Readmissions NEWS

The New Jersey Readmissions Initiative

By Diane Babuin and Ya-ping Su

New Jersey, historically among the highest states in 30-day hospital readmission rates and associated cost per patient, is finally making some headway in reducing readmissions and cost. In the last six months of 2010, 21.6% of hospitalized New Jersey Medicare fee-for-service patients were readmitted within 30 days after discharge from the hospital. In the last six months of 2012, that rate dropped to 20.0% -- a relative reduction of 7.4% (Table 1, page 4). Using an established population-based readmission monitoring measure for Medicare beneficiaries[1] comparing October 1, 2010 – September 30, 2011 to October 1, 2012 – September 30, 2012, New Jersey has the highest absolute reduction in readmission rate in the nation; the state also ranked fifth in relative reduction in readmission rates.

Studies have shown that each hospitalization of an elderly patient can lead to cognitive decline[2], can increase the patient's chance of contracting an infection[3] and can cause considerable stress for the patient's family or caregivers. Translating the achieved reduction into impact on New Jersey Medicare beneficiaries means there were 8,768 fewer New Jersey beneficiary readmissions in 2012 than would have been expected if the readmission rate per 1,000 Medicare beneficiaries stayed the same as in 2011. The related cost impact is also significant; the 8,768 readmissions prevented in 2012 represent a cost savings of $84.17 million[4].

While the state as a whole is trending in the right direction, there were significant variations in the readmission rates and improvements in communities across New Jersey. The exact causes of variation are difficult to determine, although there does seem to be some correlation between income and unadjusted raw readmission rates as shown in Table 1. Hunterdon County, with the highest median-household income (and second-largest percentage of non-Hispanic white population), has the lowest readmission rate. Hudson County (not shown in this table) has the highest readmission rate, has the state's most diverse population and has a median income among the bottom third of counties in the state.

Table 1. New Jersey Counties by Median Income and Readmission Rates

	Medicare Readmission Rate*				
	Jul-Dec 2010	Jul-Dec 2012	Absolute Improvement	Relative Improvement	Median Income**
Hunterdon	**19.4**	**17.0**	**2.4**	**12.4%**	**$100,980**
Somerset	**19.0**	**19.2**	**-0.2**	**-1.1%**	**$97,440**
Morris	**18.4**	**18.5**	**-0.1**	**-0.5%**	**$96,747**
Sussex	**18.8**	**17.0**	**1.8**	**9.6%**	**$83,089**
Monmouth	**21.6**	**18.6**	**3.0**	**13.9%**	**$82,265**
Essex	**25.1**	**22.9**	**2.2**	**8.8%**	**$55,125**
Passaic	**22.1**	**21.6**	**0.5**	**2.3%**	**$54,944**
Atlantic	**20.8**	**20.8**	**0.0**	**0.0%**	**$54,766**
Cape May	**20.7**	**18.3**	**2.4**	**11.6%**	**$54,292**
Cumberland	**20.5**	**20.9**	**-0.4**	**-2.0%**	**$50,651**
NJ State Average	**21.6**	**20.0**	**1.6**	**7.4%**	**$67,681**

***HQSI's analysis of Medicare Fee-For-Service acute care hospital discharges during the measurement time period. Exclude discharges where patients was transferred to another acute care hospital or died after discharge. Readmission rates are not risk-unadjusted.**
**** USA.com. *New Jersey Median Household Income County Rank* [Internet]. Bedminster (NJ): World Media Group, LLC; [date unknown; cited 2013 Jul 23]. Available from: http://www.usa.com/rank/new-jersey-state--median-household-income--county-rank.htm**

There are many factors that impact readmission rates, and socio-economic factors don't tell the whole story. Well-known drivers of readmissions include lack of standard and known preventive processes as patients move between healthcare settings, ineffective or unreliable sharing of relevant clinical information among providers, and lack of awareness and engagement of patients and their families in managing chronic health conditions. Poor transition planning, no follow-up care, lack of community support, or unidentified social needs such as assistance with transportation or meal preparation can also contribute. The healthcare business economic environment and reimbursement policy may also play significant roles.

The reality of socio-economic healthcare disparity remains important, but there are ways to reduce readmissions no matter what the underlying cause. Based on work being done by the national Quality Improvement Organization (QIO) program across the country, and supported by what is being measured in New Jersey, the most important strategy is to break down silos between health settings and providers and to work as a community on behalf of the shared patient population. This last point was illustrated in the January 23, 2013 issue of the *Journal of the American Medical Association* (*JAMA*) which published a report of a three-year pilot care transitions program funded by the Centers for Medicare & Medicaid Services (CMS). This large quality improvement effort involved 14 communities in states with a participating QIO, including New Jersey. The results show that interventions aimed at improving care transitions -- when patients move from one care setting to another, such as from a hospital to home -- reduced re-hospitalizations for Medicare patients by almost 6% in the 14 participating communities nationwide[1]. This community-based approach, coordinated by a QIO, is markedly different from commonly used hospital-based approaches, which often focus on patients with a specific disease or in a specific hospital unit. But just saying care is "community-based" is not enough. Healthcare for the most vulnerable and sickest patients is complex, especially when there are multiple illnesses and socio-economic factors involved.

