

Kaiser Permanente Policy Story, v1, No. 1

Improving Quality and Reducing Cost – Preventing Hospital Readmissions for Heart Failure

- Several new federal policy initiatives seek to reduce preventable hospital readmissions.
- Among Medicare beneficiaries, one in five hospitalizations results in a readmission within 30 days. In 2006, nearly 4.4 million hospitalizations were potentially preventable.
- Kaiser Permanente implemented a program to improve hospital-to-home transitions for heart failure patients, leading to a 30% reduction in preventable hospital readmissions.
- Enablers of Kaiser Permanente’s success include: information technology, patient engagement, and ongoing monitoring of discharge processes and outcomes.

Policy Context

Policymakers are providing incentives for reducing preventable hospital readmissions, including financial penalties for hospitals with high rates of preventable readmissions and the posting of hospital readmission rates. Under the Affordable Care Act’s Hospital Readmissions Reduction Program, hospitals with relatively high preventable readmission rates for selected conditions (heart attack, heart failure, and pneumonia) will see a reduction in Medicare reimbursement beginning October, 2012. Beginning in 2015, the Secretary of Health and Human Services may expand the list of applicable conditions beyond the three noted.

Further, the Centers for Medicare and Medicaid Services added all-cause hospital readmission rates to the 2012 STAR rating system for Medicare Advantage and Part D plans. These ratings are used to evaluate plans based on quality of care and customer service. Under the Affordable Care Act, STAR ratings are linked to quality-based payments.

The Challenge

Hospital care accounts for one-third of total health care spending. One in every five hospitalizations among Medicare beneficiaries results in a readmission

within 30 days of discharge. In 2006, nearly 4.4 million hospitalizations were potentially preventable.¹ Heart failure accounts for the greatest number of potentially preventable readmissions, and it is one of the conditions selected by Medicare to receive reduced reimbursement in hospitals with high readmission rates. Reducing potentially preventable heart failure readmissions could save \$903 million.²

Kaiser Permanente Solution – the Heart Failure Transitional Care Program

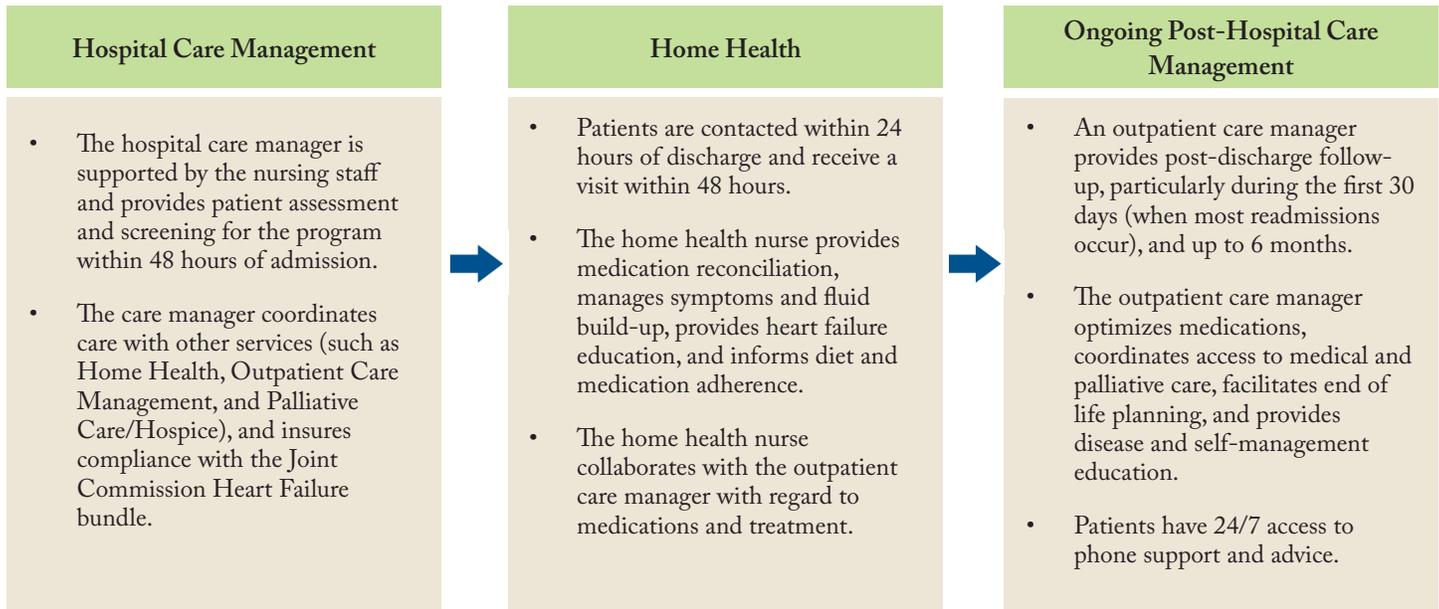
Reducing preventable hospital readmissions is a complex challenge for health care systems. Kaiser Permanente identified the transition from hospital to home as a critical stage in reducing readmissions.

In 2007, we implemented an evidence-based program to improve clinical quality, reduce hospital length of stay and readmission rates, and improve the quality of life and safe transitions for patients with heart failure. The Heart Failure Transitional Care Program (Figure 1) includes three components: hospital care management, home health evaluation, and ongoing post-hospital care management. These three elements combine to provide a seamless model of care for high-risk heart failure patients.

“There is no magic bullet for these complex heart failure patients; it is imperative to have an interdisciplinary integrated approach in caring for these patients across the continuum of care.”

Dr. Sandra Koyama, Regional Physician Co-Lead, Heart Failure Program,
Kaiser Permanente Baldwin Park Medical Center

Figure 1. The Heart Failure Transitional Care Program



Outcomes

The Heart Failure Transitional Care Program led to:

- An improvement in the quality of care;
- A 30% decrease in hospital readmission rates for patients with heart failure;
- A significant reduction in mortality rates, resulting in an estimated 410 lives saved;
- Cost savings of about \$12 million; and,
- High levels of satisfaction with care expressed by 70-80% of patients.

Practical Implications and Transferability

Kaiser Permanente’s experiences in improving heart failure transitions to reduce preventable readmissions

can serve as a model for other organizations. We operate on a global budget, so the financial incentive to stay within budget is aligned with reducing preventable hospital readmissions. Although a heart failure transitional care program may be easier to implement within a prepaid delivery system, the interventions can be applied in other models, especially Accountable Care Organizations.

Key enablers include:

- The use of electronic health records to standardize templates and identify recently discharged patients who need follow-up calls and visits;
- A commitment to engage patients in every aspect of the transition process; and,
- Monitoring of the process and outcomes to assure quality, effectiveness and patient satisfaction.

For more information, please contact:

Kaiser Permanente Institute for Health Policy at <http://www.kp.org/ihp>

¹ Russo, C. A., Jiang, H. J. and Barrett, M. *Trends in Potentially Preventable Hospitalizations among Adults and Children, 1997-2004*. HCUP Statistical Brief #36. August 2007. Agency for Healthcare Research and Quality, Rockville, MD.

² *Report to Congress: Reforming the Delivery System*. Rep. MedPac, June 2008.