

# **SUPPORTING STATEMENT**

## **Part A**

Adapting Best Practices to Reduce Avoidable Hospital Readmissions for  
Medicaid Patients

**Version: November 26, 2012**

Agency of Healthcare Research and Quality (AHRQ)

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## Justification

### 1. *Circumstances that Make the Collection of Information Necessary*

The mission of the Agency for Healthcare Research and Quality (AHRQ) set out in its authorizing legislation, The Healthcare Research and Quality Act of 1999 (see <http://www.ahrq.gov/hrqa99.pdf>), is to enhance the quality, appropriateness, and effectiveness of health services, and access to such services, through the establishment of a broad base of scientific research and through the promotion of improvements in clinical and health systems practices, including the prevention of diseases and other health conditions. AHRQ shall promote health care quality improvement by conducting and supporting:

- a) research that develops and presents scientific evidence regarding all aspects of health care;
- b) the synthesis and dissemination of available scientific evidence for use by patients, consumers, practitioners, providers, purchasers, policy makers, and educators; and
- c) initiatives to advance private and public efforts to improve health care quality.

Also, AHRQ shall conduct and support research and evaluations, and support demonstration projects, with respect to (A) the delivery of health care in inner-city areas and in rural areas (including frontier areas); and (B) health care for priority populations, which shall include (1) low-income groups, (2) minority groups, (3) women, (4) children, (5) the elderly, and (6) individuals with special health care needs, including individuals with disabilities and individuals who need chronic care or end-of-life health care. The reauthorization of the Agency for Healthcare Research and Quality (AHRQ) in 1999 established the Agency as a leader in support of research designed to improve the quality of health care, reduce its costs, promote patient safety and reduce medical errors, and broaden access to effective services.

One particular mission of AHRQ is to improve the efficiency of health care through reducing unnecessary health care costs while maintaining or improving quality. The proposed data collection supports this goal through acquiring a better understanding of strategies to assist safety net hospitals in reducing readmissions for Medicaid patients. Previous research has shown that a focus on transitional care, including needs assessment, discharge planning, post-discharge intervention, and care coordination can reduce avoidable readmissions<sup>1,2</sup>. Based on this evidence, there have been a number of strategies and resources developed for hospitals to reduce avoidable readmissions, including:

- The Aging & Disability Resource Centers Evidence-Based Care Transitions program by the Administration on Aging & CMS to support state efforts in implementing evidence-based care transition models for older adults and individuals with disabilities.

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<sup>1</sup> Richards S, Coast J. Interventions to improve access to health and social care after discharge from hospital: a systematic review. *Journal of health services research & policy*. Jul 2003;8(3):171-179.

<sup>2</sup> Coleman EA, Parry C, Chalmers S, Min SJ. The care transitions intervention: results of a randomized controlled trial. *Archives of internal medicine*. Sep 25 2006;166(17):1822-1828.

- The State Action on Avoidable Rehospitalizations (STAAR) initiative by the Institute for Healthcare Improvement to improve care transitions and care coordination through state-based multi-stakeholder collaborative efforts.
- The Hospital-to-Home (H2H) initiative by the American College of Cardiology to reduce readmissions for patients with cardiovascular conditions.
- Project Re-Engineered Discharge (RED), funded by AHRQ and the National Institutes of Health (NIH) National Heart, Lung, and Blood Institute, to reduce re-hospitalizations by improving hospital discharge processes.

However, the majority of these strategies and resources focuses on general patient populations or specifically targets the elderly and/or disabled, primarily Medicare populations. Recent research finds that rates of readmission among Medicaid-insured non-elderly adults equals that of the elderly, Medicare-insured population and is 60 percent higher than a privately-insured population<sup>3</sup>. It is not known whether existing resources and strategies to reduce readmissions address the circumstances and characteristics of Medicaid-insured patients. Particular socio-demographic characteristics more prevalent in populations insured through Medicaid, such as low-income, racial and ethnic minority, low literacy, housing instability, mental illness, substance abuse disorders, chronic and disabling conditions, language barriers, and discontinuous insurance coverage may mean that strategies for reducing readmissions need to be tailored specifically to the unique needs of this population.

