

# To improve our patients' health, look beyond reducing readmissions

**I**N THIS ISSUE OF the *Cleveland Clinic Journal of Medicine*, Drs. Ayache, Boyaji, and Pile share evidence-based strategies for reducing the risk of readmission for patients with acute exacerbations of chronic obstructive pulmonary disease (COPD).<sup>1</sup> They emphasize standardizing practice by combining effective clinical management with appropriate patient education, communication, and postdischarge follow-up.

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Reducing the rate of preventable hospital readmissions (as well as avoiding admissions in the first place) is the right thing to do for the patient. Moreover, broader adoption of the strategies that they outline in their article will be critical to the success of health care organizations in improving patient outcomes and navigating a rapidly evolving landscape of reimbursement and reporting changes associated with the Centers for Medicare and Medicaid Services (CMS) Readmissions Reduction Program. Hospital readmission rates, while imperfect measures of the quality of care, demonstrate opportunities to optimize transitions of care. Success in our efforts to improve the health of our patients will likely be aligned with reductions in preventable admissions and improved attention to care coordination.

## ■ HOSPITALS ARE PENALIZED FOR EXCESSIVE READMISSION RATES

With nearly 20% of Medicare beneficiaries being rehospitalized within 30 days of discharge, at a cost of \$17 billion annually,<sup>2</sup>

Congress enacted the Hospital Readmissions Reduction Program<sup>3</sup> as part of the Affordable Care Act (ACA) in 2012. The Centers for Medicare and Medicaid Services (CMS) had already been reporting the readmission rates for heart failure, acute myocardial infarction, and pneumonia since 2009 ([www.medicare.gov/hospitalcompare](http://www.medicare.gov/hospitalcompare)). Building on this work, the Affordable Care Act implemented financial penalties against hospitals that had excessive rates of readmissions for these conditions.

The Affordable Care Act put 1% of a hospital's Medicare base payment at risk for all inpatient diagnoses in 2013—not just the three listed here. The risk is 2% in 2014 and will rise to 3% in 2015. In its first year, more than 2,200 United States hospitals were penalized a total of approximately \$280 million because of readmission rates above the national mean. Nearly 10% of hospitals incurred the maximum 1% penalty, and about 30% paid no penalty.

The Secretary of the Department of Health and Human Services has the authority to extend the Readmissions Reduction Program to additional high-volume or high-expenditure conditions, and the department has announced it will expand the program in October 2014 (fiscal year 2015) to include two additional conditions: elective hip or knee replacement and COPD.<sup>4</sup> In both cases, CMS began by publicly reporting these rates before including them in the program. Additional readmission measures, including those for stroke and hospital-wide all-cause readmissions, are also publicly reported and receive increased attention but are not yet included in the Readmissions Reduction Program.

doi:10.3949/cjcm.81a.14063

## ■ UNFAIRLY PENALIZING THOSE THAT SERVE THE POOR

Avoidable causes of readmissions include hospital-acquired infections and complications, inadequate medication reconciliation and management, poor communication and coordination of care among the members of the health care team, and suboptimal care transitions.<sup>5</sup> But other important drivers of readmissions are outside of a hospital's direct control. These include mental illness, lack of social support, and poverty.<sup>6</sup>

A criticism of the Readmissions Reduction Program is that it disproportionately penalizes hospitals that serve the poorest patients.<sup>7</sup> Currently, CMS readmission risk models do not adjust for socioeconomic factors. Further, CMS responds to these concerns by noting that it does not want different outcome standards for poor patients, and that adjusting for these factors may conceal potential health care disparities in disadvantaged populations.

## ■ NEW MISSION FOR HOSPITALS: MITIGATE SOCIOECONOMIC BARRIERS

Effective programs to reduce hospital readmissions must address the clinical interventions and patient education needs in the COPD discharge checklist discussed by Ayache et al, but must also attempt to mitigate social disadvantages that drive up readmissions for patients at highest risk.

