Groups Focus On Cutting Hospital Readmission Of Medicare Patients

BY ROY MOORE AND JAN SHUXTEAU

One in five Medicare beneficiaries leaving the hospital will be readmitted within a month due to fragmented care, shorter patient stays in the hospital and problems moving from one type of patient setting to another. Within three months, a third will be readmitted. In just a year, more than two-thirds will be readmitted or dead.

Analysis of Medicare claims finds that three-quarters of the first-month readmissions are preventable and take a financial toll on the entire healthcare sector. The Medicare Payment Advisory Commission said readmissions account for $15 billion in spending, of which $12 billion is preventable.

Industry observers point to a fragmented system of care as the chief culprit and believe that empowering patients to better manage their healthcare is the best way to prevent avoidable readmissions. The Centers for Medicare & Medicaid Services started demonstration projects in Birmingham, Baton Rouge, Atlanta and 11 other regions, seeking to improve through comprehensive community efforts the quality of care for Medicare beneficiaries who transition among care settings.

CMS said there's no magic number for ideal readmission rates. A recent *New England Journal of Medicine* article estimated that 10 percent of readmissions are planned.

QIOs Take Lead In Care Coordination

Medicare Quality Improvement Organizations (QIOs) in the states began work last year on the three-year projects aimed at improving readmission rates. These organizations are the Alabama Quality Assurance Foundation, the Louisiana Health Care Review and the Georgia Medical Care Foundation. These QIOs are independent organizations that contract with CMS to improve care. They are examining hospital and community systemwide interventions, interventions that target specific diseases or conditions and interventions that target specific reasons for admission.

Table 7-1: Locations of Cross-Setting Pilots By QIOs

Regions	Northeast	Midwest	Southeast	Southwest	Great Plains/ Rocky Mnts	West
Communities Targeted	Providence, R.I.	Western Pennsylvania	Metro Atlanta East	Harlingen, Texas	Omaha	Whatcom County, Wash.
	Upper Capitol Region, N.Y.	Evansville, Ind.	Miami		North West Denver	
	Southwestern New Jersey	Greater Lansing Area, Mich.	Tuscaloosa, Ala. Baton Rouge, La.			

Source: Centers for Medicare & Medicaid Services

By selecting just 14 QIOs for the pilot, CMS hoped to increase competition and help spur innovation among them. "CMS selected only those 14 QIOs that had the most promising and cost-effective propos-

als through a competitive procurement process," CMS spokesman Don McLeod said. "The local-level healthcare drivers in certain communities were not factors in our decisions. Since the Care Transitions communities are located in geographically diverse locations throughout the country, every community will have unique challenges to overcome."

Policymakers and industry observers attribute the high levels of readmissions to gaps in planning, communication breakdowns and delays in scheduling post-hospitalization care. In particular, they cite medication discrepancies, in which a patient who took a drug intravenously at the hospital needs to switch to an oral form when he returns home.

The federal government says this situation can be changed by focusing on quality from a communitywide perspective. By reducing fragmented care, officials hope to improve the process so patients, caregivers and providers can keep patients from returning unnecessarily to the hospital. Instead of a single solution, Care Transitions teams will look into their own regions to determine why hospital readmissions occur and how patients transition between settings.

Certain chronic conditions lend themselves to patients being rehospitalized. They include heart failure and chronic obstructive pulmonary disease, which are never truly cured and have predictable relapses.

Amy E. Boutwell, M.D., coprimary investigator at the State Action on Avoidable Rehospitalizations Initiative at the Institute for Healthcare Improvement, said part of the problem is fragmented care. "Rehospitalizations represent the highly fragmented nature of the healthcare delivery system that many of us already intuitively appreciate. So this is using data to highlight what many of us see as a real challenge in the healthcare system," Boutwell said.

Table 7-2: CMS Contract Represents New Direction For QIO Program

Projects that span the entire spectrum of the health care community	Focusing on quality improvement resources where they are needed the most	Addressing key priorities of healthcare quality, including identification and reduction of disparities across a continuum of care and across racial/ethnic, geographic, socioeconomic and demographic lines

Source: FMQAI

Boutwell said the core problem is the fee-for-service model in Medicare that compensates providers for proving a service instead of focusing on a systemic approach. Various models being tested, including the medical home model, are seeking to address this issue.

IHI has developed its own transitional care model for congestive heart failure patients. It has shown the ability to cut readmissions at an Iowa hospital. She recommends improving transitions of care from the hospital to home health or the nursing home. High-risk patients should receive enhanced services, including coaching, while patients and their families need to be engaged.

The issue has taken on new importance as Congress debates healthcare reform. Sens. Max Baucus and Charles Grassley, the chairman and ranking member of the Senate Finance Committee, respectively, have proposed changes in Medicare that would reward or penalize physicians, hospitals and nursing homes based on their quality of care. Among the proposals advanced by the senators is one that would provide extra money for doctors who hire nurses to manage follow-up care for Medicare patients after being discharged from the hospital for certain chronic diseases. Before any changes to reimbursements are made, the federal government is examining ways to improve readmission rates.