Additionally, safety net hospitals, which serve large populations of the most vulnerable in society and where Medicaid is often a major payer, face unique conditions. Not only do they serve more vulnerable populations, they are often constrained by their financing and governance structures. Safety net hospitals generally operate on lower financial margins than other hospitals because they are often underpaid for many services provided to Medicaid recipients and the uninsured. Faced with declining contributions from state and local governments and payment reduction from both public and private payers, many are struggling to meet the growing demand for their services with stagnant or declining revenues. Resources addressing hospital readmissions may also have to be tailored to meet the unique circumstances of safety net settings.

This project is a quality improvement project designed to help three hospitals to address the critical issue of avoidable Medicaid readmissions. The project's overall goal is to help participating hospitals to understand the specific nature of the Medicaid readmissions problems at their facilities, learn about evidence-based strategies for reducing them, and conduct small-scale, qualitative tests of strategies. This project is not designed to directly affect and evaluate readmissions, but to improve hospitals' knowledge and processes for addressing this issue.

This project is guided by the following five objectives:

- **Objective 1:** Coach or guide participating hospitals through a process of identifying key factors (“drivers”) related to Medicaid readmissions in their setting through a

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<sup>3</sup> Wier LM, Barrett M, Steiner C, Jiang HJ. All-Cause Readmissions by Payer and Age, 2008: Statistical Brief #115. *Healthcare Cost and Utilization Project (HCUP) Statistical Briefs*. Rockville (MD)2006.

secondary analysis of their claims data and the use of a data collection tool (*Diagnostic Interview Tool*);

- **Objective 2:** Help hospitals to map existing strategies related to readmissions and care transitions (primarily to those related to Medicare and all payer readmission strategies);
- **Objective 3:** Help hospitals to understand the potential evidence-based strategies that could be applied to Medicaid readmissions and coach participating hospitals through a process of choosing a strategy that addresses one or more of the identified drivers in their setting (selected strategies may be modified by an individual hospital if involved staff see modification as necessary to address Medicaid drivers);
- **Objective 4:** Coach participating hospitals to undertake *qualitative testing* (an approach drawn from the field of quality improvement science) in cycles (also referred to as “waves”) to determine if a strategy is working;
- **Objective 5:** Engage in joint learning (involving all participating hospitals) to share their experiences in identifying Medicaid readmission drivers, choosing improvement strategies, and testing strategies.

Having consumer and community provider perspectives on the drivers of Medicaid readmissions (objective 1) and on the strategies being tested (objective 4), would add valuable insight to the project. To this end, the contractor, John Snow, Inc. (JSI) has adapted the *Diagnostic Interview Tool* that has previously been used in this type of work to make them more applicable to the Medicaid patient population. Among other things, this meant editing the questions to reflect the literacy levels and prevalent health conditions among the Medicaid population.

The *Diagnostic Interview Tool* is divided into three subcomponents:

- 1) **Medical records review** -- The medical records review will gather background information about a patient’s index admission and readmission. Data to be abstracted from the medical record includes patient demographic information, gender, living arrangements, dates and timing of index and readmissions, lengths of stay, diagnoses on admission, source of admission, discharge disposition, and other transition factors, name/setting of primary care provider (PCP), and whether an appointment was made with the PCP before discharge. Attachment A is the tool to be used to help identify drivers of readmission. A nearly identical tool (Attachment B), which includes all of the data from Attachment A and an additional data element related to the strategy being tested, will be used to add patient and provider insight to this phase of the project.
- 2) **Patient/family/caregiver interview** -- After completion of the patient’s medical record review, interviews will be conducted with the patient and a family member or caregiver, who has permission to discuss the patient’s case. The purpose of the patient/family/caregiver interviews is to obtain the patient/family perspective, in their own words, of their index admission, their transition period, and their readmission. Data to be collected includes perspectives on reasons for readmission, discharge experience, extent to which they were able to follow any discharge instructions provided, setting to which they were discharged,

