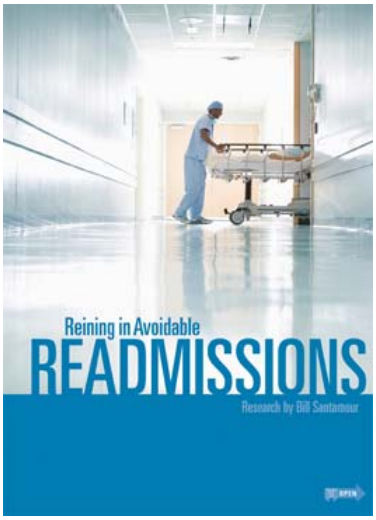
Gatefold

Reining in Avoidable Readmissions

The Affordable Care Act sets penalties for hospitals with higher-than-average rates of avoidable readmissions. Here's a primer on the problem and tools to help tackle it.

Research by Bill Santamour



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Helping patients stay out of the hospital once they've been discharged has been a longtime quality-improvement priority for many hospitals and health networks. Now it's become a financial priority, too, thanks to provisions of the Patient Protection and Affordable Care Act that set penalties for hospitals with higher-than-average rates of avoidable readmissions for patients with specified conditions.

The key word is avoidable. Medical experts say a zero rate of readmissions is not only impossible to achieve, it would not be desirable. Many readmissions are pre-planned for necessary follow-up care, such as chemotherapy treatments for certain cancer patients. A large percentage of readmitted patients are elderly, have multiple chronic conditions, and face complex and sometimes confusing medical regimens when they return home. What's more, penalizing providers indiscriminately for all readmissions might discourage some from bringing patients back even when it would be appropriate.

Nevertheless, health care professionals agree that many readmissions would not be necessary if planning for post-discharge started early, was much more robust and thorough, actively involved the patient and her family, created a strong partnership with all post-acute care providers and was based on a hospital's own data as well as evidence-based best practices culled from national quality projects.

This gatefold provides a snapshot of the issues surrounding avoidable readmissions—why they are a concern, how you can understand their impact specifically on your hospital, and how tools like the Health Care Leader Action Guide to Reduce Avoidable Readmissions can help you achieve this particular quality-improvement goal.

The Crux of the Law

Under the Patient Protection and Affordable Care Act, the Centers for Medicare & Medicaid Services will compile national data on readmission rates for eight conditions selected by the Health & Human Services secretary.

Starting in FY 2013, hospitals with readmission rates above the 75th percentile will have payments for the original hospitalization reduced by 20 percent if a patient with a selected condition is rehospitalized with a preventable readmission within seven days and by 10 percent if the patient is readmitted within 15 days.

"Medicare payment reductions for excess readmissions are calculated by a formula that divides the observed rate by the expected rate, then subtracts a standard quality value of 1. Thus, for example, a hospital with an expected congestive heart failure readmission rate of 190 cases out of 1,000 but an observed rate of 200 readmissions for the year (a 20 percent readmission rate versus the 19 percent anticipated, or 1 percent excess readmissions) will collect not $80,000 less than the $8 million it bills to Medicare for care to those 1,000 CHF patients (1 percent). Rather, it will be paid $421,053 less!"—David Ollier Weber, *H&HN Weekly*, Sept. 27, 2010

Source: Deloitte Center for Health Solutions, Health Care Reform Memo, July 12, 2010, www.deloitte.com

Three Guiding Principles

1. Coordinate post-hospital care across settings.
2. Take quick action to reconcile patient medications and schedule follow-up appointments with primary care physicians and specialists.
3. Engage patients and families to play active roles in managing their health needs.

Source: California HealthCare Foundation, 2010

Checklist: Developing a Detailed Self-Portrait

As part of the State Action on Avoidable Rehospitalizations (STAAR) initiative, hospitals in four states—Massachusetts, Michigan, Ohio and Washington—in January began using a worksheet to track their five most recent rehospitalizations. The worksheet begins with nine questions about each of the readmitted patients.

1. What was the number of days between the last discharge and this readmission date?
2. Was the follow-up physician visit scheduled prior to discharge?
3. If yes, was the patient able to attend the office visit?
4. Were there any urgent clinic/ED visits before readmission?
5. What was the functional status of the patient on discharge?
6. Was a clear discharge plan documented?
7. Was evidence of "teach-back"documented?
8. List any documented reason(s) for readmission.
9. Did any social conditions (transportation, lack of money for medication, lack of housing) contribute to the readmission?

Source: Commonwealth Fund and the Institute for Healthcare Improvement, 2010

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