# Higher Stakes, Troubling Trends and New Ways to Take Control

**"Readmission Penalties Reach Record Highs"**

**"Half of Nation's Hospitals Fail Again to Escape Medicare's Readmission Penalties"**

These were among the many headlines following the release of CMS reports in 2013, 2014 and 2015 on its Hospital Readmissions Reduction Program. Noted within the reports:

- Medicare fined roughly 2,600 hospitals for having too many patients return within a month for additional treatments

- The average fine, which affects every Medicare stay for penalized hospitals, will total more than $428 million.

Yet despite these well-publicized reminders of the high cost of patient readmissions, this widely prevalent problem seems to be getting worse instead of better.

A recent survey of 320 C-suite, senior-level and quality professionals from hospitals nationwide found that most were overconfident of their ability to reduce readmissions and underprepared for the difficult challenges that lie ahead. For the federal fiscal year 2015, the CMS's Hospital Readmissions Reduction Program fined 78 percent of hospitals with a maximum penalty rate of 3 percent. In addition, most hospital programs to reduce readmission risks are still extremely labor-intensive; the survey found that fewer than one in five hospitals use technology intended specifically to manage and control readmission risks.

This white paper will examine the potential impact of recent and proposed CMS changes. It will cover the challenges hospitals face when implementing readmissions risk reduction programs and why their efforts too often are ineffective. Lastly, it will provide guidance on best practices in readmission risk management, including the use of new technologies that can help executives and clinicians predict and manage readmissions risks for individual patients and patient populations in real time.

## CMS Changes Aimed at Curbing 'Revolving Door Syndrome'

As required by the Patient Protection and Affordable Care Act, CMS began measuring hospitals' performance on readmissions in 2008. The effort started with patients diagnosed with pneumonia, congestive heart failure, or acute myocardial infarction. The purpose of the Hospital Readmissions Reduction Program was to incent hospitals to pay attention to what happens to patients after they are discharged by penalizing those with higher than expected readmission rates. These penalties, which are based on a hospitals' performance during a preceding 3-year measurement period, are levied by lowering reimbursements for every Medicare patient -- not just those who are readmitted – throughout the fiscal year.

Reductions in Medicare reimbursement began in October 2012 for more than 2,000 hospitals with high patient readmissions for the three initial diagnoses. In February 2013, the first sentence of a Robert Wood Johnson Foundation report sounded the alarm:

> *"The U.S. health care system suffers from a chronic malady—the revolving door syndrome at its hospitals. It is so bad that the federal government says one in five elderly patients is back in the hospital within 30 days of leaving."*

Although the spinning door has slowed slightly, both the share of hospitals receiving penalties for 30-day readmissions and total fines rose again in 2015 – the first year CMS began penalizing hospitals for their performance for chronic obstructive pulmonary disease (COPD) and elective hip or knee replacement. CMS penalized a record 2,610 hospitals for high rates of readmissions (from July 2010 to June 2013) for patients with the following medical conditions:

- Heart failure (22.7% readmissions)
- COPD (20.7%)
- Heart attack (17.8%)
- Pneumonia (17.7%)
- Hip & knee replacement (5.3%)

**At an 82-bed short-term acute care hospital that participated in a Q-Centrix Readmission Reduction solution pilot study, the annual penalties for 30-day readmissions from 2013 to 2015 nearly tripled to more than $76,000.**


## Hospitals Face New Challenges and Greater Accountability

CMS has indicated that it plans to continue reducing Medicare reimbursements for excessive readmission rates for all these diagnoses. Beginning in 2017, CMS will also assess performance following initial diagnosis of coronary artery bypass graft (CABG) surgery.

Another potential change on the horizon would hold hospitals accountable for the entire episode of care -- from the time of the surgery through 90 days after discharge -- for hip and knee replacements, two of the most common surgeries that Medicare beneficiaries receive. In July 2015, the CMS proposed a major "bundled payment" initiative for these two procedures. Under this proposed five-year payment model, health care providers in 75 geographic areas would continue to be paid under existing Medicare payment systems. However, depending on quality and cost performance measures, the hospital where the hip or knee replacement took place could either receive an additional payment or be required to repay Medicare for a portion of the episode costs.

Readmissions not only have serious financial implications but can be an important indicator of the quality of care, particularly for surgical readmissions, since their major driver is complications. Focusing on readmission rates is a good way to promote accountability and improve coordination of care after patients leave the hospital.

## Stepping Up…

Clearly, hospitals need to tackle the long-standing problem of high readmission rates with greater purpose and urgency. Addressing readmission issues, however, is a complex problem with plenty of questions and no easy solutions.

- Who are the high-risk patients who need the most attention?
- What are the most effective ways to monitor and manage their treatments and prepare them for discharge?
- Are readmissions the result of mis-diagnosis or inadequate treatment?
- Are patients being discharged at the right time?
- What can be done to ensure appropriate care and patient behaviors post-discharge?

Hospitals have stepped up their efforts to reduce readmissions. In the recent survey by Q-Centrix hospitals reported employing an average of 4.5 different readmission reduction strategies.

