3M Potentially Preventable Readmissions (PPR)

Frequently Asked Questions

Contents

AHCA Related Questions

1. How will readmission data be displayed on the site?

The readmission rates will be displayed and defined as follows:

- Lower than Expected - Fewer readmissions than expected given how sick patients were
- As Expected - Expected number of readmissions given how sick patients were
- Higher than Expected - More readmissions than expected given how sick patients were
- Facilities with less than 30 cases will be displayed as an 'X'.

2. When will pediatric reporting begin for readmissions?

The pediatric readmission reporting does not have a tentative date at this time. This will be discussed further with the State Consumer Health Information and Policy Advisory Council.

3. Will this information be displayed by physician?

No, not at this time – only by facility.

4. What is the data source and time period for the readmission rates?

The Florida Center for Health Information and Policy Analysis Hospital Inpatient Database, October 2005 – September 2006

5. Can I get a copy of the audio presentation from January 23, 2008?

The webinar is setup as a zip file download at the following URL:
http://u15246067.onlinehome-server.com/Readmission_webinar/Readmission Data Conference.zip

Username: webinar_guest
Password: 14ahca

6. Will there be a disclaimer to explain the data and its use and limitations?

Yes, AHCA will work with FHA to create the verbiage that will be presented on the website – the definition, why is the readmission rate important, etc.

7. Can my facility receive a copy of the data that will assist us in reviewing those records with readmissions?

Yes, we will send out the process for receiving confidential data. AHCA can only release the confidential data for the requestor's facility.

8. Can I get a copy of the PowerPoint presentation from January 23, 2008?

Yes, please contact Beth Eastman via email at eastmane@ahca.myflorida.com for a copy.

9. Can I be added to AHCA's interested parties list for emails relating to the State Consumer Health Information and Policy Advisory Council and Technical Workgroups?

Definitely, please send an email to Beth Eastman at eastmane@ahca.myflorida.com with your contact information.

10. What are the specific APR-DRGs used in the clinical groupings?

For a complete listing of the conditions and procedures on the FloridaHealthFinder.gov website and their assigned codes, please refer to: http://www.floridahealthfinder.gov/Researchers/Reference/Methodology/Methodology.shtml

11. What is the readmission time interval?

The maximum number of days allowed between an initial admission and readmission for the readmission to be considered potentially preventable. The State of Florida uses a readmission time interval of 15 days.

12. Will the state of Florida be stratifying by payer class, size of hospital and type of hospital in the future?

No, not for this initial rollout. This will be discussed further with the State Consumer Health Information and Policy Advisory Council.

13. Will the percent of patients readmitted within the same hospital be presented in the public reports?

No, not for the initial rollout. This will be discussed further with the State Consumer Health Information and Policy Advisory Council.

14. If a facility does not have a 3M PPR module, how can they track the posted rates back to their patients for review?

Facilities are granted access for release of their confidential data from the Florida Center for Health Information and Policy Analysis upon the submission of their request in writing from their Chief Executive Officer (CEO). The letter must include the reason for requesting the data, type of data requested, and year(s) of data.

If the facility requests the confidential data set with the 3M APR-DRG or APG data elements, the facility must provide documentation that they have a current contract with 3M in addition to the letter from the CEO. Data will not be released without verification of their contract.

For further questions, please contact Adrienne Henderson at hendersa@ahca.myflorida.com or (850) 922-0594.

15. How often are the PPR rates updated on the Florida Healthfinder website?

The PPR rates on the Florida website will be updated quarterly with a rolling 12 months of data.

APR-DRG Related Questions

1. What are the APR-DRGs?

All-Patient Refined Diagnosis Related Groups (APR DRGs) are used to classify patients according to their reason for admission and discharge severity of illness. APR DRGs use data from computerized discharge abstracts to assign patients to one of 314 "base APR DRGs" that are determined either by the principal diagnosis, or, for surgical patients, the most important surgical procedure performed in an operating room. Each base APR DRG is then divided into 4 risk subclasses, determined primarily by secondary diagnoses that reflect both co-morbid illnesses and the severity of the underlying illness, creating the final set of 1,256 groups.

2. How are the APR-DRGs used in the PPR module?

The APR DRGs were used as the basis for establishing the clinical relationship between the index discharge and a readmission. They were also used to stratify the risk of a readmission for the purpose of comparing actual and expected readmission rates across hospitals. The PPR system logic recognizes that the probability that a readmission will occur depends not only on the reason for the initial admission, but also on the patient's severity of illness of the initial admission.

3. As the APR-DRG severity of illness logic is used in the PPR module, what is the definition of severity as used in the APR-DRGs.

