How to reduce readmissions to the hospital

We spent about two trillion dollars in total on health care last year.

Hospital readmissions are costly. They cost Medicare $17.5 billion in additional hospital bills. Medicare spending reached $852 billion this year according to the latest Congressional Budget Office (CBO) estimate. Hospital inpatient costs make up 25% of that figure and are projected to grow 4% annually in coming years, according to the CBO. The national average readmission rate has remained steady at around 19% for several years.

Under the Affordable Care Act, hospitals with high readmission rates will have their Medicare payments reduced. Hospitals that have surpassed the national average will pay a maximum of 1% this year, increasing to 2% in October, and then 3% the following year. There are other hospitals in the mix that will lose a fraction of these percentages based on very complex criteria such as mortality rate.

Institutions like Hackensack Medical Center in NJ, North Shore University Hospital in Manhassest, NY, and Beth Israel in Boston will lose 1% of their base Medicare reimbursement. Hospitals that serve the poor and underprivileged may be penalized more than anyone else, but at the same time some of these hospitals are still top performers. The readmission rate can be an unfair indicator for most, because some of the hospitals with higher readmission rates have lower mortality rates.

The total number of hospitals receiving penalties is 2217; about 1910 hospitals will receive less than 1% penalty. Thirty-five percent of readmission trips to the hospital took place during the first seven days after discharge and 57.4% were in the first 14 days. About 39.8% of trips back to the hospital were emergency room visits. This can result in fragmented care, duplication of services, increase in medical errors and higher costs all around.

The hospitalization rate among Medicare fee for service enrolled averages 343 discharges per 1000 enrollee and CMS (Centers for Medicare and Medicaid Services) is focusing on the top three diagnoses to reduce readmission rate:

A) **Congestive heart failure readmission rate: 23%.**
28.2% at the 50th percentile. 61% of these are within the first 15 days — the median was 12 days.

B) **Pneumonia readmission rate: 17.3%.**
21.8% at the 50th percentile. 62.6% of these within the first 15 days — the median was 12 days.

C) **Acute myocardial infarction: 20.8%.**
21.8% at the 50th percentile. 67.6% within the first 15 days — the median was 10 days.

Nearly two million Medicare patients are readmitted within thirty days of discharge each year.

CMS will expand its focus to additional diagnoses. The healthcare reform bill mandates expanding the focus to four additional diagnoses by 2014. Although there is no final decision which other diagnoses might be included under the readmission reduction umbrella, likely candidates include COPD and Coronary Artery Bypass graft. If costs are reduced and patient outcomes improved by focusing on these specific conditions, it is only a matter of time before CMS extends readmission reimbursement policies to all causes.

Strategies and steps for readmission reduction should include:

1) **Informing patients and family members** — this is the key to reducing readmission numbers. Often providers find that patients who say they understand medical instructions at the hospital may second guess themselves when they return home. You would apply teach back method to ensure understanding.

2) **Implementing medication reconciliation** — providers can work with the pharmacy staff to address any discrepancies with medications that may cause inadvertent complications. Pharmacy staff can introduce themselves to patients during the hospital stay and follow up post discharge to address any questions and check on patient adherence to taking their medications. That in turn can reduce readmission.

3) **Follow up calls** — studies have shown that nurses that are involved in utilization departments can identify goals, inform patients about community resources, and establish ways to prevent poor outcomes while at the same time reducing costs.

4) **Identifying at risk patients** — 43% of the general patient population is defined as "at risk." To focus on those patients you may consider the following:

    A) Length of stay
    B) Acuity of admission
    C) Comorbidity index
    D) Emergency room visits in the past six months as indicators of possible readmission

5) **Create a Safety net** — design a backup system such as a call center and facilities that can provide immediate medical care, such as stand alone EDs or urgent care centers with resources. These call centers should have resources including primary care and specialists to be able to talk to the patient and address their needs.

6) **Expedited Appointments** — gather a group of doctors, including primary care physicians, available for immediate follow-up care and expedited appointments. This will help in the transitional period to accomplish two goals: patient safety and preventing readmission by addressing patient concerns. Studies show that more than 70% of office visits can be completed over the phone. This can be done via telemedicine, especially for facilities that may not have access to an abundance of specialists. The University of Pennsylvania model, which established a partnership with AETNA and Kaiser Permanente, *cut readmissions by 28% within the first 24 weeks and by 13% within a year.*

7) **Support** — success depends on support from management. The end result of the strategy to reduce readmissions is:

    A) Protected reimbursement
    B) Improvement of quality and safety
    C) Improved patient satisfaction

Implementing effective strategies will require the C suite to invest in IT and staffing; this should be their top priority.

Although many of the proposed models by different entities have common strategies, it will be the plan of execution that matters most to a successful goal achievement.

Steve Okhravi, MD, MBA, CPE