Using Medicare Data to Drive Improvement: Place, Value and Change

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Community Based Improvement

- All the components needed to construct a health system are within a region
- Common values are more likely to emerge
- Solutions to problems depend upon context, and context is known most accurately locally
- Platforms for dialogue exist or can be created
- Other health determinants are attributes of a region

Nolan TW. US Health Care Reform by Region. Cambridge, Massachusetts: Institute for Healthcare Improvement; February 2010. Accessed October 11, 2010 at http://www.ihi.org/knowledge/Pages/Publications/USHealthCareReformbyRegion.aspx.

This project:

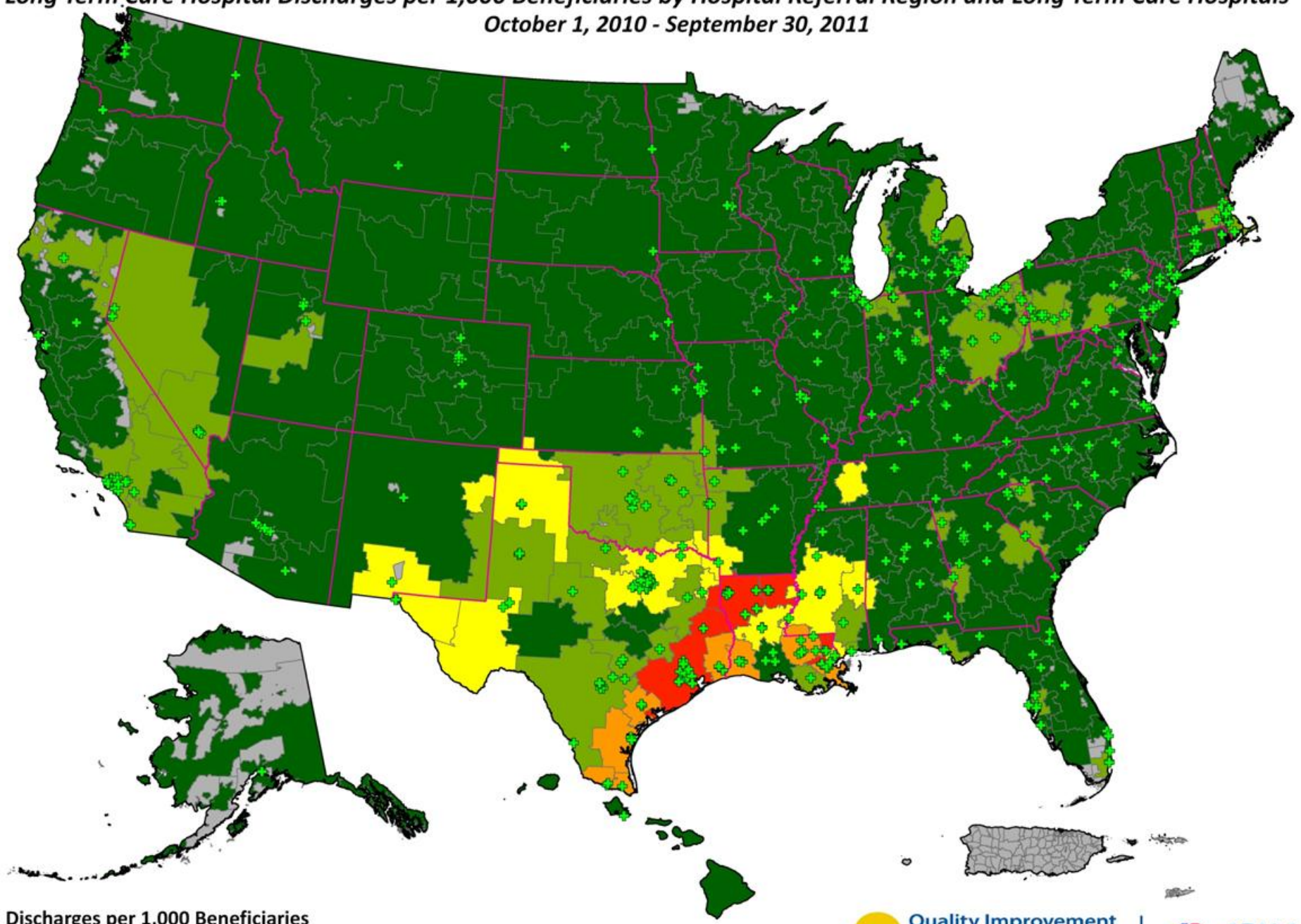
- From the proposal generally
  - " To work with communities that show substantial variation in cost, quality, or both in comparison with national norms"
- From the LTCH focus
  - Utilization and expense
- Calculation
  - The chosen ones…

