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CMS Targets Hospital Readmissions as a Probable Marker for Poor Quality of Care, Wasted Revenues and Resources

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CMS is targeting readmissions to the hospital within 30 days of discharge as a probable marker for both poor quality of care and money going down the drain. While CMS weighs Medicare reimbursement cuts for readmissions, it also is investing in strategies to lower readmission rates. One CMS-funded study by the Medicare quality improvement organization (QIO) for Colorado found that coaching patients during and after their hospital stays can reduce readmissions by as much as 50%. And now CMS is funding as many as 18 QIO projects aimed at reducing readmissions in communities around the country.

"This is not primarily about people being rehospitalized because of mistakes made in the hospital," says Stephen Jencks, M.D., a former senior clinical adviser to CMS. "This is about making transitions effectively [to physicians, community resources or post-acute care]. This is about taking care of people with ongoing problems or chronic illnesses and frailty. When the transition is not done well, evidence suggests they wind up back in the hospital."

Almost 18% of Medicare patients are readmitted within 30 days of discharge, CMS said in the proposed inpatient prospective payment system (IPPS) rule for fiscal year 2009. Thirteen percent of the readmissions — $12 billion worth — were "potentially avoidable," the IPPS rule states. That's just the money part. Readmissions, CMS added, may be linked to poor quality of care.

CMS is seeking public comment on three proposals to take the financial reward out of readmissions: (1) direct adjustments to DRG payments for preventable readmissions, (2) adjustments to DRG payments through a performance-based payment methodology, and (3) public reporting of readmission rates, according to the IPPS rule.

Readmissions have already hit the Medicare program-integrity radar screen. For one thing, readmissions within 30 days recently were added to the list of Hospital Payment Monitoring Program (HPMP) risk areas. HPMP is CMS's main vehicle to reduce inpatient payment errors, but it's ending July 31 after nine years. However, CMS's other program-integrity contractors, including recovery audit contractors and zone program-integrity contractors, will continue hospital post-payment audits.

"Focusing on readmissions is a great way to tackle inappropriate use of hospital stays," maintains Jane Brock, M.D., medical officer for the Colorado Foundation for Medical Care, the QIO that did the study for CMS on reducing readmissions. She says readmissions are "the intersection of three things we care about: cost, quality and patient safety."

There are multiple reasons for readmissions. The way the system works, providers are paid for providing separate services, so care is often fragmented. Hospitals pay discharge planners, and home health agencies pay intake coordinators, "but no one makes sure the patient got from Point A to Point B," Brock says.

Also, a lot of patients aren't seen by physicians promptly after discharge, says Jencks, who is now a Baltimore-based consultant. The discharge planner may not make it clear to patients that they need to be seen right away (depending on their condition), and "many doctors' offices are not run in a very patient-friendly way," he says.

Another problem — "reconciling medications" — can ultimately land patients back in the hospital, Jencks says. They may be unclear about which medications they are supposed to resume taking, which to stop taking and which new ones to start taking. And "summaries from the hospital aren't going to the doctor fast enough to be useful in the immediate post-discharge period," he says. But there's no one at the hospital to call for help.

Jencks says that "there are two simple but important activities" hospitals can do unilaterally to help reduce the likelihood of Medicare readmissions. They are (1) establish an emergency call number at the hospital to help patients until their primary care physicians take over, and (2) make sure patients don't walk out the door until they have made a follow-up appointment (and if it's a patient with a significant chronic condition, the appointment must be within the first week after discharge).

Coaching Drives Rates Down

The Colorado Foundation for Medical Care cut the readmission rate significantly for patients in a special CMS-funded project, Brock says. The study used the "Care Transitions Intervention" model designed by Eric Coleman, M.D., of the University of Colorado Health Sciences Center, she says.

Coleman's model calls for a coach — a nurse who is at least an RN — to help patients transition back to the community and improve patient self-management. The coach visits the patient once in the hospital and once at home within 48 hours of discharge. The coach also calls the patient three times. Alicia Goroski, a project manager for the Colorado QIO, explains that the coach is not providing care. Instead, the coach is engaging the patient in his or her own recovery and self-management. "Patients, after all, are really the ones in charge of their daily care and must know how and be able to carry out the care plan," says Risa Hayes, a quality improvement coach at the Colorado QIO.

During the five contacts with the patient, the coach focuses on "four pillars": (1) medication self-management, (2) use of a patient-centered record (a user-friendly booklet for the patient to record a brief patient history, medications, allergies, immediate health goals and questions for the doctor), (3) follow-up with primary care physicians and specialists, and (4) knowledge of red flags - signs that the patient's condition is getting worse and how to respond.

"The majority of the home visit is spent on medication discrepancies," Goroski says. Usually when patients get home, they have a lot of questions. Do I still take my old medications? Are the new medications a different version of ones I already take? Am I not supposed to take this one, or did they just forget to put it on the list? "The coach has the patient gather all their medications, prescriptions and the hospital discharge summary. The coach 'quizzes' the patient on each medication, sorts out the duplicates and discrepancies and has them call their primary care physician" to get definitive answers, Hayes says. Most of the coaching is completed in fewer than 28 days after discharge.

Each coach worked with a patient for an average of four weeks to "test the feasibility of the intervention," Goroski says.

The Colorado QIO applied Coleman's model to 248 patients in one Denver-area "community," she says. A community was defined as at least one hospital, one home health agency, one skilled nursing facility (SNF) or rehabilitation facility and one physician office. "We wanted to get all those entities to work together because so many of these patients cycle through all four of those settings," she says.

The results were impressive:

- ***14 days after discharge:*** 8% of coached patients were readmitted, compared with 17% of uncoached patients.
- ***30 days after discharge:*** 13% of coached patients were readmitted, compared with 20% of uncoached patients.
- ***60 days after discharge:*** 15% of coached patients were readmitted, compared with 29% of uncoached patients.

"That means at two months following discharge, coached patients were half as likely to have been readmitted as the uncoached patients," Brock says. The reason the results are so striking is that CMS is requiring QIOs that implement Care Transitions projects over the next three years to achieve only a 2% reduction in the readmission rate (as long as it's statistically significant). Even a 2% cut in readmissions would save Medicare millions, but obviously greater reductions are achievable. However, at the time the QIO projects were put out to bid, the Colorado QIO did not yet know the results of its coaching study.

CMS will be funding up to 18 Care Transitions projects to reduce readmissions around the country in the QIOs' ninth Scope of Work (its next set of contracts), which starts Aug. 1. QIOs can try different approaches to reduce readmissions, as the coaching method is not mandated.