and any other assistance needed. As for the medical records review, two tools are used: Attachment C (*Patient/Family/Caregiver Interview Tool – Drivers*) to help identify drivers of readmission and Attachment D (*Patient/Family/Caregiver Interview Tool – Test Strategies*) to add patient/family/caregiver and provider insight on the strategy being tested.

- 3) Provider interview -- Provider interviews will complete the *Diagnostic Interview Tool*. Two providers per readmission case will be interviewed. Providers will be asked why they believe the patient was readmitted and what they think could have been done to avoid the readmission. Attachment E (*Provider Interview Tool – Drivers*) and Attachment F (*Provider Interview Tool – Test Strategies*) are the tools used for the provider interviews.

Four waves of data collection are proposed. The first wave will be conducted after OMB approval to inform the hospitals' work on the causes of Medicaid readmissions (objective 1). This process will give them a better understanding of the causes of Medicaid readmissions from the consumer and provider perspectives by supplementing the secondary analysis of claims that has already been conducted at each hospital. The *Diagnostic Interview Tool* will be used with up to 10 patients at each hospital.

Waves two through four of data collection will occur after each hospital decides on and implements a series of strategies to address one or more of its drivers of readmission. For example, the data collection tool could be used to acquire consumer and provider feedback on the strategy to institute a RED discharge checklist in a particular ward by a hospital. Each hospital is expected to implement three different strategies to address their drivers of readmission over the course of the project; thus, there will be three corresponding data collection waves to assess each of these strategies. As with wave one, the *Diagnostic Interview Tool* will be used with up to 10 patients at each hospital for each wave of data collection.

This AHRQ project could be undertaken without these data collection tools but it would be a detriment to the project, the participating hospitals, and the field of readmissions reduction. The Affordable Care Act and a great deal of research have explicitly endorsed placing a greater emphasis on patient-centered care. Tools such as those proposed are critical to the development of more patient-centered care in hospitals, which are treating and readmitting large numbers of Medicaid patients.

This study is being conducted by AHRQ through its contractor, John Snow, Inc. (JSI), pursuant to AHRQ's statutory authority to conduct and support research on healthcare and on systems for the delivery of such care, including activities with respect to the quality, effectiveness, efficiency, appropriateness and value of healthcare services and with respect to quality measurement and improvement. 42 U.S.C. 299a(a)(1) and (2).

## **2. Purpose and Use of Information**

The purpose of the primary data collections is to add insight and direct patient/family and provider input and experience into all phases of the project. The first data collection will provide patient/family and provider insight into the process of identifying drivers related to Medicaid readmissions. Based on these drivers, existing readmissions strategies will be assessed for their

suitability in addressing these factors. Participating hospitals will then select existing or modified strategies to test in their settings using a rapid cycle quality improvement process. Participating hospitals will each engage in three cycles of testing. Primary data collection will occur during each of these testing cycles for purposes of gathering patient/family and provider insight into the testing process.

Hospital staff will conduct the data collection and will aggregate the information and provide a summary report to the project team. No identifiable patient data will be included in the report. The data derived from each data collection wave will rest with each participating hospital. Neither the contractor (JSI) nor AHRQ staff will be involved directly in collecting the patient or provider assessments or aggregating the results.

Data in the aggregate will be shared among all participating hospitals, JSI, and AHRQ for purposes of joint learning and to inform potential changes or modifications to existing readmissions resources to better accommodate Medicaid-specific readmissions issues.

