



PROFESSION

National Quality Forum upholds rehospitalization measure

The action moves the metric one step closer to inclusion in Medicare’s program that penalizes hospitals with high readmission rates.

By KEVIN B. O'REILLY, amednews staff. Posted July 16, 2012.

The National Quality Forum’s board of directors in late June reaffirmed its decision to endorse a measure of all-cause readmissions. Many hospital leaders say the metric is unfair and could have adverse, unintended consequences if it is used to determine payment.

In April, the Washington-based multistakeholder, standards-setting organization endorsed the measure after it won support from four of the forum’s seven participating councils. The metric, developed by researchers at Yale University under contract with the Centers for Medicare & Medicaid Services, would estimate a hospitalwide rate of unplanned readmissions within 30 days for any condition among adult patients. Nearly 20% of Medicare patients are readmitted within a month, according to an April 2, 2009, study in *The New England Journal of Medicine*.

Under the measure, hospitals’ results would be risk-adjusted to account for the fact that some conditions are likelier than others to send patients back to the hospital. But the metric does not adjust for patients’ race, ethnicity or socioeconomic status — factors that researchers have linked to a higher probability of rehospitalization.

For example, a Feb. 16, 2011, study in *The Journal of the American Medical Association* examined more than 3 million hospital discharges for patients with congestive heart failure, acute myocardial infarction or pneumonia from 2006 to 2008. Overall, black patients had a 13% higher rehospitalization rate than white patients. And black patients treated by hospitals that care for many minority patients were 23% likelier to be readmitted, the study said.

A May 1, 2011, study in the journal *Circulation: Heart Failure* examined the socioeconomic link among nearly 16,000 heart failure patients rehospitalized between 1987 and 2004. Very sick patients living in low-income areas were 40% likelier to be readmitted within a month, compared with similarly ill patients in high-income areas, the study said.

The readmissions metric now goes to the Measure Applications Partnership, a forum-convened organization that over the next six months will review how to use it in federal public reporting and performance-based payment programs. The group is likely to make its recommendation by Feb. 1, 2013, said Thomas B. Valuck, MD, senior vice president of strategic partnerships at the forum.

CMS officials have said they will await the outcome of the partnership process before acting to include the all-cause readmissions measure as part of the Affordable Care Act’s hospital readmissions reductions program. Starting Oct. 1, hospitals with higher than average readmission rates for patients with congestive heart failure, acute myocardial infarction or pneumonia could see their Medicare payments cut by up to 1%. The potential penalties will rise to 2% in 2014 and 3% in 2015. These metrics also do not take race, ethnicity or socioeconomic status into account.

Dispute over linking measure to pay

Using the all-cause readmissions metric to determine pay would penalize hospitals for factors beyond their control, such as the proportion of their patients who are poor or on Medicaid, said Blair Childs, senior vice president of public affairs at Premier Inc. The Charlotte, N.C.-based purchasing and quality-improvement alliance of 2,600 U.S. hospitals joined several other organizations that asked the forum to reconsider its endorsement of the all-cause readmissions metric.

“Hospitals that treat a lot of dual eligibles are often in communities with poor health care infrastructures,” Childs said. “When somebody’s discharged from that kind of hospital — even if the hospital does everything pretty well — there’s a higher probability that that person’s going to be readmitted as opposed to if that person’s in an affluent suburb with a more robust health care infrastructure, with more effective follow-up and better access to primary care physicians.”

Harlan M. Krumholz, MD, said hospitals should stop making excuses for their performance on readmissions. He and his colleagues at Yale developed the all-cause readmissions metric.

“In the house of medicine, we have ample opportunities to improve the ways in which we care for patients and assist them in their recoveries as they leave the hospital,” said Dr. Krumholz, director of the Yale-New Haven Hospital Center for Outcomes Research and Evaluation in Connecticut. “We should be focused on socioeconomic status after we’ve cleaned up our own habits in the hospital and across the spectrum, from inpatient to outpatient. Our systems continue to be rife with errors, miscues, miscommunications, inadequate education of patients and poor preparation for discharge.”

Not all readmissions are preventable, but improved coordination of care would benefit patients regardless of their race or income level, Dr. Krumholz said. He added that CMS should consider offering financial and clinical assistance to help poor-performing hospitals that serve a disproportionate share of low-income and minority patients improve their readmission rates.

“We need to come together and solve the problem together,” Dr. Krumholz said.

ADDITIONAL INFORMATION:

WEBLINK

“Endorsement Summary: All-Cause Readmissions,” National Quality Forum, April
(www.qualityforum.org/News_And_Resources/Endorsement_Summaries/All-Cause_Readmissions_Endorsement_Summary.aspx)

“Thirty-Day Readmission Rates for Medicare Beneficiaries by Race and Site of Care,” *The Journal of the American Medical Association*, Feb. 16, 2011 (jama.jamanetwork.com/article.aspx?doi=10.1001/jama.2011.123)

“Socioeconomic status, Medicaid coverage, clinical comorbidity, and rehospitalization or death after an incident heart failure hospitalization: Atherosclerosis Risk in Communities cohort (1987 to 2004),” *Circulation: Heart Failure*, May 2011
(www.ncbi.nlm.nih.gov/pubmed/21430286/)

“Rehospitalizations among patients in the Medicare fee-for-service program,” *The New England Journal of Medicine*, April 2, 2009 (www.ncbi.nlm.nih.gov/pubmed/19339721/)

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