On October 1, 2012, the Centers for Medicare & Medicaid Services (CMS) implemented the Preventable Readmissions Program. Approved by the Affordable Care Act as part of healthcare reform, the Preventable Readmissions Program aims to reduce the estimated $1.7 billion spent annually on readmissions. It will accomplish this goal through the assignment of a penalty to those prospectively paid hospitals determined to have excess readmissions. The Preventable Readmissions Program joins the Value-Based Purchasing Program already in place to exert a combined potential 2 percent adjustment to Medicare DRG payments (Value-Based Purchasing = 1 percent and Readmissions = 1 percent) in fiscal year 2013 with increasing amounts through 2016.

For healthcare organizations with higher Medicare beneficiary case mixes, the 1 percent of Medicare reimbursement translates into significant dollars. In fact, Medicare officials have projected that the 1 percent readmissions penalty is expected to total over $960 million across the roughly 3,500 hospitals potentially impacted. How, when, and how much healthcare reform will impact hospitals can be seen in the timeline below.

Many hospitals are deeply concerned to learn that they may endure Medicare reimbursement penalties for higher rates of 30-day readmissions. After all, how can hospitals control what brings patients back to their facility? A focus on preventable readmissions is the answer.

As health reform changes are phased in, the continuum of care becomes more important than ever. This new emphasis on the continuum of care is a game changer for both hospitals and patients. Not only are hospitals working hard to improve the care provided to patients while they’re in the hospital, we’re also striving to do an even better job of keeping them well after they return home.

The good news is that healthcare as an industry is accustomed to meeting challenges. We’ve faced changing payment systems, vertical integration, nursing shortages (and surpluses), a host of process improvement initiatives, and much more. However, we know that our industry can and will attain and sustain excellence. And one of the biggest reasons we can rise to the occasion is because of the people who work in the healthcare field. The passion and dedication to the work we do and the people we serve is unrelenting. It is in our DNA to provide the best possible care to our patients.

Healthcare leaders know they will be held accountable for preventable readmissions rates—and in light of the overwhelming list of metrics that demand attention, many are concerned that the tactics to impact this issue haven’t been broadly defined. And the implications, of course, go far beyond financial ones: Patients are still our patients even after they are discharged. We naturally want to be confident they are receiving great care and continuing to heal outside the hospital walls.

Our goal in seeking to reduce readmissions isn’t to discharge the patient and say goodbye forever. Rather it is to rethink our care plan to include phases, such as an inpatient care plan and a transitioned home care plan. This is a process that will take time; however, we can begin now by making efforts to better understand the variables causing readmissions and what can be done to impact them.
Readmissions have been a persistent problem for a while now: As a nation we’ve shown little improvement in this critical patient care area. Data released by CMS shows somewhat stagnant performance on hospital readmissions for heart attacks, heart failure, and pneumonia. In an update on the Hospital Compare website on July 19, 2012, CMS revealed that readmission rates over the past three years (from July 2008 through June 2011) decreased only 0.1 percentage points in heart attack and heart failure patients and rates actually increased by 0.1 percentage points in pneumonia readmissions. The rates during that three-year period were 19.7 percent for heart attack patients, 24.7 percent for heart failure patients, and 18.5 percent for pneumonia readmissions. Learn more in one of our previous publications, “Preventable Readmissions: Why the Answer to This Critical Issue Is (Literally) at Our Fingertips,” which can be downloaded at www.studergroup.com.

Now, let’s examine the specifics of the Hospital Readmissions Reduction Program (Section 3025) that went into effect on October 1st. Base DRG payment rates will be reduced based on a hospital’s ratio of actual to expected 30-day readmissions in three areas: acute myocardial infarction (AMI), heart failure (HF), and pneumonia (PN). (The maximum payment reduction will be 1 percent in FY 2013, will move up to 1.25 percent in FY 2014, and will be capped at 2 percent for FY 2017 and beyond.) Also, the list of items CMS will hold hospitals accountable for is expected to expand in the future.

Given the accelerated sense of urgency around readmissions, how best can we tackle this issue? There is no single solution, and certainly no single group of stakeholders who are accountable. There are several strategies that, when executed well, will impact the complex reasons for readmissions and work to decrease readmissions overall. Just as patient care has become more complex and faceted—sometimes involving other healthcare settings after the patient leaves the hospital—readmissions prevention plans need to take that same “continuum of care” approach.

Recent studies have shown that by extending clinical care through ways such as post-visit calls, you will gain higher patient perception of care while lowering readmission rates.

For the past several years Studer Group* has worked inside our “learning lab” of more than 850 healthcare organizations to build evidence around the strategies and tactics that lead to success in the three readmissions areas. And in our quest to continue pursuing solutions, we recently hosted a “nursing and non-nursing senior leaders think tank” to talk to nursing and quality leaders about how they are best preparing to address these challenges. While there are many different approaches to reducing preventable readmissions, there was clear consensus among this group that ultimately hospitals will become chronic disease managers, and care will become increasingly longitudinal—especially in the first 30 days post-discharge.

