Peers for Progress
Peer Support Around the World
A program of the American Academy of Family Physicians Foundation

ISSUE SPOTLIGHT

REDUCING HOSPITAL READMISSIONS

A New Opportunity for Peer Support in the Affordable Care Act

Key Points

- Reducing hospital readmissions for congestive heart failure, acute myocardial infarction, and pneumonia requires a patient-centered, multidisciplinary approach using health teams that span hospital and community settings.
- Social support is a strong predictor of hospital readmissions and mortality in heart failure patients. Low social support is associated with worse health status and more depressive symptoms during myocardial infarction recovery.
- A comprehensive readmission reduction strategy begins prior to initial hospitalization. Patient education and self-management are critical throughout the entire course of care.
- As part of a health team, peer supporters can provide psychosocial support, reinforcement patient education, provide coaching on implementing discharge plans, promote timely out-patient care, and link patients to community resources.

A major challenge for the Affordable Care Act (ACA) is to reduce overall healthcare costs while improving quality of care. Policymakers are convinced that reducing hospital readmissions is a feasible approach to achieve both of these goals. Through performance-based penalties, the ACA is taking an aggressive course to rapidly reduce excess hospital readmissions. This effort will require greater coordination of care between healthcare providers and increased cooperation between hospital and community resources.

Peer support programs can improve transition of care, promote outpatient physician visits, reduce patient stress, and provide social support to help discharged patients avert preventable hospital readmissions. Several ACA provisions are expanding the role of community health workers, making them eligible for Medicare reimbursement as patient navigators and as part of multidisciplinary care teams. Hospitals can take advantage of these funding opportunities to leverage peer support to improve healthcare quality and reduce rehospitalizations.

Why Target Hospital Readmissions?

According to a 2009 study by Jencks and colleagues, hospital readmissions for Medicare beneficiaries were highly prevalent and costly. 19.6% of beneficiaries were rehospitalized within 30 days and 34% were rehospitalized within 90 days, costing $17.4 billion of the $102.6 billion in hospital payments from Medicare (data from 2004). According to some estimates, as many as 34% of rehospitalizations are preventable. Readmission rates are associated with hospital, patient, social, and community factors.

Examples of hospital factors:
- Quality of care
- Infrastructure
- Human and financial resources
- Other organizational characteristics

Examples of patient factors:
- Socioeconomic status
- Race and ethnicity

Examples of social factors:
- Housing stability
- Social support
- Behavioral issues
- Neighborhood factors

Examples of community factors:
- Strength and number of primary care providers and other health care resources
- Community hospitalization rates
- Services and supports beyond health care
- Poverty

"The evidence of variability in readmission rates, of a failure to provide close patient follow-up, and of inadequate communication between doctors and patients and among doctors at the time of discharge has raised concerns that many readmissions may be preventable and has pointed to policy changes that might both improve health outcomes and substantially lower costs.

Arnold Epstein, MD
New England Journal of Medicine

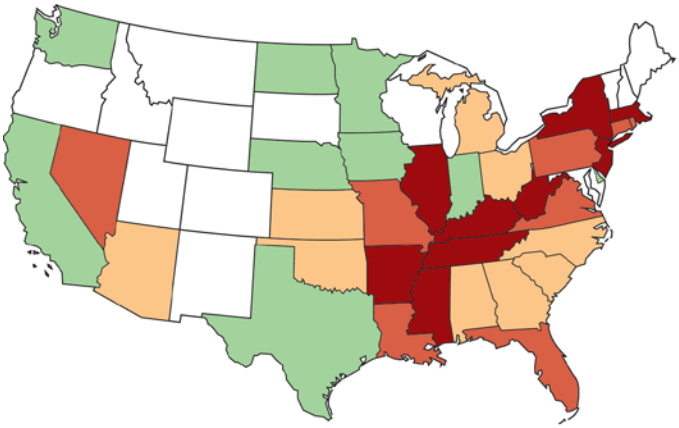
Despite the complex factors that affect readmission rates, there are some strategies that have been proven to be effective. The following strategies were identified in a report from the Robert Wood Johnson Foundation.

