Reducing Hospital Readmissions by Addressing the Causes

Reports that 20% or more of unplanned hospital readmissions are avoidable has led to considerable interest in policymakers in reducing readmissions.[1] Actively reducing hospital readmissions is seen as a route to lower Medicare spending and improved patient care.

The Affordable Care Act (ACA) established a penalty program for preventable readmissions. Under the Hospital Readmissions Reduction Program,[2] since Fiscal Year 2012, hospitals have had their Medicare reimbursement reduced if certain patients were readmitted within 30 days of discharge. Other payment and delivery system reforms enacted in the ACA, such as bundled payments[3] and accountable care organizations,[4] also seek to improve transitions from acute care to post-acute settings, thereby reducing hospital readmissions. Skilled nursing facilities will be eligible for incentive payments for reducing hospital readmissions under a Value-Based Purchasing Program that was enacted as part of the Protecting Access to Medicare Act of 2014.[5]

While many efforts focus on payment reforms that discourage or penalize avoidable readmissions or (for skilled nursing facilities) reward nonhospitalization, a new study focuses on the *causes* of readmissions.[6] "Preventability and Causes of Readmissions in a National Cohort of General Medicine Patients"[7] is "an observational study . . . of 1000 general medicine patients readmitted within 30 days of discharge to 12 US academic medical centers between April 1, 2012, and March 31, 2013." Researchers interviewed patients; surveyed up to five physicians for each patient (including the patient's primary care physician, physician from the original hospital admission [called the index admission], and current attending physician); reviewed inpatient and outpatient medical records; and had two physicians independently review the results for each patient and determine whether the patient's readmission was preventable.

The physicians' reviews, which included the patient interview, complete medical record, and at least one physician survey, had "2 key objectives: (1) to determine whether readmission was potentially preventable and (2) to identify factors that contributed to readmission, regardless of preventability." In their reviews, physicians compared what they found with "an 'ideal health system.'" This frame of reference meant, for example, that if a readmission was related to a patient's inability to get a post-discharge appointment, the readmission was determined to be preventable.

Case reviews found that the readmissions of 269 of 1000 patients (26.9%) were potentially preventable. More than half of these readmissions (140 of 269 cases, 52.0%) were determined to be potentially preventable because of "gaps in care during the initial inpatient stay." Premature discharge from the hospital was a key factor leading to preventable readmissions. The researchers identified hospitals as the key location where interventions could be most effective in preventing rehospitalization. They suggested that some readmissions "may be prevented with better attention to patients' readiness for discharge, in terms of their ability to manage care after discharge or recover from (or develop an effective management plan for) symptoms, such as dyspnea, vomiting, and pain."

Although patients who were rehospitalized generally reported similar hospital experiences in their initial hospital stays, whether or not their readmission was determined to be potentially preventable, patients who reported not knowing how to reach their physician after discharge from the hospital were more likely to have their readmission classified as potentially preventable.

The four factors "most strongly associated with potentially preventable readmissions" were

- “Premature discharge from the index hospitalization;”
- “Failure to relay important information to outpatient health care professionals;”
- “Lack of discussions about care goals among patients with serious illnesses;” and
- “Emergency department decision-making to admit a patient who may not have required an inpatient stay.”

The four most common factors affecting potentially preventable admissions identified in the study were

- “Emergency department decision-making;”[8]
- “Inability to keep appointments after discharge;”
- “Premature discharge from the hospital;” and
- “Patient lack of awareness of whom to contact after discharge.”

Facts *not* associated with potentially preventable readmissions were patients’ functional status, reports of care processes, and satisfaction.

The research supports the need for better discharge planning by hospitals and better coordination of care between acute care hospitals and post-acute providers. *See* the Center for Medicare Advocacy’s materials on discharge planning.[9]

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[1] An early article on this issue is Stephen F. Jencks, Mark V. Williams, Eric A. Coleman, “Rehospitalization among Patients in the Medicare Fee-for-Service Program,” *New England Journal of Medicine* 2009;360:1418-28 (updated Apr. 2, 2009), http://www.nejm.org/doi/pdf/10.1056/NEJMsa0803563.
[2] Section 3025 of the ACA, 42 U.S.C. §1395ww(q); 42 C.F.R. part 412 (§412.150 through §412.154). CMS, Readmissions Reduction Program (HRRP), https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/readmissions-reduction-program.html.
[3] Section 3023 of the ACA, 42 U.S.C. §1395cc-4; CMS, Bundled Payments for Care Improvement Initiative, https://innovation.cms.gov/initiatives/bundled-payments//
[4] Section 3022 of the ACA, 42 U.S.C. §1395jjj.
[5] Pub. L. 113-93, §215, codified at 42 U.S.C. §1395yy(g).
[6] The Center reported decades worth of research and evidence documenting that having more nurses in nursing facilities reduces rehospitalization of residents. See CMA, “More Nurses in Nursing Homes Would Mean Fewer Patients Headed to Hospitals,” (Alert, March 10, 2011), http://www.medicareadvocacy.org/more-nurses-in-nursing-homes-will-mean-fewer-patients-headed-to-hospitals/.
[7] *JAMA Internal Medicine* doi:10.1001/jamaintermed.2015.7863 (published online, March 7, 2016), http://archinte.jamanetwork.com/article.aspx?articleid=2498846.
[8] While it is hoped that this refers to medical decisions, it may refer to the increased use of outpatient “Observation Status” rather than inpatient admission. For more information on the harmful effects of Observation Status on Medicare beneficiaries, see http://www.medicareadvocacy.org/medicare-info/observation-status/
[9] Alfred J. Chiplin, Jr., “Breathing Life into Discharge Planning” (May 31, 2004), http://www.medicareadvocacy.org/wp-content/uploads/2013/08/Discharge_BreathingLifeIntoDischargePlanning06.22.04.pdf; CMA, “Discharge Planning: Rights and Procedures for Medicare Beneficiaries in Various Care Settings,” http://www.medicareadvocacy.org/medicare-info/discharge-planning/; CMA, Discharge Planning, http://www.medicareadvocacy.org/?s=discharge+planning&op.x=0&op.y=0.