### ***3. Use of Improved Information Technology***

The data collection tools can be completed manually or downloaded and completed on a computer. The medical records reviews will be conducted through each hospital's electronic health record (EHR). The patient and family/caregiver interviews will take place face-to-face during the selected patient's hospitalization or over the phone within a week of discharge. If needed, interpreter services will be secured through the hospital's usual processes. The provider interviews will be brief, face-to-face or telephonic interviews.

Each hospital will decide whether and how the data collected is to be stored over time. There will be no project-imposed requirements for creating or maintaining a database.

### ***4. Efforts to Identify Duplication***

The primary data that hospitals are being asked to collect is unique to the circumstances of each participating hospital, Medicaid-insured patients, safety net settings, and Medicaid readmissions. Other efforts related to reducing avoidable readmissions focus on Medicare populations or all-cause readmissions. Background research for this project did not reveal any systematic processes for assessing factors related to Medicaid readmissions or evaluating existing tools/resources for their application to Medicaid-insured populations and/or safety net settings.

### ***5. Involvement of Small Entities***

None of the participating hospitals is considered a small entity.

### ***6. Consequences if Information Collected Less Frequently***

Primary data collection will be conducted to add patient/family and provider perspective to the drivers of Medicaid readmission and to strategies being tested to address some of these drivers (four separate waves of data collection). To collect the data less frequently would mean that first-

hand experience of those involved in readmissions (i.e., patients/families and providers) is not included in the process of identifying drivers related Medicaid readmissions, in the assessment of strategies to address these factors, or in suggestions arising from the project about adaptations needed for existing readmissions strategies and best practices needed to address Medicaid-specific readmissions.

## **7. Special Circumstances**

This request is consistent with the general information collection guidelines of 5 CFR 1320.5(d) (2). No other special circumstances apply.

## **8. Federal Register Notice and Outside Consultations**

### **8.a. Federal Register Notice**

As required by 5 CFR 1320.8(d), notice was published in the Federal Register on March 28, 2012 for 60 days, and again on June 13, 2012 for 30 days (see attachment G). No comments were received.

### **8.b. Outside Consultations**

The basis of the proposed tool had previously been used in the Institute for Healthcare Improvement's STAAR program as a quality improvement tool to help assess readmissions drivers and test various strategies to reduce readmissions. The Co-Principal Investigator of JSI's project team, Dr. Amy Boutwell, is the founder and original co-principal investigator of the STAAR initiative and has worked with dozens of hospitals to reduce readmissions through the STAAR framework and using the *Diagnostic Interview Tool*. The tool was revised to incorporate Medicaid specific issues, such as socio-demographic considerations more prevalent in a Medicaid population (e.g., literacy, language, housing stability), diagnoses more prevalent in Medicaid population (e.g., mental health and substance abuse), and resources and transitional care settings more applicable to Medicaid-insured populations (e.g., temporary or unstable housing, social service connections, safety net ambulatory settings). These items were added based on discussions with AHRQ, the project's advisory board, and the participating hospital teams as well as the secondary data analysis conducted by the hospitals to determine their drivers of Medicaid readmissions.

## **9. Payments/Gifts to Respondents**

No payments or gifts will be provided to respondents.

## **10. Assurance of Confidentiality**

Individuals and organizations will be assured of the confidentiality of their replies under Section 934(c) of the Public Health Service Act, 42 USC 299c-3(c). They will be told the purposes for which the information is collected and that, in accordance with this statute, any identifiable information about them will not be used or disclosed for any other purpose. The purpose of the interviews will be explained to both patients and their family members/caregivers as well as to

providers before beginning the interview with permission secured before proceeding. In that hospital staff will be conducting the primary data collections, the medical records reviews and the interviews with patients/family members/caregivers and providers will be subject to the same hospital policies regarding patient confidentiality. No individual level data will be shared with others outside of the hospital team involved in the project.

