

## Rehospitalizations among Patients in the Medicare Fee-for-Service Program

**TO THE EDITOR:** In the special article on rehospitalizations among patients in Medicare fee-for-service programs, Jencks et al. (April 2 issue)<sup>1</sup> conclude that rehospitalizations among Medicare beneficiaries are prevalent and costly.

In the recent report, mentioned in the article by Jencks et al., of the lack of benefit of coordination of care in the Medicare demonstration projects, the coordination of care consisted primarily of monitoring the patient by telephone and of providing patient education.<sup>2</sup> Although this type of disease management might be helpful for elderly people who can direct their own care, it is not surprising that it would be ineffective in a population of elderly people with multiple serious chronic illnesses and activity limitations. Counsell et al.<sup>3</sup> found that the rate of emergency department visits and hospital admissions decreased among frail, high-risk elderly patients who received geriatric care management services.

An integrated program that provides safe transitions from acute care settings with the use of “hands-on” care management in the home can allow people with complex chronic illnesses and functional deficits to remain in the community with much less need for acute care and with an improved quality of care.

Eric C. Rackow, M.D.

SeniorBridge  
New York, NY 10022  
erackow@seniorbridge.com

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2. Peikes D, Chen A, Schore J, Brown R. Effects of care coordination on hospitalizations, quality of care, and health care expenditures among Medicare beneficiaries: 15 randomized trials. *JAMA* 2009;301:603-18.
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**TO THE EDITOR:** As Jencks et al. state, researchers have recognized the rehospitalization problem for some time.<sup>1</sup> The Institute of Medicine documented this issue and other quality-related and cost-related health care problems more than a decade ago.<sup>2</sup> The present study provides evidence that the problem may be worsening.

The current system provides high-technology interventions without routinely identifying the

care that is most appropriate for each patient. It also fails to place value on the management of chronic disease or on a system of coordinated care. Correcting these problems could reduce rehospitalizations and the need for index hospitalizations.

We believe that now is the time to move from studying the problem to acting on it. Since August 2008, the Quality Improvement Organizations of the Centers for Medicare and Medicaid Services (CMS) have worked in 14 states to implement the Care Transitions Program, an evidence-based initiative to help communities reduce rehospitalizations. The CMS and the Quality Improvement Organizations measure the progress of a project with the use of a claims-based system, similar to the one suggested in the article by Jencks et al. Initial project results are expected in early 2010, and the CMS expects to expand the program nationwide in August 2011.<sup>3</sup>

Barry M. Straube, M.D.

Paul E. McGann, M.D.

Michael T. Rapp, M.D., J.D.

Centers for Medicare and Medicaid Services  
Baltimore, MD 21244-1850  
ocsqbox@cms.hhs.gov

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2. Hewitt M, Simone JV, eds. Ensuring quality cancer care. Washington, DC: National Academy Press, 1999.
3. The Care Transitions Program home page. (Accessed June 25, 2009, at <http://www.qualitynet.org/medqic>.)

**TO THE EDITOR:** The article by Jencks et al. would have been more informative if data had been presented separately for patients discharged to nursing homes and those sent to their own homes. It is common practice for nursing homes to send patients who exhibit the slightest symptom to the emergency department for evaluation. Once they are there, the path of least resistance usually leads to an inpatient bed. The readmission rate could be reduced if physicians were available to examine and treat patients in the nursing home.

A notable finding in Figure 2 of the article by Jencks et al. is the sharp change in slope, between 20 and 30 days after discharge, of the dashed line that shows readmission rates. This may indicate the point at which patients were able to obtain an appointment to see their primary care

physicians after their discharge from the hospital. Overall, this study shows the false economy of underpaying primary care physicians.

Richard Rohr, M.D.

Guthrie Clinic  
Sayre, PA 18840  
rohr\_richard@guthrie.org

**THE AUTHORS REPLY:** Rackow is correct that data from the Medicare demonstration projects do not show that integrated geriatric care is ineffective; our aim was to point out that “case management” as commonly practiced and as made available through the demonstration projects does not seem to be protective. In addition, most of the integrated-management efforts have been evaluated in relatively small trials and have not been taken to a large scale. For this reason, we share the enthusiasm expressed by Straube et al. for the potential of the pilot programs of the Quality Improvement Organizations’ Care Transitions Program, and we are pleased that they will be expanded to all states in 2011. We are also encouraged by the Institute for Healthcare Improvement–Commonwealth Fund project STAAR (State Action on Avoidable Rehospitalizations)<sup>1</sup> in Massachusetts, Michigan, and Washington; the Society of Hospital Medicine–John A. Hartford Foundation’s Project BOOST (Better Outcomes for Older Adults through Safe Transitions),<sup>2</sup> which is being implemented in 30 hospitals in 24 states; the use of transition coaches to empower patients<sup>3</sup>; and the independent efforts of Kaiser Permanente, Geisinger, the Pittsburgh Regional Health Initiative, and others to improve transitions. These and other projects offer the opportunity for a highly productive community of effort and learning.

As Rohr suggests, we would have liked to examine the relationship between rehospitalization rates and the setting to which the patient was discharged, but as we noted, the coding of the

discharge destination in the Medicare hospital billing data appears to be unreliable. We share his view that the availability of primary care services is a key to successful transitions, but we doubt that changes in payment policy will be sufficient to produce a major improvement. Some people feel that payment changes are a magic bullet that will solve the problem. We believe that the rapidity and magnitude of change will also depend on strong leadership, standardization of practices, transparent measurement of performance, technical assistance for providers, involvement of families as well as patients, coordinated community efforts, and modifications to the regulatory environment. Unsuccessful transitions result, in part, from a severely fragmented health care system, and major improvement demands community teamwork among those who discharge patients, those who receive them, and patients and their families. A safe transition from the hospital to the community or a nursing home requires care that centers on the patient—who moves across organizational boundaries—rather than on care that is structured by the walls surrounding each provider.

Stephen F. Jencks, M.D., M.P.H.

8 Midvale Rd.  
Baltimore, MD 21210

Mark V. Williams, M.D.

Northwestern University Feinberg School of Medicine  
Chicago, IL 60611

Eric A. Coleman, M.D., M.P.H.

University of Colorado at Denver  
Denver, CO 80045

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## Case 11-2009: A Man with Fever, Headache, Rash, and Vomiting

**TO THE EDITOR:** In the Case Record of a man with fever and rash (April 9 issue),<sup>1</sup> acute infection with the human immunodeficiency virus (HIV) was the definitive diagnosis. The rash in acute HIV infection is commonly described as maculopapular or morbilliform.<sup>2</sup> The authors note

that the rash in this patient was nonvesicular, which is why they excluded infection with varicella-zoster virus (VZV). On the other hand, acute HIV infection cannot be ruled out in the presence of a vesicular rash. We evaluated a 28-year-old man presenting with fever and a diffuse vesicular