

Educating patients a fix, but it lacks cash carrot

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All it took was a bathroom scale, a pill organizer and a home visit from a nurse.

Those were the weapons Washington Hospital used to combat a sharp rise in readmission rates for patients with congestive heart failure.

Funded with an initial \$70,000 grant, a nurse traveled to patients' homes and armed them — with knowledge. She gave them a \$22 digital scale with large numbers and this advice: a sudden gain of three pounds in a day is a warning flag they shouldn't ignore.

The seven-year program was a hit. Readmissions among patients treated for congestive heart failure fell to 2.4 percent from 21 percent, said Pamela Cummings, director of case management at the hospital. But a little over a year ago, the program ended because it couldn't get money for the nurse, the scales, or the \$8 heart care books handed to patients and their families.

"It makes me sad," Cummings said. "I felt like we were doing a good thing for patients."

Hospital charges for readmissions totaled more than \$1.25 billion statewide in 2009. A Tribune-Review investigation found some readmissions could be avoided with inexpensive solutions, but hospitals have little financial incentive to address the problem.

"You're potentially giving up money by giving up readmissions," said Michael Chernew, a professor of health care policy at Harvard Medical School in Boston. "It's like going to the insurers and saying, 'Please give me less money.' "

Dr. John J. Reilly, vice chair of clinical affairs at the University of Pittsburgh School of Medicine, agreed: "You're asking the hospital to make the investment to do this and the result is they get fewer admissions. ... It doesn't set a hospital president's heart aflutter."

Reilly and Dr. Rene Alvarez, a cardiologist at the University of Pittsburgh Medical Center's Cardiovascular Institute, said their career experience is that hospitals lack the desire to address the problem of readmissions because it costs them money.

Hospital administrators said cutting readmissions is a complex proposition that entails more than support of one program, regardless of its cost. They argued many patients who are readmitted often are elderly and very sick, with debilitating illnesses such as diabetes, asthma and heart failure.

Such illnesses often require patients to see more than one doctor and take several medications. All too often, the patients end up back at a hospital because they don't follow instructions — or maybe didn't understand them or even get any — and develop side effects from medicine and complications such as pneumonia.

"There's no silver bullet," said Tami Minnier, chief quality officer for University of Pittsburgh Medical Center, where combined readmissions at UPMC Presbyterian and UPMC Shadyside lead all hospitals in the state. "You have to understand the problem, understand the solution and almost tailor it to the patient."

DABBLING IN SOLUTIONS

Officials at UPMC, a nonprofit whose operating revenue grew to a record \$8 billion in 2010, would not say how much it is paid to treat readmissions. In one pilot program created to address readmissions, UPMC officials zeroed in on patients with congestive heart failure — an illness with a national readmission rate of 18 percent.

Patients in one unit at Presby received improved discharge instructions in a specially made binder and a call from a nurse within 24 hours of leaving to check how they were doing. Officials recorded 11 readmissions between July 1, 2010, and Feb. 9, 2011, compared with a baseline of 94 readmissions in 2010.

However successful, Minnier said it might not be easy to replicate these programs across UPMC's network of 20 hospitals. The cost of a nurse to educate patients is about \$60,000, she said, and UPMC would have to hire more than one.

Instead, UPMC is putting an undisclosed amount of money into a plan to create a nurse avatar — a computer-generated nurse that would provide patients with discharge instructions.

"Even if the avatar cost a quarter-million dollars, it's a one-time expense," Minnier said. "If you hire five nurses, that's \$300,000 a year times five years; that's \$1.5 million. (The avatar) will work 24 hours a day, seven days a week without costing as much."

UPMC's attempts to address readmissions grew from a program started at UPMC St. Margaret, near Aspinwall. There, a solution to keep patients with pulmonary disease from returning to the hospital focused in part on teaching patients how to use inhalers — a handheld, often easy-to-use gadget that opens airways, reduces irritation and stops shortness of breath.

Administrators said patients were discharged not knowing how to use the instruments. Many wound up coughing, gasping for air and needing hospital care. The hospital wouldn't give specific readmission numbers.

