



Issue Brief



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Support for this research was provided by The Commonwealth Fund. The views expressed represent the authors' synthesis of the meeting discussion and do not necessarily reflect those of particular panelists, the Institute for Healthcare Improvement, or The Commonwealth Fund or its directors, officers, or staff.

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Commonwealth Fund pub. 1703
Vol. 24

Hospital Readmissions: Measuring for Improvement, Accountability, and Patients

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ABSTRACT: The Commonwealth Fund and the Institute for Healthcare Improvement convened 15 experts in May 2013 to help address the current controversy over the measurement of hospital readmissions. Experts agreed that Medicare should, through payment and other means, be encouraging greater coordination of care, improvement in care transitions, and mitigation of risks that leave patients vulnerable to readmission. While the current readmissions metric is undoubtedly an imperfect proxy for broader health system failures, it also provides a valuable foundation on which to build a better policy—one that is useful for improvement, fair for accountability, and above all, relevant to patients.

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OVERVIEW

The national dialogue around efforts to reduce avoidable hospital readmissions is grounded in a new understanding of what a readmission signifies and what failures it lays bare—namely, that patients are not receiving the support they need following a hospital stay. New research shows that patients leave the hospital vulnerable to a host of challenges to their recovery, many of which are unrelated to their initial diagnosis.¹

Hospitalization is not a harmless act. It disrupts routine, brings stress and inactivity, disturbs sleep, sows confusion, and increases the chance of hospital-acquired illness. The traditional imperative—just get patients out the door—will simply no longer suffice. Fortunately, this understanding has begun to inform new interventions to improve transitions across the care continuum.

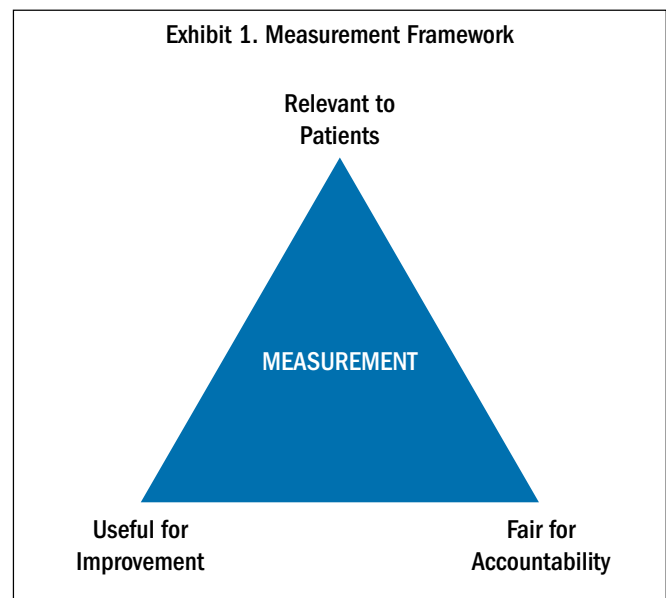
Recognition that current fee-for-service payment systems are inadequate to drive improvement led Congress to include the Hospital Readmission Reduction Program in the Affordable Care Act.² Medicare's policy for penalizing hospitals with "excess" hospital readmissions has increased focus on care transitions as never before. Today one can hardly find a hospital not working in some way to improve care coordination.

The program's implementation, however, has garnered decidedly mixed reviews. Hospitals, academics, and policymakers are heatedly debating the appropriateness of the readmissions metric—even its definition—giving the impression of fundamental disagreement about the program's value. To bring some clarity to this important discussion, particularly regarding how measurement can guide improvement, The Commonwealth Fund and the Institute for Healthcare Improvement recently convened many of the nation's leading experts on the measurement and improvement of hospital readmissions (see box on page 7).

Participants in the meeting were unanimous in their conviction that Medicare should be addressing the fragmented care, harm, and confusion that unnecessary hospital readmissions represent for patients. Panelists noted with concern that many stakeholders have interpreted academic skirmishes over the readmissions penalty as disagreement over whether Medicare should, through payment policy, and other means, be encouraging greater coordination of patient care and mitigation of the risks for patients vulnerable to readmissions.

How Medicare does this, of course, is critically important. But that debate should not obscure, panelists stressed, an otherwise broad-based agreement on the need to address the factors contributing to patients frequently returning to the hospital. That the initial policy has flaws is an argument not for abandoning the effort, but for redoubling efforts to improve the measures as well as the incentive system.

