12 Ways to Reduce Hospital Readmissions

Cheryl Clark, for HealthLeaders Media, December 27, 2010

Time flies. In just 21 months, the federal government will start penalizing hospitals with higher than expected readmission rates. And even though much about the regulations-to come remains unclear, clinicians along the care continuum are scrambling to get ready.

Or they should be. It's not just important for a hospital's bottom line. It's important for the patient.

We've been talking with some of the nation's experts on the subject, including Stephen F. Jencks, M.D., whose April, 2009 article in the New England Journal of Medicine set the tone for today's readmission prevention energy. His review of nearly 12 million beneficiaries discharged from hospitals between 2003 and 2004 found that nearly 21%, or one in five, were re-hospitalized within 30 days and 34% were readmitted within 90 days.

We also spoke with Amy Boutwell, MD, an internist at Newton-Wellesley Hospital in Newton, MA and Director of Health Policy Strategy for the Institute for Healthcare Improvement; Timothy Ferris, MD, medical director of the Massachusetts General Physicians Organization, and Estee Neuhirth, director of field studies at Kaiser Permanente in California.

Some of these strategies aren't yet proven to work in all settings, of course. And many are still in the demonstrations phase. But with national readmission rates as high one in five, and higher for certain diseases, many providers are trying anything that sounds plausible.

Here are some of the prevention strategies that these and other experts think might be worth a shot. Many involve—to a greater or lesser degree —following the patient out of the hospital, either in-person, electronically, or by phone, but others involve upside-down introspection and re-evaluation by providers along the care continuum.

1. Discharge Summaries
Dictate discharge summaries within 24 hours of discharge. Boutwell says that standard practice and policy at most hospitals is that discharge summaries are completed within 30 days of the discharge. "I was trained that the summary is a retrospective report of what happened in hospitalization. But what we need today is anticipatory guidance. Patients get discharged and go home. They can't fill their meds, insurance doesn't cover the med or they have questions. They're nervous and worried. They call their primary care provider, who didn't even know they were admitted.

Boutwell says that 30-day-discharge summary policies "might have sufficed in a time gone by. But that doesn't work anymore. Information needs to be available at the time of discharge. There's a growing recognition of this need, but staff bylaws haven't changed."

2. Lengthen the Handoff Process
At every juncture in patient care process, especially discharge, have teams talk to each other about the patient. And by the way, don't call them discharges. Call them "transitions." Standardize them for a variety of providers, from hospital to rehabilitation facility to skilled nursing facility to home and back.
Boutwell says that "taking this person-centered approach shifts the concept from discharge, which is a moment in time and you're done with it, to a transition—a shared accountability. We need to make sure the receiving providers understand who this patient is, with a 360-degree view.

Jencks adds that "senders and receivers, for example hospital discharge planners and skilled nursing facility staff and home health” meet often enough so they can learn about the realities of the transitions they initiate and receive.

3. Provide Medication on Discharge
Send the patient home with 30-day medication supply, wrapped in packaging that clearly explains timing, dosage, frequency, etc. Some health centers with Medicaid patients may be trying this strategy, which is difficult for hospitals to do with Medicare patients because of distinctions between Part A and Part B payment. Still, for some high-risk populations, such as patients with congestive heart failure and those who have been readmitted before, it might be worth it for the hospital to absorb the cost.

4. Make a Follow-up Plan Before Discharge
Have hospital staff make follow-up appointments with patient's physician and don't discharge patient until this schedule is set up. A key is to make sure the patient has transportation to the physician's office, understands the importance of meeting that time frame, and following up with a phone call to the physician to assure that the visit was completed.

5. Telehealth
We couldn't find anyone using video monitors to communicate on a daily basis with the use of such software as Skype, for example, but some readmission experts say it's an interesting approach to keep up visual as well as verbal communication with patients, especially those that are high risk for readmission.

On a more practical scale, Home Healthcare Partners in Dallas uses health coaches, intensive care clinicians, and **wireless technology** to record vital signs on a daily basis for about 2100 discharged Medicare fee-for-service beneficiaries for between 60 to 120 days. So far, they have done this for about 7,000 unduplicated patients in the last two years, for several hundred hospitals in Dallas and Louisiana, says HHP's CEO, Wayne Bazzle.

The target population for **intense monitoring** includes those with four or five co-morbidities and who have a primary diagnosis of congestive heart failure, chronic obstructive pulmonary disease, diabetes, Alzheimer's and hypertension.

Bazzle says that the effort involves phone calls of between five and 15 minutes, and is frequent enough with the same team "so we have their trust. We can help them stay out of the hospital if they're more truthful with us about what's going on, and if we see some deterioration, we can help them cope. Normally it's a medication management issue, or they've become a little too relaxed with their diet."

6. Identify Frequent Flyers
Customize your hospital's admission and re-admission rates for demographic and disease characteristics to identify those at highest risk, and expend extra resources on their care needs. This may involve **special programs for homeless patients**, such as the one effort by a cohort of Los Angeles hospitals who grappled with how to safely discharge homeless patients without violating city laws.

