



# Acute Care Readmission Reduction Initiatives: Major Program Highlights

Under the Patient Protection and Affordable Care Act (ACA), acute care hospitals with high readmission rates for acute myocardial infarction (AMI), heart failure (HF), and pneumonia may lose up to 1 percent of their Medicare payments for fiscal year (FY) 2013, up to 2 percent for FY 2014, and up to 3 percent for FY 2015.<sup>1</sup> In FY 2015, four additional conditions will be included under the Readmissions Reductions Program: chronic obstructive pulmonary disease (COPD), coronary artery bypass graft (CABG), percutaneous transluminal coronary angioplasty (PTCA) and "other vascular" surgical procedures.

Beginning October 1, 2012, the Centers for Medicare and Medicaid Services (CMS) began reducing hospitals' Medicare payments based on 30-day hospital readmission rates for the three conditions. The reductions are based on hospitals' 30-day risk-adjusted readmission rates relative to national averages. Penalties are imposed for each hospital's percentage of potentially preventable Medicare readmissions for those conditions. Two-thirds of all applicable hospitals (2,213) nationally, including approximately one-third of Michigan hospitals (55), were penalized in FY 2013 as a result of this provision.<sup>2</sup> Total penalties were approximately \$280 million<sup>3</sup> nationally and \$14 million<sup>4</sup> in Michigan.

Further information about the CMS readmissions penalty may be found at <http://www.cms.gov>. Additional information about reducing unnecessary admissions may be found at <http://www.pso.ahrq.gov>.

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The Center for Healthcare Research & Transformation (CHRT) illuminates best practices and opportunities for improving health policy and practice. Based at the University of Michigan, CHRT is a non-profit partnership between U-M and Blue Cross Blue Shield of Michigan to promote evidence-based care delivery, improve population health, and expand access to care.

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# Program Summaries

A number of initiatives are under way across the country to try and reduce readmission rates. Some of those key programs, along with research results to date, are summarized below (in alphabetical order).

## 1. Collaborative on Reducing Readmissions in Florida

<http://collab.fha.org>

### Current Implementation Sites

The program is currently being implemented in 107 hospitals in 16 health systems throughout Florida.

### Stated Goals

Program goals are to reduce potentially preventable readmissions within 15 days and 30 days. Specifically, the goal was to reduce statewide average readmission rates by December 31, 2010, for patients with the following conditions using national measures of quality care:

- Heart failure (HF) to <8%
- Acute Myocardial Infarction (AMI) to <6.5%
- Pneumonia to <4%
- Bypass surgery to <8%
- Hip replacement to <2.5%

### Target Population

The focus is on patients admitted for HF, AMI, pneumonia, bypass surgery, or hip replacement.

### Main Interventions

As the name suggests, this program has created a hospital collaborative to provide shared learning environment to reduce readmissions. The collaborative uses the Institute for Healthcare Improvement (IHI) model to discuss causes, possible solutions and develop tools. It includes two to three in-person meetings and monthly teleconferences to facilitate additional sharing or learning.

Collaborative subgroups focus on discharge planning, payment reform, patient information, and coordination with post-acute care.

The collaborative has created a website to provide a forum to download information and tools.

### Results

The collaborative did not meet its goals. During federal fiscal year (FY) 2011, statewide 15-day readmission rates for patients with the following procedures were:<sup>5</sup>

- HF: 11.7%
- AMI: 11.8%
- Pneumonia: 7.1%
- Bypass surgery: 10.3%
- Hip replacement: 4.9%

Results for 30-day readmissions are not currently being reported.<sup>6</sup>

## 2. The Care Transitions Program®

[www.caretransitions.org](http://www.caretransitions.org)

### Current Implementation Sites

The Care Transitions Program® is located in more than 600 health care institutions in 39 states, including, for example, the John Muir Physician Network, located in California.

### Stated Goals

The program aims to encourage patients and caregivers to have more active roles during care transitions to reduce readmissions.

### Target Population

The program focuses on persons aged 65 years and older who are living in the community and have at least one of 11 diagnoses: congestive heart failure, coronary artery disease, cardiac arrhythmias, chronic obstructive pulmonary disease, diabetes mellitus, spinal stenosis, hip fracture, peripheral vascular disease, deep venous thrombosis, and pulmonary embolism.

### Main Interventions

A personal health record (PHR) Transitions Coach, who is an advanced practice nurse (APN), meets with patients in hospitals to introduce what the PHR is and its purpose and arranges home visits. The Transitions Coach visits patients at their home within 48 to 72 hours of their discharge. The coach also makes three phone calls to the patient within the first 28 days after each patient's discharge from the hospital.