Key to making community-based healthcare work is the use of patient transfer processes and quality improvement methodologies. Every community and every population of patients is different, with its own unique environment comprised of a combination of health, socio-economic, structural, policy and financial factors.

Taking the time to identify the community-based root causes of readmission, using risk-stratification to develop plans for high-risk patients, tracking readmission data, partnering to share knowledge and, if possible, resources, and careful selection of interventions are what lead to fewer readmissions and ultimately better care.

"Readmissions are not a hospital problem, they are a community problem." says Dr. Andrew Miller, the medical director for Healthcare Quality Strategies. "Although hospitals are currently being penalized for readmissions, successful transitions involve nursing homes, hospice providers, visiting nurses, physician practices, county offices of aging, mental health providers, and the pharmacists who manage a patient's medication in the readmission complex." Dr. Miller adds "This is not just about the hospital. It's also about where the patient lives and the coordination in that community."

While the Federal readmission penalties levied on hospitals since October 1, 2012 under the Affordable Care Act (ACA) are driving increased collaboration in New Jersey and elsewhere, many of the partnerships and cooperative relationships in the state predate ACA. In New Jersey cities like Trenton and Camden, which have large numbers of disadvantaged or low income residents, healthcare providers, and local community-based organizations, have long been using data-driven, community-based approaches to improve transitions of care for patients, reduce avoidable readmissions, and aim for better health outcomes.

The Camden Coalition of Healthcare Providers, led by Dr. Jeffrey Brenner, a family physician and leader in innovative solutions for improving the health of urban, underserved communities, is driving a citywide collaboration to improve care featuring care management and care transition programs designed to target high-cost, complex patients for improved care transitions and care coordination. The Trenton Health Team, a community health improvement collaborative, is dedicated to expanding access to high quality, coordinated healthcare for Trenton's underprivileged population.

HQSI has assisted several communities across New Jersey working to reduce avoidable hospital readmissions. One of these communities -- The Central Jersey Care Transitions Program -- was selected for participation in the national Community-based Care Transitions Program (CCTP) created by the ACA. This central New Jersey program is being led by one of the nation's largest visiting nurse associations in partnership with six hospitals, three home health care agencies, one community based organization, and three area agencies on aging. Each year, the program will serve 4,000 patients over age 65 with multiple chronic illnesses and other social and medical risks in an effort to reduce readmission across three counties in central New Jersey.

These CCTP community-based partnerships are looking at new and different types of interventions to reduce readmissions, like coaching programs and working at improving communications with nursing facilities. "Hospital discharge planners are starting to talk to nursing homes or family doctors in advance of a patient's discharge to discuss what follow-up care the

patient needs to help them keep their chronic conditions under control," says Miller. "There is communication -- it's not perfect yet -- but it is happening."

Currently, 61 of 63 hospitals in New Jersey are being penalized by Medicare for excessive readmission rates. The intervention work of these community coalitions over the last few years is not yet completely reflected in the current readmission penalties levied on hospitals by Medicare. The calculation for Federal Fiscal Year 2013 (ending September 30, 2013) is based on three years of data from July 2008-June 2011, which includes older data that would not be expected to reflect meaningful improvements. Going forward, based on community awareness and adoption of transition improvements, hospitals in the state should see fewer penalties as patients experience fewer readmissions within 30 days of discharge since 2011.

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References:

1. Brock J, Mitchell J, Irby K, Stevens B, Archibald T, Goroski A, Lynn J; Care Transitions Project Team. Association between quality improvement for care transitions in communities and re-hospitalizations among Medicare beneficiaries. *JAMA* [Internet]. 2013 Jan 23[cited 2013 Jul 22];309(4):381-91. Available from: http://jama.jamanetwork.com/article.aspx?doi=10.1001/jama.2012.216607

2. Wilson RS, Herbert LE, Scherr PA, Dong X, Leurgens SE, Evans DA. Cognitive decline after hospitalization in a community population of older persons. *Neurology*. 2012 Mar 27:78(13):950-956.

3. U.S. Department of Health and Human Services. Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries [Internet]. Washington (DC): U.S. Department of Health and Human Services; 2010 Nov [cited 2013 Jul 22]. Available from: http://oig.hhs.gov/oei/reports/oei-06-09-00090.pdf

4. Estimate based on average hospital admission or readmission cost of $9600 per person as referenced in The Centers for Medicare & Medicaid Services (CMS)' s Community-based Care Transitions Program (CCTP) application. Available from: http://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/downloads/CCTP_Solicitation.pdf