Hospitals told to reduce patient readmissions or lose money

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Nurse Marge McDermott, right, explains to Patricia Miller, left, how her vital signs will be monitored remotely. Hospitals are bolstering efforts to educate patients about their discharge care and follow up after they leave the hospital. McDermott is with St. Joseph Home Health's remote monitoring program. The program allows McDermott to monitor Miller's vitals and be alerted of irregularities.

ANA VENEGAS, STAFF PHOTOGRAPHER

Medicare will dock payments this year for 15 hospitals in Orange County, and more than 200 throughout California, in hopes of spurring them to reduce the number of patients who are re-hospitalized too quickly.

Government and commercial insurers view lower readmissions as a sign of higher-quality care and greater cost consciousness by hospitals.

The pay cuts, coming under Obamacare, are among the many factors motivating hospitals to spend more time educating patients about their illnesses and partnering with outside caregivers to ensure that treatment doesn't stop after discharge.

The move coincides with broader changes afoot in the industry, as payments from government and commercial insurers are based increasingly on medical outcomes rather than the volume of services provided. Under increasing pressure from more empty beds and lower revenues, hospitals are pondering new models that rely less on traditional inpatient business.

For patients, especially people with serious diseases, the new thrust means closer monitoring while they are in the hospital and a more seamless transition to follow-up care after they leave. In many cases, it also affords them a host of support services to ensure they are following their post-discharge marching orders and getting the medical attention they need.

The penalties, levied on hospitals that readmit too many patients within a month of their discharge, come in the form of reductions in Medicare payments for inpatient care.

Many hospital executives, however, say Medicare's formula for setting the penalties is not entirely fair. And some doctors warn that discouraging readmissions is not always the best thing for patients.

“There are things we don't control, and we certainly don't control patient behavior either,” says Nancy Pratt, chief quality and patient safety officer for St. Joseph Health System, which operates St. Jude Medical Center in Fullerton, St. Joseph Hospital in Orange and Mission Hospital in Mission Viejo and Laguna Beach.

“You could do everything right and still end up having a patient readmitted.”

The Medicare payment cuts seem small – just $227 million nationwide – but hospital operators and industry analysts say they are yet one more squeeze on revenues in a new world of declining reimbursements. And money aside, hospitals must pay attention to their reputations.

“The bottom line is no hospitals want to have on their records that they have a number of violations or penalties,” says Jim Lott, a former senior executive with the Hospital Association of Southern California who now consults with hospitals on improving post-discharge care and reducing readmissions. “You can charge them $100,000; you can charge them $5,000. It's more important that you not have any negative hits on your record, because that's what messes with you in the marketplace.”

In Orange County, the average Medicare penalty assessed this year is a 0.11 percent payment cut, unchanged from last year. The penalties range from 0.62 percent for Fountain Valley Regional Hospital to 0.01 percent for Hoag Memorial Presbyterian, Garden Grove Hospital and West Anaheim Medical Center. Eight Orange County hospitals have no penalties.

Hospitals getting payment cuts can lose anywhere from hundreds of thousands of dollars – as is the case with Fountain Valley – to only a few thousand. Orange County hospitals were penalized more heavily than their counterparts across the state. For all of California, the average Medicare payment cut for excess readmissions is 0.07 percent, also unchanged from last year.

Medicare inpatient payments to California hospitals totaled $13.4 billion in 2012, the most recent year for which data are available. Nationwide, the total was nearly $140 billion.

This year, the maximum readmissions fine on any hospital is 2 percent, up from 1 percent in 2013, the first year of the penalty program. It maxes out at 3 percent next year. Eighteen hospitals in the U.S. got the maximum penalty this year, none in California. The highest penalty in the state was 1.33 percent, levied against the state-run Porterville Development Center in Tulare County.

SAVING MONEY

About 12 percent of Medicare patients readmitted to the hospital may not need to be, according to a study by the Medicare Payment Advisory Commission, a congressional agency. Reducing these preventable readmissions by 10 percent could save Medicare $1 billion annually, the report found.

Although Medicare tracks readmissions for all causes, it is penalizing hospitals this year for only three types of cases: pneumonia, heart attack and heart failure. It has recently added two more – chronic obstructive pulmonary disorder and hip and joint replacements – for which excess readmissions will be factored into penalties next year.

For the most part, hospitals seem resigned to the payment reduction program, but they are not happy about it. They say it punishes them for factors beyond their control and hits hospitals serving the poor the hardest. Some argue that the stick approach creates an environment of fear and anxiety that is not conducive to the kind of communication needed to avoid errors and optimize care.

