

# Preventing Hospital Readmissions: A \$25 Billion Opportunity

## Opportunity

Preventable hospital readmissions: \$25 billion in wasteful health care spending



Preventable hospital readmissions are a significant avoidable cost in the U.S. health care system, costing an estimated \$25 billion annually.<sup>2</sup> Driven largely by poor discharge procedures and inadequate follow-up care, nearly one in every five Medicare patients discharged from the hospital is readmitted within 30 days.<sup>3</sup> Across all insured patients, the preventable readmission rate is 11 percent, while the rate for Medicare patients is 13.3 percent.<sup>4,5</sup>

### Preventable Readmissions

#### The highest rates of preventable readmissions are patients:

- With heart failure, COPD, psychoses, intestinal problems, and/or who have had various types of surgery (cardiac, joint replacement, or bariatric procedures).<sup>6</sup>

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## Solutions

# 836,000

of the more than 7 million 30-day hospital readmissions annually could be prevented

Total hospital readmissions could be reduced by up to 12 percent by improving procedures for admitting and discharging patients, providing better follow-up care, and utilizing health information technology.

### Improving Procedures

#### Upgrade Discharge Services With:

- Clear, detailed discharge plans tailored to patients and family members, clinicians, case managers, and payors.
- Nurse advocates to arrange timely follow-up appointments to primary care providers.<sup>7</sup>
- Medication reconciliation to ensure that pre- and post-discharge medication lists are consistent.
- Clinical pharmacist phone calls post-discharge to monitor medication use.<sup>8</sup>

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## Drivers for Change

- Payment Reform for Providers
- System Service Improvements
- Quality Measurement

A number of tested policy actions have track records in reducing readmissions. These include strengthening both hospital admission and discharge requirements, creating new readmission-based quality measures, and changing payment systems, including paying for technologies and innovative models of care.

### Action Steps

#### Payment Reform for Providers

- Reward providers with a share of net financial savings earned from reducing costly and preventable hospital readmissions.
- Create alternative payment models, such as bundled payments, to cover the entire episode of care, encouraging coordination and delivery of high-value services.
- Encourage adequate payment for proven technologies that monitor and encourage compliance in patient groups at highest risk of readmission.

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## Opportunity continued

- Who are taking six or more medications, who have depression and/or poor cognitive function, and/or who have been hospitalized in the previous six months.
- Who are discharged on weekends and holidays.

### Patients are readmitted because:

- They have limited or no access to good post-hospital care (e.g., rehabilitation) in their communities.
- They have received inadequate information about post-discharge care.
- There is poor transmission of hospital records and discharge instructions to:
  - Primary care clinicians who manage post-discharge recovery.
  - Organizations that authorize or provide post-discharge care.
- They experience preventable medical errors and complications during the first hospital stay.

## Solutions continued

### Improve Follow-up Care

- Provide patients with timely access to care in the community, such as health care professional visits.

### Upgrade Patient Profiling Systems

- Identify patients at high risk for readmissions and connect them to additional discharge support.<sup>9</sup>

### Utilize Health IT

- Monitor patients in their homes using telehealth technologies to transmit clinical data to providers.
- Empower patients through telehealth systems to be better informed about their conditions and self-care measures they can take to prevent readmissions.

## Drivers for Change continued

### System Service Improvements

- **Upgrade Discharge Procedures:** Require that discharge procedures include scheduling initial appointments for patients with health care professionals who will provide follow-up care.
- **Reform Admission Procedures:** Require that hospital admission authorization includes:
  - The identification of a health care professional to manage post-discharge care.
  - A process for health care professionals to receive hospital records and discharge plans.

### Quality Measurement

Measure that patients receive adequate continuity of care planning, including:

- Post-discharge instructions.
- Information about help they will need at home or symptoms they should watch for during their recovery.

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**This series was produced in collaboration with NEHI ([www.nehi.net](http://www.nehi.net))**

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## Notes

### Opportunity

1. New England Healthcare Institute (NEHI), *How Many More Studies Will It Take? A Collection of Evidence That Our Health Care System Can Do Better*, Cambridge, MA: NEHI, 2008. Available at [www.nehi.net/publications/30/how\\_many\\_more\\_studies\\_will\\_it\\_take](http://www.nehi.net/publications/30/how_many_more_studies_will_it_take). Last accessed November 2010.
2. PriceWaterhouse Coopers' Health Research Institute, *The Price of Excess: Identifying Waste in Healthcare*, 2008. Available at [www.pwc.com/us/en/healthcare/publications/the-price-of-excess.jhtml](http://www.pwc.com/us/en/healthcare/publications/the-price-of-excess.jhtml). Last accessed November 2010.
3. Jencks SF, Williams MV, Coleman EA, Rehospitalizations among patients in the Medicare fee-for-service program, *New Engl J Med*, 2009;360(14):1418-1428.
4. Goldfield NI, McCullough EC, Hughes JS, et al., Identifying potentially preventable readmissions, *Health Care Financ Rev*, 2008;30(1):75-91.

5. Medicare Payment Advisory Commission (MedPAC). *Report to the Congress: Promoting Greater Efficiency in Medicare*. Washington, DC:MedPAC, 2007. Available at: [www.medpac.gov/documents/jun07\\_EntireReport.pdf](http://www.medpac.gov/documents/jun07_EntireReport.pdf). Last accessed November 2010.

6. Jenks, Williams, Coleman.

### Solutions

7. Jack BW, Chetty VK, Anthony D, A reengineered hospital discharge program to decrease rehospitalization: a randomized trial, *Ann Intern Med*, 2009;150(3): 178-187.
8. Ibid.
9. Society of Hospital Medicine (SHM). *Project BOOST: Care Transitions Implementation Guide*. Philadelphia, PA:SHM, 2008. Available at: [www.hospitalmedicine.org/ResourceRoomRedesign/RR\\_CareTransitions/html\\_CC/Implementation.cfm#](http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/html_CC/Implementation.cfm#). Last accessed November 2010.

*This publication is supported by a grant from the Robert Wood Johnson Foundation ([www.rwjf.org](http://www.rwjf.org)).*