“Reducing and Preventing Hospital Readmissions”

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Conflict of Interest Statement:
My opinions and statements in this presentation are mine alone, and do not necessarily represent those of Aetna or Aetna management.

In 2011, there were approximately 3.3 million adult 30-day all-cause hospital readmissions in the United States, and they were associated with about $41.3 billion in hospital costs.

Officials estimate $17 billion of that comes from potentially avoidable readmissions.

nearly 18 percent of Medicare patients who had been hospitalized were readmitted within a month

Section 3025 of the Affordable Care Act added section 1886(q) to the Social Security Act establishing the Hospital Readmissions Reduction Program, which requires CMS to reduce payments to IPPS hospitals with excess readmissions, effective for discharges beginning on October 1, 2012. The regulations that implement this provision are in subpart I of 42 CFR part 412 (§412.150 through §412.154).

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html
The agency calculates readmission rates on discharges for all five categories that occurred from July 1, through June 30. CMS omits rehospitalizations that had been planned by medical professionals before the patient left. In assessing rates, CMS takes into account the severity of illness, the age of the patient, the patient's additional medical conditions and other factors. Officials then estimate what they believe was an appropriate readmissions rate, given the mix of patients and how hospitals nationally were performing. The penalty is based on the difference between the projected rate and the actual rate.


Medicare Fined 2,610 Hospitals In Third Round Of Readmission Penalties


three-quarters of hospitals that are subject to the Hospital Readmissions Reduction Program are being penalized

Over the course of the year, the fines will total about $428 million


This year, hospitals can lose as much as 3 percent of their Medicare payments under the program, which is overseen by the federal Centers for Medicare & Medicaid Services (CMS).

http://kaiserhealthnews.org/encyclopedia/madm/0001/maintain_summary_readmissions-penalties-readmissions-penalties/

There are higher and more widespread fines in 2014 because Medicare began evaluating readmissions of two new categories of patients—those initially admitted for elective knee or hip replacements, and those suffering lung ailments such as chronic bronchitis. Those patients were assessed along with the heart failure, heart attack and pneumonia patients Medicare has examined since the penalties began in October, 2012.

CMS will reduce each payment for a patient stay from October 2014 through September 2015, which is the federal fiscal year. These penalties apply to patients admitted for any condition, not just the five conditions that were used to determine if a hospital had too many readmissions.


Resources for Reducing Unnecessary Hospital Readmissions

The Role of the Patient Safety Organization

http://www.pso.ahrq.gov/Topics#resources
PSOs are required to collect and analyze data in a standardized manner. AHRQ created the Common Formats (common definitions and reporting Formats) to help providers uniformly report patient safety events and to improve health care providers’ efforts to eliminate harm.

https://www.pso.ahrq.gov/common

Re-Engineered Discharge (RED) Toolkit


A variety of forces are pushing hospitals to improve their discharge processes to reduce readmissions. Researchers at the Boston University Medical Center (BUMC) developed and tested the Re-Engineered Discharge (RED). Research showed that the RED was effective at reducing readmissions and posthospital emergency department (ED) visits. The Agency for Healthcare Research and Quality contracted with BUMC to develop this toolkit to assist hospitals, particularly those that serve diverse populations, to replicate the RED.

The Project BOOST® Mentored Implementation Program is a national initiative led by the Society of Hospital Medicine (SHM) to improve the care of patients as they transition from hospital to home.

The Project BOOST® Mentored Implementation Program is a yearlong initiative wherein hospitals receive expert mentoring and peer support to aid in improving the care of patients as they transition from hospital to home. BOOST mentors help hospital teams to map current processes and create and implement action plans for organizational change. BOOST provides a suite of evidence-based clinical interventions that can be easily adapted and integrated into each unique hospital environment.
Medications at Transitions and Clinical Handoffs (MATCH) Toolkit for Medication Reconciliation


Medication reconciliation is a complex process that impacts all patients as they move through all health care settings. The process involves comparison of a patient's current medication regimen against a physician's admission, transfer, or discharge orders to identify discrepancies. Study data show that an effective process can detect and avert most medication discrepancies, potentially avoiding a large number of adverse drug events and related costs for care of affected patients.

The AHRQ Innovations Exchange

The AHRQ Innovations Exchange includes a repository of user-submitted experiences on implementing a quality improvement effort around unnecessary readmissions. The exchange includes lessons learned, tools, and user-developed resources.

https://innovations.ahrq.gov/search/node/readmissions
AHRQ’s PSNet offers a searchable compendium of resources and tools on hospital discharge and related topics, such as medication reconciliation. The PSNet also offers a primer that explains how problems with the hospital discharge process can lead to adverse events or complications that result in patients returning unnecessarily to the hospital.

http://psnet.ahrq.gov/collection.aspx