

Heart Failure Readmission Rates

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Hear failure (HF) is the most common hospital admission diagnosis in patients ≥ 65 years, accounting for more than 700,000 hospitalizations per year among Medicare beneficiaries.

In July 2009, the Centers for Medicare and Medicaid Services (CMS) began publicly reporting 30-day all-cause readmission rates for HF. This was done in an effort to underscore preventable readmissions, improve care, and manage costs. The median readmission rate for Medicare fee-for-service beneficiaries is 24.7%.

Ross and colleagues¹ evaluated trends in readmission after HF hospitalization and found that they have not changed in recent years. They found similar readmission rates (23.7%-23.9%) over the 3-year period from 2004 to 2006. Bueno and associates² note that for patients admitted with HF during the past 14 years, there has been a reduction in length of stay and in-hospital mortality, less marked reductions in 30-day mortality, but increases in 30-day readmission rates. Of note is that these observations used risk-standardized readmission rates derived from CMS administrative data and did not take into account patient nonadherence with the postdischarge care plan.

DiDomenico and colleagues³ pointed out that nonadherence has contributed to HF readmission, particularly for the very elderly and socioeconomically disadvantaged patient populations. Research on this topic leads to one prospective study of 161 elderly patients which found that medication nonadherence contributed to 15% of the readmissions. In a survey of 173 patients, their caregivers, and providers, nonadherence was judged to be a contributing factor in 13% to 26% of the HF readmissions. Murray and coworkers⁴ also observed that medication nonadherence contributed to a threefold higher readmission rate in HF patients.

It is clear that there are many challenges faced by patients as they recover from an acute illness. One of these challenges is the smooth transition from hospital to home after discharge. Some of the questions that need to be addressed include the following: Do patients have a complete list of medications they are to go home with, and do they understand the importance of these medications and how to take them correctly? Do they have a follow-up appointment? Do they fully comprehend the symptoms that require medical attention and whom to call when they occur? Without proper

discharge planning and transition to home, patients will continue to enter the revolving hospital readmission door.

The data on hospital readmission rates suggest that all hospitals have room for improvement. Additionally, beginning in 2013, utilizing 2012 clinical data, Medicare payments to hospitals with high readmission rates will be reduced by 1% in federal fiscal year 2013 and by 3% in 2015. Therefore, hospitals across the country are grappling with the issue of lowering HF readmission rates. Many have identified the need for improved hospital and postdischarge care, predischARGE planning, home-based follow-up, and patient education. The American College of Cardiology is helping in this endeavor with the Hospital to Home (H2H) program. H2H is a national quality improvement initiative to reduce cardiovascular-related readmissions and improve the transition from inpatient to outpatient status. The goal of the program is to reduce the 30-day all-cause readmission rate among patients discharged with HF and acute myocardial infarction by 20% nationally by December 2012. H2H will provide hospitals and practices with evidence-based strategies and tools to improve care transitions. Presently there are over

1000 institutions enrolled in the program.

Jennifer Ballard-Hernandez, NP-AACC, a nurse practitioner at Hoag Hospital (Newport Beach, CA) is an enthusiast of the H2H program, and comments, "H2H has provided a framework and guidance to deliver the most current evidence-based practices. It standardizes the process." In her estimation, the greatest strength of the H2H program is that "it serves as a national clearing house for best practices." Ballard-Hernandez states that after enrolling in the program and applying strategies outlined by the H2H program, her institution demonstrated a reduction in 30-day all-cause HF readmission rates from 20.7% to 13.3% (Personal communication, February 2011).

One of the issues regarding HF readmission rates is that they are all-cause readmission rates. Additional concerns include coding issues, forcing providers to be more precise about the principal admitting

diagnosis. Educating providers to differentiate between different types of HF such as systolic versus diastolic, as well as distinguishing between volume overload in renal failure and HF, is imperative. Additionally, coders need to work with clinical staff for more precise and accurate coding. It appears that having discussions with patients in the office setting about prognosis and code status, and involving palliative care or supportive care staff, may be beneficial in reducing HF admissions.

DiDomenico and associates³ and others propose that the CMS risk-standardized models currently being used to publicly report hospital 30-day HF readmission rates after hospitalization be changed to include adjustment for patients' adherence to discharge care plans. As these issues get more delineated, the push for decreasing readmissions for HF continues.

CMS created Hospital Compare (www.hospitalcompare.hhs.gov), in partnership with the Hospital

Quality Alliance, to make consumer-friendly information on hospital quality, patient experiences, and other metrics available. This information indicates how often Medicare patients with HF or other conditions return to the same hospital or a different hospital within 30 days of their initial stay. Now is the time for all providers of cardiac services to become acquainted with their data to acquire an understanding of how to improve HF readmission rates. ■

References

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