Severity of illness (SOI) is defined as "the extent of physiologic decompensation or organ system loss of function." The APR DRG Classification System assignment process assesses the relative severity of the patient's illness. This is accomplished by stratifying each basic class of patients (e.g., patients with coronary bypass surgery) into severity of illness. The four severity of illness subclasses and the four risk of mortality subclasses are numbered sequentially from 1 to 4 indicating, respectively, minor, moderate, major, or extreme severity of illness

PPR Related Questions: Clinical

1. What does the Potentially Preventable Readmission (PPR) Module attempt to accomplish? How does a statistically significant PPR rate increase the probability that a PPR is truly preventable?

If a hospital has a statistically significant higher rate of specific types of readmissions than comparable hospitals, opportunities may exist for either quality of care and/or both coordination process/discharge planning with the outpatient sector. **Most importantly, not all readmissions are preventable.** A PPR is a return admission to an acute care hospital and the return admission is identified as potentially preventable. Preventability is determined by:

1. Identifying that the return admission is related to the initial admission and
2. Determining that the readmission rate could be decreased by **either** providing excellent care during the initial admission and/**or** putting into place the best possible coordination plans with the outpatient setting – including both the outpatient health professional team and the patient/family/caregiver

2. Who developed the clinical logic for the PPR module?

Together with clinicians working with the National Association of Children's Hospitals and Related Institutions, 3M developed PPRs utilizing an expert panel of clinicians from various specialties to review all logic for clinical accuracy. Customer feedback, the result of constant clinician review and validation, was also incorporated into the process. Thus, the PPR module is a clinical model that has been extensively verified with historical data.

3. What are some of the most important clinical aspects of the PPR logic?

1. There are certain global exclusions such as left against medical advice, multiple trauma/burns, neonates, and obstetrical patients.
2. In general, many **(but not all- there are many exceptions)** medical readmissions are potentially preventable when they occur after either medical or surgical initial admissions
3. In general, many (**but not all- there are many exceptions**) surgical readmissions are not potentially preventable when they occur after either medical or surgical initial admissions.

4. What is a readmission chain?

A readmission chain is a sequence of readmissions that are all related to a single initial discharge. For example, a discharge for CABG followed by a readmission for pneumonia, which is then followed by a

readmission for a PTCA, is an example of a readmission chain. The admissions for the pneumonia and the PTCA are both readmissions related to the CABG discharge if they occur within the pre-specified time window. The identification of readmission chains provides for a more precise specification of the readmission pattern associated with the care rendered during and following specific types of initial discharges. This is essential in order to be able to compare readmission rates for specific types of initial admissions across hospitals.

5. How was the PPR methodology adjusted for patients who have an abnormally large number of readmissions (i.e. a long readmission chain), like in the case of a non compliant patient or patient with a sickle cell?

For the State of Florida study, no outlier policy was employed.

6. Are transfers to another acute care hospital considered a PPR?

No. Transfers terminate the readmission chain and they can not be considered an initial admission, therefore they can not start a chain.

7. How does the PPR logic handle readmissions to Long Term Acute Care Hospitals (LTCHs) and Nursing Homes?

LTCH and Nursing home data was not provided in the analysis dataset from Florida and therefore do not impact the PPR assignment or rates. Transfers to these types of facilities are not considered either an initial admission or a readmission. They are termed non-events. They are ignored from the PPR assignment.

8. **How are same day psych and rehab handled in the PPR methodology, as well hospice, swing bed, LTCH and nursing home data? Specifically for Discharge Status 62, 63, and 65?**

Same day psych and rehab discharges will be excluded from the PPR methodology. Thus, when the Florida data is run, same day admissions to a psych and rehab facility or unit following an admissions with a discharge status of 62 or 65 will be treated as a "non-event" and therefore not count as a readmission. We also will include discharge status 05 other facility, 51 hospice medical facility, and 61 swing bed to the list of discharge status that allow a following same day admission to be treated as a "non-event " and therefore not count as a PPR. LTCH and nursing home data are not in the dataset, however, we will also add discharge status 63 and 64 to the list in order to be complete.

9. If a patient were admitted for a heart attack and then discharged to a rehab facility, then the person is readmitted to the hospital with in 15 days for a Coronary Artery Bypass Graft will it count as a PPR?

No, because almost all surgeries are not considered a readmission if they occur within the time window after a medical initial admission

10. How are readmissions for chemotherapy handled in the PPR Methodology?

Chemotherapy readmissions are excluded and are not considered PPRs.

11. How does the use of the POA (present on admission) indicator impact the PPR reports?

The present on admission indicator is not used in the PPR logic.

12. Are same day readmissions excluded from the PPR assignment?

Same day readmissions from an acute care hospital to a psych unit in the **same** hospital are **not** considered readmissions. All other same day readmissions are considered readmissions

13. Will the readmission be counted against the hospital with the original hospitalization, related episode. For example, if a patient with chest pain were discharged from Hospital A and readmitted in 8 days to Hospital B with acute myocardial infarction (and this was considered a PPR), the readmission would be reflected within the rates of Hospital A.

Yes.

14. How frequently does the PPR methodology get updated?

The PPR methodology is updated annually.

