



NPA Hospital Utilization/Readmissions Analysis Summary of Results to Date December 1, 2011

PROJECT DESCRIPTION/OBJECTIVES: In late 2010, NPA embarked on an effort to analyze PACE participants' hospital utilization experience, focusing in particular on hospital readmissions. The catalyst for this was considerable focus from policymakers and others on hospital readmissions as a quality measure. Reports document substantial proportions of Medicare beneficiaries who are hospitalized are readmitted to hospitals within 30 days of discharge suggesting significant opportunities for improving care transitions. Because of the PACE interdisciplinary team's focus on assuring effective care coordination over time and across settings, we hypothesized that PACE participants' utilization and readmissions experience would compare favorably to that of comparable populations outside PACE. In addition, our goal was to identify PACE organizations that are particularly successful at averting avoidable hospitalizations and to share their processes with their PACE peers.

DATA AND METHODS: We requested hospital utilization and enrollment data from PACE organizations for the time period 6/1/08-7/31/10. Extensive efforts were made to validate the accuracy of these data. Data for 55 PACE sites were available for Year 1 analyses, and 61 sites were included in Year 2 analyses. For both Years 1 and 2, hospital utilization and readmission rates were calculated over a 12-month period.

RESULTS: Our analysis supports the hypothesis that the PACE model's focus on care coordination has a positive effect on reducing hospital readmission rates. This positive effect is similarly observed in the number of days PACE participants spend in hospitals and the number of hospital stays PACE participants experience. Our analyses supporting these findings are summarized below:

30-day all cause hospital admission rates. Overall, the 30-day all cause readmission rates in PACE were 19.3% in Year 1 (6/1/08-5/31/09) and 19.1% in Year 2 (5/1/09-4/30/10). There was considerable variation across sites' readmission rates, e.g., of the 55 PACE organizations included in the analysis for Year 1, 24 had readmission rates at or below 15% and another 16 had readmission rates at or above 20%. By comparison, the PACE readmission rate (19.1%) was 17% lower compared to the national readmission rate for 65+ dual eligible beneficiaries (22.9%) in 2008.¹ This is notable given the significantly higher acuity of PACE participants, all of whom are at a nursing home level of care, relative to the 65+ dual eligible population.

Hospital discharge rates. PACE hospital discharge rates per 1000 participants were 538 discharges/1000 participants in Year 1 and 547 discharges/1000 participants in Year 2, again with considerable variation across sites. In comparison, the hospital discharge rate for dual eligible beneficiaries, including individuals less than 65, was 574 discharges/1000 in 2005², slightly above the PACE experience in 2008 and 2009. The hospitalization rate in PACE (547/1000 participants) was 43% lower than for non-PACE dually eligible recipients of Medicaid home and community-based services (HCBS) (962/1000) and 24% lower than for dual eligibles receiving Medicaid nursing home services (719 vs. 547).

Hospital days/1000/annum. Hospital days/1000 PACE participants/annum were 3,440 and 3,473 in Years 1 and 2, respectively, again with considerable variation across sites. Compared to the dual eligible beneficiary population, PACE participants experienced 15% fewer hospital days/1000/annum (4,076 vs. 3,473). PACE participants experienced 46% and 34% fewer hospital days/1000/annum compared to dual eligibles receiving HCBS and receiving nursing home care, respectively (6,447 and 5,247 vs. 3,473).

¹ Oelschlaeger, Allison, Centers for Medicare and Medicaid Services, <http://www.academyhealth.org/files/2011/sunday/oelschlaeger.pdf>

² Walsh, E.G., et al. December 2010. "Cost Drivers for Dually Eligible Beneficiaries: Potentially Avoidable Hospitalizations Supplemental Tables." Final Task 5 Report. Prepared for the Centers for Medicare and Medicaid Services. Washington, DC. RTI Project Number 0209853.022.