

New Dartmouth Atlas Study Highlights Preventable Hospital Readmissions

One in six Medicare patients wind up back in the hospital within a month after being discharged

FLASHBACK: Medicare Advantage plans have [significantly lower readmission rates](http://www.ahipresearch.org/hospitalreadmissions.html) (<http://www.ahipresearch.org/hospitalreadmissions.html>) than FFS Medicare

A new [Dartmouth Atlas Project](http://www.dartmouthatlas.org/) (<http://www.dartmouthatlas.org/>) report analyzing trends in hospital readmissions found that “roughly one in six Medicare patients wind up back in the hospital within a month after being discharged for a medical condition.” The report found “little progress over a five-year period in reducing these hospital readmissions and improving care coordination for Medicare patients.” Moreover, hospital readmission rates for some conditions “have increased nationally and for many regions and at hospitals, including some of America’s most elite academic medical centers.”

According to David C. Goodman, M.D., M.S., lead author and co-principal investigator for the Dartmouth Atlas Project, the findings of the study “highlights widespread and systematic failures in coordinating care for patients after they leave the hospital.” Some highlights of the study (taken from their [press release](#)):

(http://www.dartmouthatlas.org/downloads/press/Post_Acute_Care_Release_092811.pdf)

- “Nationally, there was relatively little change in 30-day readmission rates from 2004 to 2009, regardless of the cause of the initial hospitalization. Readmission rates following surgery were 12.7 percent in both 2004 and 2009, while readmission rates for medical conditions rose slightly from 15.9 percent in 2004 to 16.1 percent in 2009.”
- “...most regions across the country did not experience significant reductions in readmissions from 2004 to 2009. Readmissions decreased after medical discharges in 11 regions, with Bismarck, N.D. experiencing the largest decrease, from 16.3 percent in 2004 to 14 percent in 2009. There was an increase in readmissions in 27 regions, the highest in Aurora, Ill., which increased from 14.3 percent in 2004 to 18 percent in 2009.”
- “Only seven academic medical centers had significant changes in 30-day readmission rates following medical discharge from 2004 to 2009.”
- “In 2009, the percentage of patients readmitted to the hospital within 30 days of an initial discharge varied markedly for both medical and surgical discharges across regions of the country. Among patients who first visited the hospital for medical treatment, 16.1 percent were admitted to the hospital within 30 days.”
- “These findings highlight the pervasive problems with patient care after hospital discharge, and underscore the importance of primary care systems in reducing avoidable hospitalizations. While there are many different reasons for higher readmission rates across regions and hospitals, prior research has documented the failings of current care coordination and the high proportion of readmissions that can be avoided by improving care.”

[FLASHBACK: Medicare Advantage Plans have Significantly Lower Hospital Readmission Rates than FFS Medicare](#)

Health plans have invested in programs and services to help patients navigate the complicated delivery system to get the care they need and avoid complications and unnecessary hospital visits. AHIP's Center for Policy and Research has conducted a [series of studies](#) comparing hospital readmission rates in Medicare Advantage to the original Medicare program. This research allows for an apples-to-apples comparison between private-sector programs and the fee-for-service (FFS) Medicare program. The data show that seniors in private Medicare Advantage plans have significantly lower hospital admissions and readmissions than seniors in the original FFS Medicare. This is largely due to Medicare health plans' diseases management and care coordination programs that help seniors get the care they need, including appropriate follow-up care after a hospitalization.

