



# Taking Aim at Reducing Hospital Readmission Rates

It has been three years since the Centers for Medicare & Medicaid Services (CMS) implemented progressive penalties to hospitals that have higher 30-day unplanned readmission rates for certain conditions. The Hospital Readmissions Reduction Program (HRRP), enacted under Section 3008(a) of the Affordable Care Act, was designed to urge hospitals to improve patient care and reduce costs.

Beginning in October 2012, hospitals that participated in Medicare's Inpatient Prospective Payment System (IPPS) began to see a 1% reduction in reimbursement for what the CMS deemed to be excessive readmission rates for the most costly diagnoses: acute myocardial infarction, pneumonia, and congestive heart failure. Since that time, the CMS has expanded the program to include reimbursement reductions for readmissions related to additional diagnoses such as hip/knee replacements, Chronic Obstructive Pulmonary Disease (COPD) and, in 2017, plans to include readmission penalties for Coronary Artery Bypass Graft surgery. In addition, what began as a 1% reduction penalty in 2012 has climbed to 3% in 2015 and researchers estimate that approximately 2600 hospitals nationwide will lose a combined \$420 million dollars in penalties this year.<sup>1</sup>

## Top ten states with the highest average hospital penalty for readmissions:

Kentucky 1.19%  
Virginia 1.01%  
West Virginia 0.99%  
Arkansas 0.83%  
Washington DC 0.77%  
New York 0.75%  
New Jersey 0.73 %  
Illinois 0.72%  
Ohio 0.71%  
Missouri 0.71% reduction.<sup>1</sup>

Aside from the increased stress and dissatisfaction that a readmission poses for patients, Medicare estimates that it pays an average of \$15,000 for each episode of care and that cost doubles to \$33,000 for preventable readmissions. A 2009 analysis of Medicare claims data from 2003-2004 revealed that just under 20% of Medicare discharges were readmitted within 30 days and 50% of those individuals had not seen their private physician between the time they were discharged and their subsequent readmission.<sup>2</sup>

In recent years, a number of government and quasi-governmental groups have created programs designed to assist hospitals in meeting the challenge of reducing their preventable readmissions. While the CMS began by focusing on the Medicare population having conditions with the highest rates of readmission, several recent studies have shown that other factors such as hospital location, the availability of community resources, socioeconomic status, and improving communication across the continuum of care may have a greater impact upon preventable hospital readmission rates.<sup>3 4</sup>



Hospitals have begun to see some progress by testing various strategies aimed at identifying patients at risk, strengthening the discharge process, scheduling follow-up appointments, improving communication with community providers, conducting nurse-directed follow-up calls, providing necessary medications, and enhancing patient education about their illness. But progress has been slow for some and there is wide variability in the readmission rates across the country, heavily influenced by the availability of local healthcare resources and the overall socioeconomic status of the community.<sup>5 6 7 8 9</sup>

In fact, a 2013 analysis of Medicare claims revealed a rather meager overall decline in hospital readmission rates from 19% in 2007 to just 18.4% in 2012.<sup>10</sup>

Success for the highest performing hospitals seems to come from their ability to network with community resources and apply a multifaceted approach to ensuring patients are well educated prior to discharge and have the necessary resources post-discharge to comply with their treatment plan and follow-up care. Hospitals are either devoting the resources and staff to accomplish this or partnering with transitional care companies that can conduct follow-up calls, help patients get their medications, or even provide transportation to the doctor's office if needed. A recent study revealed that when patients received transitional care following hospital discharge, they were 20% less likely to be readmitted within the first year than those who did not receive transitional care assistance.<sup>11</sup>

### National Programs

From 2009 -2013, several national programs, both privately and publically-funded, were launched with the goal of helping hospitals to reduced preventable readmissions.<sup>12</sup>

The Re-Engineered Discharge (RED) program at Boston University offers a toolkit and extensive templates for improving the discharge process. A follow-up study showed that the use of RED interventions reduced the number of emergency department visits and readmissions within 30 days by 30 percent.<sup>13</sup>

The Society of Hospital Medicine offers training and technical expertise to hospitals through its Project BOOST (Better Outcomes for Older Adults through Safe Transitions). A recent study of the program's success revealed a 2% reduction in the rate of readmissions after 12 months for the hospitals involved in the study.<sup>14</sup>

