HARVARD PUBLIC HEALTH REVIEW

SPECIAL COMMENTARY
APRIL 2016

Beyond Adjustments for Socioeconomic Status in Hospital Readmissions Penalties

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As a hallmark of value-based payment reform, the Medicare Hospital Readmissions Reduction Program (HRRP) policy attempts to improve the quality of US health care by holding hospitals accountable for patient outcomes in the post-acute period. Specifically, it does so for medical conditions such as heart failure, pneumonia and acute myocardial infarction by financially penalizing hospitals for preventable readmissions.[1]

Despite laudable intentions, however, the policy has produced well-documented controversy. Some view readmission rates as a flawed measure in which patients' socioeconomic status (SES) confounds hospital quality.[2][3] Because low SES has been associated with worse disease outcomes, critics are also concerned that the HRRP unintentionally and unfairly penalizes hospitals for uncontrollable factors and caring for poor patients.[4]

In turn, these debates have focused the attention of hospital leaders, policy researchers and federal policy makers on a timely question: should penalties for quality metrics such as readmissions rates be adjusted for patients' socioeconomic status? Hospital readmissions remain a key focus of many health services studies. The National Academy of Medicine has

been commissioned to provide a series of reports that identify social risk factors and methods for accounting for them in Medicare payment programs.[5] The Department of Health and Human Services itself is required through the IMPACT act – federal legislation focused on improving the delivery and reporting of post-acute care services among Medicare beneficiaries – to submit a congressional report by late this year assessing the impact of SES on quality and utilization.[6] Collectively, this work will provide insight about policy opportunities relating quality and socioeconomic status.

Independent of those results, however, health system and policy leaders should recognize that risk adjustment is only one facet in using quality measurement and socioeconomic considerations to promote better health. Given the proliferation of value-based payment reforms and the accountability they place on hospitals during the post-hospitalization period, there is another, important question to consider: will any amount or form of SES adjustment produce better health if hospitals do not also engage new partners and adopt clear, public health-minded organizational strategies.

Because policies such as the HRRP intentionally expand quality measurement to measures and outcomes beyond hospitalization, we believe the answer in most cases is 'no'. In fact, without a fundamental shift in care delivery strategy, SES adjustment alone may actually exacerbate rather than alleviate any unfairness in financial penalties.

There are several reasons for this. First, despite evidence that certain socioeconomic factors are associated with poor disease outcomes, there are no absolutes when it comes to the dynamic interplay between SES factors and quality metrics. Each measure and context should be considered individually.[7]

It is also notable that the first report by the National Academy of Medicine committee consists of a "conceptual framework" that further distinguishes between related but distinct social and socioeconomic factors.[5] As we uncover the complexity in different factors and evaluate their influences on health outcomes, it seems unlikely that national policy intervention alone can capture every consideration in ways that seem "fair" to every hospital. Not everything that matters can be measured, and using the categories defined by the National Academy of Medicine as an example, facets of patients' *social relationships* (e.g., social support) and

residential & community context (e.g., social disorder or cohesion) are far harder to operationalize than *gender* and *socioeconomic position* – a marker of access to resource access and social status – in payment policy.[5]

Second, even if adjustment could mitigate the financial impact of caring for socioeconomically vulnerable patients, alone it does not address the population-level roots of these issues. In fact, "fully adjusted" payment would only increase the pressure on hospitals to improve patient outcomes – which pose no less of a challenge as long as underlying population level risk factors remain unaddressed. Moreover, to the degree that providers are at least partially responsible for patient health across the care spectrum (a fundamental tenet of value-based reforms), adjustment can potentially counteract the momentum for organizational change. By removing the urgency to redesign care delivery processes, it could create implicit acceptance of lower quality care for disadvantaged patients and inadvertently lead the medical community to "hit the target but miss the point" in promoting quality and health.[3][8]

Instead, we believe that hospitals can contribute to more durable solutions by adopting public health-minded organizational strategies and committing resources to out-of-hospital interventions. Beyond care management methods such as tele-monitoring, patient navigators, or home visits, this shift would also involve working with community or government partners on interventions such as food security and housing. For hospitals serving large vulnerable populations in particular, these broader collaborations can be critical for not just addressing the population-level "root" of patient needs, but also expanding accountability for events such as readmissions to public health departments and other stakeholders. We are likely to underachieve at addressing socioeconomic influences on health outcomes if we do not improve upon the *status quo* in which hospitals and public health entities generally lack shared accountability for health outcomes.

Some hospitals and communities have begun displaying the potential in such approaches. For example, Montefiore Medical Center, which cares for a large proportion of Medicaid and other vulnerable patients, began providing housing and transportation support based on evidence that supportive housing can reduce the costs of care and health outcomes.[9][10] Simultaneously, the New York Medicaid program's multi-billion-dollar Delivery System Incentive Payment program aims to encourage

"the kind of collaboration [necessary] to really meet the needs of the Medicaid population" among a greater number of health care providers, community-based organizations and social service providers.[11]

In New Jersey, a non-hospital coalition of health care providers, community partners and patient advocates have taken up a similar charge to use public health approaches to improve quality and reduce the costs of care for the area's vulnerable populations.[12] Championed originally by primary care providers who saw how issues such as diet, housing and safety could be as important as medications for influencing health outcomes, the group now works with local hospitals using real-time data to identify patients with frequent hospital admissions.[13] Fundamental to the coalition's vision is to not only address patients' "medical issues, but also behavioral and social barriers to wellness" by "[linking] patients to resources throughout the community, including primary care, transportation, housing, and other wrap-around services . . . and support they need to avoid readmissions."[12]

Not only do initiatives such as those in New York and New Jersey encourage and enable hospitals to create capacity themselves or partner with resourced entities; they also convey the implicit awareness that the effort to address certain quality measures ought to be a joint one.

Admittedly, specific strategies will differ by hospitals based on organizational context, patient population and other local factors. Certain hospitals – particularly those that care for large proportions of high need or vulnerable populations – may also possess limited capacity to expand services outside hospital walls. Therefore, as the merits of SES adjustment and other strategies are evaluated, we agree with recommendations by the Medicare Payment Advisory Commission that hospitals be compared to others with similar case mix for the purposes of calculating financial penalties.[14] Simultaneously, however, it is instructive that some of the early examples of hospitals adopting public health strategies include those that care for a disproportionately high percentage of vulnerable patients. Their successes reinforce the fact that organizations can leverage community support and collaborations, in addition to financial capital, to pursue public health-minded, out-of-hospital health interventions.

Ultimately, understanding and addressing the influence of social and economic factors on health outcomes is central to the sustained success of value-based payment reforms. In part, the solution will involve policy

interventions that minimize unintended consequences for vulnerable patients and the hospitals that care for them. However, adjustment is not the only important question when it comes to socioeconomic status, readmissions penalties and better health. Adoption of public health-minded organizational strategies, and the solutions and collaborations that can emerge from them, are also sorely needed.

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