

## The First Step Is (Re)Admitting That You Have a Problem, The Readmissions Risk-Adjustment Debate and Successful Strategies for Reducing Re-hospitalization

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In 2015, more than half of U.S. hospitals were penalized a combined \$420 million under the Hospital Readmissions Reduction Program (HRRP), an Affordable Care Act program that penalizes hospitals with 30-day readmission rates above national benchmarks with across-the-board reductions of as much as 3% in annual Medicare reimbursements.<sup>1</sup> The introduction of these penalties and readmission-based quality measures for Medicare Shared Savings Program Accountable Care Organizations (ACOs) has left hospitals and ACO participants scrambling—with varying degrees of success—to develop strategies to lower readmission rates. New research, however, tends to corroborate what many providers have long intuited: readmissions rates, which are not adjusted for the impact of deleterious demographic and socioeconomic factors outside of the hospital's influence, are a fundamentally flawed barometer of quality of care.

Nevertheless, the Centers for Medicare & Medicaid Services (CMS) continues to penalize high readmission hospitals—many of which serve the poorest patients and already suffer from a lack of resources—by withholding revenue, an approach that can be viewed as self-defeating. CMS, however, has held steadfast against such criticism, reasoning that “holding hospitals to different standards for the outcomes of their patients of low sociodemographic status” may “mask potential disparities or minimize incentives to improve the outcomes of disadvantaged populations.”<sup>2</sup> These divergent positions underscore a simmering debate among health care policymakers over how to appropriately address the influence of sociodemographic status upon readmission rates.

Notwithstanding the controversy surrounding the adjustment of readmissions targets for sociodemographic factors (and which particular sociodemographic factors should be taken into consideration), hospitals seeking to drive down readmission rates have become a veritable laboratory for experimentation with different mitigation strategies, some of which—discharge planning and coordination with home health organizations, for instance—have proven remarkably successful.

In addition to scrutinizing readmissions penalties, their impact on hospitals, and the debate over adjustment for sociodemographic factors, this article examines the successful mechanisms that providers have implemented proactively to

decrease readmission rates, with the objective of sparking a dialogue regarding optimal reform to readmission standards while providing hospitals and ACOs with options for reducing their exposure to penalties or reduced ACO shared savings payments.

### The Sociodemographic Conundrum

In fiscal year 2015, penalties under the HRRP were assessed based on readmissions rates between July 2011 and June 2014 for Medicare patients who were originally hospitalized for heart attack, heart failure, pneumonia, chronic lung problems, or elective hip or knee replacements.<sup>3</sup> Numerous studies and surveys published since the inception of the HRRP have concluded that penalties have been imposed disproportionately on hospitals that cater to a higher proportion of patients exhibiting particular demographic or socioeconomic traits (hereinafter, “sociodemographic factors”), leading many to question whether the HRRP effectively targets quality-of-care concerns.<sup>4</sup> In 2015, at least three-quarters of the hospitals in Alabama, Connecticut, Florida, Massachusetts, New Jersey, New York, Rhode Island, South Carolina, Virginia, and the District of Columbia received lower payments as a result of the HRRP.<sup>5</sup> New Jersey led the nation with 97% of its hospitals being penalized.<sup>6</sup>

Most recently, a study published by *JAMA Internal Medicine (JAMA)* concluded that hospitals serving Medicare beneficiaries with more chronic conditions, less education, and fewer assets, among other factors, have the highest reported readmission rates and that “[t]he higher prevalence of clinical and social predictors of readmission among patients admitted to hospitals with higher readmission rates is likely driven by factors largely outside of a hospital's influence.”<sup>7</sup> The findings, the *JAMA* study concluded, “call into question the extent to which variation in hospital readmission rates reflects quality of care and, by extension, the extent to which this variation should serve as the basis for financial penalties.”<sup>8</sup> Moreover, the authors observed, the financial penalties imposed on high readmission hospitals result in perverse consequences:

Hospitals serving healthier, more socially advantaged patients may not have to devote any resources to achieving a penalty-free readmission rate, whereas hospitals

serving sicker, more socially disadvantaged patients may have to devote considerable resources to avoid a penalty. By selectively increasing costs or lowering revenue for hospitals serving patients at greater risk of readmission, the HRRP therefore threatens to deplete hospital resources available to improve overall quality for populations at high risk of poor outcomes.<sup>9</sup>

The *JAMA* findings seriously undercut the purported rationale for imposing readmission penalties under HRRP—the promotion of quality care. Acknowledging HRRP’s shortcomings, the *JAMA* authors call for legislation requiring “adjustment of readmission rates and other quality measures for patients’ socioeconomic status and more health-related variables.”<sup>10</sup> Such legislation has been introduced in Congress.<sup>11</sup>

Against the growing chorus of detractors, CMS continues to defend the efficacy of reimbursement penalties, arguing that strong policy considerations favor excluding sociodemographic data from readmission rate adjustments. For instance, CMS has touted the decline in readmission rates from 19% to 17.8% between 2008 and 2013.<sup>12</sup> Notwithstanding new data demonstrating that more than a third of this reduction may be due to hospitals designating return patients as “observation” rather than inpatient<sup>13</sup> (thereby avoiding the triggering of a “readmission”), hospitals *have* achieved a notable decline in readmissions. This reduction may be attributable to implementation of initiatives detailed later in this article.

For the purposes of HRRP, CMS has adopted the readmission measures and related methodologies endorsed by the National Quality Forum (NQF), a nonprofit organization that promotes patient care and health care quality, including the 30-day time window, risk-adjustment methodology, and exclusions of certain readmissions.<sup>14</sup> The current NQF criteria include risk adjustment or stratification for outcome performance measures on the basis of clinical factors like comorbidity or severity of illness.<sup>15</sup> Stakeholders have long clamored for CMS to take account of characteristics beyond those included in the NQF-endorsed risk-adjustment methodology, asserting that patient race, language, life circumstances, environmental factors, and socioeconomic status factors significantly affect health outcomes, and that readmission penalties may disproportionately impact hospitals serving a largely minority and/or economically distressed population, a hypothesis borne out in the *JAMA* study discussed above.<sup>16</sup>

CMS consistently has rejected such calls for reform.<sup>17</sup> Most recently, in the preamble to the Fiscal Year 2016 Inpatient Prospective Payment System Final Rule, CMS pushed back against commenters requesting adjustments for sociodemographic factors, stating:

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[W]e continue to have concerns about holding hospitals to different standards for the outcomes of their patients of low sociodemographic status because we do not want to mask potential disparities or minimize incentives to improve the outcomes of disadvantaged populations. We routinely monitor the impact of sociodemographic status on hospitals’ results on our measures. To date, we have found that hospitals that care for large proportions of patients of low sociodemographic status are capable of performing well on our measures . . . .<sup>18</sup>

CMS went on to note, however, that “NQF is currently undertaking a 2-year trial period in which new measures and measures undergoing maintenance review will be assessed to determine if risk-adjusting for sociodemographic factors

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is appropriate for each measure.”<sup>19</sup> If NQF determines that adjusting for such factors is appropriate, the revised NQF-endorsed risk-adjustment methodology probably would be adopted prospectively by CMS through notice-and-comment rulemaking.<sup>20</sup> Accordingly, the findings of the trial, to be reported to the NQF board in 2017, are likely to have profound consequences on the future implementation of the HRRP and the manner in which performance measures are risk adjusted for purposes of other Medicare quality incentive programs.<sup>21</sup>

The policy issues that NQF is considering are worthy of closer examination given the significant implications of any changes. In its Technical Report laying the framework for the two-year trial, NQF recognizes that the purpose of risk adjustment is to “improve the ability to make comparative conclusions about quality” and that “[a]voiding incorrect conclusions or inferences about quality is important to consumers/patients and purchasers in making informed decisions about where to obtain care; to payers, health plans, and providers regarding rewards/penalties; and to providers and plans in terms of reputation and the ability to improve care for the various subpopulations that they serve.”<sup>22</sup> Nevertheless, the report acknowledges that current NQF criteria do not account for economic status and demographics even though the “impact of sociodemographic factors on health and healthcare has been well documented . . . [and] most epidemiological and health services research studies that focus on quality commonly adjust for patient [sociodemographic factors].”<sup>23</sup>