The role of LTCH within a regional system of care

- From MedPAC
  - Distinguish medical complexity
  - Ensure equitable payments
- From the LTCH advocacy website
  - Higher quality, lower mortality
- From CMS…
  - Data…

Long Term Care Hospital Discharges per 1,000 Beneficiaries by Hospital Referral Region and Long Term Care Hospitals

October 1, 2010 - September 30, 2011



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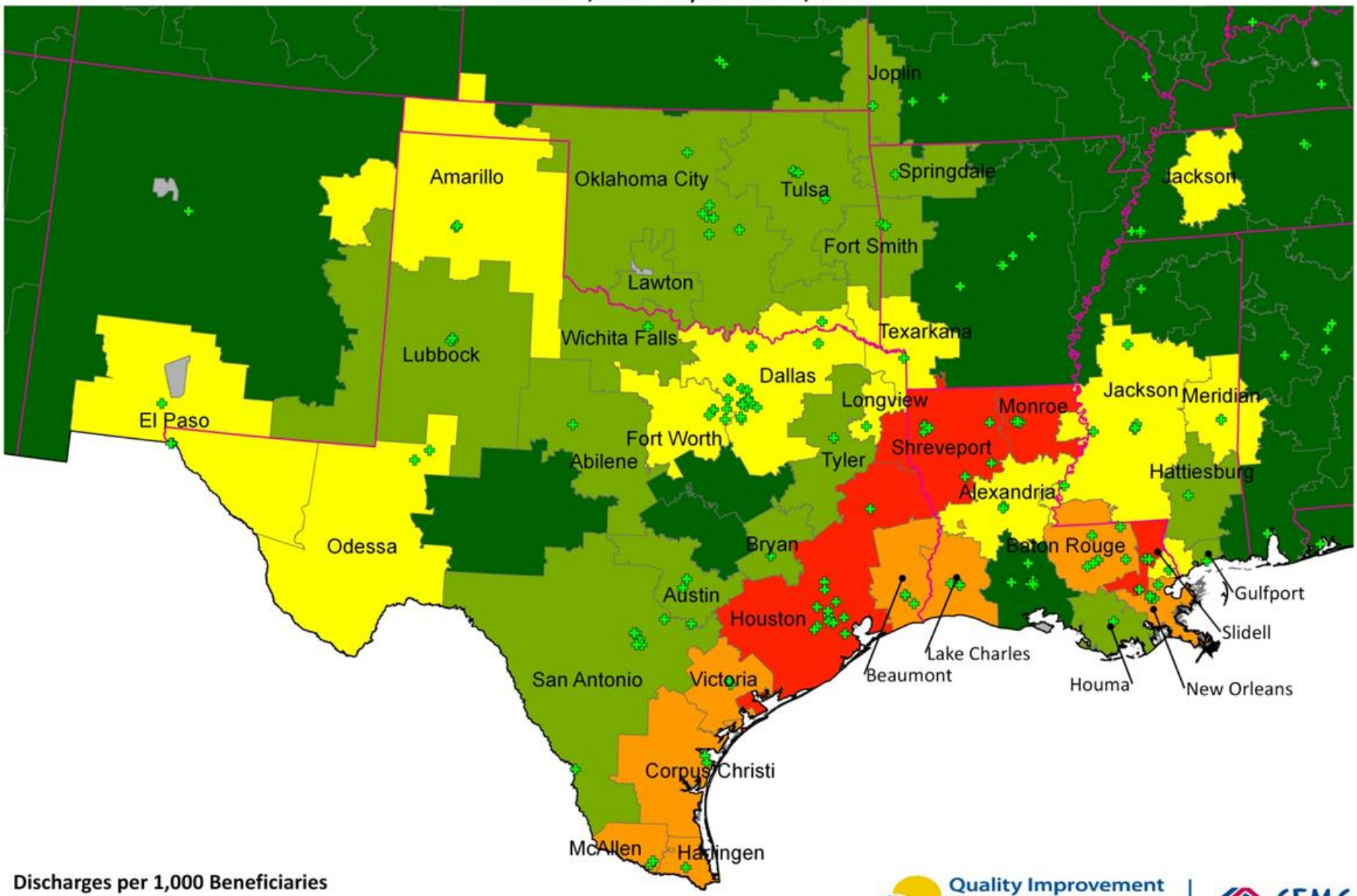
Data Source: www.dartmouthatlas.org

Long Term Care Hospital Discharges per 1,000 Beneficiaries by Hospital Referral Region and Long Term Care Hospitals

