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NEWSLETTER ARTICLE

In Focus: Preventing Unnecessary Hospital Readmissions

By Sarah Klein

Reducing hospital readmissions—especially those that result from poor inpatient or outpatient care—has long been a health policy goal because it represents an opportunity to lower health care costs, improve quality, and increase patient satisfaction at once.

"It's a win, win, win," says Robert Berenson, M.D., senior fellow with the Urban Institute in Washington, D.C., and formerly the director in charge of Medicare payment policy at the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services, or CMS).

The rate at which patients return to the hospital and the cost of those readmissions are staggering by most accounts, though the figures vary depending on the age of the patients involved and the severity of their illnesses. [1] MedPac's 2007 report to Congress found 17.6 percent of Medicare patients were readmitted to hospital within 30 days of discharge, accounting for $15 billion in spending in 2005. [2]

While some readmissions may be necessary, many are not. "If there is such a thing as low-hanging fruit, this is low-hanging fruit," Berenson says.

An Agency for Healthcare Research and Quality study of patients admitted to hospital with preventable admissions found 19.4 percent had at least one

preventable readmission within six months. The cost of those admissions, which occurred in four states in 1999, was $729 million, or $7,400 per readmission. [3] The numbers are not much better in the commercial population. When PacifiCare Health Systems Inc. reviewed discharge data for its enrollees between 2005 and 2006, it found readmission rates at hospitals ranged from as low as 0 percent to as high as 44 percent, with an average around 10 percent.

"Many of the quick returns to the hospital appear to be avoidable and represent a major setback for the patient," Michael Rapp, M.D., J.D., director of CMS' quality measurement and health assessment group, said in a statement. According to Rapp, the reasons for early rehospitalization include defects in care, medication errors, failure to plan for necessary equipment, and shortcomings in the preparation of the patient and family for his or her care outside the hospital.

Poorly Defined Problem
Financing mechanisms don't help. The fee-for-service system, as well as some capitation methods, offer few incentives for preventing readmissions that result from poor outpatient care or complications related to an initial hospitalization. "The incentives are not aligned to support the coordination of care at transitions," says Amy Boutwell, M.D., M.P.P., content director with the Institute for Healthcare Improvement (IHI) in Cambridge, Mass., which is working on methods to engage patients, caregivers, and payers in reducing rehospitalization rates on a regional basis.

Creating incentives requires some consensus about the nature of the problem itself, which is a challenge in complex systems where breakdowns in care occur at different points. Is the primary problem "potentially preventable hospitalizations," "inappropriate hospitalizations," or "readmissions"? Boutwell says all three terms are used to describe potentially problematic hospitalizations. But each suggests a different root cause and solution.

According to Boutwell, the term "potentially preventable hospitalizations" is used to describe hospitalizations from conditions such as dehydration and angina, which result in hospitalization if left untreated or inadequately treated in the outpatient setting. Reducing those would require focusing on the ambulatory setting to determine how such patients are falling through the cracks. Such an intervention may be tailored to patients, rather than providers, to encourage their early use of health care services. It may also require bolstering the primary care system to ensure patients have adequate access to doctors and doctors have sufficient resources to provide chronic care management services.

The second term, "inappropriate hospitalization," refers to the use of hospitalization for problems that can be managed on an outpatient basis but aren't, perhaps for patient or provider convenience. A study by David Grabowski, Ph.D., an associate professor of health care policy at Harvard Medical School, and colleagues found approximately 40 percent of nursing home-to-hospital transfers in New York were inappropriate, meaning the problems could have been handled at a lower level of care.[4] This suggests that closer monitoring of nursing home care and hospital admissions for those patients is required, rather than a review of the ambulatory care system.

The third term, "readmissions," is used to describe situations in which patients return to the hospital within days or months of their initial hospitalization. The cause may be related to a patient's treatment during the first hospitalization, or it may be the result of a secondary condition, suggesting possible quality problems in the hospital care received during the initial visit or problematic transitions between hospitals and the outpatient care setting.

Looking for Solutions
So where should those working to reduce avoidable hospitalizations focus their attention? Staff at the IHI believe the focus should be on rehospitalizations. "An emphasis on rehospitalizations will focus energy and attention on a commonly accepted goal and provide a concrete basis on which to initiate activities," Boutwell says. In addition, there is a large body of evidence suggesting ways to reduce rehospitalizations, including chronic disease management, remote patient monitoring, and/or improved home care. Further, the impact of these interventions would be system-wide, and would affect inappropriate and preventable hospitalizations, too.

But choosing this focus introduces another complication: Should providers attempt to reduce readmissions for specific conditions—perhaps for those with highest incidence of hospitalizations and/or cost, such as heart failure, chronic obstructive pulmonary disease, and renal failure—or should they look at the problem more broadly, by treating all readmissions as equal? The answer isn't so straightforward.

"One of the things that is very striking about congestive heart failure work is how often people's readmissions are not related to congestive heart failure. It begs the question: how many of these interventions are condition specific and how many more general," says Helen Burstin, M.D., senior vice-president of performance measures for the Washington, D.C.-based National Quality Forum.

Pursuing low readmission rates for all conditions may identify other important

problems in the system or at least require that providers focus on all patients. "You should do it globally," says Norbert Goldfield, M.D., medical director of 3M Health Information Systems in Wallingford, Conn. Otherwise, clinicians "make a beeline" toward those conditions on which they are being judged and pay less attention to those that are not under scrutiny.

However the problem is defined, many think the data should also reflect the stage of a patient's illness. To be helpful, readmissions data need to be combined with other quality measures "to make sure you are looking at readmissions that are likely to be indicative of a problem in care, rather than the expected course of treatment of a disease," says Nancy Foster, vice president for quality and patient safety policy at the American Hospital Association in Washington, D.C.

Finally, would financial penalties for unnecessary readmissions encourage better care and improve communication between hospitals, doctors, and patients? Of all the unanswered questions about the most effective and efficient way to reduce readmissions, this may be the one that provokes the most disagreement.

"It's not just the hospital that's responsible. We need shared accountability," Burstin says. "With the emergence of the advanced medical home, we can begin to make that argument."

Others think hospitals should be paid reduced rates for readmissions—at least for a select group of diagnoses, such as heart failure, for which readmissions can be reduced by good care, focused discharge planning, and follow-up after discharge. "I wouldn't pay nothing" for the care of rehospitalized patients, Berenson says. "You pay the marginal cost," of additional services.

Still others urge caution. Arnold Epstein, M.D., M.A, chair of the department of health policy and management at the Harvard School of Public Health, says it seems premature to use financial incentives to reward or punish hospitals with low or high rates of readmission without more data to substantiate the nature of the problem and to identify what hospitals can do to ameliorate the situation. "I think it's fine, perfectly fine, to hold them responsible for effective discharge planning, assuring a smooth transition to ambulatory care, and other services that are clearly under their control." But doing more could have dire consequences and may not be helpful, he says. "Hospitals are operating on 1 percent, 2 percent, and 3 percent margins."

References

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PUBLICATION DETAILS

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