We’ve captured some of the top solutions from our ongoing work as well as from the think tank that are having an impact on organizational results. While you may not implement or even consider them all, remember that there are actions you can take today that will impact your readmissions tomorrow.
We are presenting them in a two-part series. Here we will focus on tactics to use while the patient is under your direct care. In the next installment, we will cover tactics to use at discharge and afterward.

**First, identify a preventable readmissions “point person.”** Whether it’s a case manager, a CNO/VP of nursing, a VP of quality, a hospitalist, or a team of several representatives, it’s important to have someone who is focused on and accountable for preventable readmissions. When everyone is in charge, no one is in charge. If you already have a point person in place, be sure the team knows who he or she is and that there is plenty of information flowing both ways. Leadership accountability is always a differentiator when it comes to achieving results. Just as hospitals have incentives and penalties for performance, ensure your leaders do as well.

For example, Studer Group partner Greenville Memorial Hospital in Greenville, SC, tracks data on a quality dashboard. They were able to reduce readmission rates to 9 percent (target 10.7 percent) by hardwiring Studer Group Must Haves® such as Hourly Rounding® and post-visit phone calls. They also saw improvement across all Clinical and Care Measures, as well as mortality rate.

**Consistently identify high-risk patients within the diagnoses at admission.** Consider patient variables that may increase likelihood to be readmitted: patient’s diseased state, historical admission history, patient’s mental acuity as well as the patient’s support structure at home and willingness and ability to assist with their own care.

This helps organizations have a stronger predictability model. When patients receive this designation, it triggers care providers to build specific actions into their care. For instance, high-risk patients might get an extra visit from hospitalists, a daily visit from a case manager, and, ideally, a follow-up home care visit two days post-discharge. (Some organizations have found a way to provide these home visits for free—for instance, by sending nursing students who have been given specific training.)

Also, educate staff as to what makes a patient “high risk.” Define exactly what “high risk” means at your organization and what the implications are for those patients, not just while they’re in the hospital but once they are recovering at home. Once readmitted, did you learn the patient was taking medicine inappropriately? Were they following their diet strictly? Check for indicators such as these that can lead to readmission. Understanding impact and potential side effects post-discharge makes providers more likely to comply with the care plan and help them watch for similar situations in the future.

**Make all staff members aware of high-risk patients.** Try putting a system in place to ensure that everyone knows which patients are designated high risk. For example, a colored arm band might generate appropriate questions and special care during inpatient stay. This will allow staff members to do everything possible to ensure that patients are compliant with medications, dietary guidelines, and so forth.

Most organizations do some form of post-visit phone calls to check in on high-risk patients. We’re seeing this tactic become more important than ever. When care teams are aware of high-risk patients while they’re in the hospital, they are far more likely to target those patients when making post-visit phone calls to check on compliance with medications, follow-up appointments, and discharge instructions.
Pinpoint and follow up with patients who have four-plus ED visits in one year. Today’s chronic ED visitors may become tomorrow’s preventable readmissions. Once you’ve identified these high-risk patients, you can assess them and provide post-visit calls or home care visits later. You might manage the follow-up care yourself, or you might do as other hospitals are doing and partner with EMS or local nursing schools. This is a critical group to keep in touch with in order to make sure they are managing their conditions in terms of diet and exercise needs, medications, follow-up visits, and so forth.

Connect why continuum of care is important. Bring together the nursing staff and articulate the what, but more importantly, why continuum of care affects the patient. Explain how it affects patient outcomes. Ask what more we can do or what we can do differently as nurses to further benefit our patients and positively impact outcomes. It may seem like we’re asking for a lot of new behaviors, but by explaining the why, we can show how this impacts our patients and the organization.

With any change in area of focus, relentless work around the quality connection will change behaviors. To create urgency and impact around staying connected to patients once discharged, one organization includes their high-risk recovering patient counts in their huddles at shift change. “We have a total of 20 patients today; 15 are on the unit and 5 are recovering at home.” This keeps our discharged patients top of mind and helps us remain focused on reducing possible readmissions.

This is only the beginning of a long road to changed behavior with the new rulings. This insight focused on the updates and some initial ways to start improvements today. Stay tuned for part two of this series that will provide specific tactics for further reducing readmissions.

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About Studer Group®:
Studer Group works with over 850 healthcare organizations in the U.S. and beyond, teaching them how to achieve, sustain, and accelerate exceptional clinical, operational, and financial outcomes. As the metrics the industry publicly reports get expanded—and as reimbursement is increasingly tied to these results—organizations are forced to get progressively better at providing top-quality care with fewer dollars. Studer Group helps partners install an execution framework called Evidence-Based LeadershipSM (EBL) that aligns their goals, actions, and processes. This framework creates the foundation that enables them to transform the way they provide care in this era of rapid change. This commitment to helping organizations accelerate their ability to execute led to Studer Group’s receiving the 2010 Malcolm Baldrige National Quality Award.

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