Insurers are looking to trim costs by reducing readmissions. For patients with HIV, and their providers, this may lead to some unanticipated consequences. Here are some suggestions for reducing the risk.

Among the Affordable Care Act’s numerous provisions designed to reign in costs and improve quality, one will penalize hospitals financially if Medicare patients with certain diagnoses are readmitted within 30 days of discharge. Although the policy is currently limited to Medicare patients and applies to just a handful of diagnoses (including heart failure, pneumonia, and acute myocardial infarction), it could be just a matter of time before this expands to affect a far broader range of patients and conditions.

The cost of a readmission reduces the amount of money providers retain, thus providing an incentive to identify opportunities to prevent readmissions. Altogether preventable readmissions cost the U.S. healthcare system an estimated $25 billion a year. Avoiding just one out of every 10 Medicare readmissions could save $1 billion, according to the Medicare Payment Advisory Commission (MedPAC).

It’s not just a Medicare issue: New delivery models such as accountable care organizations (ACOs) base reimbursements on quality indicators that often include readmission rates. Commercial insurers and Medicaid may also jump on the readmission penalty bandwagon. The consequences of a tight focus on readmission rates for providers who treat HIV-infected patients, however unintended, could be considerable.

As researchers from Johns Hopkins Medicine in Baltimore found when analyzing a large database of hospital admissions, at 22% the readmission rate for HIV-infected patients is 59% higher than for non-HIV infected individuals. While the higher readmission rates occurred in every diagnostic category, they were highest in psychiatric, gastrointestinal/liver, endocrine/metabolic, oncologic, and neurologic diagnoses. The cause for readmission generally differed from that for the index admission.

“I think the primary reason is that having HIV, even well-controlled HIV, means you’re just susceptible to getting more frequent illnesses than those without the infection,” said lead author Stephen A. Berry, MD, an assistant professor of infectious diseases. “So, when you’re discharged, even if the care you received during the initial hospitalization was very comprehensive and thorough and accurate, there’s a good chance you’ll be sick again soon, despite the best efforts.”

Still, in a separate study of patients from the Johns Hopkins’ AIDS clinic, Dr. Berry and his colleagues found that the strongest predictor of readmission was a low CD4 count and/or an opportunistic infection on the index admission. This is important, because hospitals could use such information to target those patients for more intensive discharge planning.

Reducing Readmissions

There are numerous reasons for preventable readmissions, including poor quality of care, poor discharge planning (particularly medication reconciliation and ensuring follow-up appointments), and poor post-discharge care. With readmission penalties as high as 2% of total Medicare payments, hospitals across the nation have targeted these issues with improved discharge planning, personalized or telemonitoring follow-up care, and better coordination of care between settings.

“Here at Johns Hopkins there’s a lot of attention to readmissions,” Dr. Berry said. In fact, he recently presented the result of his studies to his department chairman who is trying to reduce the overall
readmission rate for the department. Even though HIV-infected individuals represent just .01% of beneficiaries, “that number is going to grow, so hospitals are trying to be forward-thinking and find everything they can do to bring down their readmission rates.”

For HIV patients, that means evaluating CD4 status and antiretroviral therapy (ART) upon admission, he said, in addition to intensive discharge planning.

“There’s a critical moment of that transition,” Dr. Berry said—that handoff from the inpatient to the outpatient setting—“and HIV probably represents a situation where it’s more critical than most,” given the complicated medication regimens those with the disease face.

One of the most surprising findings of the Johns Hopkins study, Dr. Berry said, was that seeing an HIV provider within 30 days of discharge did not seem to protect against readmission. The reason, he suspects, is that the study population came from a specialty clinic, where the same physician follows patients in the hospital and after discharge. He’s now evaluating a larger database to see if this finding holds.

“Thirty-day readmission rates are increasingly becoming a benchmark for hospital quality of care and reimbursement. A basis of comparison specific to HIV will be important to clinicians, hospital administrators, and policymakers attempting to create best-practice readmission targets for populations which include substantial numbers of [persons living with HIV].”


When it comes to follow-up, he suggests that clinicians and hospitals focus on medication reconciliation. Even in his academic medical center, he said, residents and fellows preparing HIV patients for discharge make numerous mistakes that he has to correct.

Medication reconciliation is not easy, he said, requiring not only a deep knowledge of the drugs themselves, but an understanding of what the patient’s insurance will cover, barriers to adherence, and communication about the side effects and regimen. “That’s a tough thing to do right if you don’t know HIV well, and even if you do know it well but don’t take a lot of time for it.”

Other options hospitals might consider to reduce readmissions include telephone or in-person follow-up from a nurse manager, particularly for high-risk patients. If there hasn’t been good communication between the hospitalist and the outpatient HIV doctor, the nurse or social worker can provide a bridge between settings, Dr. Berry said, communicating about the medical condition and the inpatient course of treatment.

Those providers with the most experience treating HIV would be well advised to pay close attention. The current risk adjustment formula for readmissions does not include HIV, so that practices and hospitals that treat a relatively large proportion of HIV-infected patients may be most vulnerable to the financial consequences of this new cost-cutting strategy.

REFERENCES: