LABOR MANAGEMENT PROJECT
Research Bulletin
LABOR MANAGEMENT PROJECT
an employer and 1199SEIU partnership
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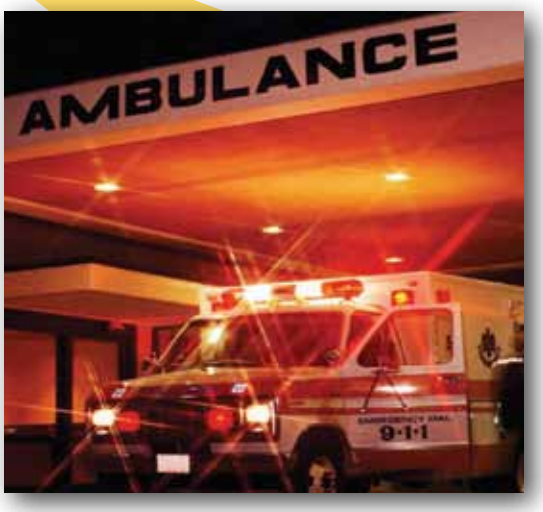
Hospital Readmissions

- Rehospitalizations are costly, potentially harmful, and often avoidable.
- Nearly one in five hospitalized Medicare patients ends up back in the hospital within 30 days of discharge.
- Hospitals around the country are now at risk of receiving financial penalties for having high rates of patients readmitted to a hospital within 30 days of their initial discharge.
- This Labor Management Project Research Bulletin provides general information about how and why hospitals are being penalized for high readmission rates.
- It also details some strategies that labor and management can implement together to reduce readmissions.



FREQUENTLY ASKED QUESTIONS

What is the readmissions penalty?
- As part of the Affordable Care Act, The Centers for Medicare & Medicaid (CMS) established readmission penalties to encourage hospitals to decrease avoidable readmissions.
- Starting in 2013, hospitals with higher-than-average 30-day readmissions for heart failure (CHF), acute myocardial infarction (AMI), and pneumonia (PN) received reduced Medicare payments.

Do readmissions penalties apply to all hospitals?
No. The penalties apply to inpatient acute hospitals with higher than average readmission rates. They do not include critical access, psychiatric, rehabilitation, long-term care, children's, and cancer hospitals. Penalties only apply to Medicare inpatient payments.

Are ALL readmissions within 30 days penalized?
No. CMS looks at 30-day readmissions that are higher than what is expected based on a national average. CMS makes adjustments based on the patient's illnesses and age when calculating the readmission rate, but does not consider socioeconomic status.

What if a patient is readmitted for something other than CHF, AMI, or PN?
If the readmission is within 30 days, it counts toward the hospital's readmission rate – it does not matter what the patient is readmitted for.

How much are hospitals at risk of losing?
- In 2013, the sum of penalties across the U.S. amounted to $280 million. Losses for hospitals in New York City ranged from $11,000 to $2.6 million.
- Hospitals have lost up to 1% of inpatient Medicare payments in 2013.
- In 2014, hospitals will lose up to 2% of inpatient payments.
- In 2015, the penalty will increase to 3%.

What can Labor and Management do together?
The next page provides some examples of best practices. First, however, we suggest that labor and management meet together and discuss some key questions:
- What is our 30-day readmission rate for CHF, AMI and PN?
- How can we be educating patients (and their families) about their diagnosis and care from the moment of admission?
- What role can all hospital workers play in addressing the challenge of readmissions?

Why Do 30-Day Readmission Rates Matter?

Better Patient Outcomes

Patients who receive better care both during their hospitalizations and when they return to the community are less likely to be readmitted to the hospital within 30 days of discharge. Hospitals are therefore focusing on "care transitions" to ensure that meaningful discharge instructions are given, that information regarding the patient stay is provided to the next caregiver, and that patients receive appropriate follow-up care.

Penalties Hurt Hospitals' Bottom Lines

Readmissions penalties will add up over time. Hospitals must not only consider the size of this year's penalty, but also project their cumulative penalties across future years.

High Costs to the Public

Spending on readmissions is substantial. The New York State Health Foundation estimates that 30-day readmissions cost the State $3.7 billion per year.

What can we do to reduce our 30-day readmissions rates?

Here is a compilation of BEST PRACTICES synthesized from four evidence-based interventions: Project RED, Transitional Care Model, Care Transitions Program, and Evercare. Hospitals around the nation are implementing these strategies to decrease their readmission rates.

Where can we get more information about readmissions?

Readmission Improvement Tools
http://www.whynotthebest.org/contents/index/2/7

Project RED Website
http://www.bu.edu/fammed/projectred/

Reducing Readmissions in New York
http://nyshealthfoundation.org/uploads/resources/reducing- hospital-readmissions-payment-incentives-september-2011.pdf

Compendium of Promising Interventions
http://www.hwic.org/resources/details.php?id=5076

Project Boost Implementation Guide
http://www.hospitalmedicine.org/Resource-RoomRedesign/RR_Car eTransitions/PDFs/Workbook_for_Improvement.pdf

Care Transitions Toolkit
http://www.cfmc.org/integratingcare/files/Care_Transitions_toolki t_090611_Final.pdf

Establish Care Manager Positions

Assign staff to serve as the primary coordinators of care across each patient's entire episode of care (pre- and post- discharge). These individuals may have a variety of titles: care managers, care navigators, care coordinators, case managers. Note that 1199SEIU is currently reviewing newly negotiated positions in this area to determine common duties, qualifications, and suitability.

Identify High-Risk Patients

- Perform a comprehensive, holistic assessment of each patient's needs, including the reason for the primary hospitalization as well as other complicating or coexisting events
- Identify high-risk patients (e.g., patients with higher rates of hospital utilization in the preceding 6 months, chronically-ill, elderly) and address their needs based on their unique risk levels:
  - **Level 1:** Individuals who are primarily healthy and living independently. Provide phone-based consultation, mail, and coordinate community services.
  - **Level 2:** Individuals with numerous chronic conditions and/or significant functional disabilities. Coordinate care and community services. Meet frequently with families to discuss patient's care needs, prepare treatment plans, and address end-of-life issues.
  - **Level 3:** Individuals with advanced illnesses in the last year of life. Provide hospice and palliative care services. Respond to the needs of patient and their families, minimize symptom burden, and support patients' values.

Educate Patients

- Adequately educate patients about their diagnoses throughout the hospital stay.
- Educate patients about self-managing medication
- Help patients complete personal health records.
- Educate patients about "red flags" or warning signs/symptoms and how to respond if a problem arises.
- Actively engage patients, their families, and informal caregivers in educational and support activities.
- Give patients written discharge plans and assess patients' understanding of the plans.

Improve Discharge Planning

- Develop a personalized, evidenced-based plan of care after initial patient assessment.
- Prior to patient discharge, make all necessary appointments for primary care follow-up, test result follow up, and post-discharge testing.
- Implement policies and procedures to notify physicians of their patients' discharges, encourage follow-ups on test results, and check on patient progress.
- Ensure that patients have adequate transportation and support for post-discharge services.
- Help uninsured and underinsured patients identify resources such as free clinics and prescription drug assistance programs.
- Confirm post-discharge medication plans and refill prescriptions prior to discharge.
- Share patients' electronic medical records and discharge summaries with all outpatient providers.

Follow-Up after Discharge

- Call patients or conduct home visits to reinforce patients' discharge plans and offer problem solving within 72 hours of discharge.
- Provide ongoing telephone support (24 hours per day, seven days per week) for an average of two months post-discharge.
- Establish strong lines of communication with and among patients, their health care providers, and their families and informal caregivers.