



MISSOURI HOSPITAL ASSOCIATION

# “Connecting Readmissions, Reimbursement and Improvement”

a supplement to the  
HIDI Readmission Focus Reports

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## **How Hospital Readmission Rates Will Affect Your Medicare Reimbursement**

Beginning with fiscal year 2013, inpatient prospective payment system hospitals with higher than expected readmissions rates for heart failure, heart attack and pneumonia will experience decreased Medicare payments for all Medicare discharges. This change was mandated by the Patient Protection and Affordable Care Act (PPACA).

Performance evaluation and payment will be based on the 30-day readmission measures for the reporting period, beginning in 2011. Because readmissions occurring in as early as next year could affect future Medicare reimbursement, it is critical that hospitals analyze their data and develop strategies, when necessary, to reduce avoidable readmissions.

The base inpatient payment for hospitals with actual readmission rates higher than their Medicare-calculated, risk-adjusted, expected readmission rates will be reduced by a maximum penalty of 1 percent in FY 2013, 2 percent in FY 2014 and 3 percent in FY 2015 and beyond. This reduction will apply to all Medicare discharges. Hospitals with a small number of applicable patient cases will be excluded from the provision.

Beginning in FY 2014, PPACA gives the secretary of U.S. Department of Health and Human Services the authority to expand the list of conditions to include chronic obstructive pulmonary disorder and several cardiac and vascular surgical procedures. The secretary also is directed to calculate and report all payer readmission rates for the conditions selected for the readmissions financial penalties program.

### **What Hospitals Can Do to Decrease Readmissions**

The MHA Center for Education will be host webinars in 2011 that specifically address how to reduce avoidable readmissions. Announcements of future offerings will be posted on [www.mhanet.com](http://www.mhanet.com).

Numerous initiatives and interventions have been developed or tested to reduce avoidable readmissions. The following list includes evidence-based models aimed at reducing unplanned readmissions and other educational and clinical tools that have shown promise.

- [Healthcare Leader Action Guide to Reduce Avoidable Readmissions](#) — This new resource developed by Health Research & Educational Trust (HRET) outlines strategies and interventions to reduce avoidable readmissions. It also includes an overview of major evidence-based readmission reduction programs.
- [Project RED, The ReEngineered Discharge](#) — MHA, in collaboration with HRET and The Agency for Healthcare Quality and Research, is bringing this [initiative](#) to Missouri in 2011. Project RED re-engineers the workflow process and improves patient safety for patients discharged back into the community. It provides a set of 11 discrete, mutually reinforcing

components provided by a discharge advocate and reinforced by a telephone call after from a clinical pharmacist after discharge.

- [H2H – Hospital to Home](#) — The H2H national quality initiative, co-sponsored by the American College of Cardiology and the Institute for Healthcare Improvement, is an effort to improve the transition from inpatient to outpatient status for individuals hospitalized with cardiovascular disease.
- [STate Action on Avoidable Rehospitalizations \(STAAR\)](#) — a multistate, multistakeholder approach to dramatically improve the delivery of effective care at a regional scale launched by the Institute for Healthcare Improvement in 2009.

Funded through a grant from The Commonwealth Fund, this initiative aims to reduce rehospitalizations by working across organizational boundaries in four states — Massachusetts, Michigan, Ohio, and Washington — by engaging payers, state and national stakeholders, patients and families, and caregivers at multiple care sites and clinical interfaces. As the work progresses, IHI is making information and resources available for other states, regions, or organizations across the continuum to learn from the initiative. New resources include a [worksheet](#) to help participating hospitals perform an in-depth review of the last five readmissions to identify opportunities for improvement.

- [Transforming Care at the Bedside How-to Guide: Creating an Ideal Transition Home for Patients with Heart Failure](#) — Launched in 2003, Transforming Care at the Bedside (TCAB) ([www.ihl.org/IHI/Programs/StrategicInitiatives/TransformingCareAtTheBedside.htm](http://www.ihl.org/IHI/Programs/StrategicInitiatives/TransformingCareAtTheBedside.htm)) is a national program of the Robert Wood Johnson Foundation and the IHI. One of the most promising changes that have been developed within TCAB is “creating an ideal transition home” for patients who are being discharged from medical and surgical units within hospitals. Although this guide specifically focuses on patients with heart failure, the proposed changes for creating an ideal transition home can be generalized and adapted to improve the discharge process for all patients.
- [INTERACT II \(Interventions to Reduce Acute Care Transfers\)](#) — This series of educational and clinical tools, developed with support from the Commonwealth Fund, is designed to reduce the number of avoidable transfers from nursing homes to hospitals. The goal is to improve the early identification and evaluation of changes in residents’ status that could lead to hospitalizations, as well as to improve communication about these changes.
- [Project Boost: The BOOSTing \(Better Outcomes for Older adults through Safe Transitions\)](#) — The Project Boost Implementation Guide includes steps to improve the discharge process in your hospital. The Society for Hospital Medicine developed this initiative, with support from the John A. Hartford Foundation.
- [The Care Transitions Intervention<sup>SM</sup>](#) — Developed with funding from The John A. Hartford Foundation and The Robert Wood Johnson Foundation. This program is designed to provide patients with tools and support that promote knowledge and self-management of their condition as they move from hospital to home.

- [Taking Care of Myself: A Guide for When I Leave the Hospitals](#) — Providers can use this AHRQ guide to give patients the information they need to help them care for themselves when they leave the hospital.
- [Best Practice Guide to Action](#) — The Continuity of Care Transfer Project presents an overview of a transfer process developed by the Missouri Department of Health and Senior Services' Long-Term Care Best Practice Coalition, in collaboration with the Missouri Hospital Association, hospitals and LTC centers. The collaboration resulted in the determination of necessary information to be communicated and the development of processes and tools to improve handoff communication when transfers occur.

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