Continuity of Care

Readmissions *from page 1*

out of every five (19.6%) Medicare beneficiaries who were discharged from the hospital were readmitted within 30 days; 34% were readmitted within 90 days, according to an analysis of Medicare claims during 2003-2004 (N. Engl. J. Med. 2009;360:1418-28).

Some $26 billion could be saved over 10 years by reducing those rehospitalizations, according to President Obama's budget.

The project represents "a new approach" for the agency, according to Dr. Barry M. Straube, CMS' chief medical officer. Participants "will look in their own backyards to learn why hospital readmissions occur locally and how patients transition between health care settings," he said in a statement.

In each region, the effort is being directed by a state Quality Improvement Organization. Each QIO will help create interventions targeting specific diseases or conditions or targeting specific reasons for readmissions. Care Transitions teams will then design strategies to go after the "underlying local drivers of readmissions."

A lot of attention will focus on thoroughly educating patients about their diagnosis and medications before hospital discharge, said Dr. Andrew Miller, coleader of the New Jersey Care Transitions Project. In addition, greater effort will be made to ensure that patients have a follow-up appointment with their primary care physician within 3-4 days post discharge, he said.

The longer people go between discharge and that first primary care visit, "the more likely it is that they will wind up in the hospital," noted Dr. Bruce Bagley, medical director for quality improvement for the American Academy of Family Physicians. And yet, no agency is measuring that length of time. If it does become a measure, hospitals and primary care physicians will be forced to communicate.

Much of what's driving the readmissions rate is the robust emergence of hospitalist activity in some areas, which corresponds with a sharp decline in the percentage of primary care physicians who make hospital rounds when their patients are in the hospital, Dr. Gulshan Sharma said in an interview.

Dr. Sharma of the University of Texas Medical Branch, Galveston, and colleagues conducted a retrospective cohort study of 3,020,770 hospital admissions between 1996 and 2006. Among patients with an identifiable primary care physician, they found, 44% were seen by that physician while the individual was hospitalized in 1996, compared with 32% in 2006 (JAMA 2009;301:1671-80).

About a third of this "decrease in continuity between 1996 and 2006 was associated with growth in hospitalist activity," the authors wrote. Furthermore "there is a rough correspondence of regions of the country with the biggest decreases in continuity and those with the greatest increases in hospitalists activity."

"Medicare allows reimbursement for only one generalist physician for concurrent care in the hospital, so there is a financial disincentive for outpatient physicians to follow their patients in the hospital if they are receiving hospitalists care," they continued.

Still, "hospitalists aren't going away," Dr. Sharma said, and nor should they since they greatly enhance the efficiency of care, both inside and outside the hospital, by allowing primary care physicians to see more patients in their offices instead of having to make hospital rounds.

But developing better communication is key to lowering the readmissions rate. According to a meta-analysis, direct communication between hospitalists and primary care providers occurred in less than 20% of cases (JAMA 2007;297:831-41).

Electronic health records would go a long way to bridging that gap between inpatient and outpatient providers, but as yet less than 11% of U.S. hospitals have a "basic" electronic health record system operating in at least one major clinic unit, according to another study.

Even fewer hospitals (1.5%) met the definition of having a "comprehensive" EHR system operating in all major clinical units, according to a 2008 survey of nearly 3,000 nonfederal acute care general hospitals in the United States (N. Engl. J. Med. 2009;360:1628-38).

A comprehensive EHR system was defined as having 24 functions—such as clinical documentation, test and imaging results, computerized provider-order entry, and decision support elements—across all major clinical units in the hospital.

The sites for the Care Transitions Project are Providence, R.I.; Upper Capital Region, N.Y.; Western Pennsylvania; Southwestern New Jersey; Metro Atlanta East; Miami; Tuscaloosa, Ala.; Evansville, Ind.; Greater Lansing, Mich.; Omaha, Neb.; Baton Rouge, La.; Northwest Denver; Harlingen, Tex.; and Whatcom County, Wash. The pilot will continue through summer 2011. Success will be gauged by the number of readmissions occurring in each area. The agency plans to make readmission rates at hospitals around the country available to the public later this year on the Hospital Compare Web site (www.hospitalcompare.hhs.gov). ■

Mary Ellen Schneider contributed to this report.

