WHITEPAPER

How to Reduce Avoidable Readmissions and the Cost of Care

US Hospitals spend $41.3 billion per year on 3.3 million adult 30-day all-cause readmissions.[1] To address the rate of readmissions, the Centers for Medicare & Medicaid Services (CMS) have established financial incentives in the form of penalties for hospitals and skilled nursing facilities (SNFs).

Starting in fiscal year 2013, CMS began reducing Medicare fee-for-service payments to hospitals with higher-than-expected readmissions rates for specific conditions through the Hospital Readmissions Reduction Program (HRRP), which was established by the Affordable Care Act.[2]

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Similarly, the Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program reduces payments to skilled nursing facilities that fail to meet requirements for all-cause, unplanned hospital readmissions for SNF patients within 30 days of discharge from the hospital.[3] Under the SNF VBP Program, CMS withholds two percent of a SNF's fee-for-service Part A Medicare payments and redistributes up to 60 percent as an incentive for improvement. About 73 percent of SNFs received a penalty for fiscal year 2019.[4] Of the 27 percent that received the bonus, only 3 percent earned the maximum amount of 1.6 percent.[5]

Readmissions serve as a key measure for the quality of patient care in the US. This whitepaper discusses factors that increase the risk for readmissions, costs associated with readmissions, and how providers across the nation have been able to lower readmission rates.

Factors That Lead to Readmissions

While readmissions have decreased since the implementation of readmission reduction programs, the highest readmission rates are still among Medicare patients.[6] Additionally, several conditions have consistently high readmission rates. The Healthcare Cost and Utilization Project (HCUP) and the Agency for Healthcare Research and Quality (AHRQ) found that half of the "principal diagnosis" types at the initial admission were associated with a readmission rate at least 10 percent higher than the overall readmission rate in 2016.[6]

Health Condition or Diagnosis at Index Admission

One study found that individuals with complex conditions were involved in the vast majority of potentially avoidable admissions and readmissions.[7] As certain conditions put patients at a higher risk for readmission, pinpointing these conditions early on can help providers assess risk and make care decisions accordingly.

The Cost of Readmissions

One report showed the average cost of a readmission compared to the initial admission was about 30 percent higher for Medicaid, over 5 percent higher for Medicare, 11 percent higher for uninsured, and nearly 32 percent higher for private.[8]

In 2016, the average cost of readmission across any principal diagnosis was $14,400 while the initial admission cost $12,500 on average, according to a HCUP study.[6]

Additionally, over two thirds of identified diagnosis types had an average readmission cost of at least 10 percent more than the initial admission.

In 2011, the top three conditions with the most 30-day all-cause readmissions by payer type were:[1]

- Medicare: Congestive heart failure, septicemia, and pneumonia
- Medicaid: Mood disorders, psychotic disorders, and diabetes
- Private: Maintenance chemotherapy or radiotherapy, mood disorders, and complications of surgical procedures or medical care
- Uninsured: Mood disorders, alcohol-related disorders, and diabetes

Five years later, conditions like congestive heart failure, pneumonia, mood and psychotic disorders, and diabetes still ranked among the top diagnoses present in readmissions. In 2016, the top seven conditions with the most 30-day all-cause readmissions were[6]

- Blood diseases
- Neoplasms
- Infectious/parasitic diseases
- Endocrine/metabolic diseases, which includes diabetes
- Respiratory system diseases, which includes pneumonia and chronic obstructive pulmonary disease (COPD)
- Mental/behavioral disorders
- Circulatory system diseases, which includes congestive heart failure

Medicare Status

Of the $41.3 billion in costs associated with readmissions in 2011, $24 billion of those costs were Medicare.[1] Between 2010 and 2016, Medicare readmissions dropped seven percent, likely due to programs such as the HRRP and SNF VBP Program. However, in 2016, the 30-day all-cause readmission rate for stays billed to Medicare was still higher than all other payment types—and nearly twice as high as those with private insurance.[6]

Because Medicare patients are older, many of them are more likely to have complex or comorbid conditions and end-of-life care needs that impact their ability to get appropriate care in traditional primary and specialist care settings. Lack of transportation to regular appointments can also impact their care, leading to hospital readmissions later on. These variables need to be considered when addressing readmissions rate for this population.

Additional Factors

A study of readmitted patients showed that nearly 27 percent of readmissions were considered potentially preventable. Researchers identified the following factors as affecting potentially preventable readmissions:[9]

- Premature discharge from index hospitalization
- Emergency department (ED) decision-making (due to a limitation of the health system rather than a shortcoming)
- Failure to provide important information to outpatient providers
- Patient's inability to keep appointments after discharge
- Lack of patient discussion or education on post-discharge instructions and care goals

Avoidable readmissions are costly and reduce the quality of care a patient receives. However, using technology and real-time data, providers can share information, coordinate care, and make more informed decisions—all of which help prevent unnecessary readmissions.

Reducing Readmissions: Success Stories

The following five success stories include hospitals, skilled nursing facilities, clinics, and home health providers that have used Collective Medical's platform—designed to connect care teams via real-time, ADT-based notifications—to better track patients, provide timely follow-up care, and ultimately prevent potentially avoidable admissions and readmissions. By reducing readmissions, these providers were able to avoid CMS penalties, save on care costs, and ultimately improve the care of their patients.

