I’ll See You Again in 30 Days

Dear Dr. Jeff:

Our leadership team has been asked to “fix” our facility’s reported 30-day rehospitalization rate. It seems that everyone from the Center for Medicare & Medicaid to our local hospital is tracking this as a measure of quality. Isn’t this really a measure of the quality of care the patient received in the hospital? Wouldn’t a sick patient who is getting worse go back to a hospital? Is this really just an exercise in gaming the system?

Dr. Jeff responds:

The initial impetus to record hospital readmissions was the direct result of financial concerns. After the Diagnosis Related Group (DRG) hospital reimbursement system stimulated the movement to discharge patients “quicker and sicker,” and average length of stay numbers were retranslated as maximum length of stay criteria. Insurers and particularly Medicare became concerned that they were essentially paying twice for the same hospitalization when patients were quickly readmitted. The arbitrary guideline of 30 days after discharge was adopted as a measure of whether a hospitalization was inappropriately terminated before the patient was adequately stabilized and a safe discharge plan was in place.

Eventually, modest hospital payment penalties were implemented for readmissions for congestive heart failure DRGs, and these were expanded to other disease categories. Although the penalties are small enough for many hospitals to conclude that it is cheaper to simply accept the penalty than spend the money to change systems, many would prefer to avoid the penalties, particularly when the work and cost falls largely on others.

DEAR DR. JEFF

Jeffrey Nichols, MD, CMD

Five-Star Upgrade

Beginning this month, CMS has added measures regarding readmissions to the Five-Star quality rating system for skilled nursing facilities. They also include admissions to observation stays with full hospital admissions in their calculations. Measures will include 30-day and 100-day rates of return to the hospital as well as non-hospice deaths. Separately, they also include a quality measure that calculates referrals within 30 days of a Part A visit to an ED when that referral does not lead to a hospitalization (if it does produce a hospitalization or observation stay, then it is included in the first category). Although it is asserted that planned hospital returns will be excluded from the calculations, given that the sole data source is Medicare claims, it is questionable whether this will truly occur. Scores will be risk adjusted, but the exact method by which Medicare will calculate this is unclear, particularly as the specifics of risk for hospital readmission are not well established. The numbers will be generated from 6-month rolling data with a collection period that started in April. Although quality measures in general play a comparatively small part in the Five-Star calculations, they will be available on the Nursing Home Compare website for review. Financial penalties will follow in the future.

It is hard to argue that an episode of care that includes a patient being rapidly readmitted to the hospital for the same diagnosis represents high-quality care. Nevertheless, almost a quarter of all referrals to nursing homes for post-acute care lead to readmission within 30 days, despite the penalties. New bundled payment mechanisms—which are being implemented initially for lower extremity joint replacements with scheduled expansion to other diagnoses—will expand that window from 30 days to 90 days for readmissions related directly to the initial admission, indicating a more realistic view of a single episode of illness. Indeed, if we look at the management of highly prevalent chronic diseases such as chronic obstructive pulmonary disease, congestive heart failure, or diabetes mellitus, community management that produced outcomes with even two or three hospitalizations per year still suggests inadequate care, even if they don’t raise any red flags.

Current Path of Care

The current standard of care for acutely ill frail patients begins with a brief hospitalization, usually under the care of a hospitalist who specializes in the management of acute illness but who has never seen this particular patient before and who does not expect to see the patient again or manage any condition other than the presenting problem. Hospitalists have been associated with shorter lengths of stay and lower costs than community physicians. After discharge, patients may go to the SNF, be discharged with referral to a certified home health agency (CHHA), or simply go home with prescriptions and a plan for follow-up with a community practitioner. Referral to a nursing home-based program, again often under the care of practitioners who generally have no prior connection to the patient, has been typical for patients who require further complex nursing services—including intravenous therapy or wound care—or who require extensive rehabilitation. Interestingly, national statistics for CHHAs indicate that despite the likelihood that their referred patients are more stable than those referred to nursing homes, their 30-day readmission rates are even higher than those of SNFs. This occurs, at least in part, because the hospitalist has terminated their care while the community physicians may be unaware of the details of the hospital stay—indeed, often unaware that their patient was even hospitalized—and are often reluctant to manage problems associated with immediate post-discharge management.

Coping with patients on multiple antibiotics admitted late Friday night directly from a hospital ICU is at higher risk to return to the hospital than a relatively healthy senior who has undergone an elective joint replacement. Because currently reported rates are not risk adjusted, your measured readmission rate may appear very good or very bad regardless of any actions by the facility, due to your particular case mix. However, the trends of a changing medical system, accelerating with bundled payments, will direct more high-risk patients into nursing home post-acute units and direct more stable orthopedics patients into modified intensive home care regimens.

Silver Lining

Despite the automatic temptation to see all these changes as another manifestation of the world going to hell in a handbasket, there are actually many positives. First, despite the many limitations of nursing home care, there is currently no better place for a sick elderly patient than the SNF. The mandatory Minimum Data Set assessments and requirements for patient-centered care planning is more comprehensive and geriatric-friendly than the hospital setting, even in hospitals that feature acute care of the elderly units or geriatric emergency departments. Cognitive assessments, depression screening, functional measures, drug regimen reviews, and involvement of the resident and family in care planning are universal in SNFs.

The time allowed in a Medicare A stay is more suitable for the “start low, go slow” medication model than the rushed hospital stay. The nurses, rehabilitation specialists, dietary staff, and social workers in the nursing home are typically much more skilled and experienced in the special needs of frail seniors than hospital staff. Foley catheters are usually removed. Unnecessary medications should be discontinued or tapered off. Even when patients eventually transition back to their community-based primary care provider, care needs should not simply be deferred; collaboration in care is certainly advisable. Facility access to the hospital’s electronic health record can help physicians to assess the appropriateness of current interventions and unmet resident needs.

Of course, patients who need to go to the hospital should go. Although focusing on the exact number of days that a patient has been out of the hospital and delaying a needed readmission would be gaming the system, minimizing medical complications, evaluating gaps in patient care, and preventing patients from bouncing back and forth through different institutions reflects higher quality care that we should all aspire to.

Dr. Nichols is president of the New York Medical Directors Association and a member of the Caring for the Ages Editorial Advisory Board.