals to treat patients — not to keep them away by keeping them healthy — hospitals can actually lose money by providing better care. **Empty beds mean lost revenue**. "

(Abelson, R. "Hospitals Pay for Reducing Costly Readmissions", *NYT*, May 9, 2009.)

Why do this analysis?

The challenge:

"Berkshire Medical Center has successfully reduced heart failure readmissions. Regular clinic visitors had a 30-day readmission rate of about 3 percent in 2008, compared to a national average of 24.5 percent among heart failure patients. **However, financially, the hospital lost about 30 heart failure admissions in 2008—or about $225,000 in revenue"**

(Winslow, R. and Goldstein, J., "Cutting Repeat Hospital Trips—Simple Idea, Hard to Pull Off," *WSJ*, July 28, 2009.)

Why do this analysis?

Forewarned is forearmed

- Use your data as the starting point for an informed clinical and financial plan to support successful efforts to reduce avoidable readmissions
- We present this information to support and inform your hospital's efforts to improve the quality, safety, and patient experience of individuals

Approach

1. Asked voluntary hospital finance leaders if they had performed this analysis and if it would be informative for them
2. Hospital finance leader partnered with a clinical leader to look at one patient's story in detail
   - Personal, clinical and financial story
3. Financial leader analyzed revenue, expenses, and margin associated with the entire experience
   - Identified unique factors for the hospital – payment types, capacity constraints, allocation of overhead, efforts to lower overhead, readmissions initiatives, etc.
4. Conducted1 -2 interviews to:
   1. Understand the process used
   2. Hear the lessons learned
   3. Test questions and challenges to the analysis until participants were confident in their process and findings; use it with their colleagues
5. STAAR faculty compiled lessons into case studies and drafted the roadmap tool

Interview Questions

- What percentage of your daily inpatient census is 30 day all cause readmissions?
- What types of patients are in observation status?
- What financial variables do you look at when examining the impact of readmissions?
  - Revenue, expenses, direct and indirect costs, variable and fixed costs, etc?
- What is the average **direct** and **total** margin per patient?
- How does your organization allocate indirect costs?
- If your hospital were to reduce readmissions (30%, 50%), which costs could be influenced and which would remain fixed?
- Is there excess demand in your hospital service area? Would your organization be able to backfill these beds if readmits were reduced?

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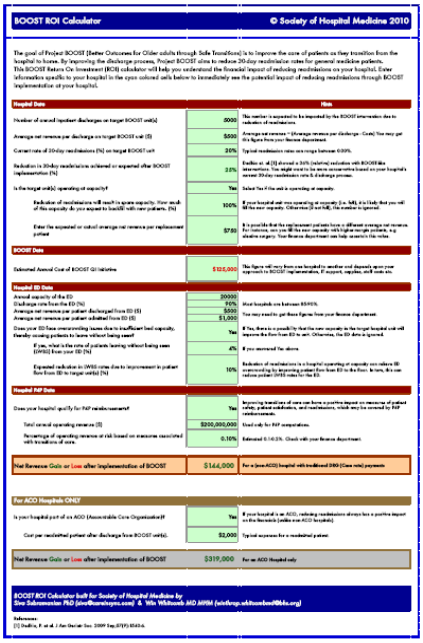
STAAR Financial Impact Analysis Roadmap
1. Calculate the all-cause 30 day readmission rate for the hospital and the percentage of the average daily census due to readmitted patients.
2. Partner Financial Lead with Clinical Lead and review the personal, clinical, and financial story of one (or more) recently readmitted patient(s). - Calculate revenue, expenses, and margin. - Analyze clinical/operational insights from this story.
3. Conduct a financial analysis on a sample set of readmissions for a select time period (1 month, 12 months, etc). - Analyze characteristics of this sample set (payer mix, LOS, conditions, outliers, etc) - What is the average direct and total margin per readmitted patient in this sample?
4. What financial variables does your hospital consider when examining the impact of readmissions? - Revenue, expenses, direct costs, indirect costs, variable costs, fixed costs, etc. - How does your organization define direct, indirect, fixed and variable costs? - How does your organization allocate indirect costs?
5. How do readmissions to your hospital, *today,* influence your hospital's bottom line?
6. If you were to successfully reduce readmissions by 10%, 30%, 50%, which costs would be influenced and which costs would remain fixed?
7. What is your hospital's ability to influence (reduce) fixed costs? In the near and long term?
8. Is there latent demand in your hospital service area? Would you expect to keep volume stable if readmissions decreased? What would happen to ED visits? Observation stays?
9. What there anything that surprised you about this analysis?
10. Is there anything that your hospital will do differently as a result of this analysis?



