MOHEG Student Essay Award
Sociodemographic Factors Impacting Hospital Readmission Rates
Saint Louis University- MHA Program, May 2018
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September 22, 2014

"No", is a powerful two-letter word. This word might be used multiple times a day, but it is not one I plan to use often within our changing healthcare system. There are policy implementations, new programs, and culture changes happening within our healthcare system every day. In order to create a stronger system, saying 'yes" to continual change is necessary. I am passionate about improving quality of care as indicated by hospital readmission rates. Therefore, I say "yes" to improving the effectiveness of the Hospital Readmission Reduction Program (HRRP) by taking sociodemographic factors into consideration when determining penalties.

Section 3025 of the Affordable Care Act and section 1886 (q) of the Social Security Act formally states the current Hospital Readmission Reduction Program (HRRP) within the United States healthcare system (U.S. Department of Health and Human Services, [HHS] 2015). Within the HRRP program Centers of Medicare and Medicaid Services penalizes hospitals for higher than expected readmission rates for clinical conditions, such as heart attack, pneumonia, and acute myocardial infarctions. Penalties are three percent of their Medicare payments, which can greatly affect their hospital. (AHA, 2015). Hospitals and stakeholders have voiced concerns of the current program and how risk adjustments should be included when determining HRRP penalties within the U.S. healthcare system (AHA, 2015).

Policy makers are constantly looking for ways to increase quality of care while decreasing Medicare program spending. Hospital readmission rates are indicators of the hospital's quality of care for their patients. Prior to the HRRP one in five Medicare beneficiaries discharged from hospitals were readmitted within thirty days. These readmissions varied widely by hospital and geographic location (MRP, 2013). As more diagnoses have been added to the

HRRP, hospital penalties have increased by seventy-eight percent in 2015 (Boccuti & Casillas, 2015).

The Hospital Readmission Reduction Program accounts for several factors in calculating penalties for hospitals, but it does not take into account sociodemographic status within the population and how it affects readmission rates (Boccuti & Casillas, 2015). This has been a controversial issue for several years as hospitals serving populations from lower sociodemographic groups have faced higher penalties (AHA, 2015).

An evaluation of the Hospital Readmission Reduction Program policy at Henry Ford Hospital in Detroit, Michigan found that individuals living in high-poverty neighborhoods were twenty-four percent more likely to be readmitted (AHA, 2015). Additional researchers evaluated readmission rates for more than four thousand hospitals for patients with acute myocardial infarction, cardiovascular conditions, and pneumonia. They found sixty percent of distinction in hospital readmission rates were due to sociodemographic factors (AHA, 2015). Hospitals who served low-income patients were eighty-five percent more likely to receive HRRP penalties (AHA, 2015). Analyzing these evaluations of the policy reveals that excluding sociodemographic factors creates a disadvantage for hospitals treating higher risk readmission patients.

The Medicare Payment Advisory Commission (MedPAC) recommended that the Centers for Medicare and Medicaid Services should take sociodemographic factors into account when calculating HRRP penalties. The modification allows hospitals to have a fixed target readmission rate based on the percentage of patients receiving Supplemental Security Income benefits (AHA, 2015). It still holds hospitals accountable for the quality of care they provide their patients.

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The current HRRP has been successful in limiting the number of readmissions for Medicare patients. However, because the program does not incorporate sociodemographic factors, hospitals are penalized for factors outside their control. Implementing sociodemographic factors will properly distribute penalties to hospitals in all areas in the U.S. The policy modification will continue to motivate and improve quality of care based on accurate criteria. MedPAC's recommendation of the sociodemographic model mediates outside factors and barriers restricting healthcare systems from addressing the source of the problem. (AHA, 2015).

I have worked in two hospital systems serving diverse populations and found that not every individual comes from the same background and that their health status outside the hospital impacts their overall health. As a future administrator, it is my responsibility to consider the role of social demographic factors in the population's health. The drive to implement new solutions and modifications comes from our ability as administrators to take action. In order to produce change, it requires a team effort within the hospital and stakeholders outside the hospital.

Programs like the HRRP will be a part of the continual change within our healthcare sector. Without new modifications, programs, and policies the U.S. healthcare system will stagnate. We need a process for revising unfair rules, regulations and penalties. As an emerging leader, I need to be aware of the policy environment and work with other stakeholders to advocate for positive change within the healthcare system. My motto is a quote by Benjamin Franklin: "Well done, is better than well said". Benjamin Franklin's quote inspires me to always take action when it comes to implementing change that will positively influence numerous stakeholders within our healthcare system.

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