Establishing an Infrastructure to Implement Strategies for Reducing Maryland Hospital Preventable Readmissions (MHPR)

Background

Hospitalizations are costly, accounting for approximately 31 percent of total health care expenditures. [1] In Medicare, inpatient care accounts for 37 percent of spending, [2] and readmissions contribute significantly to that cost: 18 percent of all Medicare patients discharged from the hospital have a readmission within 30 days of discharge, accounting for $15 billion in spending.[3] In Maryland, the rate of all-cause Medicare readmissions is close to 22% making Maryland one of the poorest performing states for readmissions.

Based on analysis of 2007 readmission data using 3M Potentially Preventable Readmission (PPR) methodology:

- The top performing hospitals had 15-day rates of readmission just below 4%
- The bottom performing hospitals had 15-day rates of readmission just above 12%
- The overall 15-day readmission rate was 6.74%
- The overall 30-day readmission rate was 9.81%
- For readmission in 15 days, there were $430.4 million (5.3%) estimated associated charges
- For readmissions in 30 days there were $656.9 million (8.0%) estimated associated charges

Strategies to Reduce Readmissions

The Health Care Leader Action Guide to Reduce Avoidable Readmissions released in January of this year by the AHA's Health Research and Educational Trust, the Commonwealth Fund, and the John A Hartford Foundation provides a comprehensive overview of steps that hospitals and their leadership can take to reduce readmissions. Key steps outlined by the Action Guide are summarized below.

1. Examine current rates of readmission, including readmission rates for various conditions, by practitioner, by readmission source (home, nursing home, etc), and for various timeframes (e.g., 7, 15, 30 days). In addition, perform targeted chart reviews of patients frequently readmitted to ascertain patterns contributing to the readmissions.
2. Assess and prioritize improvement opportunities, including focus on:
   - Specific patient populations with high readmission rates- e.g., establish risk assessment processes for older patients with co-morbidities.
   - Stages of the care delivery process- e.g., discharge processes could be strengthened to include a component of patient/caregiver education to empower them to take charge of their care post-discharge.
   - Hospital's organizational strengths- e.g., hospitals serving ethnically diverse patients could harness the language skills of a multilingual staff in communicating care plans or discharge instructions to patients and caregivers.

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[1] Catlin, A. et al. "National Health Spending in 2006: A Year of Change for Prescription Drugs," *Health Affairs*, January/February 2008, Vol. 27, No. 1, pp. 14-29.

[2] Medicare Payment Advisory Commission. 2006. Healthcare Spending and the Medicare Program: A Data Book. Washington DC: Medicare Payment Advisory Commission, p.9.

[3] Medicare Payment Advisory Commission. 2007. Report to the Congress: *Promoting Greater Efficiency in Medicare*. Washington, DC: Medicare Payment Advisory Commission, p. 103.

- Hospital's priority areas and current quality improvement initiatives- Mandatory and voluntary quality improvement programs in which hospitals are currently involved could serve as a vehicle for prioritizing readmissions focus.

3. Develop an action plan of strategies to implement in your hospital. The Action Guide includes three Tables that identify the level of effort to implement the various strategies below as well as the entities currently using the strategies.
   - During hospitalization, for example:
     - Risk screen patients and tailor care
     - Establish communication with PCP, family, and home care
     - Use ―teach-back‖ to educate patient about diagnosis and care
     - Use interdisciplinary/multidisciplinary clinical team
     - Coordinate patient care across multidisciplinary care team
     - Discuss end-of-life treatment wishes
   - At discharge, for example:
     - Implement comprehensive discharge planning
     - Educate patient/caregiver using ―teach-back
     - Schedule and prepare for follow-up appointment
     - Help patient manage medications
     - Facilitate discharge to nursing homes with detailed discharge instructions and partnerships with nursing home practitioners
   - Post discharge, for example:
     - Promote patient self management
     - Conduct patient home visit
     - Follow up with patients via telephone
     - Use personal health records to manage patient information
     - Establish community networks
     - Use tele-health in patient care

4. Monitor your hospital's progress. The key to sustaining efforts to reduce readmissions is for hospital leaders to monitor their facilities' progress. This fourth step is especially critical since this guide is structured to encourage hospitals to pick individual strategies to implement. Monitoring the hospital's progress will inform hospital leaders of the efficacy of these strategies and perhaps guide them in implementing additional strategies.

HSCRC will recommend adoption of the 3M PPR methodology to measure risk adjusted rates of readmission. A measure that should also be considered for implementation perhaps as part of the QBR is the Care Transition Measure (CTM), a performance measure used to promote quality improvement in the area of transitional care. The CTM was developed by the University of Colorado Health Sciences Center under the leadership of Dr. Eric Coleman and with the support of The Robert Wood Johnson Foundation, The Commonwealth Fund, The National Institute on Aging, and the Paul Beeson Faculty Scholars in Aging Program. The measure is in the public domain and no fees are assessed for use—permission for use is requested only to track the use of the CTM in order to report back to funding agencies.