Are hospitals in a position to do this? Too often, it is assumed that patients have access to medications, transportation to follow-up appointments, and social support. Early identification of patients at highest risk of being affected by lack of these factors and innovative solutions for mitigating these risks are important considerations in our efforts to reduce hospital readmissions.

## ■ HOW MANY READMISSIONS ARE TRULY PREVENTABLE?

Experts disagree on how many readmissions are truly preventable. Readmission rates for the sickest patients treated at tertiary or academic medical centers may reflect high-quality care in well-managed patients who otherwise would have died during the index admission.<sup>8</sup>

In early studies, the Medicare Payment

Advisory Commission estimated that up to three-quarters of readmissions are preventable.<sup>9</sup> In contrast, studies that used clinical instead of administrative data suggest preventable readmissions make up as little as 12% of total readmissions.<sup>10</sup>

Regardless of the actual percentage, Medicare's risk-adjustment model relies exclusively on administrative data that do not fully account for nonpreventable factors and do not completely address unrelated or planned rehospitalizations. CMS is attempting to address these issues with an expanded readmission algorithm that excludes more planned and unrelated readmissions from the penalty calculation.

Ironically, the current structure of the Readmissions Reduction Program does little to address its intended goal of eliminating the perverse financial incentives for hospitals and physicians to readmit patients. Payments are still episode-based and reward readmissions. The \$280 million that CMS expects to receive from the program this year covers less than 5% of the nearly \$12 billion attributed to preventable rehospitalizations.<sup>11</sup>

## ■ WHAT PATIENTS NEED, NOT WHAT SUITS PROVIDERS

Hospital readmission rates are publicly reported, but it is shortsighted to think about readmissions outside of the broader context of the "medical home." One must consider the role of primary care providers before and after an index admission in addition to the role of postacute care providers for some patients after discharge. Neither is directly affected by the current penalty program, but both are critical to effective solutions and optimizing value-oriented care.

Readmission rates are suboptimal measures, as they address presumed failures of hospital transitions rather than measuring care coordination and providing meaningful incentives to coordinate care. Yes, there is much to do to ensure effective transitions from the hospital to home or postacute settings. But to truly transform health care and deliver value, shouldn't we strive to redesign the work flow around what patients need rather than what suits providers?

**Reducing preventable readmissions is the right thing to do, but not all readmissions are avoidable**

This effort should focus on managing the conditions that bring patients to the hospital. Medical homes and optimizing chronic disease care can play pivotal roles in improving quality and reducing costs. Coordination of care and disease-management programs have led to cost reductions of 30% or more<sup>12</sup> and have reduced admission rates by more than 10%.<sup>13</sup> While the nation waits for health care reimbursement models to better reward patient quality outcomes and population health while reducing costs, we can use measures such as the Agency for Healthcare Research and Quality's Prevention Quality Indicators to identify early interventions in the ambulatory care setting that can prevent admissions, complications, and exacerbation of disease.

Payers should also experiment with and promote innovative bundled-payment models such as Geisinger Health System's ProvenCare program, which sets a fixed price for surgical procedures and up to 90 days of posthospital care, including readmission. These warranty-like programs overcome financial incentives to readmit patients in Medicare's volume-based diagnosis-related group payment system.<sup>5</sup>

Re-engineering the delivery of care requires realigning resources to improve efficiency and effectiveness. In the short term, hospitals that successfully reduce readmission rates can expect *reduced* net reimbursements, as the penalties currently do not exceed the lost revenue of readmissions.

Reducing preventable readmissions is the right thing to do, but not all hospitalizations and rehospitalizations are avoidable. Many readmissions reflect appropriate and necessary care. The relentless focus on the readmission rate diverts attention and resources from more proactive solutions and innovative approaches for increasing health care safety, quality outcomes, and value.

Hospitals are caught between the volume and value paradigms. Payment programs that reward proactive disease management and care coordination will do the most to reduce health care costs and improve the quality of care. Hospitals have a responsibility to efficiently and effectively manage acute care and optimize hand-offs to the next provider. Medicare's payment policies do not do enough today to align the financial and quality-of-care incentives. ■

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