Community Assessment Is Part Of Alabama Model

The Alabama project, called PATH (Post Acute Transitions in Healthcare) is based in the Tuscaloosa Hospital Referral Region that includes Tuscaloosa, Bibb, Greene, Hale, Fayette, Lamar and Pickens counties

southwest of Birmingham. Except for Tuscaloosa, the communities are rural. Some are in the state's black belt—named for the rich, dark soil of the area—and historically poor and underserved.

The organization has a dual focus of working with communities and with providers. It is first assessing each community, trying to understand its dynamics. "We ask such things as: 'What is it like to be a patient in your community and who are your frequent re-admitters?'" said Dianne Richmond, PATH project manager.

Secondly, the program helps physicians and hospitals better understand what their patients need to know in order to manage their own health and avoid rehospitalization. "We want them to develop services that are a good fit and enable them to efficiently help patients manage their care," she said.

Alabama has a readmission rate of 19.5 percent. Because the pilot involves community assessment, the number of people it could touch cannot be accurately determined. There are about 42,000 Medicare beneficiaries in the pilot region.

PATH activities revolve primarily around hospitals but also include home health agencies and nursing homes. With the cooperation of facilities' medical staff, PATH identifies the processes involved in patient discharge, the internal management of patients, risk factors for readmission and the ways in which patients and providers relate to each other.

"We have a lot of interaction, such as group sessions at hospitals and nursing homes with all of us sitting down in a room and talking about transition of care, transfer patterns and how to excel at those service lines," Richmond said.

Louisiana And Georgia Use Care Transitions

To reduce unplanned readmissions, the Louisiana Health Care Review, the Georgia Medical Care Foundation and some of the other QIOs adopted a modified approach to the Care Transition Intervention, developed by Eric Coleman, M.D., and his colleges at the University of Colorado. Alabama is seeking partners in order to institute the program.

CTI pairs patients and caregivers with a transition coach. The coach helps when patients leave the hospital setting to go home, providing advice on how to manage their own care. During the coaching period, patients learn how to manage medicines, identify potential complications, use a personal health record, and seek early follow-up care from their primary-care physician.

LHCR already has high hopes for CTI based on preliminary results at seven Baton Rouge hospitals. The readmission rate was slightly above 18 percent when the program began there earlier this year. "In the first three months, we coached 70 patients and have only had three readmissions, which means the rate fell to 4 percent," said Bob Johannessen, a spokesman for LHCR.

In Baton Rouge, LHCR is putting the program in five hospitals, 26 nursing homes and 26 home health agencies, located in the East Baton Rouge and Ascension parishes. Of the nearly 10,000 yearly discharges in the area, LHCR expects about 600 patients to go through the program and be coached each year. The state has a readmission rate of 21.9 percent, according to CMS.

"We work with two key populations: the hospital and the patients," Johannessen said. "With the hospitals, we try to make sure the discharge process is as clean as possible, that patients get the right information and that they understand what is provided to them. The health coach serves as intermediary to make sure that happens. Secondly, we work directly with patients to make sure they understand the instructions given them. We focus on what to do when they get home, how to manage their medicines and who to call if they have a question."

He said discharge is a confusing and stressful time for patients and their families. "The things they're being told and the things they hear aren't necessarily the same," he said.

Georgia Pilot Employs Three Concepts

In Georgia, the pilot takes place in physician offices and hospice as well as hospitals, nursing homes and home health agencies. Like Louisiana, its conceptual foundation is Coleman's Care Transition Intervention, but it also employs a program led by GMCF in a previous contract called Home Health Acute Care Hospitalization Best Practices Interventions Package, which seeks to reduce acute-care hospitalizations. In addition, it follows guidelines from its own CMS-funded nursing home special study, "Reducing Avoidable Hospitalization of Nursing Home Residents."

The nursing home study examined factors contributing to avoidable hospitalizations among residents of Georgia nursing homes and outlined tests to reduce them. "An interdisciplinary team carried out the special study over an 18-month period [July 2006 through December 2007]," said Will Battles, a spokesman for GMCF.

In baseline, 77 percent of hospitalizations in three pilot nursing homes were rated as potentially avoidable, compared to 49 percent during the intervention.

The intervention centered on INTERACT communication tools developed as part of the project, said Battles. INTERACT was recently recognized by IHI as one of 15 promising interventions for reducing rehospitalizations.

Georgia's pilot centers on providers in Gwinnett, Newton and Rockdale counties and includes any Medicare patient under their care. Its goal is to implement interventions during the transition of one patient setting to another that measurably improve post acute care coordination, which will in turn reduce avoidable rehospitalization.

There are about 67,000 Medicare patients in the three-county area. In the year prior to the project, there were approximately 15,000 Medicare hospital discharges. The state's total Medicare hospital readmission rate is 19.1 percent, according to CMS.

Outlook

Avoidable hospital readmissions represent a drain on the healthcare system that not only drive up costs, but put seniors at risk. Through its demonstration project, CMS and its Quality Improvement Organizations can see what different regions are doing to reduce the fragmentation of care that seems to be at the core of the problem. Because similar problems are seen in the commercial insurance setting, improvements made concerning Medicare patients should benefit the entire healthcare sector. ■