### Results

Randomized controlled trial (RCT) results show a decrease in readmission rates:<sup>7</sup>

- All-cause readmission rates dropped to 8.3 percent from 11.9 percent for 30-day readmissions, and to 16.7 percent from 22.5 percent for 90-day readmissions.
- Same-diagnosis readmission rates fell to 3 percent from 5 percent for 30-day readmissions, and to 5 percent from 10 percent for 90-day readmissions.

The John Muir Physician Network reduced its 30-day readmission rate over one year (from 11.7 percent to 6.1 percent) and its 180-day readmissions fell from 32.8 percent to 18.9 percent.<sup>8</sup>

## 3. **Evercare Care Model**

[http://www.innovativecaremodels.com/care\\_models/17](http://www.innovativecaremodels.com/care_models/17)

### **Current Implementation Sites**

The program is used in 38 states.

### **Stated Goals**

The program aims to reduce hospital readmissions by customizing patient care and improving care coordination.

### **Target Population**

The program focuses on people living in long-term care facilities; Medicare Part A and/or B recipients who either qualify for a Medicare Savings Programs (MSP) or qualify for Medicaid benefits (dual eligible), and people with long-term or advanced illness, who are older, or who have disabilities.

### **Main Interventions**

Advanced practice nurses (APNs) and other care managers develop personalized care plans; coordinate multiple services; facilitate better communications between patients, caregivers, and health care providers; and ensure effective integration of services. Depending on where a patient lives and his/her health status, four levels of care (ranging from minimal to extensive) may be provided. The program also incorporates elements of the Care Transitions Model through use of Transitions Coaches.

### **Results**

Results from a quasi-experimental research design show:

- Hospitalization rate reduced by 45 percent with no change in mortality
- Emergency department (ED) visits cut by 50 percent

The major effect was cost-effective management of cases, with \$103,000 in hospital costs saved per year per APN.<sup>9</sup>

## 4. **Guided Care<sup>®</sup>**

<http://www.guidedcare.org>

### **Current Implementation Sites**

The program is implemented in eight health systems throughout the United States.

### **Stated Goals**

Program goals are to improve health care quality and outcomes and reduce costs.

### **Target Population**

The program focuses on patients aged 65 years and older with multiple chronic illnesses who are at high risk for hospitalization.

### **Main Interventions**

Primary-practice based teams, which include Guided Care nurses, supplement care by conducting comprehensive assessments of patients at home, coordinating care, conducting monthly monitoring of patients, and educating patients and their caregivers about self-management skills.

### **Results**

RCT results<sup>10</sup> show a 29.7 percent reduction in home care visits; no statistically significant reduction in other service use was found. A subset of Kaiser Permanente patients, however, showed a drop in the use of skilled nursing facility (SNF) and other health services.

## 5. Hospital to Home

<http://h2hquality.org>

### Current Implementation Sites

The program is deployed in multiple states, including sites in Michigan.

### Stated Goals

The program goal was to reduce all-cause readmission rates among patients discharged with HF or AMI by 20 percent by December 2012.

### Target Population

The program focuses on discharged patients with HF or AMI.

### Main Interventions

The initiative provides a web-based community to share tactics, resources, tool kits, and best practices. Emphasis is placed on medication management post-discharge, early follow-up (within one week), and symptom management.

### Results

No results have been published.<sup>11</sup>

## 6. Preventing Readmissions through Effective Partnerships (PREP)

<http://www.ihatoday.org/uploadDocs/1/prepbrochure.pdf>

### Current Implementation Sites

The program is used in 201 hospitals in Illinois in partnership with Blue Cross Blue Shield of Illinois and Illinois Hospital Association.

### Stated Goals

The program aims to reduce 30-day readmission rates; specifically, to improve the aggregate state readmission rate in Illinois from 20.3 percent to below 17.5 percent.

### Target Population

All patients are included.

### Main Interventions

Efforts include:

- Redesigning hospital discharge processes
- Improving transitions of care
- Developing and improving palliative care programs
- Reducing readmissions from infections
- Measuring reductions in readmissions using standardized metrics

Hospitals receive technical assistance and access to resources from a number of sources, including: Project Re-Engineered Discharge (Project RED); Project Better Outcomes for Older Adults through Safer Transitions (Project BOOST); the Illinois Transitional Care Consortium's Bridge Model, which uses social workers for the co-management of patients as they transition from hospital to home; and training on palliative care and goals of care from the Feinberg School of Medicine at Northwestern University.