Those efforts begin by stepping back and recalling the purpose of measuring readmissions. Our target should be the poorly coordinated care that leaves too many patients and families cut off from help, confused about how to care for themselves after discharge, and at high risk for harm. And while the current readmissions metric is undoubtedly an imperfect proxy, it does provide a valuable foundation on which to build a better policy—one that is useful for improvement, fair for accountability, and above all, relevant to patients (Exhibit 1).³



RELEVANT TO PATIENTS

The panel's experts called for a suite of measures that more broadly reflect the patient's experience and for stronger engagement of patients and the community in the development of measures. Developing patient-centered measures, as some participants noted, begins with viewing the care experience through the eyes of patients—to understand what matters to them and what barriers they face.

Medicare's current metric, which assesses hospital readmissions based only on three conditions and only up to 30 days, captures just a sliver of the patient's experience. Patients do not suffer less at 31 days or when their initial diagnosis is diabetes, rather than heart failure. Moreover, the measure fails to capture equally harmful preventable *admissions*, which many panelists believe should be incorporated into a set of related accountability measures.

Measures such as days between hospital encounters or days alive at home permit assessment along a continuum, which may better track what patients desire from health care. Attending to patient needs also requires that readmissions be considered in the context of balancing measures—such as mortality, length of stay, and use of observation status—to help ensure health systems are not eliminating necessary admissions, readmissions, or days in the hospital.⁴

USEFUL FOR IMPROVEMENT

Hospitals today have little generalizable evidence to help them scale up care coordination efforts that have been shown to work in a particular setting or for a specific patient population. Unfortunately, increased attention to the 30-day readmissions rate does little to help. This is no surprise: improvement and accountability measures have inherently different purposes and properties. Designed to facilitate provider comparison, accountability measures focus heavily on risk-adjustment, tend to be outcome-focused, and are collected retrospectively over long periods of time (e.g., a three-year rolling average). These measures tell you which providers are doing better, and which ones are doing worse. What they're not good at telling you is how.

Improvement measures, which analyze local performance over time, are used to assess whether interventions are producing their intended outcomes. These measures are often not risk-adjusted, as comparison is not their intended use. One valuable improvement measure for hospital readmissions is a count of readmissions, assessed weekly and charted over time. Using a readmissions rate for this purpose—for example, readmissions per 100 discharges—can obscure fluctuations in admissions, thus impairing the measure's ability to detect improvement.

Compared with accountability measures, improvement measures have received little attention to date. This limited awareness has stalled improvement efforts, and, in the words of a panelist engaged in hospital improvement, hindered the ability “to build will and engage staff.” Fortunately, we do know with

some confidence what the ideal characteristics of an improvement measurement set are, and how to go about developing it.⁵ As one participant described it:

First, figure out what your aim is. Then, pick a basket of three to eight measures that clarify that aim, and look at them every month. Find balancing measures too to ensure you're improving, rather than just squeezing the system. Finally, make use of existing systems to capture measures and build collection into your daily routine.

The State Action on Avoidable Rehospitalizations (STAAR) initiative (see box below) provides other examples of important process improvement measures, including: the percentage of admissions in which patients and family caregivers were included in assessing posthospital needs; the percentage of patients with a follow-up appointment made prior to discharge; and the percentage of discharges in which critical information is transmitted at the time of discharge to the next site of care.

FAIR FOR ACCOUNTABILITY

A significant criticism of the Medicare readmissions penalty is that hospitals are held financially accountable for certain aspects of care that are beyond their control, given that improvement requires action across care settings. Some of the experts participating on the panel discussed the need for the addition of population-based measures (admissions and readmissions per

The **State Action on Avoidable Rehospitalizations (STAAR) initiative** was a four-year project of the Institute for Healthcare Improvement supported by a grant from The Commonwealth Fund. Launched in 2009, STAAR aimed to reduce rehospitalization rates in Massachusetts, Michigan, and Washington state by engaging hospital-based cross-continuum teams—hospitals partnering with home health agencies, nursing facilities, office practices, community-based support services, and patients. The initiative worked in collaboration with multistakeholder state-level steering committees, which coordinated and aligned complementary programs across the state, identified and mitigated systemic barriers, and promoted a common framing of the issues through provider and stakeholder networks. This effort resulted in 148 hospitals working in partnership with over 500 community-based organizations across three states to improve transitions in care and reduce avoidable rehospitalizations. For more information, visit <http://www.ihl.org/offerings/Initiatives/PastStrategicInitiatives/STAAR/Pages/default.aspx>.

1,000 population) that would promote mutual accountability for community-wide improvement among hospitals, postacute care providers, and community-based organizations. Panelists also stressed the need to include holistic measures that reach beyond the hospital (such as a community’s “capacity not to hospitalize,” as one participant put it) and reflect how instrumental care coordination and community interventions are to achieving good outcomes.