High Discharge Rate Spotlight

October 1, 2010 - September 30, 2011



Discharges per 1,000 Beneficiaries

- 0.14 - 5.00
- 5.01 - 10.00
- 10.01 - 15.00
- 15.01 - 20.00
- 20.01 - 34.27
- ZIP Codes not included in an HRR
- Long Term Care Hospital
- State
- HRR Boundary

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Selecting Areas

Considered:

- LTCH per capita costs
- LTCH share of PAC per capita costs
- Total per capita costs
- Average risk score
- Share of episode costs going to LTCH

The Chosen Ones

		Number of Beneficiaries	Total per capita RA/STD	LTCH per capita RA/STD	LTCH Share of All PAC (RA/STD $'s)	Avg Risk Score
	Nation	**25,832,920**	**$7,500**	**$80**	**6.4%**	**1.15**
High LTCH HRR	LA - Shreveport	75,149	$9,104	$785	31.5%	1.19
	TX - Houston	371,152	$8,559	$431	21.8%	1.15
Low LTCH HRR	NY - Albany	187,577	$6,568	$3	0.4%	1.19
	CA - Santa Cruz	20,484	$6,027	$2	0.2%	1.13

The ‘low’ communities

- Albany, NY
  - High efficiency Medicare region w/o a LTCH
  - In a state with CON program
  - Medicaid as a prominent payer
- Santa Cruz, CA
  - Efficient market overall w/o a LTCH
  - High rate of hospice/palliative care use
  - Effective HC collaborative structure (15+ years)
- Now thinking about LTCH – starting with a community needs assessment

The ‘high’ communities

- Houston, TX
  - 23+ LTCHs
- Shreveport, LA
  - 5 LTCHs (39 in the state)