- Plan for earlier hospital discharge
- Offer more intense education for new diagnoses
- Flag high-risk patients and provide case management
- Use multidisciplinary approach to discharge
- Check in with patients that have chronic conditions
- Provide follow up care
- Encourage connection with primary care providers

Medicare's Hospital Readmission Reduction Program (HRRP)

Section 3025 of the ACA established the Hospital Readmissions Reduction Program (HRRP), which requires the Centers for Medicare & Medicaid Services (CMS) to reduce payments to Inpatient Prospective Payment System (IPPS) hospitals with excess readmissions, effective for discharges beginning on October 1, 2012. Readmissions are defined as an admission to a hospital within 30 days of a discharge from the same hospital. Applicable conditions include acute myocardial infarction, heart failure, and pneumonia. Read the full measures and payment adjustment methodologies at the CMS website.

It is estimated that 2,217 hospitals across the country will be penalized in this initial round of evaluations, of which 207 will receive the maximum penalty. 887 hospitals had acceptable readmission rates and 346 hospitals did not meet the minimum number of cases for evaluation. The maximum penalty for the first year is 1% of base Medicare reimbursements, increasing to 2% in October 2013 and 3% in October 2014. In total, these hospitals will lose $280 million in Medicare funds this year, which accounts for 0.3% of the amount that Medicare pays to hospitals.



Critics of the HRRP contest that this program unfairly penalizes hospitals that serve high-risk, low-income, and minority populations, when in fact those hospitals need the money most. Some hospitals that have implemented reforms have not seen improvements, leaving some to wonder how to effectively tackle the issue. Fortunately, the ACA offers grants to help hospitals implement reforms and coordinate patient care in the community. For example, the Quality Improvement Program for Hospitals with High Severity Adjusted Readmission Rate will use patient safety organizations to help underperforming hospitals reduce their readmission rates. The Community-Based Care Transitions program is helping community-based organizations test models for improving care transitions for high-risk Medicare beneficiaries.

Peer Support as a Strategy to Reduce Rehospitalization

Several studies (Coleman et al. 2006, Naylor et al. 2004, Jack et al. 2009) have demonstrated the effectiveness of transitional care after hospital discharge in reducing rehospitalization rates. These programs have utilized coaches and nurses to deliver the intervention in the community. We propose that peer supporters would be well-positioned to deliver trusted, community-based support from "someone that's been through it before." The role of the peer supporter would be to reinforce clinical messages, help solve problems, provide social support, and link patients to outpatient care.

Rich et al. (1995) tested a nurse-directed, multidisciplinary intervention that improved quality of life and reduced hospital use for elderly patients with congestive heart failure. The intervention consisted of comprehensive education of the patient and family, a prescribed diet, social-service consultation and planning for an early discharge, a review of medications, and intensive follow-up. This multidisciplinary team includes a research nurse, a registered dietician, and a geriatric cardiologist. A peer supporter would add another dimension to this multidisciplinary team. Through individualized home visits and telephone contact, peer supporters can reinforce patient education, promote medication and dietary adherence, and identify recurrent symptoms that should be referred to outpatient treatment.

Kaiser Health News reports that "hospitals that treat the most low-income patients will be hit particularly hard (by the penalties)." It is likely that these hospitals serve a large number of Medicaid and dual beneficiaries. A small percentage of high-risk patients accounts for a large proportion of Medicaid spending through frequent hospital admissions. Raven et al. (2011) piloted an intervention that reduced hospitalizations in this population by 37.5%, reduced usage of emergency care while increasing outpatient visits, and decreased Medicaid costs by $16,383 per patient over 12 months.

This patient-centered intervention was multidisciplinary and strengthened cooperation between hospital and community resources. Peer supporters would enhance the care team's ability to 1) provide coordinated care that is responsive to patient needs, 2) provide care that continues into the community, 3) serve patients "where they are" both physically and mentally, and 4) share data and track progress among team members.

Conclusion

The penalties imposed by the ACA's Hospital Readmission Reduction Program is prompting hospitals to reform their policies around patient discharges and continuing care. Epstein writes that "the care that prevents rehospitalization occurs largely outside hospitals." As part of a multidisciplinary care team, peer supporters are uniquely positioned to provide the type of community-based care that could prevent unnecessary rehospitalizations. Furthermore, Jencks et al. reports that "risk of rehospitalization persists over time." As one of the four key functions of peer support is to provide ongoing support, peer supporters would be following up with patients months following a discharge.

Reducing rehospitalizations is only one of the many ways in which peer supporters/community health workers helps achieve the goals of the Affordable Care Act. See our ACA Issue Brief to learn more about opportunities for peer support in the ACA.

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