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PROFESSION

Hospitals make almost no headway in cutting readmissions

About 1 in 6 Medicare patients was rehospitalized within 30 days in 2009 -- a rate that must improve by October 2012 to avoid penalties.

By KEVIN B. O'REILLY, amednews staff. *Posted Oct. 10, 2011.*

Hospitals struggled to lower readmission rates among Medicare patients between 2003 and 2009, according to a September report from the Dartmouth Institute for Health Policy & Clinical Practice. The report comes as hospitals prepare for Medicare penalties for high readmission rates that start in October 2012.

Researchers affiliated with the institute's Dartmouth Atlas of Health Care examined the records of all 10.7 million Medicare patient hospital discharges from July 1, 2003 to June 30, 2009, and found little progress.

Patients hospitalized for congestive heart failure, pneumonia, surgery, hip fractures or other medical conditions had 2009 readmission rates either the same or slightly higher than in 2004.

Surgery patients were the least likely to be readmitted, with 12.7% being rehospitalized within 30 days -- a rate that went unchanged from 2004 to 2009. Patients with congestive heart failure were the toughest to keep out of the hospital, with 20.9% returning within 30 days in 2004. By 2009, the rate rose to 21.2%.

"The report highlights widespread and systematic failures in coordinating care for patients after they leave the hospital," said David C. Goodman, MD, lead author of the report. "Irrespective of the cause, unnecessary hospital readmissions lead to more tests and treatments, more time away from home and family, and higher health care costs."

There was one bright spot. In 2004, after one year of claims experience, 19.4% of patients admitted with acute myocardial infarction were rehospitalized within a month of discharge. By 2009, the rate had improved to 18.5%.

The vast majority of patients in the study were sent home after discharge, except for patients admitted for hip fractures, who usually were sent to facility-based rehabilitation. Nearly 60% of patients failed to see their primary care physicians within two weeks of discharge, though the rate varied by condition. Half of pneumonia patients saw their primary care doctors within 14 days, but only one in five surgery patients did. The report also found wide variation in rehospitalization rates by region and hospital.

"The need to develop more efficient systems of care that include discharge planning and care coordination is clear," said Elliott S. Fisher, MD, MPH, who co-wrote the report. "The report shows the opportunity for improvement and the importance of aligning efforts to reduce readmissions with other policy and payment initiatives."

Financial penalties coming

Beginning in October 2012, hospitals could see their Medicare pay cut by up to 1% if they have higher-than-expected 30-day readmission rates for patients with a heart attack, heart failure or pneumonia. The cut could be as much as 3% starting in October 2014.

An April 2, 2009, study in *The New England Journal of Medicine* estimated that the Centers for Medicare & Medicaid Services paid $17.4 billion for unplanned rehospitalizations in 2004. The figures not only caught the attention of policymakers in Washington but of hospital administrators and quality improvement experts, said Nancy Foster, vice president for quality and patient safety policy at the American Hospital Assn.

Since the push to reduce readmissions picked up steam in 2009, it should come as no surprise that figures from the first half of that year show little progress, Foster said. She expects greater improvements to be found when the Dept. of Health and Human Services' Hospital Compare website is updated next summer, although the effect will be muted because the agency reports three-year rolling averages for hospitals.

"We're really at the leading edge of being able to see some of the impact of the changes that people have made in their discharge processes, and in their advice to patients about managing their medications and managing their own health so they don't have to return to the hospital," Foster said, pointing to efforts such as Boston University Medical Center's Project Re-Engineered Discharge. "People looking at their own data believe these changes have had a substantial impact. We'll be looking for confirmation of that in the Hospital Compare data next year."

The Dartmouth report should come as a wake-up call to everyone concerned with the high readmission rate, said Joseph Ming Wah Li, MD, president of the Society of Hospital Medicine, which represents 10,000-plus practicing hospitalists. More than 100 hospitals nationwide are participating in the society's Project BOOST, or Better Outcomes

for Older adults through Safe Transitions.

"These findings underscore the need for the hospital, the patient, the outpatient and inpatient providers to work together in a coordinated fashion to make sure that the patient receives the quality of care that minimizes the risk of preventable hospital readmissions," Dr. Ming Wah Li said.

Along with its report, Dartmouth released a tip sheet for patients when leaving the hospital. The guide advises patients to ask for postdischarge planning help while still in the hospital and write a plan that captures elements such as expected discharge date, scheduled follow-up appointments, medication list, needed medical equipment and how to respond to anticipated symptoms.

ADDITIONAL INFORMATION:

WEBLINK

"After Hospitalization: A Dartmouth Atlas Report on Post-Acute Care for Medicare Beneficiaries," The Dartmouth Institute for Health Policy & Clinical Practice, Sept. 28 (**www.dartmouthatlas.org/downloads/reports/Post_discharge_events_092811.pdf**)

"Rehospitalizations among patients in the Medicare fee-for-service program," *The New England Journal of Medicine*, April 2, 2009 (**www.ncbi.nlm.nih.gov/pubmed/19339721**)

Hospital Compare, Dept. of Health and Human Services (**www.hospitalcompare.hhs.gov**)

Project Re-Engineered Discharge, Boston University Medical Center (**www.bu.edu/fammed/projectred**)

BOOSTing (Better Outcomes for Older adults through Safe Transitions) Care Transitions resource room, Society of Hospital Medicine (**www.hospitalmedicine.org/boosttoolkit**)

"Care About Your Care: Tips for Patients When They Leave the Hospital," The Dartmouth Institute for Health Policy & Clinical Practice (**www.dartmouthatlas.org/downloads/reports/Atlas_CAYC_092811.pdf**)

"Examining the Drivers of Readmissions and Reducing Unnecessary Readmissions for Better Care," *TrendWatch*, American Hospital Assn., September (**www.aha.org/research/reports/tw/11sep-tw-readmissions.pdf**)

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