CMS Motivated to Reduce Costly Hospital Readmissions…Are Programs and Penalties Working?

The Centers for Medicare and Medicaid Services (CMS) has estimated tha almost one-fifth of Medicare patients admitted to hospitals return within 30 days. These hospital readmissions cost the govern over $26 billion each year, and some of them are due to mismanaged transitions from home to hospital.

The Hospital Readmissions Reduction Program (HRRP) went into effect on October 1, 2012 and requires CMS to reduce payments to certain hospitals with "excess readmissions." Therefore, federal health officials now impose penalties on hospital high rates of Medicare readmissions for the same medical episode.

However, the measures to improve post-discharge patient well-being at home (thereby preventing another trip to the hospital) stop at the punitive variety. The government has also begun sponsoring pilot projects that send medical professionals (like nu and social workers, for instance) into patients' homes after discharge to assess how patients are doing and offer assistance.

The elderly are especially vulnerable to gaps in hospital-to-home transitions

A discharge from the hospital may seem like a cause for celebration and relief, but it can be the beginning of heightened healt woes for many.

Typically, discharge instructions are given relatively quickly and all at once, as the patient is about to depart. And even for tho sincerely paying attention, the information can be overwhelming to digest. Add to that the issue of someone suffering from dementia or confusion and without family support, and you have a situation where there's a likelihood that the patient will forg take medications, perhaps take the wrong one, or encounter other medical problems that could have been prevented with pro education or assistance.

"You are trying to reach them and do that education at such a critical time," says Joe Parker, lead nurse of care transitions at Palomar Health in San Diego, "but they are nowhere near cognitively ready to receive that. And we don't have the luxury of ti wait."

The University of Colorado has established a program that monitors patients for a month following their discharge from the hospital, attending to various needs like helping schedule medical appointments, properly manage their prescriptions, and understand what potential signs of trouble might look like so they can be proactive and head it off.

San Diego County is the recipient of a federal grant to create smoother, successful patient transitions from home to hospital a has adapted the Colorado program in the process of creating their own. The county's Aging and Independence Services ager joined efforts with four hospital systems (Palomar Health, Scripps Health, Sharp HealthCare, and University of California, San Diego) to offer care to over 50,000 Medicare beneficiaries representing a particularly high risk of health problems following ho discharge.

Hospital spokespersons and San Diego County have stated that social service agencies and hospitals have heretofore functioned as disconnected entities when it came to individuals under their purview. The San Diego program is intended to bridge that gap.

Cecile Davis, coordinator of the remote patient monitoring for Sharp HealthCare, says, “There is a point where the hospital can’t do any more” (for discharged patients). “The key is to know when to turn them over to the community.”

CMS saved millions in San Diego County alone since programs and penalties established

Insiders note that both the penalties and the programs are beginning to yield measurable results nationwide. For instance, the San Diego County program saved Medicare approximately $13.8 million between 2013 and 2015, the bulk of that attributable to decreased hospital readmissions.

Despite the encouraging news, experts point out that there is a great deal of work to be done.

Mary Naylor is a gerontology professor at the University of Pennsylvania School of Nursing. She also designed a hospital-to-home transitions model to ameliorate gaps-in-care issues.

Naylor worries about the month-long-monitor mindset built into the typical aftercare programs. “It’s not just thinking about today or tomorrow or the next 30 days,” she says. “For chronically ill, older people, what is their long-term trajectory?”

Although the San Diego County program and others of its kind offer services where there were none before—and therefore are inarguably a good thing—they don’t represent a comprehensive blanket of care. These programs assist only a segment of Medicare enrollees (participating hospitals determine which patients will be involved in the program prior to their discharge), and individuals are not eligible for services during stays in nursing homes.

Carol Castillon manages the care transitions program for San Diego County. She says that the overarching question nurses and social workers need to ask themselves when assessing a discharged patient’s particular needs is: “What are the long-term services we can bring in so that this person isn’t coming back to the hospital?”

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