### **11. Questions of a Sensitive Nature**

The primary data collection tools include questions about mental health status and substance use, which are sensitive areas of inquiry. In that these interviews are conducted by hospital staff, the patient confidentiality procedures of the hospital pertain to the information collected. Individual-level information will not be shared with entities or individuals not expressly allowed under the hospital's patient confidentiality policies. Hospital staff conducting the interviews will be trained by the JSI project team, with coaching provided as to how to address sensitive topics.

Additionally, verbal informed consent will be obtained from all interviewees before commencing with the questions (consent language is included on the patient/family/caregiver and provider interview tools).

### **12. Estimates of Annualized Burden Hours and Costs**

This section provides estimates of the annualized burden hours and costs for respondents and for hospital staff engaged in conducting the primary data collection. The primary data collection has three components: a) medical records review; b) patient/family/caregiver interviews; and c) provider interviews. Three safety net hospitals are participating overall. Participating hospitals will be asked to administer the three-component *Diagnostic Interview Tool* at four different points in the project: to help identify factors related to Medicaid readmissions and during each of three cycles of testing newly implemented strategies. Up to 10 readmission cases will be selected at each of the four data collection points.

In that the primary data collections are intended to inform the factors related to Medicaid readmissions and inform the testing of strategies, there is no set number of readmissions cases required during each of the four data collection rounds. Participating hospitals will be instructed that it is a process that should continue until patterns of response converge and little new information is being learned, with 10 cases as the maximum during any one of the four rounds of data collection.

The data collection tools have been adapted from ones used by the STAAR initiative and by JSI's Co-Principal Investigator. Estimates of burden hours are based on the Co-PI's experience using these tools in dozens of hospital settings.

The primary data collection will be conducted by a nurse, or someone with equivalent level of experience, selected by each participating safety net hospital from among its staff. Exhibits 1 and 2 below capture the estimated burden and cost of the nurse (or equivalent other) conducting each component of the data collection. Based on the experience of JSI's Co-PI, from her previous STAAR work, the medical records review process takes on average 20 minutes to complete;

patient/family/caregiver interviews take on average 10 minutes to complete, with two persons interviewed (total of 20 minutes); and provider interviews take on average 5 minutes to complete, with 2 providers interviewed per readmission case (total 10 minutes). Exhibit 1 captures the estimated burden to each participating hospital and respondents. Exhibit 2 estimates costs to participating hospitals and respondents based on wages.

### Exhibit 1. Estimated Annualized Burden Hours

Data Collection Tool Components	# of Hospitals	# of Readmission Cases per Hospital	# of Data Collections	Hours per Case	Total Burden Hours
Medical records reviews	3	10	4	20/60	40
Patient/family/caregiver interviews					
- QI Nurse	3	10	4	20/60	41
- Patient/family/caregiver (2)	3	10	4	20/60	41
Provider interviews					
- QI Nurse	3	10	4	10/60	20
- Provider Interviews (2)	3	10	4	10/60	20
<b>Total</b>	3	10	4	1 hr. 20 min	162

### Exhibit 2. Estimated Annualized Cost Burden

Data Collection Tool Components	# of Cases	# of Data Collections	Total Burden Hours	Average Hourly Wage Rate	Total Cost Burden
Medical records reviews	10	4	40	\$31.10*	\$1,244
Patient/family/caregiver interviews					
- QI Nurse	10	4	41	\$31.10*	\$1,275
- Patient/family/caregiver (2)	10	4	41	\$7.05^	\$ 289
Provider interviews					
- QI Nurse	10	4	20	\$31.10*	\$ 622
- Provider Interviews (2)	10	4	20	\$86.96*	\$1,739
<b>Total</b>	10	4	162	--	\$ 5,169

\*May 2010 National Occupational Employment and Wage Estimates. United States.

[http://www.bls.gov/oes/current/oes\\_nat.htm#29-0000](http://www.bls.gov/oes/current/oes_nat.htm#29-0000). Accessed 11/18/11.

