

Readmissions: The Cold, Hard Facts

Failed transitions in care lead to substantial increases in costs, morbidity, mortality and reputational risk.

Nearly 20% of patients experience an adverse event during the transition from hospital to home. **The majority of adverse events in one study were medication-related (66%).**¹

At the time of hospital discharge 50% of patients have lab results pending. Primary care physicians may be unaware of 66% of the results **although 12.6% require urgent action.**²

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One study found that outpatient workups were recommended on approximately one third of patients being discharged from the hospital, but these workups were not completed more than a third (35.9%) of the time.³

Potentially avoidable hospital re-admission is a national problem affecting **17.6% of all Medicare patients, costing Medicare over \$12 billion each year.***

Of the Medicare beneficiaries who are readmitted within 30 days **64% receive no post-hospital care.***

The Commonwealth Fund reported in 2007 that **Louisiana** had the highest Medicare 30-day readmission rate in the nation at 23.8%. That rate had slightly improved in the 2009 State Scorecard to 21.3%.

Section 3025 of the Patient Protection & Affordable Care Act (PPACA) requires CMS to create the Hospital Readmissions Reduction Program (HRRP), **imposing reimbursement adjustments on hospitals with higher rates of readmission.**

In the Hospital-Consumer Assessment of Healthcare Providers & Systems Survey (H-CAHPS) Medicare patients consistently report

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greater dissatisfaction in discharge-related care than in any other aspect of care measured by CMS.

Section 3001 of the Patient Protection & Affordable Care Act (PPACA) requires the Centers for Medicare & Medicaid Services (CMS) to create the Hospital Value-Based Purchasing Program (HVBP). **Eight dimensions of the H-CAHPS are included in the HVBP Program and will affect 30% of a hospital's Total Performance Score for FY 2013.**

Working with eQHealth Solutions, the Medicare Quality Improvement Organization (QIO) for Louisiana, Baton Rouge-area hospitals participating in the CMS Pilot Project to reduce avoidable readmissions **achieved a decrease in the readmission rate for the community from 18.9-22.4% at baseline to 11.2% at re-measurement.**

* Source: Medicare Payment Advisory Commission

1. Forester A, et al. The Incidence and Severity of Adverse Events Affecting Patients After Discharge from the Hospital. *Ann Intern Med.* 2003; 138: 161- 167.
2. Roy, C. et al. Patient Safety Concerns Arising From Test Results That Return After Hospital Discharge *Ann Intern Med* 2005; 143:121-128
3. Moore C et al. Tying up loose ends: discharging patients with unresolved medical issues. *Arch Intern Med* 2007; 167:1305-1311

As the QIO for Louisiana, eQHealth is part of a national network - sharing knowledge and tools for improving health quality, efficiency and value.



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