IMPLEMENTING HEALTH REFORM

Community Based Care Transitions Program

Reducing preventable hospital readmissions is one goal of last year's health reform effort. The Affordable Care Act tests ways to bring readmissions down, including a new Medicare pilot project called the Community Based Care Transitions Program. The 5-year pilot, which began earlier this year, offers funding to hospitals and community-based organizations that partner to provide transition care services to Medicare patients who are at high risk for readmission. Medicare officials have said that they expect hospitals will work with their community partners to begin transition services within 24 hours prior to discharge, provide culturally and linguistically appropriate post-discharge education, provide medication review and management, and offer self-management support for patients. Congress has provided $500 million to fund the program over 5 years.

Dr. Janet M. Nagamine, a hospitalist in Santa Clara, Calif., and a patient safety expert, explained the challenges associated with this process.

Clinical Neurology News: What are the challenges in reducing hospital readmissions?

Dr. Nagamine: We have to keep in mind that the length of stay has decreased dramatically while the acuity has increased dramatically. We need to recognize and separate those readmissions that are preventable versus those that are not. If you look back over the last 30 years, our length of stay is less than half of what it used to be. That means that for patients older than 65 years, they used to be in the hospital an average of 12.6 days. Now they are in the hospital for about 5.5 days. The challenge is to figure out why some patients come back. I believe that there are some things we can't affect that much. For example, many elderly patients with end-stage chronic conditions are likely to be readmitted. But there is also evidence that only about half of the patients who leave the hospital have followed up with their primary care physician within 30 days of discharge. That speaks to an opportunity that we can address. Too often people get fixated on readmission numbers, but you've got to look at the context, make sure you're focusing on preventable readmissions, and apply specific targeted interventions.

We're starting to do things in a more stepwise fashion, planning for discharge from the day patients come in.

DR. NAGAMINE

We also need to look at reengineering the discharge process. Even though length of stay has been reduced, we haven't really changed the way that we discharge patients. We walk in and we write an order in the morning that says discharge home and then there's a flurry of activity. We're now starting to do things in a more stepwise fashion, planning for discharge from the day patients come in. Reengineering the discharge process will involve everyone in the hospital as well as across the continuum of care.

CNN: Is there a danger in focusing on readmissions? What factors need to be considered to ensure that hospitals that treat the sickest patients aren't labeled as ineffective?

Dr. Nagamine: That's where risk adjustment is really important. You've got to compare apples to apples. Some tertiary care centers see a lot of complex, sick patients, a very different population from than the typical community hospital.

CNN: Congress has appropriated $500 million to fund this program over 5 years. Is that enough?

Dr. Nagamine: I am not a health economist, but I think of this program as providing seed money to get things rolling. I doubt it would be enough to accomplish everything, but it would be seed money to start moving in that direction.

CNN: The Affordable Care Act also tests bundled payments and withholding payment to hospitals that fail to reduce readmissions. What do you see as the best way to change payment policy to encourage a reduction in readmissions?

Dr. Nagamine: Payers need to create an incentive for the right behaviors. For example, in reducing readmissions, physicians spend a lot of time in care coordination and education. Those things aren't compensated, thus those things really aren't happening as well as they should be.

CNN: Hospitals can't reduce readmissions on their own. What do you see as the ideal partnership between hospital-based physicians and community-based primary care physicians? How far away are we from that ideal collaboration?

Dr. Nagamine: I think we're a lot further away from that ideal than we'd like to be. We need to create better linkages. Depending on the work setting, there are many challenges and barriers to getting in touch with primary care physicians. In large metropolitan areas with many hospitals, simply finding and connecting with the right physician can be a real barrier.

The second barrier is making the follow-up appointments. You want to make sure that your patient is seen in a timely fashion and that the primary care physician has the discharge summary with pertinent details of the hospital stay as well as specific follow-up that is needed. Believe it or not, those things, which in the age of cell phones and all this technology should be easy, aren't. There are folks looking into electronic transfer of information and that's helping. But right now, we have a hodgepodge of different systems in various hospitals and medical clinics. Until we can get consistent transfer of information, we won't be doing as well as we should. Sometimes the primary care physicians don't even know their patient was admitted to the hospital when they see them in their office for a posthospital visit. That's unacceptable. ■

Dr. Nagamine *is a hospitalist at Kaiser Permanente Hospital in Santa Clara, Calif., and past chair of the Society of Hospital Medicine's Quality and Patient Safety Committee. She also is chair of the California BOOST Collaborative, which aims to reduce readmissions by improving the hospital discharge process.*

CMS Proposes Rules for Accountable Care Organizations

BY MARY ELLEN SCHNEIDER

After months of deliberation, officials at the Centers for Medicare and Medicaid Services released a proposed rule outlining how physicians, hospitals, and long-term care facilities can work together to form accountable care organizations and share in the savings they achieve for Medicare.

The voluntary program was created under the Affordable Care Act and will begin in January 2012. Under the proposal, accountable care organizations (ACOs) could include physicians in group practice, networks of individual practices, hospitals that employ physicians, and partnerships among these entities, as well as other providers. The idea is for ACOs to be a partnership among a range of physicians, including specialists and primary care providers. However, only primary care providers will be able to form an ACO, according to CMS.

Based on the proposed rule, providers in the ACO would continue to receive their regular fee-for-service payments under Medicare, but they could also qualify for additional payment if their care resulted in savings to the program.

The proposed framework requires that ACOs meet certain quality standards and demonstrate that they have reduced costs in order to be eligible to share in any savings. The proposal outlines 65 quality measures in five quality domains: patient experience, care coordination, patient safety, preventive health, and care of at-risk and frail elderly populations.

Dr. Donald Berwick, CMS administrator, said during a press conference to announce the proposed rule that he doesn't know how many ACOs will form under the program, but that the level of interest is "enormous."

Since the Affordable Care Act was passed last year, the health care community has been buzzing about how ACOs might be structured and if they could succeed in reducing health care costs. Integrated care organizations like Geisinger Health System in Danville, Pa., are considered to have a leg up because their hospital and outpatient care is already coordinated.

But Dr. Berwick said that the proposal allows for ACOs at various levels of development to participate. For example, less developed ACOs can choose to receive only shared savings for 2 years before assuming risk. More mature organizations can assume risk immediately but be eligible for greater levels of shared savings.

CMS officials estimate that the program could result in as much as $960 million in Medicare savings over 3 years.

Although federal officials said that they expect the coordinated care to pay dividends in savings to Medicare, ACOs will not be set up like HMOs. Medicare beneficiaries will continue to be able to see their choice of providers under fee-for-service Medicare.

Providers will be the ones that enroll in ACOs and must notify patients that they are receiving care within an ACO.

In addition to the ACO proposed rule, the Department of Justice and the Federal Trade Commission have also issued guidance on how physicians and hospitals that form an ACO can steer clear of antitrust laws.

Officials at the CMS and the Office of the Inspector General have also issued a notice on potential waivers that could be granted in connection with the shared savings program, and the Internal Revenue Service has issued new guidance for tax-exempt hospitals seeking to participate in the program.

The CMS will be accepting comments on the proposed rule for 60 days.

The agency also plans a series of open-door forums and listening sessions to explain the proposal and to get feedback from the public. ■

INDEX OF ADVERTISERS

Forest Laboratories, Inc.
Namenda 19-20

UCB, Inc.
Vimpat 10a-10d

University of Pittsburgh Medical Center
Corporate 9