The Los Angeles project now discharges homeless patients who meet certain criteria to a half-way type of house in nearby Bell, and saved $3 million for hospitals in its first few months. Expansions in other parts of Southern California are underway.
7. Understand What's Happening After Discharge
Kaiser Permanente is using video cameras to **chronicle home settings** and the entire care process to determine what's happening to the patient after discharge that provoked a readmission.

The team is also using video of the care team, from the pharmacist, home care providers, nurses, and physicians about their care of that patient, to highlight wrinkles and cracks in the system that brought the patient back to the hospital.

So far, Kaiser officials say that the video project has contributed to a reduction in readmission rates at some hospitals where it has been tried, such as from 15.7% to 9% at Kaiser's South Bay Medical Center near Los Angeles, because it gave the team information to streamline care, says Kaiser's Neuwirth.

8. Provide Home Care on Wheels
Just like Meals-on-Wheels can be scheduled in advance, so can case management, housekeeping services, transportation to the pharmacy and physician's office. At Piedmont Hospital in Atlanta, in collaboration with the Area Agency on Aging, patients having elective knee surgery get coupons and prescheduling, "so that by the time you get out of the hospital, it's waiting there for you," Boutwell says. She adds that this kind of a pre-arrangement for post-transition care is "spreading like wildfire," among a number of hospitals, but so far it's mainly being tried with elective patients.

9. Consider Physician Medication Reconciliation
A recent paper in the *New England Journal of Medicine* by Yuting Zhang, of the University of Pittsburgh noted the wide geographic variation among physicians' prescribing practices with medications that should be avoided in patients over age 65. She also noted variation in prescribing practices for drugs that have a high risk for negative drug-disease interaction.

Jencks says that Zhang and colleagues "are pointing us to a rather important gap in the most common thinking about transitions—that we are to make sure that patients are able to get and take medications, get recommended follow-up, and generally do as they are told. But we know that medication plans can be in life-threatening error, that physicians often recommend a time-to-follow-up that is too long, that discharge plans are often written in ignorance of the patient's pre-admission history and experience. In general, we need to be much more critical of the plans patients get."

10. Make Sure Patients Understand
Patients may nod, and say they understand what they're supposed to do after they leave the hospital. But "teach back," in which they and their caregivers repeat back those instructions, even to more than one hospital caregiver, needs to be constantly reinforced, readmission experts say. Jencks says that caregivers need to understand that their patients are often heavily medicated, stressed, groggy and confused. And that their disease state may impair their ability to understand what they are being told, much less remember it two days later.

11. Focus on Highest-risk Patients
Examine the readmission patterns at your hospital and see which patients, with which conditions, diseases or procedures, have the most readmissions. If resources are limited as they are at most hospitals, push them toward a select group of patients in a more intense way to see if increased effort makes a difference.

For example, in his New England Journal of Medicine Paper, Jencks showed that for certain diseases or...
conditions, and in certain parts of the country, readmission rates are even higher than the national average of one in five. For example, for medical patients, the readmission rate for heart failure patients was 27%; for those with psychoses, 24.6%; chronic obstructive pulmonary disease, 22.6%. Patients with pneumonia and gastrointestinal problems were re-hospitalized at 21% and 19.2% respectively.

For surgical patients, those with vascular surgery had the highest readmission rate, 23.9%, followed by those with hip or femur surgery, 17.9%.

States with the highest rates of readmission include Washington, D.C., 23.2%; Maryland, 22%; New Jersey, 21.9%; Louisiana, 21.9%; Illinois, 21.7%; West Virginia, 21.3%; Kentucky, 21.2%; New York, 20.7%; Massachusetts, 20.2%; Mississippi, 21.1%; Missouri, 20.8%; New York, 20.7% and Oklahoma, 20.1%. Perhaps these are the places where readmissions can be most quickly reduced.

12. Listen to the Patient

Involves the emergency room, hospice or home health providers to make sure patients don't come to the emergency room for non-emergent end-of-life care issues. Providing patients and their family members with informed choices, opportunities for advance directives, and counseling in the emergency room setting may avert painful, unnecessary admissions. Look for this to be a major expansion of palliative care professionals inside the ED.

"There really needs to be a care plan that reflects the patient's wishes," Jencks says. "This is quite different from either a medical power of attorney or what is often called a living will because it lays out the goals of treatment.

"Cure? Palliation? Functional independence? Playing dominoes with friends? Hospice? This kind of plan has little relevance to persons without substantial chronic conditions, but it is totally relevant to a patient with one or more chronic conditions that have required hospitalization. With such a plan, one can often avoid readmissions that really do not serve the patient's needs or values. What is, after all, worse than a readmission? Readmission of a patient who does not want to be readmitted," Jencks says.

See Also:
Readmissions Reduction Effort at Kaiser Involves Cameras
Revolving Door Of Readmissions and ED Visits More Extensive and Expensive
What a TV Show Can Teach Us About Readmissions
Facilities Get Creative to Reduce Hospital Readmissions

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