^ Mean value of average monthly benefit for disabled workers and their dependents as of December 2008 (\$1063) and <http://www.ultimatedisabilityguide.com/statistics.html> (accessed on 11/18/11 and annual income threshold federal poverty level for family of four (\$14,404).

### **13. Estimates of Annualized Respondent Capital and Maintenance Costs**

There are no direct costs to respondents other than their time to participate in the study.

### **14. Estimates of Annualized Cost to the Government**

The estimated annual and total cost listed in Exhibit 3 corresponds to the cost of the primary data collection component of the AHRQ project. The primary data collection tasks, while adding an essential perspective to the overall project, represent a small incremental cost to the project overall. The costs to the Federal Government are minimal because the hospitals conduct the data collection and do the analysis. The role of AHRQ's contractor in this process is minimal. The contractor revised the data collection tool, will train the hospital teams in how to collect and analyze their data, and will engage with the hospital teams in a review of their analyzed data. These three tasks represent the total costs to the Federal Government and are included in Exhibit 3 below. As shown, the estimated total cost to the government to complete these three tasks is estimated to be \$16,625. The tasks occur throughout the 2.5 year project term (30 month); thus, it has an estimated annual cost of \$6,650. JSI staff salaries were used to calculate daily rates, with fringe and corporate overhead added in to achieve a loaded daily rate. Both staff salaries and consultant daily rates were assigned to level of effort to achieve labor costs for each task.

#### **Exhibit 3: Estimated Annual and Total Costs to the Federal Government**

<b>Task/Activity</b>	<b>Estimated Annual Cost</b>	<b>Estimated Total Cost</b>
Tool Revision	\$ 2,136	\$ 5,341
Training of Hospital Teams	\$ 1,766	\$ 4,415
Review of Summary Data	\$ 2,748	\$ 6,869
<b>Total</b>	<b>\$ 6,650</b>	<b>\$ 16,625</b>

### **15. Changes in Hour Burden**

This is a new collection of information.

### **16. Time Schedule, Publication and Analysis Plans**

The timeline for data collection, analysis, and publication is shown in Exhibit 4 below.

#### **Exhibit 4 – Timeline for data collection, analysis, and publication**

<b>Task/Activity</b>	<b>Timeline</b>
Submit 60 day Federal Register notice for public comment	March 2012
Submit OMB clearance package	June 2012
Diagnostic Interviews – Drivers (1 <sup>st</sup> wave)	1 week after OMB approval
Diagnostic Interviews – Test Strategies (2 <sup>nd</sup> to 4 <sup>th</sup> wave)	3 months after OMB approval

Observations, recommendations, and results from the project will likely be published in the public domain as one avenue for dissemination. The publications will not depend on individual client-level or case data collected, which will rest with the participating hospitals; however, publications may include reference to the aggregate data collected as reported by the participating hospitals.

The participating safety net hospitals will be responsible for the analysis of data collected, under the guidance of the JSI team. The analysis plan focuses on qualitative analysis and occurs concurrently with the data collection. Project staff from participating hospitals will be instructed to establish a routine during each data collection cycle, whereby hospital staff involved in the project meet regularly to discuss and refine themes that arise from the data collection process. Through an iterative process of discussion, additional medical records reviews and interviews, and further discussions, themes and patterns of response are refined over time. After each round of primary data collection, the participating hospital teams will be asked to share a summary of these themes and patterns with AHRQ, JSI, and other participating hospitals.

#### ***17. Exemption for Display of Expiration Date***

AHRQ does not seek this exemption.

## ***Attachments***

Attachment A: Medical Records Review Tool (Drivers)

Attachment B: Medical Records Review Tool (Test Strategies)

Attachment C: Patient/Family/Caregiver Interview Tool (Drivers)

Attachment D: Patient/Family/Caregiver Interview Tool (Test Strategies)

Attachment E: Provider Interview Tool (Drivers)

Attachment F: Provider Interview Tool (Test Strategies)

Attachment G: 60 Day Federal Register Notice