In 2011, The CMS launched the Partnership for Patients Safety Campaign (PfP) with the goals of improving care transitions and making care safer by targeting the reduction of preventable hospital acquired infections and hospital readmissions. Technical assistance and training for hospitals is available through your local Hospital Engagement Network.<sup>15</sup>

The CMS community-based Care Transitions Program specifically targets unplanned readmissions by providing funds to community-based organizations that partner with hospitals and other organizations to provide care assistance during the transition from hospital to home. The program promotes a coordinated and comprehensive approach to better managed care transitions between hospitals, nursing homes, primary care providers, home health and other providers within the healthcare community.<sup>16</sup>

Hospital leaders will find helpful resources and guidance for addressing the reduction of readmissions at the Agency for Healthcare Research & Quality's website. Setting priorities for developing your program consists, in part, of analyzing your readmission patterns, identifying outliers, coordinating discharge care, and targeting follow-up to patients at risk of readmission.<sup>17 18</sup>

Overall, studies have shown that hospitals participating in national initiatives to reduce readmission rates are better motivated to succeed and more likely to have better outcomes with reducing their readmissions.<sup>19,20</sup>

### Local efforts

Reducing the overall percentage of national hospital readmission rates since the inception of the Hospital Readmission Reduction Act has been exceedingly slow and variable. From a patient safety standpoint, readmissions can expose patients to a host of potential safety hazards such as medication and diagnostic errors, falls, stress and confusion especially for the elderly.

However, locally, there have been a number of success stories from organizations that improved their discharge and follow-up processes. For example, in a 2012 study, the Wisconsin Department of Veterans Affairs implemented registered nurse pre-discharge meetings with the patient and family, written instructions outlining key conditions that should be monitored, and the dates and times of follow-up appointments. Post-discharge calls were placed 2-3 days after discharge and medication discrepancies were resolved in almost half of all follow-up calls placed. The 30-day readmission rate dropped by 11% for those patients involved in the study and the hospital has seen sustained decreases over an 18 month period as well as a cost savings of just under a million dollars.<sup>21</sup>

Other successful programs have targeted the management of specific diseases such as heart failure. For example, a large hospital in Atlanta, GA implemented several strategies to improve patient safety and reduce their readmission rates for patients under the age of 70 years. Initiatives included strengthening the medication reconciliation process by a pharmacist, scheduling follow-up appointments prior to discharge, and conducting post discharge calls within 72 hours. Utilizing the technical expertise and tools developed by The Society



### Top Strategies for Reducing Unplanned Readmissions

- Identify high-risk diagnoses and populations
- Implement evidence-based guidelines & monitor quality of care
- Strengthen the discharge process to include patient capacity and resources to comply with treatment plan
- Provide patient/family education regarding medications
- Secure follow-up appointments and provide timely discharge summaries for primary providers prior to discharge
- Conduct patient follow-up calls to assess patient well-being and compliance with treatment plan
- Improve communication between hospital and community resources through collaborative relationships<sup>5,7,9,22</sup>

**A recent analysis by the Yale School of Public Health and The Commonwealth Fund of hospitals that participated in two national programs to reduce readmissions sought to identify which strategies were the most effective. The team concluded that the most effective strategy was ensuring patients had a follow-up appointment scheduled prior to discharge. In addition, the study noted hospitals that implemented three or more strategies had greater reductions in unplanned admissions.<sup>22</sup>**



of Hospital Medicine's Project BOOST, the hospital reported a dramatic reduction in their heart failure readmission rates (less than 70 years old) from 13.5% to 3.97% over a 12 month period.

### Conclusion

There is much to be learned from the success of others with the caveat that each healthcare community is unique in its strengths and weaknesses. However, the prevailing approach appears to be the identification of your hospital's population risk factors and the

implementation of strategies to target the discharge process, improve communication between the patients and providers, and a more proactive approach to ensuring adequate follow-up post discharge.

Reducing your hospital's readmission rates is a win-win for patient safety and satisfaction and the hospital's reputation and financial bottom line. It is our hope that this publication will provide you with some of the proven tools and resources that are available to strengthen your ongoing efforts.

### About the Author

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