The report showcases the two competing views shaping the debate whether such factors should be taken into account when risk adjusting for quality measures. Those in favor contend that adjustment for sociodemographic factors is essential to making fair comparative conclusions about quality and that the failure to account for the often lifelong prevalence

of barriers to health and health care among the disadvantaged “creates an uneven playing field for performance measurement.”<sup>24</sup> In support of this view, one commentator has emphasized that:

Asking clinics and physicians who work primarily with poor patient populations to achieve the same results as those working with wealthier populations is effectively asking for more, and in some cases, impossibly more from these providers/plans. The results of such unrealistic demands may be fewer and fewer providers/plans willing to serve the already underserved.<sup>25</sup>

Those opposed to sociodemographic adjustments protest that consideration of such factors masks disparities in quality of care and implies that differences in outcomes based on patients’ economic and demographic backgrounds should be expected.<sup>26</sup> Advocates on this side of the debate emphasize that a regime in which quality measures are risk adjusted for economic and demographic factors may give rise to situations “when persons with certain attributes (e.g., gender, race, socioeconomic status) that might be potential risk factors for a given outcome simultaneously face the likelihood of receiving substandard care because of those attributes.”<sup>27</sup>

Whether NQF ultimately endorses risk adjustment for sociodemographic factors may ultimately turn upon what the NQF board views to be the greater evil: the purported “disincentive for healthcare providers and health plans to serve disadvantaged patients” if sociodemographic factors are excluded or the professed “disincentive for healthcare providers and plans to improve care to disadvantaged patients” if such factors are accounted for.<sup>28</sup>

### **Designing and Implementing a Successful Readmission Mitigation Program**

Although NQF’s adoption of a reformed risk-adjustment protocol may prove advantageous to hospitals treating a population prone to readmissions, providers should not delay proactively addressing elevated 30-day readmission rates.

The first step is to more precisely identify the problem by determining what risk factors increase the likelihood that a patient will be re-hospitalized within 30 days. Research indicates that certain patient characteristics correlate to a higher likelihood of short-term readmission. These include more chronic conditions, less education, language barriers, fewer assets, more depressive symptoms, impaired cognition, and diminished physical functioning.<sup>29</sup> After identifying these and other risk factors in their populations, hospitals can look to programs that have proven successful at other institutions to guide the development of mitigation strategies that target at-risk patients for more intensive readmission intervention.

A review of some of the most successful programs developed throughout the country shed light on approaches institutions struggling with elevated short-term re-hospitalization rates may employ to reduce readmissions and avoid associated penalties.

The Transitional Care Model (TCM) developed by Dr. Mary Naylor and her colleagues at the University of Pennsylvania addresses the negative effects associated with the transitioning of older adults from an acute care to a home or other care setting.<sup>30</sup> A study surveying the efficacy of the TCM strategy found a significantly decreased likelihood of re-hospitalization at least once within six months of discharge for TCM patients when compared with a control group (20.3% versus 37.1%).<sup>31</sup> TCM focuses on ten essential, complementary elements that revolve around a transitional care nurse, who delivers and manages care and serves as the primary care coordinator throughout episodes of acute illness.<sup>32</sup>

Similarly, the Guided Care model developed by researchers at Johns Hopkins utilizes specially trained nurses who work with primary care physicians and office staff to improve patient outcomes by focusing on eight areas ranging from “[a]ssessing the patient and their primary caregiver at home” to “coordinating the efforts of all care providers (hospitals, specialists, rehab facilities, home care, hospice, and social service agencies)” and “[f]acilitating access to community resources.”<sup>33</sup> A 2011 research study found that participants in a Guided Care program experienced a 48.7% reduction in 30-day readmissions.<sup>34</sup>

The utilization of a Transition Coach over a four-week period is the basis for the Care Transitions Intervention (CTI) model, which boasts an overall readmission reduction rate of 20% to 50% (depending on the current readmission rate).<sup>35</sup> CTI is a self-management model with two primary components: (1) a meeting with a Transition Coach in the hospital to discuss concerns and engage patients and their family caregivers, and (2) a follow-up home visit by the Transitions Coach, accompanied by follow-up phone calls designed to increase the self-management skills of patients and provide continuity across the transition.