CHI St. Anthony Hospital

CHI St. Anthony, a 25-bed critical access hospital in rural Oregon, started identifying patients at risk for readmissions in the ED. Staff discovered that patients with COPD and congestive heart failure were among the groups associated with the highest number of readmissions.

CHI St. Anthony Outcomes

In less than three years, CHI St. Anthony was able to lower its 30-day all-cause readmission rate by *78 percent*.[10]

After this discovery, care managers were instructed to follow-up with these patients within three days of being discharged to confirm they had been properly educated about their condition and to ensure that they had an appointment set up with their primary care physician or provider.

Joyce Bailey, VP of Patient Care at CHI St. Anthony reported, “we now have the capabilities to not only understand what drives our readmission rates, but also to combat preventable readmissions at the source.”

Housecall Providers

In the US, there are four million home-limited adults that struggle to get the primary care they need, often turning to the ED and hospitals for care. As a member of the CareOregon family, Housecall Providers supports nearly 2,300 people per year with medical care at home.

Housecall Providers was determined to find better and more efficient ways of meeting Medicare Independence at Home (IAH) metrics, which measure the quality of home-based care by looking at ED visits, hospitalizations, 30-day readmission rates, patient preferences, medication management, and contact with beneficiaries.

Housecall Providers Outcomes

Housecall Providers met the six quality metrics for the IAH demonstration, saving Medicare *$1.8 million* in care costs over a risk-adjusted regional comparison group.[11] Housecall Providers received *80 percent*, or $1.2 million, of the savings.

The Portland Clinic Outcomes

Through collaboration, one health plan in the group was able to lower 30-day readmissions by *5.1 percent* from 2015 to 2018. Using increased visibility into patients, The Portland Clinic overhauled their Transitional Care Management (TCM) workflows and increased TCM coding rates by 33 percent, which led to a *30 increase in revenue*.[12]

The Portland Clinic

Reducing readmissions can also help save on care costs for clinics and health plans. The Portland Clinic has six locations throughout the Portland metropolitan area. Its leadership started looking for ways to better transition patients from hospital to clinic, avoiding unnecessary readmissions, especially as the clinic began to participate in value-based payer arrangements.

To help with these transitions, The Portland Clinic joined a larger network, and staff began receiving alerts when patients were admitted to and discharged from hospitals on this network. Knowing about each discharge through the alerts enabled staff to reach out and schedule follow-up appointments quickly. The Portland Clinic also piloted a community collaborative group in partnership with hospitals, health plans, and other clinics in order to better support patients.

Legacy Salmon Creek Medical Center

Serving Southwest Washington, Legacy Salmon Creek Medical Center is part of the Legacy Health family. Staff realized they could impact readmissions by focusing on the ED.

Cynthia Miceli, RN, BSN, CCM, ED RN Case Manager at Legacy Salmon Creek, explained, “because the ED is the point of entry for hospital admissions, readmissions, and emergency care, we needed to realize the forces behind ED traffic and use it as the center for decreasing readmissions.”

Using relevant, real-time ADT data, Legacy Salmon Creek created an ED readmissions algorithm that standardized the assessment of patient needs, factored in end-of-life care, and considered alternative care plans to readmission.

In the program’s first year, staff made over 600 referrals to primary care physicians, specialists, and hospice providers in order to redirect patients to the most appropriate care setting for their individual needs.

Legacy Salmon Creek Outcomes

Within two years, Legacy Salmon Creek saw an 81 percent reduction in overall ED visits and a nearly *25 percent reduction* in 30-day all-cause readmissions.[13] In 2018, Legacy Salmon Creek earned an Award of Excellence in Healthcare Quality by Qualis Health for its efforts in reducing avoidable ED readmissions.

Marquis/Consonus Companies

Marquis/Consonus Companies owns and maintains senior healthcare and assisted living facilities in Oregon, California, and Nevada. As a SNF provider, Marquis can lose 2 percent in Medicare fee-for-service reimbursement if it doesn’t meet readmissions improvement metrics.

Typically, SNFs don’t have visibility into patients receiving care elsewhere. They aren’t aware of when a patient returns to the hospital or is discharged into a different SNF afterwards. “Before utilizing the Collective platform, our providers could only see what happened within their four walls,” said Anthony Laflen, Director of Data Analytics at Marquis Companies. “Now, with real-time visibility, they’re able to support patients with the best possible care and keep them out of the hospital.”

Marquis Outcomes

As Marquis providers were notified in real time as patient arrived at the hospital, staff could reach out and coordinate care, potentially avoiding a costly readmission. In less than six months, Marquis saw a *60 percent drop in readmissions* across three of its Oregon-based facilities, allowing the company to avoid nearly $115,000 in CMS penalties.[14]

About Collective Medical

Collective Medical provides the nation's largest and most effective ADT-based network for care collaboration. Our risk-adjusted event notification and care collaboration platform spans across all points of care—including emergency departments, hospitals, payers, behavioral and physical ambulatory, and post-acute settings. This technology integrates seamlessly with existing workflows and allows providers to identify and support at-risk patients in real time—avoiding preventable admissions and utilization and providing better care.

Learn more at collectivemedical.com

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