TARGET: HF℠

How Target: Heart Failure℠ Can Help Facilitate Your Hospital's Efforts To Improve Quality and Reduce Heart Failure Readmissions

FACT SHEET

THE PROBLEM

It is estimated that one million heart failure patients are re-hospitalized each year, with readmission rates varying dramatically from hospital to hospital.[1] Costs associated with readmission of heart failure patients are significant. In 2004 alone, Medicare heart failure readmissions totaled 17.4 billion dollars and heart failure was the number cause of readmissions for both medical and surgical discharges.[2]

Concerns related to quality and costs of care have generated a significant interest among payers, such as the Centers for Medicare and Medicaid Services (CMS), in identifying methods for decreasing the number of re-admissions for patients discharge with a diagnosis of heart failure. Efforts are underway by CMS to try to reduce the number of readmissions by: (1) posting data on each hospital receiving CMS payment on the Hospital Compare Website and creating one-stop quality shopping for consumers on the Quality Care Finder Website, (2) linking financial reimbursement to outcome measures such as 30-day readmissions and (3) including readmissions as a priority in the Quality Improvement Organization's (QIO) 10th Scope of Work.

This fact sheet provides a brief synopsis of the federal efforts underway to reduce 30-day readmissions. It also explains how the American Heart Association's Target: Heart Failure™ program may be able to help your hospital improve quality of care and lower readmission rates.

SUMMARY OF CMS ACTIVITIES TO REDUCE HOSPITAL READMISSION FOR HEART FAILURE

Readmission data is reported on Hospital Compare and Quality Care Finder Websites.

For the past several years, CMS has been reporting 30-day all-cause, risk standardized readmission rates on Hospital Compare Website *(http://www.hospitalcompare.hhs.gov/)*. The data released in August of this year found only small changes to the readmissions rate, which compared data for the years 2007 through 2010 against data for the years between 2006 and 2009. For patients discharged with a diagnosis of heart failure, the readmission rate was 24.8% (2007-2010) as compared with 24.5% (2006-2009). Therefore, the readmission rates slightly increased for heart failure.

To further communicate to patients and their caregivers the importance of quality of care, this past August 2011, CMS also released a new Quality Care Finder website *(http://www.medicare.gov/quality-care-finder/)* which serves a "one-stop shopping" for consumers looking for information on quality or the type of services provided by hospitals, physicians, nursing homes, home care or dialysis providers.

These two Websites represent a concerted effort by CMS to make hospital-level quality data readily available to patients and caregivers.

Question:

How is your hospital performing compared to other hospitals on 30-day heart failure readmissions?

CMS is placing greater emphasis on reducing readmissions and this may affect your reimbursement.

CMS is committed to promoting high quality health care and improving patient health outcomes. The Agency recently stated that:

"Readmission to a hospital may be an adverse event for patients and many times imposes a financial burden on the health care system. Successful efforts to reduce preventable readmission rates will improve quality of care while simultaneously decreasing costs."[4]

To achieve this goal, the Agency, in accordance with Section 3025 of the Affordable Care Act (ACA), is planning to implement the Hospital Readmissions Reduction Program. This program will reduce payments to certain hospitals that have excess readmissions for patients discharged with selected conditions, including heart failure, acute myocardial infarction and pneumonia with possible future additions to the list of selected conditions.[5] The Hospital Readmission Reduction Program does not apply to discharges until FY 2013. Therefore, CMS is planning to implement the Hospital Readmission Reduction Program over two years.

For FY 2013Hospital Readmissions Reduction Program, CMS plans to use 3 years of data for discharges from July 1, 2008 through June 30, 2011 as the applicable period upon which to calculate excess readmission ratios for each of the three proposed measures. Based on the Agency's experience with the Hospital Inpatient Quality Reporting Program, CMS states that this timeframe increases the precision of the measures in distinguishing performance among hospitals.

In the final Inpatient Prospective Payment System rule, CMS states that it will also apply a methodology in calculating excess readmission rates for these conditions. The methodology is briefly described in Table 1. The findings of preliminary CMS analysis indicates that in all hospital categories approximately half of hospitals are at risk of payment reductions based on excess readmissions for heart failure, acute myocardial infarction and pneumonia.

The final Inpatient Prospective Payment System rule also notes plans to include the data capture of Heart Failure 30-day Risk Standardized Readmission Measure as one of the 55 Hospital Inpatient Quality Reporting (IQR) measures for FY 2014.

Question:

Is your hospital prepared to have part of its reimbursement directly linked to its readmission numbers?

Quality Improvement Organizations have made reducing hospital readmissions a priority.