Highlights of AHIP Studies on Hospital Readmissions:

- [Medicare Advantage is Reducing Preventable Hospital Readmissions for Seniors](#): This report was based on an analysis of hospital discharge datasets provided by the Agency for Healthcare Research and Quality (AHRQ) as well as state discharge data acquired directly from the states of Pennsylvania and Texas. In the states studied, estimated risk-adjusted readmission rates were about 27-29 percent lower in Medicare Advantage than Medicare FFS per enrollee, 16-18 percent lower per person with an admission, and 14-17 percent lower as measured per hospitalization.
- [Seniors in Medicare Advantage Receive Higher Quality Care, New Reports Show](#): This study analyzed statewide datasets on hospital admissions in California and Nevada compiled by the Agency for Healthcare Research and Quality (AHRQ). The unique data in these states allows for direct comparisons of utilization rates among enrollees in Medicare Advantage plans and in FFS Medicare. These comparisons were adjusted for health status using the Medicare risk score process for age, sex, and 70 Hierarchical Condition Categories that are used as a basis for Medicare risk adjustment. Key findings from the report include:
 - Medicare Advantage beneficiaries in California spent 30 percent fewer days in the hospitals than patients with FFS Medicare, and in Nevada, seniors in Medicare Advantage plans spent 23 percent fewer days in the hospital.
 - Medicare Advantage enrollees were re-admitted to the hospital in the same quarter for the same condition 15 percent less often in California and 33 percent less often in Nevada compared to FFS Medicare.
 - In both California and Nevada, seniors in Medicare Advantage were 6 percent less likely than seniors in FFS Medicare to be admitted to the hospital for conditions described by AHRQ as "potentially avoidable," such as dehydration, urinary tract infection, or uncontrolled diabetes.

Health Plan Innovations in Reducing Preventable Hospital Readmissions:

AHIP released a publication, [Innovations in Reducing Preventable Hospital Admissions, Readmissions, and Emergency Room Use](#), that provides company specific examples of the types of programs and services that health plans have implemented to reduce preventable hospital admissions, readmissions, and emergency room visits. Examples of the types programs include the following:

- Expanding patient access to urgent care centers, after-hours care, and nurse help lines give patients safe alternatives to emergency rooms for non-emergency care.
- Arranging for phone calls and, in some cases, in-home visits by nurses and other professionals to make sure that follow-up appointments are kept, medications are being taken

safely, care plans are being followed, medical equipment is delivered, and home health care is being received.

- Offering intensive case management to help patients at high risk of hospitalization access the medical, behavioral health, and social services they need.
- Arranging for home visits by multidisciplinary teams of clinicians, who provide comprehensive care, teach patients and their caregivers how to take medications correctly, and link families with needed community resources.
- Revamping physician payment incentives to promote care coordination and improved health outcomes.

Health Plan Innovations in Patient Safety:

More than a decade after the Institute of Medicine published the landmark report *To Err is Human*, patients still experience preventable harm all too often. In the hospital, patients continue to contract infections and other complications from medical errors, contaminated equipment, and exposure to communicable diseases. Once they return home, patients often are confused about which medications to take, aren't aware of problematic warning signs, and don't know whom to call for help. As a result, they may suffer complications or have adverse reactions to medications and end up back in the hospital.

America's health insurance plans have been on the front lines of national efforts to prevent these problems, protect patient safety, and promote smooth transitions in care. Our community has [joined](#) clinicians, hospitals, and other leaders in the health care system in supporting the U.S. Department of Health & Human Services' [Partnership for Patients](#), which seeks to reduce preventable hospital readmissions by 20 percent and decrease the occurrence of hospital-acquired conditions by 40 percent by the end of 2013. We continue to advance the ultimate goal of zero preventable harm.

A new AHIP publication, [Innovations in Patient Safety](#), highlights 16 health plans' efforts to prevent healthcare-acquired conditions, help patients transition smoothly from hospital to home, and manage chronic conditions effectively to avoid complications and preventable readmissions. In some cases, these innovations involve funding for hospital-based patient safety initiatives; in others, plans' transitional care programs work directly with patients and their families to help reduce complications and hospital readmissions. In recent years, health plans and health care providers have collaborated on innovative payment systems that reward providers for improvements in patients' care. In some cases, these quality-based reimbursements are gradually replacing the traditional, volume based fee-for-service approach to payment.

For more information, check out AHIP's blog entries on hospital readmissions:

<http://www.ahipcoverage.com/tag/readmissions/>