A related concern is that the penalty disproportionately affects hospitals that treat a relatively larger share of patients with lower incomes (Exhibit 2). Because the measure used for Medicare’s penalty is not adjusted for patients’ socioeconomic status (SES), and because patients with lower SES experience higher rates of readmissions, safety-net hospitals on average receive higher penalties under the current regime.⁶ While adjusting for SES could address this concern, such a move would simply hide and perpetuate a disparity that we as a society should be working to rectify, the panelists noted. To reconcile these competing interests, many panelists expressed interest in a proposal put forth by the Medicare Payment Advisory Commission (MedPAC) to report readmissions data without SES risk adjustment but penalize hospitals

based on their performance relative to peers with similar shares of low-income patients.⁷

Panelists also raised concerns about circumstances for which the current measure may be a poor proxy for quality of care coordination. For instance, “critical access” hospitals, which by definition are located in geographically isolated areas, may register low readmission rates in part because of the difficulty patients have returning to the hospital. The low volume of readmissions data for smaller hospitals, meanwhile, makes it difficult to determine whether deviations from the average readmissions rate reflect signal or noise. To address these concerns, MedPAC recommended allowing small hospitals to pool data for penalty purposes and switching to a higher-volume, all-conditions measure.

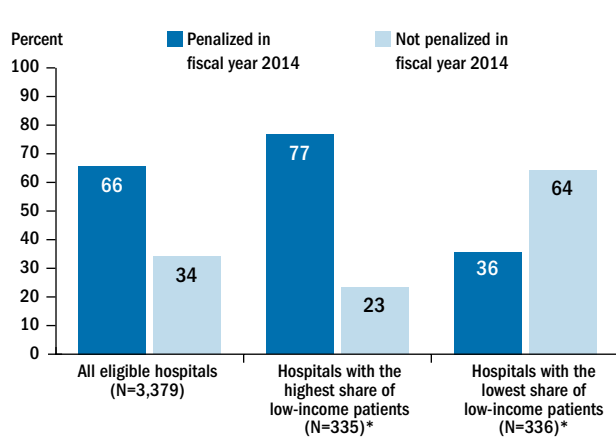
Finally, many panelists are critical of the current policy of assessing penalties relative to the mean performance. In other words, if the entire industry improves—precisely the program’s aim—hospitals collectively will incur the same amount of penalties. Not only does this have the potential to sow confusion, it could erode the will of hospital leadership to improve care coordination.

A better approach, also outlined in the recent MedPAC report, would set a fixed readmissions rate target somewhat lower than the historical average. Improving hospitals could thus be certain they would avoid penalties, and all stakeholders could reap the benefits of large-scale improvement.

BEYOND MEASUREMENT

While the above discussion illustrates the potential for improving measurement to support better patient care and coordination, many systemic factors stand in the way of progress. Although hospitals have long been where the financial resources are in American health care, many beneficial interventions require the engagement of the comparatively cash-starved realm of community-based care. Experts on the panel noted the futility of discharging vulnerable patients into communities lacking strong networks of primary care and the

Exhibit 2. Percentage of Hospitals Penalized Under the Hospital Readmissions Reduction Program for Fiscal Year 2014



* The share of low-income patients represents the highest and lowest deciles of hospitals on an index that “reflects the prevalence of admitted patients who qualify for Medicaid, the joint federal–state health program for the poor, or Medicare’s Supplemental Security Income benefit for the poor and disabled,” according to Kaiser Health News. Source: Authors’ analysis of data reported by Kaiser Health News, Aug. 2, 2013, <http://www.kaiserhealthnews.org/Stories/2013/August/02/readmission-penalties-medicare-hospitals-year-two.aspx>.

community support systems necessary to aid patients in their recovery.

And while it seems almost passé to call out the perversity of fee-for-service, the fact is that this payment system remains the dominant one. The readmissions penalty is one effort among many to correct for troubling fee-for-service incentives that encourage greater volume of care and fail to reward improvements that lead to a reduction in readmissions. In the long run, however, appending policy corrections to a flawed fee-for-service “chassis” will not be sufficient. Providers and payers face a chicken-and-egg problem here: one can argue with equal plausibility that payment reform will not happen without care delivery reform, or that care delivery reform must await payment reform. But waiting is a luxury we can ill afford; we must progress on both fronts, hoping our efforts will reinforce each other and together drive us toward better systems of care.