BOOST ROI Calculator — © Society of Hospital Medicine 2010

http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/PDFs/BOOST_ROI_Calculator.pdf

Example Findings

- One-year 30d readmissions to System A:
  - 49% of (non-OB) admissions to medicine
  - 82% readmissions to medicine
  - 71% discharged to home
  - 62% readmissions Medicare patients
- System B:
  - 73% all payer non-OB readmissions were Medicare
  - 86% “unplanned” (as opposed to “elective)

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Example Findings

- Hospital A:
  - Average daily inpatient (non-OB) census = 80 patients
  - 12 of 80 were patients who had been readmitted
- Hospital B:
  - Numbers of patients readmitted to/from observation stays within 30 days were high; he wanted to account for total patient utilization of ED, observation beds, and inpatient beds in analysis

Hospital A: Financial Findings

Expense		$ readmits	$ all pts
Average readmitted patient revenue	=	$ 12, 200	
- Average direct costs (fixed and variable)		$ 7, 800	
- Average indirect variable costs		$ 1, 000	
Average contribution margin	=	$ 3, 400	$ 5, 500
- Average indirect fixed costs		$ 3, 400	
Average total margin per readmitted patient	=	$ 0	$ 1, 600

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System A : Financial Findings

75% readmitted patients had positive contribution margin		$ readmits	$ system wide
Average contribution margin	=	$ 2, 300	
- Average indirect fixed costs and - indirect cost assessment for system			
Average total margin per readmitted patient	=	$ (900)	$ (3, 000, 000)

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Hospital B: Financial Findings

2009 30-day All-Payer Readmissions Financial Variables

Expected Payments	**$8,049,988**
Direct Costs	$5,844,682
Direct Margin	$2,205,306
Total Costs	$8,883,059
Total Margin	-$833,071

Yearly financial projections assuming 30% decline in readmissions

	Current state	30% decline in readmissions
Indirect costs	$3,038,377	$3,038,377
Direct (variable) costs	$5,844,681.63	$4,091,277.14
Total margin	($833,071)	(1,494,663)

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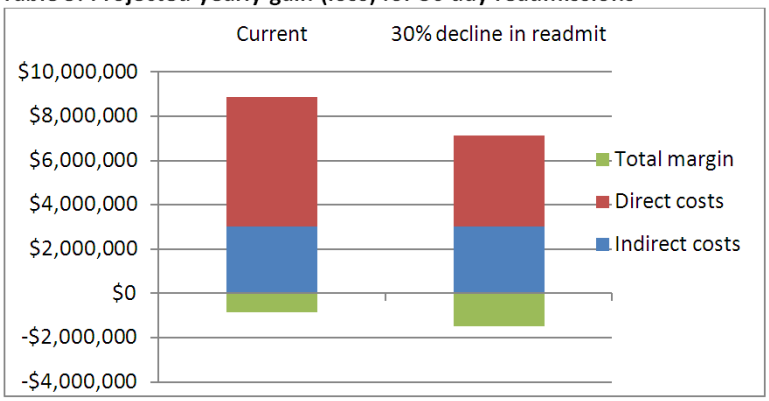
Hospital B: Financial Findings

Table 5. Projected yearly gain (loss) for 30 day readmissions



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Key Observations

- Financial partners found this exercise to be valuable and highly illuminating; surprising
- CFO – Clinical Leader partnering provided powerful joint learning
- CFOs offer a novel system-perspective to QI work
- Reimbursements for readmissions are greater than direct costs
  - Readmissions generate revenue, especially when hospitals do not operate at capacity
  - Readmissions lead to a reduction in hospital volume (at least in the short term)

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Key Observations

- Most costs associated with readmissions are fixed
- Hospitals have high fixed-cost structures
- Reducing readmissions require re-thinking fixed cost reductions
- Reducing readmissions requires incorporating this quality goal into longer term financial and strategic planning discussions
- This analysis can help inform payment and policy conversations

Framing the issue

- Most rehospitalizations are defects in care
- Reducing readmissions is possible
- Better care transitions is the right thing to do
- We need to understand the short-and-long term financial implications of reducing readmissions to support planning for success and avoid clashing priorities
- These insights can stimulate innovation in building the bridge to the future of high value, coordinated healthcare

Next Steps

- Volunteer to use the Roadmap and share learning
- Next call:
  - May 26, 2010
  - 1-2p ET
  - Agenda: Insights from hospitals who have tested the Roadmap

Note: this webinar is recorded, please encourage your colleagues to access this material if they are interested

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STate Action on Avoidable Rehospitalizations

An initiative of The Commonwealth Fund & the Institute for Healthcare Improvement

Discussion