Another program widely recognized for decreasing readmissions is Project Re-Engineered Discharge (Project RED), developed by a team of physicians at Boston University Medical Center. The implementation of the 12 mutually reinforcing components on which Project RED is based has proven successful in reducing readmission rates while increasing patient satisfaction.<sup>36</sup> These components range from determining whether language assistance is required for patients and developing a discharge plan, to assessing the degree of patient comprehension of the discharge plan and providing telephone reinforcement of the plan.<sup>37</sup> The project initially was administered by a Discharge Advocate, a specially trained nurse who interfaced with program patients, but a virtual

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discharge advocate has been employed in recent years.<sup>38</sup> A 2009 study concluded that Project RED intervention decreased hospital utilization (emergency department visits and readmissions) within 30 days of discharge by about 30%, as well as utilization among participants who frequently used hospital services.<sup>39</sup>

While the aforementioned models are not the only programs that have been developed to mitigate high hospital readmission rates, they are among the most frequently referenced by readmission reduction advocates. They also exhibit certain overlapping and parallel elements that are instructive for any institution considering strategies to address its readmission rates. In fact, some hospitals use multiple models in crafting institution-specific programs. A hospital executive quoted in a June 2011 *Wall Street Journal* article concerning readmission rates explained that “hospitals often combine Project RED’s discharge planning with after-care programs such as the Transitional Care Model . . .”<sup>40</sup> This serves to underscore that many of these models are not mutually exclusive but are often most effective when employed with other programs.

A survey of popular readmission models illuminates certain common elements critical to the success of any readmission mitigation strategy. For instance, providers are unlikely to achieve meaningful declines in readmission rates if they fail to employ a community approach emphasizing open communication and high quality care from the hospital to the home.<sup>41</sup> The various care strategies described above encourage a team approach that is led, in most cases, by a nurse who functions as the liaison between care providers and patients. The nurse also serves a crucial role in breaking down


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the various silos manifest in the care continuum by creating linkages between acute care facilities, physicians, home health agencies, and social service and community resources. A comprehensive, holistic approach led by a designated health care professional appears to be a key element to any effective readmission reduction program.

It is increasingly apparent that home health care is another vital tool in combatting elevated 30-day readmission rates. Many of the hospital systems that have reduced readmission rates provide a high level of post-discharge access to services by deploying resources of affiliated home health care organizations or by partnering with third-party organizations.<sup>42</sup> A 2011 Commonwealth Fund study analyzing four hospitals with exceptionally low readmission rates identified home health utilization as one of the common characteristics among patients' post-discharge care environments. The authors observed that "[f]ormal or strong informal relationships between hospitals and . . . nursing homes, home health care agencies, and health plans appear[ed] to [have] improve[d] outcomes for patients at the four case study hospitals."<sup>43</sup> The study noted that one hospital owned a home health service, that another closely aligned with local home health agencies, and that each hospital took "an extra step by scheduling follow-up appointments for most of their patients prior to discharge," concluding that "[s]cheduling appointments for patients can ensure they receive follow-up care and comply with recommended treatment."<sup>44</sup> Indeed, home care visits are central to the CTI, TCM, and Guided Care models described earlier. Home health care plays an essential role in readmission-mitigation strategies by encouraging post-discharge medication compliance and by otherwise ensuring that recently discharged patients are cared for in a manner that reduces the likelihood of short-term re-hospitalization.

### Conclusion

CMS' refusal to take sociodemographic status into account when assessing HRRP penalties has serious implications for hospitals, particularly those serving economically vulnerable populations. Irrespective of whether legislative or regulatory measures are taken to address the disparate impact of current readmission benchmarks, providers serving disadvantaged populations should implement programs that target patients

exhibiting readmission risk factors and that incorporate the care transition strategies common to the successful models discussed above. 

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