### Results

There are no published results (the initiative runs through 2014).<sup>12</sup>

## 7. **Project BOOST (Better Outcomes for Older adults through Safe Transitions)**

[www.hospitalmedicine.org/boost/](http://www.hospitalmedicine.org/boost/)

### **Current Implementation Sites**

The program is implemented in several states, including 24 hospitals and provider organizations in Michigan.<sup>13</sup>

### **Stated Goals**

Program goals are to reduce 30-day readmission rates; reduce length of hospital stay; improve patient satisfaction; and improve the transition of care between inpatient and outpatient providers.

### **Target Population**

High-risk general medicine patients are targeted, with particular focus on older adults.

### **Main Interventions**

Project BOOST provides evidence-based clinical intervention tools, such as a risk assessment tool, risk-specific patient and caregiver discharge preparations, standardized forms and methods for transmitting information to primary care providers, and nurse training of “teach-back” process, a method in which patients explain what they have been told in order to confirm their understanding. The program provides individualized, multi-year training and technical assistance for providers in Project Boost’s participant sites.

### **Results**

Results from one site, Atlanta’s Piedmont Hospital, since implementation in September 2008,<sup>14</sup> show:

- Reduced 30-day readmissions (8.5 percent, down from 25.5 percent) for patients under age 70
- Reduced 30-day readmission rate (22 percent, down from 26 percent) for patients over age 70

Preliminary results from other pilot sites also indicate reductions in readmissions.<sup>15</sup>

## 8. **Project RED (Re-Engineered Discharge)**

[www.bu.edu/fammed/projectred/](http://www.bu.edu/fammed/projectred/)

### **Current Implementation Sites**

The RED Toolkit has been downloaded by 500 users. Joint Commission Resources provided technical assistance to 269 hospital organizations.<sup>16</sup>

### **Stated Goals**

The program aims to reduce hospital readmissions by improving discharge processes.

### **Target Population**

The method can be applied to all discharged patients or limited to patients with specific conditions (determined by hospital leadership).

### **Main Interventions**

The discharge process includes:

- Making follow-up appointments
- Arranging post-discharge services and equipment
- Medication reconciliation
- Patient education and plan when red flags are identified
- Sending the discharge plan to the primary care provider (PCP)
- Follow-up within 72 hours

### **Results**

RCT results show:<sup>17, 18</sup>

- Approximately 30 percent decrease in hospital utilization (ED visits and readmissions) within 30 days
- Approximately 34 percent lower observed costs for the intervention group

The method was most effective for patients with high utilization.

## 9. **State Action on Avoidable Readmissions (STAAR)**

[www.ihl.org/staar](http://www.ihl.org/staar)

### **Current Implementation Sites**

The program is implemented in Massachusetts, Michigan, Ohio, and Washington.

### **Stated Goals**

Goals are to reduce 30-day readmission rates by engaging payers and other stakeholders; patients and families; and caregivers across care settings.

### **Target Population**

All patients are eligible.

### **Main Interventions**

Interventions include:

- Performing enhanced admission assessments for patient needs after discharge
- Providing effective teaching and enhanced learning through customized education for patients and caregivers and “teach back” processes in hospitals and at discharge
- Conducting real-time patient- and family-centered communication, for example, reconciling medications at discharge and providing real-time critical information to next setting of care
- Ensuring post-hospital care follow-up before discharge by scheduling in-person visits for high-risk patients within 48 hours and scheduling phone calls to moderate-risk patients

### **Results**

There are no published results yet; the program was launched in 2009 for a four-year cycle.<sup>19</sup>

## 10. **Transitional Care Model (TCM)**

<http://www.transitionalcare.info>

### **Current Implementation Sites**

The program is implemented in many states across the country.

### **Stated Goals**

Program goals are to improve coordination and continuity of care from hospital to home, and to help patients and their caregivers play an active role in their care.

### **Target Population**

The program focuses on older adults with complex needs who are transitioning from acute-care setting to home or other care settings.

### **Main Interventions**

A transitional care APN (called a Transitional Care Nurse) is key to effective transition between care settings:

- An APN visits patients to assess care needs and streamline plans of care.
- After discharge the Transitional Care APN conducts a home visit within 24-hours of discharge; the focus of the visit is on patient and family education.
- The Transitional Care APN accompanies the patient on the first post-discharge physician visit (and subsequent visits if needed).

### **Results**

Two RCTs results have been documented. The first study showed fewer readmissions in the intervention group at six months (20 percent, down from 37 percent).<sup>20</sup> The second study of elderly patients (65+) hospitalized with HF showed fewer readmissions in the intervention group at one year (104 vs. 162).<sup>21</sup>

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# End Notes

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