“Fundamentally, the penalties can have a very chilling effect,” says Julianne Morath, president and CEO of the Hospital Quality Institute, which was founded by the California Hospital Association and its regional affiliates. “If there isn't an environment of trust and safety, people don't speak up and learn. And if you don't learn, you can't predict, and if you can't predict, you can't prevent.”

Morath and many others argue that one of the biggest flaws in Medicare's penalty system is that if a patient is readmitted within 30 days to any hospital, for any reason – even one totally unrelated to the original diagnosis – it still counts against the hospital that first admitted him.

Pratt, the St. Joseph quality control officer, noted that it may be particularly difficult to control patients' health behavior in lower-income communities where resources and in-home support can often be lacking. None of St. Joseph's Orange County hospitals were penalized for excess readmissions, but its St. Mary Medical Center in Apple Valley will have to forgo 0.61 percent of its Medicare inpatient payments this year.

“The high desert is socio-economically different than Orange County, and to the extent that influences people's health-seeking behavior, that's one of the factors at work,” Pratt says.

Medicare has recognized that hospitals serving a high proportion of low-income people tend to suffer larger payment cuts because of high readmission rates. According to an analysis by the Register, such hospitals are about 25 percent more likely to be penalized.

Even those who highlight problems with the penalty program, however, laud it for inducing hospitals to work more closely – and in some cases for the first time – with outside doctors, nursing homes, home caregivers and families to ensure that discharged patients take their medications, eat the right foods and show up for follow-up appointments with their physicians. All of those factors are good predictors of whether a patient will avoid a return trip to the hospital.

“Trying to make sure this handoff between inpatient hospitalist … and the outpatient physician is seamless has some positive reward even unrelated to readmissions,” says Dhruv Kazi, an assistant adjunct professor in the division of cardiology at UC San Francisco. “The focus on patient education, transition of care, and medication reconciliation – all of these are good for their own sake.”

HIGH-RISK PATIENTS

Most hospital quality experts agree that the key to reducing unwanted readmissions is to monitor high-risk patients while they are in the hospital, make sure they or a family member understands every detail of their post-discharge orders, and then follow up after they leave to make sure they are sticking to the plan.

Patients at the highest risk for being readmitted are the ones who have multiple chronic diseases and take eight or more medications, says Giovanni Corzo, a vice president of Anaheim-based SeniorServ, part of a Medicare-funded demonstration project to reduce hospital readmissions.

It is partnering with four Orange County hospitals – UC Irvine Medical Center, Western Medical Center Santa Ana, Anaheim Regional Medical Center and St. Jude – to address some of the common problems that can drive readmissions higher.

SeniorServ employs social workers – and will soon hire nurses as well – to make home visits and connect discharged patients with services that include home-delivered meals and transportation to doctor appointments. Readmission rates for the four participating hospitals, which were around 20 percent, have been reduced to just 6 percent, Corzo says.

Other hospitals are conducting similar efforts to reduce readmissions.

At Saddleback Memorial, nurses make home visits to monitor patients and partner with their doctors to make sure appointments are being kept, says Helen Macfie, an executive at MemorialCare Health System responsible for overseeing readmission reduction efforts.

Tenet Healthcare, which operates three Orange County hospitals, instituted a readmission reduction program in 2009, well before Medicare started levying penalties, says Susan Morales, spokeswoman for Los Alamitos Medical Center, one of the chain's hospitals. The program includes

the same kind of pre-discharge preparation and patient education, followed by monitoring after the patients leave the hospital.

Fountain Valley Regional, also a Tenet hospital, declined to comment, saying the comments from Morales held true for it too.

Hospital executives and analysts say the readmission penalties alone are too small to explain why many hospitals are devoting so much time and effort to keeping their discharged patients from returning. After all, having fewer patients in their beds is a bigger drain on revenues than the penalties. Rather, hospitals are being pulled along by a confluence of factors that all move in the direction of providing more care at home, in doctors' offices, assisted living and nursing facilities.

In addition to the Medicare penalties, commercial insurersare increasingly insisting on contracts that pay hospitals based on performance rather than the volume of services they provide.

“Reducing readmissions reduces revenue, because the patient is not in the bed. But that's just the reality, because revenues could be reduced by even more if they are squeezed out of managed care networks,” says Sheryl R. Skolnick, a longtime hospital industry analyst who is a managing director of CRT Capital Group in Stamford, Conn.

If the jury is still out on whether the Medicare penalties will reduce hospital readmissions, there is also no verdict on whether reducing them is an entirely desirable goal in and of itself.

Heart failure patients who are readmitted “are often the most frail patients, for whom that readmission is their shot at staying alive,” says Kazi, the UCSF cardiologist. “So what do heart failure readmissions really mean for patients? It is still unclear.”

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