TABLE 1

Numerator	Adjusted number of readmissions at specific hospital (calculatedfor each patient and add up results for all patients): Hospital-specific readmission effect + average hospital contribution to readmission risk + [risk factor weights × patient risk factors]
Denominator	Number of readmissions if an average hospital treated the same patients (calculated for each patient and summed for all patients): Average hospital contribution to readmission risk + [risk factor weights ×patient risk factors]

Note: CMS is providing a minimum-case threshold of 25 cases for a given condition in order to have an Excess Readmission Ratio calculated.

In the 10th SOW, the QIOs will be required to integrate and coordinate care across settings within communities, improve community health by promoting preventive services and make health care costs sustainable in the long term by supporting care that keeps patients safe from costly and dangerous complications and harm. This includes focusing on efforts to reduce hospital readmissions for patients discharged with a diagnosis of heart failure, acute myocardial infarction or pneumonia.

Question:

Is your hospital working with its QIO?

Target: Heart Failure Facilitating Improved Care and Outcomes

The financial climate is causing hospitals to place a stronger emphasis on reducing the number of readmissions for specific conditions, including heart failure. Hospitals can potentially lower readmission rates and improve patient care in a number of ways, such as ensuring patients are clinically ready to be discharged, reconciling medications, improving communication with outpatient providers responsible for post-discharge patient care, improving care transitions, and ensuring that patients understand their care plans upon discharge.

Peer-reviewed evidence based literature supports that improved hospital care[6] and post-discharge care[7-8] — including pre-discharge planning,[9-10] home-based follow-up and patient education[11-12] — have been shown to lower heart failure readmission rates. For example, one recently published article found that in the first 30 days after discharge, 21.3 percent of Medicare patients were readmitted. At the hospital level, the median rate of early follow-up was 38.3 percent. Hospitals in the lowest quartile of early physician follow-up had higher rates of re-hospitalization within 30-days, than those in the other three quartiles, independent of other factors. Discharge from hospitals where a greater proportion of patients received early follow-up was independently associated with lower rates of 30-day readmission. Therefore, the published literature suggested that heart failure readmission rates might be reduced if proven interventions were more widely adopted.

Now Here Is How Target: Heart Failure can help your hospital reduce its readmission rates…

Target: Heart Failure draws from the American Heart Association's vast collection of content-rich resources for patients and healthcare professionals, including educational tools, prevention programs, treatment guidelines, quality initiatives and outcome-based programs. Among the most important of those resources is Get With The Guidelines®-Heart Failure, a hospital-based performance improvement tool that helps ensure up-to-date, evidence-based care for heart failure patients. Strategies deployed in Get With The Guidelines-Heart Failure have proven successful in lowering 30-day mortality rates and readmissions in heart failure patients, making it central to Target: Heart Failure.

Using Target: Heart Failure in concert with Get With The Guidelines-Heart Failure helps hospitals identify how it can improve the quality of care it provides to patients to reduce readmissions by focusing on a unique set of measures. Target: Heart Failure focuses on three main areas of care: (1) Medication Optimization, (2) Early Follow-up Care Coordination and (3) Enhanced Patient Education. Table 2 outlines these measures.

TABLE 2

Medication Optimization	ACE Inhibitor (ACEI) or Angiotensin Receptor Blocker (ARB) at Discharge
	Evidence-Based Specific Beta-Blockers
	Aldosterone Antagonist at Discharge
Early Follow-up Care Coordination	Follow-up Visit or Contact within 48 hours of Discharge Scheduled
Enhanced Patient Education	Heart Failure Disease Management Program Referral
	Provision of at least 60 minutes of heart failure education by a qualified heart failure educator
	Provision of AHA heart failure interactive workbook

Target: Heart Failure is always updating its tools and resources. To take best advantage of Target: Heart Failure and learn more about the program we invite you to register your hospital at *www.heart.org/targethf.*

ENDNOTES

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2 S. F. Jencks, M. V. Williams, and E. A. Coleman, "Rehospitalizations Among Patients in the Medicare Fee-for-Service Program," New England Journal of Medicine, April 2, 2009 360(14):1418–28.

3 Information on the Hospital Compare website represents whether hospitals had a lower (better) than the national rate, no different than the national rate or higher (worse) than the national rate, given how sick patients were when they were admitted to the hospital.

4 Federal Register. Vol. 76, No. 160 page 51660. Available at http://www.gpo.gov/fdsys/pkg/FR-2011-08-18/pdf/2011-19719.pdf

5 Section 1886(q)(3)(C) of the ACA has the floor adjustment factor, is set at 0.99 for FY 2013, 0.98 for FY 2014, and 0.97 for FY 2015 and subsequent fiscal years.

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