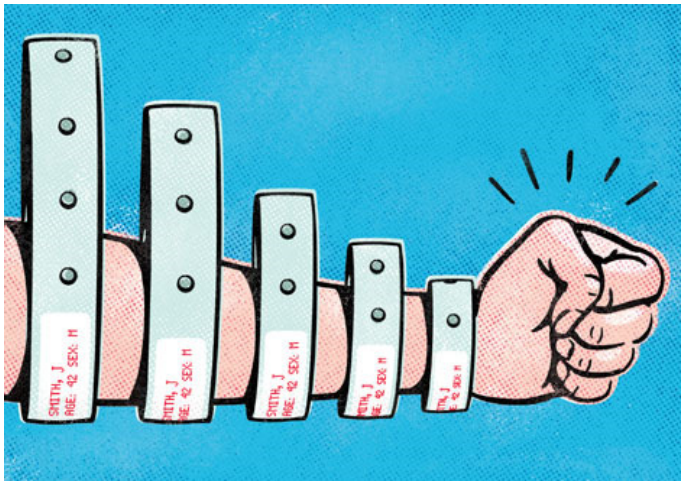
amednews.com
American Medical News

PROFESSION



[Illustration by Chris Gash / www.chrisgash.com]

# Reducing readmissions: How 3 hospitals found success

Better discharge planning and quicker follow-up care are keeping patients at home -- and helping to avert Medicare pay cuts.

By KEVIN B. O'REILLY, amednews staff. *Posted Feb. 7, 2011.*

One in five elderly patients is readmitted to the hospital 30 days after leaving. That is 2.3 million rehospitalizations a year that rack up more than $17 billion in annual Medicare costs, according to an April 2, 2009, study in *The New England Journal of Medicine*.

Experts disagree on how many of these readmissions can be prevented. About 40% -- nearly 1 million rehospitalizations annually -- are avoidable, said Stephen F. Jencks, MD, MPH, lead author of the *NEJM* study and former director of the Centers for Medicare & Medicaid Services' Quality Improvement Organization Program. In a June 2007 report, the Medicare Payment Advisory Commission said three-quarters of readmissions are "potentially preventable."

Eyeing big savings, Congress gave CMS the power under the Patient Protection and Affordable Care Act to cut hospitals' pay by up to 1% if they exceed a to-be-determined estimated 30-day readmission rate for patients with heart failure, heart attack or pneumonia, starting Oct. 1, 2012.

A hospital with 250 heart failure patients and a readmission rate 20% higher than predicted by CMS for its mix of patients would lose $250,000 in Medicare pay, according to an August 2010 *Thomson Reuters* research brief. By 2014, hospitals could lose up to 3% in pay if they have high readmission rates for an expanded list of conditions such as chronic obstructive pulmonary disease, coronary artery bypass graft and other vascular surgeries.

The rates will be posted to Medicare's Hospital Compare website.

**Nurses spend an average of 8 minutes per patient on hospital discharge education.**

The health reform law also set aside $500 million for a readmissions-reduction Medicare pilot program starting this year. The potential Medicare pay cuts, which also could be adopted by private health plans, are driving more hospitals to target their readmission rates, Dr. Jencks said.

"Physicians tell me regularly that one of the challenges of getting the hospital administrators interested in this issue is there hasn't been a plausible business case," said Dr. Jencks, an independent health care quality and patient safety consultant. "In that sense, [the new readmissions policy] is a very powerful message. It's gotten a good deal of response. There's an incredible amount of stuff going on in this area."

Preventing readmissions -- even among patients at the highest risk of rehospitalization -- is relatively straightforward, experts say.

"Right now, the things that are not being done are so basic, and that's where we can reasonably expect to see improvements," said Amy Boutwell, MD, director of health policy strategy at the Institute for Healthcare Improvement and principal investigator of the STate Action on Avoidable Rehospitalizations (STAAR) Initiative, a four-state project with 150 participating hospitals. "These are things that you'd be surprised are not being done on a daily basis."

Experts say strategies for reducing readmissions amount to two deceptively simple objectives: Make sure patients understand how to care for themselves when they leave the hospital, and make sure they get the follow-up medical attention they need to keep their conditions under control. Here is how three hospitals have achieved these goals.

**Piedmont Hospital, Atlanta**

"[Reducing readmissions] absolutely has become a burning platform," said Matthew J. Schreiber, MD, chief medical officer at Piedmont

Hospital.

Medicare's policy could cost the 481-bed, acute-care hospital in Atlanta, which brings in about $450 million annually, anywhere from $1 million to $30 million a year, depending on how CMS defines what counts as a high readmission rate and whether private health plans follow the agency's lead on pay.

"No matter how we slice it, that's a big chunk of change," said Dr. Schreiber, who began Piedmont's work on reducing readmissions in September 2008 at a 20-bed unit in the hospital. Now about 20% of the hospital's patients benefit from a package of interventions aimed at helping them avoid readmission.

