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Readmissions NEWS

Key Lessons from Hospitals with Low Readmissions

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With severe budget pressures and a MedPAC Report to Congress estimating $12 billion per year in Medicare spending for hospital readmissions deemed "potentially preventable", both clinicians and policymakers have been pursuing strategies and incentives to eliminate unnecessary rehospitalizations. But despite a growing knowledge base about how to reduce readmissions, there remains a great deal of variability in readmission rates across hospitals.

Health Management Associates, with support from The Commonwealth Fund, examined hospitals that achieved exceptionally low readmission rates to identify clinical and operational strategies, as well as the organizational, cultural, and environmental factors that lead some hospitals to create or adopt 'best practices' and achieve greater success. We studied four hospitals within the top 3 percent in terms of low readmission rates for at least two of the following: heart attack, heart failure, and pneumonia patients, as reported to CMS.

Low-Readmission Hospitals Studied:

- McKay-Dee Hospital, a 352-bed, private, nonprofit hospital in Ogden, Utah and member of Intermountain Healthcare.
- Memorial Hermann Memorial City Medical Center, a 427-bed, private, nonprofit hospital in Houston, Texas, belonging to Memorial Hermann Health System.
- Mercy Medical Center, a 305-bed, private, nonprofit hospital in Cedar Rapids, Iowa. Mercy Medical.
- St. John's Regional Health Center, an 866-bed, private, nonprofit hospital in Springfield, Missouri, and member of St. John's Health System.

While it is inadvisable to generalize from a small sample to all hospitals, and every hospital has unique strengths and challenges, several lessons emerged from the hospitals' experiences.

Care for patients correctly and readmission rates fall, performance on quality measures improves, and savings are realized as byproducts.

The low-readmission hospitals found that dedication to clinical excellence and patient safety can result in declines in readmissions and costs over the long term. This requires investments in dedicated quality improvement staff, tools such as electronic monitoring of key performance measures, development of care standards and protocols, financial incentives, and other strategies.[2]

Hospitals that do not have a major improvement infrastructure or a long history of performance measurement can still make progress. They could begin by selecting a few priorities, building data systems to measure outcomes, testing new care processes, and then incorporating them into daily protocols. A key is to standardize and simplify processes so that they are easy to follow and reflect evidenced-based care.

[2] See, for example, Case Study Series on Process-of-Care Measures: Improvement Strategies of Top-Performing Hospital, http://www.whynotthebest.org/uploads/download/43 .

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A hospital committed to providing the best care must be prepared to make decisions that may result in higher costs over the short term. For example, among the low-readmission hospitals such decisions included: ceasing to perform elective pre-term births, creating a research institute dedicated to improving care delivery, and establishing a home health network.

Committed providers are the heart of any successful improvement program. Hospitals should monitor adherence to evidence-based care standards and identify and address causes of non-adherence, including those that lead to readmissions.

Hospital leaders must also demonstrate their commitment to quality and safety. For example, leadership rounds can encourage communication between administrators and frontline staff about how to improve quality. Hospitals and hospital systems must establish accountability for meeting performance benchmarks -- with rewards and penalties -- up and down the ladder, from individual physicians to managers to CEOs.

Use information technologies as tools to improve quality, integrate care, and ease patient transitions.

While information technologies are not solutions, they can be used to support clinical, financial, and operational decisions that can improve quality and outcomes and potentially reduce readmissions. Various software systems track performance at the system, hospital, department, and provider levels, enabling creation of dashboards that benchmark performance, identify outliers, and facilitate targets and incentives for improvement. Patient registries, clinical risk assessments, and decision support software provide evidence-based protocols, warnings, and reminders. Telemonitoring devices enable hospitals to obtain critical information about discharged patients and address problems before they lead to complications that may require hospitalization.

Begin case management and discharge planning early, target high-risk patients, and ensure frequent communication across the whole care team.

Planning for patients' discharge should begin on the day of admission and involve social workers in the case of elderly and high-risk patients. Strong case management and discharge planning -- by qualified staff with manageable caseloads -- can reduce patients' confusion and ensure they receive appropriate care.

Ingredients for successful case management and discharge planning include: daily team meetings during which floor nurses, care coordinators, social workers, and hospitalists discuss each patient their expected discharge date and issues that need to be addressed; whiteboards in patient rooms that alert the patient and family to the anticipated discharge date so they can plan accordingly; scheduling of follow-up appointments before the patient is discharged; home health liaisons rounding with case managers; and effective education.

Teach patients and families how to manage their conditions.

By helping patients understand and manage their disease, hospitals can reduce patients' fear and uncertainty and avoid the medication mistakes and missed warning signs that can result in readmissions. Staff at the low-readmission hospitals credit educational methods such as teach-back -- not merely read-back -- with giving patients' greater confidence when they leave the hospital.

Staff must engage patients at their level by assessing their literacy skills and adjusting their verbal and written materials accordingly. Some hospitals have had success using pharmacists to teach patients about their medication regimens.

Targeted education to heart failure patients -- whether or not heart failure is their primary diagnosis -- can help reduce avoidable readmissions among this high-risk group. But education is important for all patients. By teaching patients how to recover from acute episodes and control even minor chronic conditions, hospitals can slow or prevent further deterioration and reduce readmissions.

Maintain a "lifeline" with high-risk patients after discharge.

Taking care of patients after discharge helps keep them from coming back to the hospital. Two strategies low-readmission hospitals have found to be effective are: 1) post-discharge phone calls for all patients with certain conditions or characteristics (e.g., heart failure, diabetes, post-catheter, elderly); and 2) use of telemonitoring devices that transmit vital information to a trained clinician who can determine whether follow-up care is needed.

In addition, hospitals can help uninsured patients find a medical home for follow-up care and provide or refer patients to community-based telephone case management when needed.

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Align the efforts of hospital and community providers to ease transitions across care settings.

Access to a continuum of care facilitates smooth transitions across settings and helps ensure delivery of appropriate care. Vertically integrated systems may have an advantage in providing continuous and coordinated care. For example, their members -- including hospitals, primary care networks, rehabilitation centers, home care agencies, nursing homes, and other providers -- may share electronic health records that give them easy access to comprehensive patient information. Still, there are ways to create effective partnerships between hospital and community providers apart from formal ownership arrangements.

The low-readmission hospitals nurtured partnerships and collaborations with non-affiliated clinics in low-income neighborhoods, as well as with specialists and even competitor hospitals that resulted in smoother patient transitions and higher-quality care. For example, a health system could extend access to its electronic health records to non-affiliated physicians through Web portals (for a fee or no fee), permitting timely access to a patient's medications, history, test results, and other information.

Improving health requires a community-wide effort. Hospitals and hospital systems must reach out to colleagues in their communities in order to manage readmissions and improve overall health. Such collaboration is likely to have benefits for the participating organizations as well as for the local population.

Incentives may help more hospitals to "do the right thing."

Traditional fee-for-service reimbursement by public and private payers, and even discharge-based payments based on individual hospital stays, create incentives for hospitals to increase the volume of hospital admissions. New payment mechanisms that alter these incentives are emerging as public and private payers are looking for ways to reduce costs and waste. Medicare, for example, is ceasing to pay for readmissions within 30 days of discharge for the same diagnosis. The Centers for Medicare and Medicaid Services is supporting efforts to expand primary care medical homes, test bundled payments that cover a total episode of care, and develop accountable care organizations -- all involving incentives to reward quality, efficiency and outcomes, such as fewer readmissions, instead of volume.

Although low readmission rates may in the short term result in lost revenue to some hospitals, two hospital leaders among the low readmission hospitals studied noted that lower readmission rates and other efficiencies help them when negotiating rates with health plans and other payers. They also stress that while they are motivated to achieve clinical excellence, incentives are needed to motivate inpatient and outpatient providers to work together to integrate patient care and take other steps to reduce avoidable readmissions.

With new opportunities presented by national health reform and other changes in the health care system, hospitals stand to benefit from being pioneers in providing high-quality, coordinated care and avoiding preventable readmissions.

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NOTE: This article is adapted from a report supported by The Commonwealth Fund. That report, together with the case studies of low-readmission hospitals on which it is based, is available for free download on The Commonwealth Fund's quality improvement Web site at http://www.whynotthebest.org/contents/index/1/7. WhyNotTheBest.org tracks U.S. hospital performance on measures of recommended care, patient experience, safety, infections, readmissions, and more. The goal is to foster health care quality improvement by promoting transparency and public reporting, and by providing tools and case studies of top performers to aid organizations in their own improvement efforts.