They hired Isabel MacKinney-Smith, a registered nurse with vast home care experience, to sit down with the patients to figure out what they were doing wrong and how to correct it. MacKinney-Smith met with patients before their discharge and, a few days later, drove to their homes for hourlong visits.

She found one woman put medicine in the wrong part of the nebulizer, a machine that delivers medicine to the lungs, and got no medicine at all. Another failed to press and release a button on the inhaler to pierce a capsule and release the medication.

The education emphasis worked. Over a two-year period that ended in November, MacKinney-Smith said educational visits to 450 patients cut readmissions among pulmonary disease patients by 38 percent.

"If there's a way to stay out of the hospital, I'll take it," said William Patton, 74, a Plum retiree who was admitted to UPMC St. Margaret over Christmas after becoming short of breath. When he was discharged with a diagnosis of pulmonary disease, he received a home visit from MacKinney-Smith. He was not readmitted. "In the hospital, it's rough," Patton said. "I try to disassociate myself from the hospital as much as I can. I only like a hospital if you really need it."

According to the Pennsylvania Health Care Cost Containment Council, UPMC St. Margaret charged an average of \$55,062 for each readmission for chronic obstructive pulmonary disease in 2009. With 24 cases that year, the charges topped \$1.3 million.

MacKinney-Smith said she doesn't know how much the program cost the hospital in lost readmissions.

"The cost savings is kind of a secondary thing," she said. "We're improving patients' quality of life, their health status, and how you put that into dollars I don't know."

Doctors, hospital administrators and even insurers who pay the bills said they've analyzed the financial implications of readmissions, but refused requests by the Tribune-Review to share details.

"It would be complicated to figure out what the cost is," said Dr. Thomas McClure, chief accountable care officer at West Penn Allegheny Health System, which lost \$89.9 million in fiscal year 2010.

McClure, whose job involves improving communication among doctors to cut costs, cited national studies showing a significant number of patients are discharged from hospitals unaware of key information about their diagnoses and follow-up care. The Mayo Clinic in 2005 published a study showing 62 percent of discharged patients could not explain the purpose of their medications and 58 percent did not know their diagnoses.

But McClure said hospitals haven't had money to fix the problems, whether it's readmissions or other issues driving up prices.

"Everybody is saying, 'How do we pay for all this?'" he said. "You've cut us, cut us, cut us, as far as reimbursements. ... Now you're asking for us to do more."

INCENTIVES TO CHANGE

Hospital officials could get help in the form of incentives. Highmark Inc., which insures about 3 million in Western Pennsylvania, began monitoring readmissions at 32 hospitals six months ago. Those that curb readmissions could receive extra payments between 1 percent and 4 percent of their total contract with the insurer through its QualityBlue program, said Dr. Carey Vinson, vice president for quality and medical performance management.

Vinson said Highmark doesn't know its cost of unnecessary readmissions or whether potential savings could be passed to people who carry Highmark insurance.

"This isn't related to premium reduction," he said. "It's related to improved care."

Motivated by Highmark's program, West Penn Allegheny Health System established teams that monitor patients readmitted within the system's six hospitals.

"We don't have this impression that we can prevent 100 percent of readmissions, and I don't think we can ever get there," said Diane Frndak, West Penn Allegheny vice president of organizational excellence.

"We're trying to focus on the right care for the patient. If the right care is a readmission, then that's what needs to happen. Is every readmission a failure? No."

Another big incentive for hospitals to look at readmissions is a change in Medicare and Medicaid programs starting next year that will make hospitals responsible for the cost of dealing with many readmissions.

Dr. Keith Kanel, chief medical officer at the **Pittsburgh Regional Healthcare Initiative**, a consortium of medical, business and civic leaders looking to cut waste and improve quality in health care, said he doesn't believe hospital administrators would deliberately cancel a readmissions project to preserve revenue. Instead, he said, they simply move the project down on the list of priorities.

"We've heard hospital administrators say, 'We will change our ways the day the law changes,' " he said. "It's understandable, but it's not acceptable because we understand how much patient carnage they will have between now and the day the law is enacted."

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