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 postdischarge 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 issues associated with reducing hospital readmissions.

CARDIOLOGY 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.

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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.

CN: 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.

CN: 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 enough to start moving in that direction.

CN: 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.

CN: 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, are not. 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 post-hospital visit. That's unacceptable. ■

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

Dems Join Republicans to Fight Appointed Payment Board

BY FRANCES CORREA

Efforts to derail the Independent Payment Advisory Board gained a bit of traction as two House Democrats joined their colleagues across the aisle in cosponsoring the Medicare Decisions Accountability Act.

Introduced by Rep. Phil Roe (R-Tenn.) in January, H.R. 452 would repeal the portions of the Affordable Care Act that would create the Independent Payment Advisory Board (IPAB).

The 15-person board, to be appointed by the President, would be charged with recommending ways to reduce Medicare spending based on the Consumer Price Index and other economic indicators. The board would submit recommendations to Congress on how to limit Medicare expenditures each January, beginning in 2015.

If Congress fails to act on those recommendations by August, the recommendations would go immediately into effect.

The IPAB's "sole purpose is to control Medicare costs – giving this board the authority to approve and deny funding for care," Rep. Roe, who is an ob.gyn., said in a statement. "The IPAB will lack full Congressional oversight, compromising its accountability to the American people."

The existence of the IPAB "permanently removes Congress from the decision-making process, and threatens the long-time, open, and important dialog between hospitals and their elected officials about the needs of local hospitals and how to provide the highest quality care to their patients and communities," according to Rick Pollack, executive vice president of American Hospital Association.

The efforts of the IPAB also would be redundant to the Sustainable Growth Rate formula, which is used each year to adjust Medicare spending for physician services, according to its opponents.

"It makes no sense to subject physicians to two separate expenditure targets while at the same time exempting large segments of Medicare providers who are subject to no target at all," Dr. Michael Maves, executive vice president of the American Medical Association, wrote in a letter to lawmakers.

"We have already seen first-hand the ill effects of the flawed SGR physician target and the steep cuts that Congress has had to scramble each year to avoid, along with the exorbitant price tag required for a long-term SGR solution," he added.

H.R. 452 is supported by the American College of Cardiology, the American Medical Association, the American Hospital Association, the American Association for Neurological Surgeons, the Alliance for Specialty Medicine, and other medical groups.

The legislation has been referred to several House committees for action and at press time had no Senate counterpart. ■