Spotlight Hits Hospital Readmissions for Heart Failure

BY MITCHEL L. ZOLER

ORLANDO — "Hospital readmissions" has become the latest bad-practice buzzword out of Washington, and the American College of Cardiology is scrambling to put a lid on unnecessary readmissions.

The ACC is alarmed because the worst readmissions offender in medicine is heart failure, linked to about one-third of all 30-day, U.S. hospital readmissions, according to data collected by the Centers for Medicare and Medicaid Services. The next biggest cause of readmissions is acute renal failure, which kicks in a relatively miniscule 4% of the total.

People think readmissions are low-hanging fruit, even though its not exactly low-hanging fruit.

DR. KRUMHOLZ

A 2008 report by the Medicare Payment Advisory Commission, a Congressional advisory group, estimated that eliminating unneeded hospital readmissions for heart failure could potentially save $900 million annually based on Medicare's 2005 numbers. (See chart.)

The stick that the CMS seems poised to wield against readmissions is bundling of reimbursement for Medicare beneficiaries. This would mean a hospital receives a fixed amount for all care for a hospitalized heart failure patient during the next 30 days, including subsequent readmissions. This clear focus on reducing hospital readmissions, with heart failure and a handful of other cardiologic disorders as prime targets, prodded the ACC to respond with a new program aimed at paring back readmissions through better attention to the hospital-to-home handoff of patients once they are discharged. During a press briefing at the annual meeting of the ACC, Dr. Jack Lewin, the college's CEO, announced the H2H program (www.acc.org/h2h/Enrollment/Default.aspx), an educational initiative in collaboration with the Institute for Healthcare Improvement.

The program seeks to encourage better communication between the attending cardiologists and hospitalists who oversee heart failure care while patients are hospitalized, and the community cardiologists, primary care physicians, and nurses who take primary responsibility for heart failure patients once they are discharged. An immediate goal of the H2H program is to cut unnecessary readmissions for heart failure patients by 20% over the next 3 years, Dr. Lewin said. The ACC will seek involvement of the professional societies of hospitalists and nurses and other groups with stakes in this issue.

The expected campaign against readmissions that the Obama administration, Congress, and the CMS are expected to launch "is a big deal. This is here to stay. This is where people will look, thinking that [readmissions] are low-hanging fruit, even though you and I know it's not exactly low-hanging fruit," Dr. Harlan M. Krumholz said in a talk on the readmissions issue at the meeting.

"We need to think about patients, and be sure there are not unintended consequences that cause patients to suffer," said Dr. Krumholz, professor of medicine, epidemiology, and public health at Yale University in New Haven, Conn. "I'm personally trying to steer [the CMS effort] away from penalizing people.

"I'm not against bundling; bundling may be okay," he said. "But we need to go through a period where people can see their performance, understand it, and have a chance to improve. Let's see if we can improve and pull in the hospitals that don't perform as well. Give us time as a community to show leadership and show what can be done before penalizing people based on measures that we know aren't perfect. I don't want us to leap too fast. It may be that the hospitals with the highest readmission rates are also the ones with the most tenuous financial status. They may be hospitals that work with difficult populations."

Dr. Krumholz also conceded that until now "hospitals did not have any incentive to improve the transition of care, and so no one worked on it." He recommended that the CMS give hospitals and health care providers incentives to do a better job in getting discharged patients hooked into outpatient, disease-management programs. The ACC's H2H program will "provide advocacy to the Hill, figure out what key strategies we should all adopt, and how we can share best practices together. My hope is that over the next 2 years [the ACC membership] will show leadership and show that we can identify the issues and move forward on them." ■

Preventable Hospital Readmissions Among Medicare Beneficiaries

Initial condition/procedure	Number of potentially preventable 30-day readmissions	Total cost of preventable readmissions
Heart failure	139,000	$903 million
Pneumonia	86,000	$577 million
Chronic obstructive pulmonary disease	85,000	$552 million
Percutaneous transluminal coronary angioplasty	68,000	$569 million
Acute myocardial infarction	31,000	$199 million
Coronary artery bypass grafting	27,000	$215 million

Note: Analysis of 2005 Medicare discharge claims data using 3M software.
Source: Medicare Payment Advisory Commission

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