

Reducing Hospital Readmissions:

What Is at Stake and What Will it Take?

Nearly one in five Medicare inpatients is readmitted to the hospital in the 30 days following discharge, most often for reasons relating to the original hospital stay (MedPAC 2007). From the perspective of patients and taxpayers, such readmissions are very costly, accounting for more than \$17 billion annually in Medicare spending (Jencks et al. 2009). With the view that many rehospitalizations could be averted through improvements in health care delivery, finding the path to reduce readmissions and capture the resulting savings has seized the imagination of many policy wonks and spurred attention, along with some action, on the front lines.

While not all readmissions are avoidable, many are, and interventions by health care providers have been shown to reduce the rate at which they occur by as much as 50 percent (Chollet et al. 2011). Preventable readmissions include those caused by infections acquired during a hospitalization or complications from treatment, premature hospital discharge, problems relating to prescribing or coordinating medicines, cross-provider communication failures, and poor planning for care transitions (Berenson et al. 2012). Readmissions could also be affected by the accessibility and quality of community-based services and by patients' compliance with providers' prescriptions for post-discharge care.

Aligning incentives and targeting resources to address problems is very challenging. Those best positioned to effect the delivery system changes needed to reduce readmissions face disincentives to act, in that hospitals benefit financially from readmissions under payment systems that provide additional reimbursement for each admission. Resources that hospitals invest in better transition, strengthened communication, or other types of prevention stand to negatively affect their bottom line, in terms of both the additional cost of the intervention and the reduced revenues that accompany successful results. In this Issue Focus, developments in the wake of the Affordable Care Act (ACA) and the ways in which foundations are contributing to efforts to grapple with this problem are discussed.

THE POLICY CONTEXT

The ACA included a number of provisions that can help tackle the problem of avoidable readmissions (Stone 2010). At the broadest level, the ACA's support for accountable care organizations is intended to promote and foster more collaborative and patient-focused care delivery. Under the Community-Based Care Transitions program, established through the ACA, the Centers for Medicare and Medicaid Services (CMS) is awarding up to \$500 million in grants to help hospitals and other health care providers improve patient transitions from the hospital to other care settings (CMS 2011).

The ACA also authorized CMS to modify hospital reimbursement under Medicare to incentivize efforts to reduce rehospitalizations. Beginning in October 2012, Medicare will dock reimbursements to hospitals having higher-than-expected readmission rates (Rau 2012a). To determine which hospitals would be subject to penalties, CMS assessed the rate of 30-day rehospitalization for patients admitted for heart failure, heart attack, or pneumonia over a three-year period beginning in July 2008, and compared each hospital's performance to the national average after adjusting for certain risk factors, such as comorbidities and frailty (CMS 2012). In the first year of the program, penalties of up to 1 percent of reimbursement will be assessed, rising to 2 percent next year and 3 percent in October 2014 (Rau 2012a).

Despite this level of attention, there is as yet no evidence that hospital readmission rates are dropping as hoped (Rau 2012b). The latest assessments show overall declines in readmission for heart failure and heart attack patients of just 0.1 percentage points, while readmissions for pneumonia patients actually increased by the same margin.

Experts and stakeholders offer a range of explanations for the disappointing results. Some say that the overlapping three-year periods as points of comparison obscure improvements made in the most recent year (Rau 2012b). Others say that the business case for hospitals reducing readmissions may remain weak and that alternative reimbursement approaches, such as payment levels set to cover any needed rehospitalization during a defined period after discharge, need to be explored (Berenson et al. 2012).

One criticism levied at the new policy relates to the possible negative impact on safety net providers, to the extent that hospitals serving disproportionate shares of disadvantaged populations may face more challenges in reducing readmissions. An analysis of the first-year penalties by *Kaiser Health News* showed that 76 percent of the hospitals with the most low-income patients will lose Medicare funds due to penalties levied during the coming year (Rau 2012a). Looking at hospitals overall, nearly two-thirds will incur penalties.

PHILANTHROPIC EFFORTS

Foundations have played a role in drawing attention to the cost and quality implications of hospital readmissions and are working at the national, state, and community level to make inroads in addressing the problem.

Foundations have funded research on the scope of the problem and how best to address it. Work by grantees of The John A. Hartford Foundation demonstrated hospital capacity to make inroads on the problem of poor care transition planning and served to shape provisions of the ACA (Langston 2010). The

New York State Health Foundation funded research to assess hospital readmissions in New York and to assess alternative payment approaches, including direct payment for the cost of hospital initiatives targeted to readmission prevention (Chollet et al. 2011). Work funded by The Commonwealth Fund includes research on lessons from hospitals implementing strategies to reduce readmissions, which pointed to steps like maintaining a connection with high-risk patients after discharge, aligning hospital efforts with community care providers, and educating patients and families in managing conditions (Silow-Carroll et al. 2011). The Commonwealth Fund also supported work to survey hospital efforts to reduce cardiac-care admissions and assess what additional steps hospitals can take to make progress in reducing readmissions (Bradley et al. 2012). Several barriers to implementing readmission reduction initiatives were identified, including constraints on staff time, insufficient resources, and complexities of coordinating efforts across providers.

A number of foundations have funded programs to reduce hospital readmissions in their communities and more broadly. For example, through its Preventable Hospital Readmissions Initiative, the United Hospital Fund has made grants to New York City hospitals to study the needs of readmitted patient populations and implement changes (United Hospital Fund 2012). The Robert Wood Johnson Foundation (2012) has supported work to reduce hospital readmissions in 16 targeted communities

through its Aligning Forces for Quality program, as well as other initiatives. And the California HealthCare Foundation (2010) provided funding to train physicians at 20 California hospitals to improve care coordination following hospital discharge.

While Medicare patients have been the focus of attention in terms of policy initiatives to date, research and readmission reduction efforts also address other vulnerable populations, including children and those with chronic conditions. The Jewish Healthcare Foundation (2010) and the Pittsburgh Foundation, for instance, collaborated to reduce hospital readmissions for patients living with HIV/AIDS in southwestern Pennsylvania.

CONCLUSION

Reducing avoidable hospital admissions means giving better care to patients at lower costs, a very attractive prospect at a time of escalating costs and financing pressure in Medicare, as throughout the health system. The path to achieving this goal might be a direct one, if incentives and resources can be targeted to the problem. Success, however, may also come indirectly as part of broader efforts to reshape health care delivery in ways that encourage cooperative efforts to improve performance in terms of efficiently achieving best possible outcomes for patients.

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