

The Relationship Between HCAHPS Performance and Readmission Penalties

With Medicare payment penalties for excess readmissions now in effect, reducing readmissions has become a top priority for hospitals and other stakeholders. The Centers for Medicare and Medicaid Services (CMS) publicly reports risk-adjusted readmission rates for heart attack, heart failure and pneumonia. The data show significant variation in performance across hospitals, indicating that some hospitals are more successful than others at addressing the causes of readmissions. A new study by Press Ganey suggests that performance on readmission metrics is associated with performance on patient experience of care measures.

Issue

Patient readmission to an acute care setting may be an indication of poor quality care or inadequate post-acute resources and services. In addition, these readmissions place a significant financial burden on the Medicare program – more than 20% of beneficiaries discharged from an acute care hospital experience readmission within 30 days, costing an estimated \$15 billion annually.

The Hospital Readmissions Reduction Program, established by the 2010 Affordable Care Act, is designed to provide financial incentives to hospitals to address the causes of patient readmission and reduce readmission rates. The program imposes a reduction in base operating DRG payments for hospitals with higher-than-expected readmissions of acute myocardial infarction (AMI), heart failure (HF) and pneumonia patients. Starting Oct. 1, 2012, hospitals that had excessive risk-adjusted readmissions from July 1, 2008, to June 30, 2011, will be penalized by up to 1% of their Medicare DRG payments. This penalty will increase to 2% in 2013 and to 3% in 2014. As a result of hospitals not meeting the program objectives, CMS estimates that the Hospital Readmissions Reduction Program will result in an overall 0.3% decrease – approximately \$280 million – in payments to hospitals in fiscal year 2013.

According to Medicare data, 2,217 hospitals will be penalized this year, with 307 (13.8%) receiving the full 1% penalty. Despite the impending financial losses, health care organizations have made little demonstrable headway in reducing readmission rates. In July 2012, CMS released its annual report, and the news was not encouraging: More than one in five Medicare patients were readmitted within 30 days of discharge, with readmission rates ranging from 18.5% for pneumonia patients to 24.7% for HF patients. Readmission rates dropped by only 0.1 percentage points for AMI and HF patients and increased by 0.1 percentage points for pneumonia patients.

Key Findings

Press Ganey analyzed hospitals' readmission penalty data in the context of their scores for CMS' Hospital Inpatient Value-based Purchasing program (VBP) to determine if there was a relationship in performance on the two pay-for-performance programs. The VBP program establishes scores for both the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey results and process of care measures. The study found a demonstrated negative association between hospitals' HCAHPS VBP scores and readmission penalties; as hospital performance on HCAHPS increased, readmission penalties decreased (see Figure 1). This pattern was most noticeable at the ends of the performance distribution: Very low HCAHPS performance (scores of 0–19) was associated with much-higher-than-average readmission penalties, and very high HCAHPS performance (80–100) was associated with much-lower-than-average readmission penalties.