Less discussed, but equally important, is the problem posed by the lack of improvement capacity in health care organizations. Innovating, testing, and implementing improvement interventions requires a skill set that is not typically included in health professional training. This skills shortage is compounded by the hurdles faced by those seeking to publish and disseminate organizational interventions in academic journals, the traditional arbiters of clinical interventions. Changing this paradigm would be a tremendous boon to the spread of quality improvement interventions that can improve care coordination, as well as other aspects of health care.

These broader barriers to care coordination are, if anything, more daunting than the measurement challenges outlined above. But none are insurmountable. Such a system, and such a mentality, is eminently possible. We have only just begun to build it.

NOTES

- ¹ H. M. Krumholz, “Post-Hospital Syndrome—An Acquired, Transient Condition of Generalized Risk,” *New England Journal of Medicine*, Jan. 10, 2013 368(2):100–2.
- ² Centers for Medicare and Medicaid Services, “Readmissions Reduction Program,” available at <http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html>.
- ³ Readmissions have traditionally been measured as a rate per 100 hospital discharges. The measure definitions used for public reporting by the federal Hospital Compare website can be found here: <http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1219069855273>. A description of the methodology used to calculate readmissions penalties under the Hospital Readmissions Reduction Program can be found at the CMS reference in note 2.
- ⁴ According the Centers for Medicare and Medicaid Services, “Observation services are hospital outpatient services given to help the doctor decide if the patient needs to be admitted as an inpatient or can be discharged. Observation services may be given in the Emergency Department (ED) or another area of the hospital. . . . Your hospital status (whether the hospital considers you an “inpatient” or “outpatient”) affects how much you pay for hospital services (like X-rays, drugs, and lab tests) and may also affect whether Medicare will cover care you get in a skilled nursing facility.” See <http://www.medicare.gov/Pubs/pdf/11435.pdf>.
- ⁵ L. I. Solberg, G. Mosser, and S. McDonald, “The Three Faces of Performance Measurement: Improvement, Accountability, and Research,” *Joint Commission Journal on Quality Improvement*, March 1997 23(3):135–47.
- ⁶ J. Berenson and A. Shih, *Higher Readmissions at Safety-Net Hospitals and Potential Policy Solutions* (New York: The Commonwealth Fund, Dec. 2012).
- ⁷ Medicare Payment Advisory Commission, “Refining the Hospital Readmissions Reduction Program,” Chapter 4 in *Report to Congress: Medicare and the Health Care Delivery System* (Washington, D.C.: MedPAC, June 2013). The Commission’s analysis found that a hospital’s share of low-income patients (defined as Medicare patients receiving Social Security income) was “a stronger and more consistent predictor of readmissions” than was patients’ race.

ABOUT THIS BRIEF

On May 28, 2013, the Institute for Healthcare Improvement and The Commonwealth Fund convened 15 experts in a policy conversation on the use and relevance of hospital readmissions measures for improvement. The four-hour meeting, held at The Commonwealth Fund's New York City headquarters, was conducted in conjunction with the State Action on Avoidable Rehospitalizations (STAAR) initiative to examine policy issues influencing progress in reducing hospital readmissions. Participants included:

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Lloyd Provost, M.S., Associates in Process Improvement
Pat Rutherford, R.N., M.S., Institute for Healthcare Improvement
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ABOUT THE COMMONWEALTH FUND

The Commonwealth Fund—among the first private foundations started by a woman philanthropist, Anna M. Harkness—was established in 1918 with the broad charge to enhance the common good. The mission of The Commonwealth Fund is to promote a high-performing health care system that achieves better access, improved quality, and greater efficiency, particularly for society’s most vulnerable, including low-income people, the uninsured, minority Americans, young children, and elderly adults. The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. An international program in health policy is designed to stimulate innovative policies and practices in the United States and other industrialized countries.

ABOUT THE INSTITUTE FOR HEALTHCARE IMPROVEMENT

The Institute for Healthcare Improvement (IHI) (www.IHI.org) is a leading innovator in health and health care improvement worldwide. An independent not-for-profit organization, IHI partners with a growing community of visionaries, leaders, and front-line practitioners around the globe to spark bold, inventive ways to improve the health of individuals and populations. IHI focuses on building the will for change, seeking out innovative models of care, and spreading proven best practices. Based in Cambridge, Massachusetts, with a staff of more than 140 people around the world, IHI mobilizes teams, organizations, and nations to envision and achieve a better health and health care future.

ACKNOWLEDGMENTS

We thank the panelists for participating in the meeting and for graciously sharing comments on a draft of this report. Shreya Patel of The Commonwealth Fund provided logistical support for the meeting.

Editorial support was provided by Chris Hollander.



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