**The achievement**

Before implementing changes, patients younger than 70 had a 30-day readmission rate of 13.05%, compared with 3.97% in July 2010. The rate for patients 70 and older was 15.9%, which has fallen to 11.2%. The patients' length of stay also dropped, even as the illness severity of the patient population rose.

"That's the *sine qua non* that you've done the job," Dr. Schreiber said. "If you reduce the length of stay and your readmission rate goes up higher, it just means you let people go from the hospital sooner without doing anything better for them. If you shorten the time they're in the hospital and reduce the rate at which they're returning to the hospital, now you're cooking with gas."

**How they did it**

- Improving the medication-reconciliation process, fixing a prevailing 46% discrepancy rate. A pharmacist now does the drug reviews, taking the extra time to question patients closely and talk with their families and primary care physicians when necessary. "Probably about two-thirds of readmissions have something to do with the patients' medications -- confusion, overdose, drug interactions, etc.," Dr. Schreiber said. "Medication review is the giant gorilla that's in the room. ... If we don't have it right on the front end when people come into the hospital, the chances of getting it right on the back end when they leave are slim to none."
- Identifying patients at high risk for readmission and ensuring that they get appropriate follow-up care. Hospital secretaries schedule physician appointments for patients and insist that they be seen within two weeks. Patients get a follow-up phone call at home within 72 hours of discharge and are expected to explain why they were in the hospital, what symptoms they should be looking for, what medications they are taking and when their next doctor's appointment is. "This is not a make-nice phone call," Dr. Schreiber said. "This is a business call. It's more like a quiz for the patient."
- Preparing patients for what happens after they leave the hospital. Piedmont uses a document that is part of a tool kit offered by the Society of Hospital Medicine's Project Better Outcomes for Older adults through Safe Transitions, which has 100 participating hospitals. The Patient PASS is a customizable, single-sheet form that lists the reason the patient was in the hospital, how to respond to various health problems, upcoming medical appointments, issues to discuss with a physician and health care contact information.

"The patient sticks it in their wallet," Dr. Schreiber said. "They bring it to their primary care doctor -- it makes that first follow-up visit so much more productive. ... That is one of the major wins for everybody."

#### Evergreen Hospital Medical Center, Kirkland, Wash.

This 275-bed hospital 11 miles northeast of Seattle is a member of the STAAR Initiative and has focused since 2003 on helping its patients with heart failure get the thorough follow-up care they need to avoid rehospitalization.

**The achievement**

While the hospital's overall 30-day readmission rate for patients with heart failure is 14% -- below the national rate of 24.7% -- the rate was 6% for the more than 800 patients referred to the hospital's nurse practitioner-staffed outpatient clinic in 2009.

Patients improved 44% on a questionnaire about their quality of life with heart failure, 26% on heart-function measures and 39% on a mood-screening instrument.

**How they did it**

- Identifying high-risk patients and referring them for care at the Evergreen Cardiac Enhancement Center within three days of discharge. The first visit is 90 minutes long and involves a thorough explanation of the medication and lifestyle changes needed to avoid further heart troubles. Patients are counseled about weighing themselves in the morning, taking their medicines, following a low-sodium diet and watching for potential emergency symptoms. Follow-up visits occur every two weeks until patients are stabilized on medication.

"It's a more comprehensive approach," said nurse practitioner Nancy Bartholomew, clinical director of the cardiac center. "We work really closely with the primary care physician and definitely keep them in the loop. We're not trying to take over their patients; we're trying to provide excellent care in this part of the patient's health and stabilize them."

#### University of California, San Francisco Medical Center

This 600-bed academic medical center also has targeted its readmission-reduction efforts on patients with heart failure, beginning its work with grant funding in November 2008.

**The achievement**

From January 2009 to January 2010, the hospital's intervention cut 30-day readmissions for its approximately 600 patients from 22% to 16%. Ninety-day readmissions started at 44% and were cut to 26%.

**How they did it**

- Improving communication among key members of the care team, and sending out e-mails to keep primary care physicians, case managers, home-care and skilled nursing facility professionals and others up to date on a patient's admission, progress while in the hospital and plan of care upon discharge. "Just that connection makes it a virtual team," said Maureen Carroll, RN, the heart failure discharge coordinator at UCSF Medical Center.

- Offering intensive bedside counseling totaling about 90 minutes from admission to discharge. "Nationally, nurses spend an average of eight minutes on discharge education -- that time spent on education is probably inadequate for anything," Carroll said.

Patients and family get a binder -- available in English, Spanish, Chinese or Russian -- all about heart failure and how to manage it. The counselors also make use of the teach-back method of patient education at bedside and in follow-up phone calls. "That's an important key -- really verifying that the patients get the information that we're giving them," Carroll said. "It's shocking sometimes what information they clearly haven't gotten."