PPR-Related Questions: Statistical

1. What patient identifiers were used to identify patients and link them to hospital readmissions?

An encrypted identifier based on a patient's social security was used to link the patient across Florida hospitals.

2. If hospitals do not submit the required patient identifiers/linkage variables or are missing the information on patients (e.g., caring for a substantial number of immigrants without Social Security Numbers or submitting missing or invalid data to AHCA), how are these discharges managed? We are assuming they would be removed from the denominator population but could not find an explanation in the methodology description. Need to move to PPR Related Questions – also, need 3M to identify how unknown social security numbers were handled and if they were removed from the denominator.

Yes. Missing or invalid patient identifiers were masked with the same ID from AHCA and were excluded from the dataset used for hospital PPR analysis.

3. What is the expected risk adjusted readmission PPR rate?

The expected risk adjusted readmission (PPR) rate is the rate that would result if a hospital experienced the same rate of PPRs given its distribution of APR DRG and severity in the state normative reference database. The expected value is relative to the hospital's actual value while the risk adjusted value is relative to actual value in the reference database. The risk adjusted value can be compared across hospitals.

4. How are the expected values determined?

A statewide PPR rate was calculated for each base APR DRG and severity level. Expected values can be computed using the statistical technique referred to as indirect rate standardization. Using indirect rate standardization, the actual PPR for a population can be compared to an expected value computed using the Florida norm. The expected value is computed by using the All-Patient Refined DRGs (APR-DRGs) to severity adjust for the hospital's mix of patients. The expected value is the average value that would result if the hospital's mix of patients by severity level had been treated at the average value in the reference normative database.

5. How were the norms constructed for the expected preventable readmission rate calculation? Is it a state wide mean?

The norms represent the statewide actual PPR rate and were constructed from the Florida Statewide dataset using 15 day readmission time interval and across hospital analysis. Readmission rates to be posted on the website will be for for Ages 18+ .

6. How was the PPR methodology adjusted for patients who have an abnormally large number of readmissions, like in the case of a non compliant patient or patient with a sickle cell?

The PPR rate is based on an initial admission having a chain of readmissions. A chain of one or more readmissions still counts as one chain of readmissions for the PPR rate and therefore does not change the PPR rate computation.

7. How was statistical significance defined?

The statistical techniques calculate the probability that an observed difference in performance between the provider and the norm is due to natural variation. A difference in performance between provider and norm is considered "significant" if the probability that a difference is due to natural variation is small. A difference was considered significant at the 0.05 level if the probability that the observed difference is due to natural variation is five percent or less (i.e., less than one chance in twenty).

PPR: Quality Improvement

1. What are some of the factors that can lead to a statistically significant higher readmission rate at one hospital in comparison to another?

The quality improvement team may wish to look at the interaction between providing excellent clinical care and the coordination of services both internally and the hand-off to the outpatient setting. Opportunities for reducing readmission rates are as follows:

- Understanding of the patient's capacity to manage in the home environment because the patient and family caregivers are not involved in identifying needs and resources and in planning for the discharge
- Care venues that meet the patient's needs based on the patient's functional physical and cognitive health status
- Prevention of medication errors, poly-pharmacy, and lack of insurance coverage for prescribed medications.
- Recognition of worsening clinical status in the hospital.

2. What is the best approach to improve compliance among patients and their families?

As part of the quality improvement process, it is often helpful to identify the reasons for non-compliance which can include financial/ lack of health insurance and psychological barriers.

3. What are some of the key questions that can be discussed as a concerted effort to decrease readmissions?

- Who should be involved in discharge planning?
- Who are the optimal candidates for discharge planning?
- What type of information is to be communicated at discharge planning?
- How should this be communicated and in what ways can this information be followed up?
- What types of services (in person/non) should optimal candidates receive post discharge?
- What is the role of hospitalists?
- What are the top clinical in-hospital failures leading to readmissions?
- What are the top clinical out of hospital failures leading to readmissions?

PPR Software Questions

1. **Is it possible to purchase the 3M PPR methodology?**

   There is a definition manual that will be available for purchase through 3M Corporation. The 3M Corporation has developed software that uses the PPR methodology to identify admission as potentially preventable. Contact your 3M Sales contact for details.

2. **Is a license for APR DRG required to understand the PPR assignment?**

   No.

3. **Is a hospital, using the PPR software, able to duplicate the state reported results?**

   The State of FL will provide each hospital cases at the pt level, if requested, within any PPR for the hospital to review on a case by case basis. In this way the hospital can review the individual cases to determine if indeed the readmission could have been prevented. This **does not** duplicate the state results, as state data includes readmissions to other hospitals. It should be emphasized that in no instance, whether they have the software or not, can a hospital duplicate the state results as hospitals do not have access to the statewide database that would give admissions to other hospitals.

4. **Are there any National norms available for the PPRs?**

   Not at this time.