**The three most commonly used strategies were:**

1. Completing a medication reconciliation process (92% of respondents)
2. Educating patients and patient caregivers pre-discharge (87%)
3. Conducting phone calls or other communication post-discharge (84%)

## … But Falling Short

Yet, as the CMS readmission penalties indicate, too many hospital readmission programs are still not achieving the desired results. Their shortcomings can be traced back to ground zero – the hospitals' inability to accurately identify high risk patients.

Many hospitals, for example, still use rudimentary pre-admission checklists to make yes-no decisions on whether a patient is high-risk. Others use the LACE index scoring tool (Length of stay, Acuity of admission, Comorbid conditions, and the number of ER visits in the last six months) to identify patients at risk of readmission. But even these more advanced assessment methods may not be that effective. A study in the Journal of General Internal Medicine found that functional status, rather than comorbidities, was a better predictor of whether someone would be readmitted to the hospital.

When hospitals do not have a clear picture of which patients need the most attention, they are forced to be more scattershot in their approach. This is one reason why so many readmission risk management programs today are labor-intensive and often require hospitals to add FTEs in nursing and pharmacy.

## Wanted: Timely, Actionable Information

As with everything else in health care, information is the lifeblood of any readmission risk management program. Yet most hospitals today do not have timely access to the most basic data needed to assess and refine their programs. Given the urgency and importance of addressing readmissions, what's even more surprising is that, in the recent Q-Centrix survey, only 18% of respondents were using technology designed to manage readmission risk.

Clinicians need better information about high-risk patients and the hospital care they receive to monitor care and intervene as needed to prevent little mistakes from causing bigger problems. A risk reduction program providing this kind of real-time data will enable hospitals to gain insights that also could help them improve other quality initiatives.

Quality and clinical leaders also could benefit from better and timelier data about patient populations and risk reduction programs, which could help them evaluate the effectiveness of various strategies and activities and quickly make any necessary adjustments. The only source for conducting this kind of trends analysis today is claims data, which is not available to hospitals until 90 days after a patient is discharged. With concurrent data, however, a hospital's COO and CQO could, for example, receive immediate feedback on whether the hospital's investment in staffing and training to implement a new standard of care for COPD and pneumonia is having a positive effect on readmission rates.

## Strategies for Success

Although the CMS reports on readmission penalties could dishearten hospitals struggling to get their rates under control, one piece of news is encouraging: According to the Medicare Payment Advisory Commission, 75% (or 4.4 million) of Medicare hospital readmissions may be preventable.

How can hospitals do a better job preventing avoidable readmissions? While hospitals face different challenges unique to their organizations, clinical protocols and patient populations, the following practices generally are considered key elements for success.

- Identify and target patients at the highest risk for readmissions, particularly heart failure patients, the very elderly, and patients with complex medical and social needs.
- Closely monitor and manage the in-hospital treatment of these patients and alert the care team to act quickly when "red flags" indicate the need for immediate interventions.
- Use concurrent data to evaluate readmission reduction strategies and programs and make necessary refinements to increase their effectiveness.
- Enhance coaching, education, and support for patient self-management.
- Improve core discharge planning and transition processes out of the hospital, especially those related to medication reconciliation and patient compliance.
- Use readmissions data to gain insights into the connections between readmissions, mortality and patient safety.

## New Technology for Readmission Risk Management

These best practices reaffirm the dire need for more and better information to help hospitals become more proactive in controlling the various factors that increase risks for readmissions. The most effective and practical way to collect and manage this information is to use stand-alone technology specifically designed for readmission risk management programs. Unlike a bolted-on module to an EHR solution, this approach not only captures more robust and applicable risk data but also does not require any changes in providers' workflow.

**Four Things to Look for in a Readmission Tool**

Health information technology is essential to improve quality and integrate care across settings. When considering how you can use this technology to reduce your readmission rates, find a solution that will enable you to:

1. Accurately predict each patient's risk for readmission
2. Optimize your resources by focusing on patients posing the highest risk
3. Provide real-time, actionable data to your caregiving teams
4. Customize your readmission risk management program to address your specific patient population and easily integrate with your current clinical practices

# Are You Ready for 'The Readmissions Decade'?

## Talk to Us

Considering that nearly four out of every five hospitals are being be fined for excessively high readmission rates, it's not surprising that this issue has gained top-of-mind awareness among hospital executives and clinical leaders. The stakes will soon go up, too, as CMS plans to add new DRGs to its Medicare reimbursement "penalty list" and introduce bundled payment initiatives that will hold hospitals financially accountable for entire episodes of care.



Q-Centrix helps partner hospitals get their readmissions under control. Our new Readmission Reduction solution is a powerful tool for identifying and managing patients at high risk for early hospital readmission based on the core drivers of readmission combined with data on your hospital's unique patient population. It provides real-time dashboards to manage risks while the patient is still in the hospital and is supported by industry's largest and broadest team of nurse-educated, quality information specialists.

Talk to us to learn more about how we can partner with you to tailor a readmission risk management program to your hospital's patient population and care management processes to ensure that your highest-risk patients receive recommended discharge planning, patient education, care coordination, and medication reconciliation services.

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