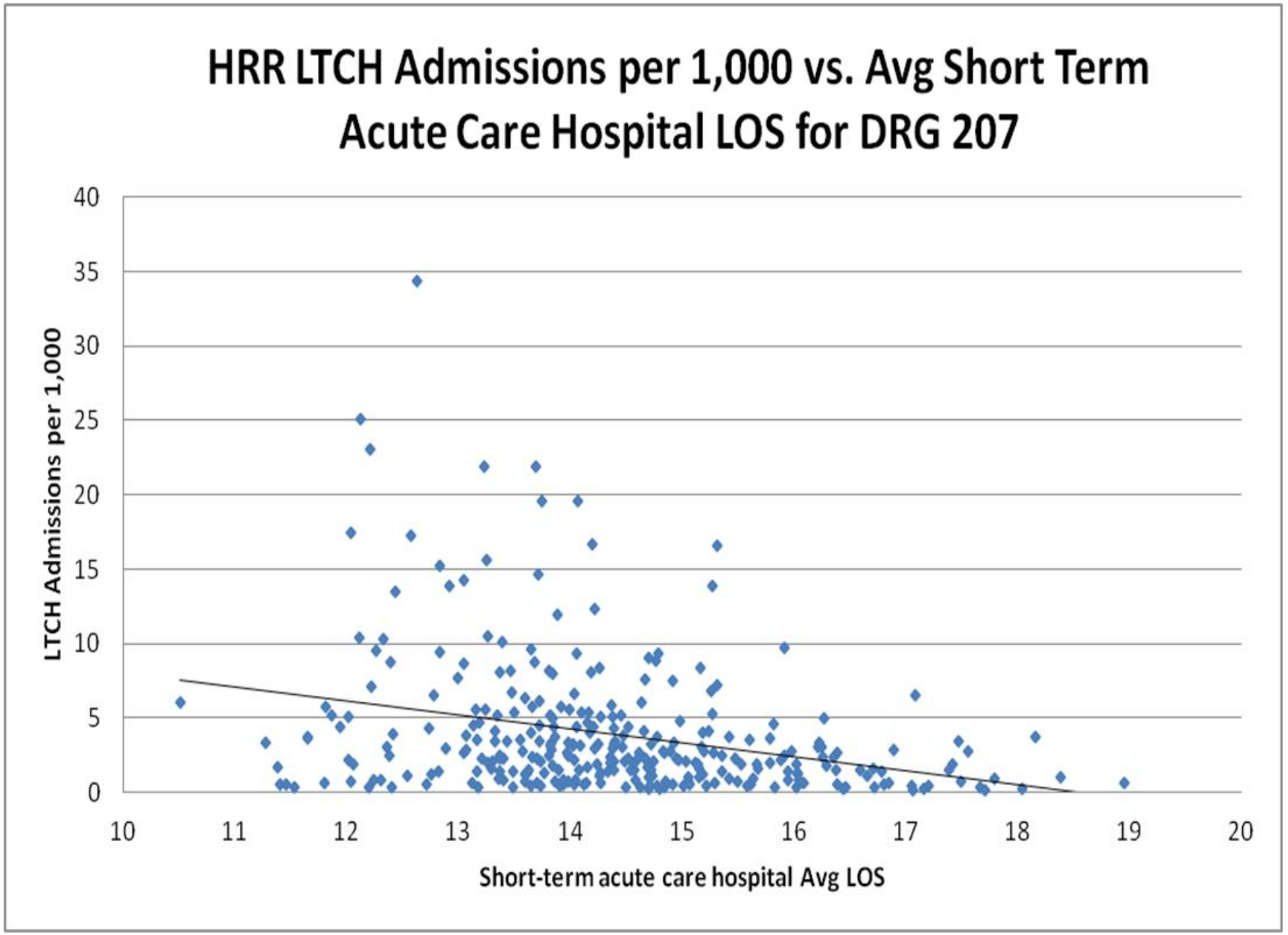
Top LTCH DRGs by HRR

DRG	National (n=35,836,293)			Houston HRR (n=531,928)			Shreveport HRR (n=101,478)			Dallas HRR (n=447,750)			Boston HRR (n=662,180)			Los Angeles HRR (n=735,258)		
	Rank	*#*	*%*	*Rank*	*#*	*%*	*Rank*	*#*	*%*	*Rank*	*#*	*%*	*Rank*	*#*	*%*	*Rank*	*#*	*%*
207	1	16,732	11.4%	4	583	4.8%	11	77	2.2%	2	312	5.9%	3	303	5.5%	3	467	7.1%
189	2	13,484	9.2%	3	750	6.2%	1	410	11.9%	1	405	7.7%	1	643	11.8%	4	369	5.6%
871	3	8,541	5.8%	1	1,221	10.0%	2	297	8.6%	4	198	3.8%	10	112	2.0%	1	1,341	20.4%
177	4	5,048	3.4%	2	835	6.9%	9	86	2.5%	3	229	4.3%	7	144	2.6%	2	539	8.2%
592	5	3,498	2.4%	7	333	2.7%	3	140	4.0%	6	171	3.2%	NR	NR	NR	17	85	1.3%

DRG	National (n=35,836,293)			Houston HRR (n=531,928)			Shreveport HRR (n=101,478)			Dallas HRR (n=447,750)			Boston HRR (n=662,180)			Los Angeles HRR (n=735,258)		
	Rank	*LOS*	*Pymt*	*Rank*	*LOS*	*Pymt*	*Rank*	*LOS*	*Pymt*	*Rank*	*LOS*	*Pymt*	*Rank*	*LOS*	*Pymt*	*Rank*	*LOS*	*Pymt*
207	1	36	$65,051	4	35	$67,067	11	39	$63,090	2	37	$71,022	3	54	$71,713	3	39	$78,847
189	2	25	$29,927	3	22	$31,667	1	24	$29,710	1	22	$32,007	1	47	$32,960	4	25	$36,761
871	3	23	$28,065	1	23	$29,836	2	25	$27,660	4	22	$27,844	10	26	$29,820	1	25	$33,302
177	4	23	$29,554	2	24	$32,074	9	26	$28,315	3	24	$31,380	7	23	$26,775	2	26	$34,936
592	5	27	$28,047	7	26	$31,092	3	28	$27,084	6	25	$29,139	NR	NR	NR	17	31	$35,776

207: respiratory w/ vent > 96 hrs; 189: pulmonary edema; 871: septicemia; 177: respiratory w/ MCC; 592: skin ulcers w/ MCC

Table depicts average LOS and payment figures for Medicare FFS beneficiaries


HRR LTCH Admissions per 1,000 vs. Avg Short Term Acute Care Hospital LOS for DRG 207
LTCH Admissions per 1,000
40
35
30
25
20
15
10
5
0
10
11
12
13
14
15
16
17
18
19
20
Short-term acute care hospital Avg LOS

Potential CMS data sources

- Available now
  - Hospice/SNF
- In process
  - Sequential claims (care pattern analysis)
  - Medicaid data (potential cost shifting)
  - Part B data (role of outpatient providers)
- Future possibilities
  - ICU claims
  - Interrupted stays/readmissions to acute care hosp
- Currently unavailable
  - Palliative care

So the question is…

What should we/policymakers know when they look at the national map?

- Where should these patients go?
  - Where DO they go in Albany and Santa Cruz??
- How can we know that LTCH referral is the best option?
- How can we better show the role of LTCHs in community care patterns?
  - Short term acute hospital LOS?
  - Appropriate referral to EOL services?
  - P-DC Mortality? (30d, 90d, 365d, other?)
- How does value (cost/outcome) vary?