There is no shortage of successful strategies to help patients avoid rehospitalization, experts say. What has been lacking is the will to adopt them.

"This isn't necessarily about implementing a protocol, but about leadership at the organizational level to make transitions of care a priority," said the STAAR Initiative's Dr. Boutwell. "At thousands of hospitals across the United States, transitions are absolutely an afterthought. There is very rarely a systematic approach to handing the care over to the next provider in the community.

"What we see is that it's not so much about the ideas as it is the intention and the motivation. That's where the results are found."

The print version of this content appeared in the Feb. 14 issue of *American Medical News*.

**ADDITIONAL INFORMATION:**

### Who is most likely to return

Medicare patients who receive hospital care for heart failure are the likeliest to be readmitted within a month of discharge. This chart also shows other conditions with high 30-day rehospitalization rates among patients 65 and older.

| Condition at hospital discharge | Readmission rate |
|---|---|
| **Heart failure** | 26.9% |
| **Psychosis** | 24.6% |
| **Vascular surgery** | 23.9% |
| **Chronic obstructive pulmonary disease** | 22.6% |
| **Pneumonia** | 20.1% |
| **Gastrointestinal problem** | 19.2% |
| **Nonmajor hip or femur surgery** | 17.9% |
| **Major bowel surgery** | 16.6% |
| **Cardiac stent placement** | 14.5% |
| **Major hip or knee surgery** | 9.9% |

Source: "Rehospitalizations among patients in the Medicare fee-for-service program," *The New England Journal of Medicine*, April 2, 2009 (**www.ncbi.nlm.nih.gov/pubmed/19339721**)

### From the hospital to the clinic

Office-based doctors play a key role in helping patients avoid rehospitalization, experts say. Physicians caring for patients discharged from the hospital should:

- Review daily any information received from the hospital about admissions and anticipated discharges.
- Provide appropriate and timely follow-up by seeing high-risk patients within 48 hours and moderate-risk patients within five days.
- Re-evaluate the patient's clinical status since discharge and reconcile the treatment plan and medications due to any changes.
- Assess the patient's goals, wishes and ability to manage self-care and initiate a new overall plan of care that is developed collaboratively with the patient.
- Share the new plan with other physicians and clinicians in the community and schedule regular times in the daily office schedule to make these connections.

Source: "Guide for Field Testing: Creating an Ideal Transition to the Clinical Office Practice," Institute for Healthcare Improvement, June 2010 (**www.ihi.org/NR/rdonlyres/A0D34607-A486-4BD0-8262-89374F5E7761/0/STAARGuideforFieldTestingOfficePractice.pdf**)

**WEBLINK**

"Rehospitalizations among patients in the Medicare fee-for-service program," *The New England Journal of Medicine*, April 2, 2009 (**www.ncbi.nlm.nih.gov/pubmed/19339721**)

"Payment policy for inpatient readmissions," chapter 5 in MedPAC's "Report to the Congress: Promoting Greater Efficiency in Medicare," June 2007 (**www.medpac.gov/chapters/jun07_ch05.pdf**)

"Healthcare reform: Pending changes to reimbursement for 30-day readmissions," Thomson Reuters, August 2010 (**www.thomsonreuters.com/content/healthcare/pdf/pending_changes_reimbursements**)

Community Based Care Transitions Program, Centers for Medicare & Medicaid Services (**www.cms.gov/demoprojectsevalrpts/md/itemdetail.asp?itemid=cms1239313**)

STate Action on Avoidable Rehospitalizations Initiative, Institute for Healthcare Improvement (**www.ihi.org/staar**)

BOOSTing (Better Outcomes for Older adults through Safe Transitions) Care Transitions resource room, Society of Hospital Medicine (**www.hospitalmedicine.org/boosttoolkit**)

"Guide for Field Testing: Creating an Ideal Transition to the Clinical Office Practice," Institute for Healthcare Improvement, June 2010 (**www.ihi.org/nr/rdonlyres/a0d34607-a486-4bd0-8262-89374f5e7761/0/staarguideforfieldtestingofficepractice.pdf**)

Transitional Care Model, University of Pennsylvania School of Nursing NewCourtland Center for Transitions and Health (**www.transitionalcare.info**)

The Care Transitions Program, University of Colorado Denver School of Medicine Division of Health Care Policy and Research (**www.caretransitions.org**)



**RELATED CONTENT**

» **Health system reform expected to boost house calls** Jan. 3
» **No benefit from telemonitoring heart patients** Dec. 6, 2010
» **Discharge missteps can send seniors back to hospital** Column Feb. 15, 2010
» **75% of discharge summaries don't mention pending test results** Aug. 31, 2009

HOME - LATEST ISSUE - SITE GUIDE - ABOUT - CONTACT - AMERICAN MEDICAL ASSOCIATION