IMPLEMENTING HEALTH REFORM

Community Based Care Transitions Program

Reducing preventable hospital readmissions is one goal of last year's health reform effort.

The Affordable Care Act tests ways to bring readmissions down, including a new Medicare pilot project called the Community Based Care Transitions Program. The 5-year pilot, which began earlier this year, offers funding to hospitals and community-based organizations that partner to provide transition care services to Medicare patients who are at high risk for readmission.

Medicare officials have said that they expect hospitals will work with their community partners to begin transition services within 24 hours prior to discharge, provide culturally and linguistically appropriate post-discharge education, provide medication review and management, and offer self-management support for patients. Congress has provided $500 million to fund the program over 5 years.

Dr. Janet M. Nagamine, a hospitalist in Santa Clara, Calif., and a patient safety expert, explained the challenges associated with reducing hospital readmissions.

CLINICAL ENDOCRINOLOGY NEWS: What are the challenges in reducing hospital readmissions?

Dr. Nagamine: We have to keep in mind that the length of stay has decreased dramatically while the acuity has increased dramatically. We need to recognize and separate those readmissions that are preventable versus those that are not.

If you look back over the last 30 years, our length of stay is less than half of what it used to be. That means that for patients older than 65 years, they used to be in the hospital an average of 12.6 days. Now they are in the hospital for about 5.5 days. The challenge is to figure out why some patients come back. I believe that there are some things we can't affect that much. For example, many elderly patients with end-stage chronic conditions are likely to be readmitted. But there is also evidence that only about half of the patients who leave the hospital have followed up with their primary care physician within 30 days of discharge.

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DR. NAGAMINE

That speaks to an opportunity that we can address. Too often people get fixated on readmission numbers, but you've got to look at the context, make sure you're focusing on preventable readmissions, and apply specific targeted interventions.

We also need to look at reengineering the discharge process. Even though length of stay has been reduced, we haven't really changed the way that we discharge patients. We walk in and we write an order in the morning that says discharge home and then there's a flurry of activity.

We're starting to do things in a more stepwise fashion, planning for discharge from the day patients come in. Reengineering the discharge process will involve everyone in the hospital as well as across the continuum of care.

CEN: Is there a danger in focusing on readmissions? What factors need to be considered to ensure that hospitals that treat the sickest patients aren't labeled as ineffective?

Dr. Nagamine: That's where risk adjustment is really important. You've got to compare apples to apples. Some tertiary care centers see a lot of complex, sick patients, a very different population from the typical community hospital.

CEN: Congress has appropriated $500 million to fund this program over 5 years. Is that enough?

Dr. Nagamine: I am not a health economist, but I think of this program as providing seed money to get things rolling. I doubt that it would be enough to accomplish everything, but it would be seed money to start moving in that direction.

CEN: The Affordable Care Act also tests bundled payments and withholding payment to hospitals that fail to reduce readmissions. What do you see as the best way to change payment policy to encourage a reduction in readmissions?

Dr. Nagamine: Payers need to create an incentive for the right behaviors. For example, in reducing readmissions, physicians spend a lot of time in care coordination and education. Those things aren't compensated, thus those things really aren't happening as well as they should be.

CEN: Hospitals can't reduce readmissions on their own. What do you see as the ideal partnership between hospital-based physicians and community-based primary care physicians? How far away are we from that ideal collaboration?

Dr. Nagamine: I think we're a lot further away from that ideal than we would like to be. We need to create better linkages. Depending on the work setting, there are many challenges and barriers to getting in touch with primary care physicians.

In large metropolitan areas with many hospitals, simply finding and connecting with the right physician can be a real barrier. The second barrier is making the follow-up appointments. You want to make sure that your patient is seen in a timely fashion and that the primary care physician has the discharge summary with pertinent details of the hospital stay as well as specific follow-up that is needed. Believe it or not, those things, which in the age of cell phones and all this technology should be easy, aren't.

There are folks looking into electronic transfer of information and that's helping. But right now, we have a hodgepodge of different systems in various hospitals and medical clinics. Until we can get consistent transfer of information, we won't be doing as well as we should. Sometimes the primary care physicians don't even know their patient was admitted to the hospital when they see them in their office for a post-hospital visit. That's unacceptable. ■

DR. NAGAMINE *is a hospitalist at Kaiser Permanente Hospital in Santa Clara, Calif., and a past chair of the Society of Hospital Medicine's Quality and Patient Safety Committee. She is also the chair of the California BOOST Collaborative, which aims to reduce readmissions by improving the hospital discharge process.*

Interest Builds for Primary Care Residencies

BY MARY ELLEN SCHNEIDER

FROM THE NATIONAL RESIDENT MATCHING PROGRAM

For the second year in a row, more U.S. medical students are choosing careers in primary care, according to this year's National Resident Matching Program data.

The number of U.S. medical school seniors choosing family medicine rose by 11% over last year. Overall, 2,708 family medicine residency positions were offered this year. Of those, 94.4% were filled, with 48% filled by U.S. medical graduates. This is the highest ever overall fill rate for the specialty, according to the American Academy of Family Physicians.

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More U.S. medical school seniors also matched to internal medicine residencies, with the overall fill rate remaining roughly the same as in 2010.

Overall, 5,121 internal medicine positions were offered in 2011. Of those, 98.9% were filled, with 57.4% of the slots being taken by U.S. medical graduates. In 2010, 54.5% of the 4,999 positions offered were filled by U.S. medical graduates.

In pediatrics, interest by U.S. medical students rose about 3% from 2010. This year, 98.2% of the total 2,482 positions offered were filled. U.S. medical graduates filled 71.2% of the pediatric positions in 2011.

Leaders in primary care said the growing interest by medical students is likely due to the increased attention to primary care and the importance being placed on it, in part due to last year's passage of the Affordable Care Act.

Dr. Steven E. Weinberger, executive vice president and CEO of the American College of Physicians, said students may be drawn to the idea of coordinating care and being the principal source of care for patients.

"Whenever an area of health careers is more important to the future, it's going to resonate with student choice," said Dr. Roland A. Goertz, who is president of the American Academy of Family Physicians.

Emergency medicine, anesthesiology, and neurology were also more popular among U.S. medical graduates in this year's match. For example, of the 266 PGY-1 positions that were offered in neurology in 2011, 59.8% went to U.S. medical graduates. This is up from 49.6% last year, when 228 positions were offered.

This year's residency match offered more first- and second-year positions than in 2010. Overall, there were 638 more residency slots available. Of the first-year positions offered, more than 95% were filled. ■

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