FIGURE 1: ASSOCIATION BETWEEN READMISSION PENALTY AND HCAHPS VBP SCORE

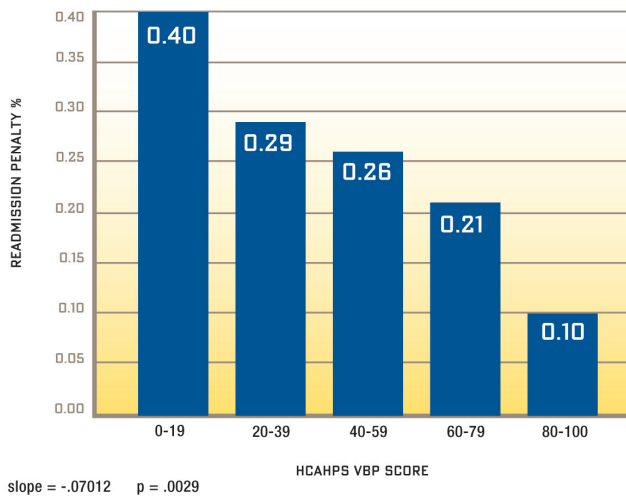
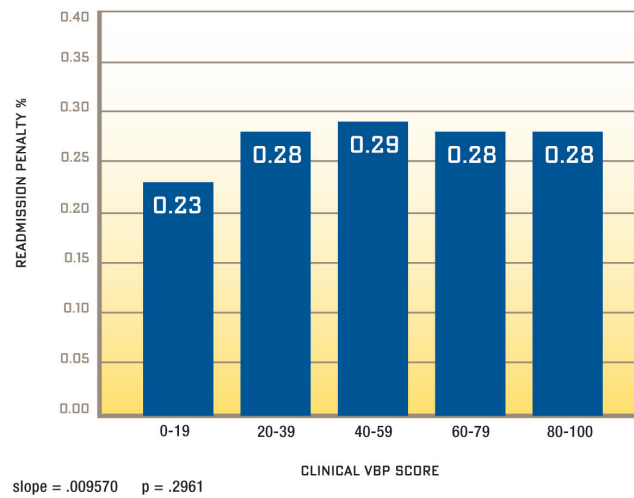


FIGURE 2: ASSOCIATION BETWEEN READMISSION PENALTY AND CLINICAL VBP SCORE



In contrast, there was no relationship between clinical VBP scores and readmission penalties at either the individual facility level or the group level (see Figure 2).

These findings support previous research on the link between patient experience and clinical quality; Boulding, et al. (see references, below) found that higher overall patient satisfaction and satisfaction with discharge planning were associated with lower 30-day risk-standardized readmission rates. As in the current study, HCAHPS scores, not clinical measures, were more closely linked to readmission rates.

Press Ganey Observations and Recommendations

Hospitals that wrestle with high readmission rates may be tempted to see a solution in this analysis. But while the association between performance on HCAHPS and readmissions is clear, it's not causal. Improving HCAHPS performance will not by itself lower readmission rates. Rather, the organizational culture, management and systems that enable a hospital to perform well on HCAHPS will also facilitate better performance on readmissions and other outcomes.

Readmissions and HCAHPS are multifaceted, and performance on these metrics is sensitive to myriad factors – chief among them clinical practice, processes, systems, patient factors, cultural factors and community resources. But while national trends suggest that hospitals struggle to identify and address the factors that influence readmissions, this analysis, coupled with numerous examples from the field, demonstrates that many hospitals have effectively implemented strategies to succeed in reducing readmission rates and improving HCAHPS scores.

To effectively combat patient readmissions, hospitals can benefit from a foundational strategy that starts first and foremost with the patient – and efforts that are aimed at improving HCAHPS scores are an excellent initial step. The majority of the HCAHPS survey questions address communications between caregivers and patients. Effective communications is fundamental to ensuring that patients become engaged in their care and, consequently, better equipped to follow discharge instructions and self-monitor after leaving the acute care setting.

Press Ganey research and client experience have demonstrated repeatedly that the single most effective strategy for improving performance in patient experience is purposeful hourly rounding by nursing staff. Numerous Press Ganey clients report success at beginning the discharge education process during hourly rounds, well in advance of a patient's discharge.

Coupling a “sustainable discharge” strategy with an overall patient-centric approach is extremely effective at reducing likelihood for readmission. A sustainable discharge strategy comprises identifying and addressing patient-specific factors that could lead to readmission, strategic

patient education, developing a patient-focused after-care plan and ensuring a smooth transition to a post-acute setting. Tactics that drive success in achieving sustainable discharges include: dedicated patient transition coaches, proactive planning for non-medical barrier to treatment adherence, post-discharge phone calls, scheduled follow-up care, and use of cross-setting discharge planning tools and teams.

About the Study

CMS Hospital Readmission Reduction Program data are based on discharges from July 1, 2008, to June 30, 2011. VBP performance data are based on discharges from July 1, 2011, to March 31, 2012.

Relationships between readmission penalties and VBP scores (HCAHPS, clinical and total) were analyzed using correlation and LOESS local regression techniques.

References

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