E-SURVEY OF THE MONTH:

INDUSTRY PULSE FROM THE HEALTHCARE INTELLIGENCE NETWORK™

White paper analysis of HIN monthly e-survey results on trends shaping the healthcare industry.

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Preventing Hospital Readmissions

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According to a September 2006 report from the Commonwealth Fund,[1] hospital 30-day readmission rates for Medicare patients vary widely across states and hospital regions — from 14 percent to 22 percent. Commonwealth estimated that if all readmission rates could be reduced to the rates achieved by the top-performing 10 percent of regions, Medicare would save an estimated $1.9 billion annually.

With readmission rates affecting quality and profitability, the healthcare industry is taking notice. In a January 2007 e-survey, healthcare organizations told the Healthcare Intelligence Network (HIN) what they're doing to trim hospital readmissions.

Hospitals, health plans, providers and industry support organizations report that they are banking on provider partnerships, education and communication to pare the number of patients being readmitted to hospitals. More than three-quarters of the 200-plus healthcare organizations responding to HIN's January 2007 non-scientific online survey on this topic say their organizations have made these reductions a priority. More than 75 percent are now or soon will be at work to pare hospital admission rates.

For initiatives already underway, in-person, print and telephonic communications play a pivotal role. Telephonic outreach is employed by 56 percent of respondents, followed by improved discharge instructions (52 percent), scheduled follow-up visits (44 percent), home visits (nearly 42 percent) and the use of hospitalists during inpatient stays (nearly 34 percent). Information technology (IT) — via telehealth and 24/7 telemonitoring — increasingly forms the backbone of these services.

Recent research points to a need for improved communications. A recent review article in the Journal of the American Medical Association found that primary care physicians (PCPs) often do not receive adequate patient information from the hospital-based physician following discharge.

The researchers found that direct communication between hospital

Disclaimer: HIN survey results are not based on a scientific sampling but on the number of responses to the HIN monthly online survey at www.hin.com.

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physicians and PCPs during the discharge process occurred infrequently. Only 3 percent of PCPs reported being involved in discussions about discharge, and 17 percent to 20 percent reported always being notified about discharges.[2]

Efforts Aimed at High-Cost, High-Utilization Patients

Nearly 76 percent of respondents say readmission reduction attempts are first aimed at the seriously ill and/or those with multiple comorbidities. Patients with caregivers arwe given priority by nearly 50 percent of respondents, and those suffering from dementia targeted by 26 percent.

How Hospitals and Health Plans Are Attempting to Reduce Hospital Readmission Rates in Their Populations

Focus	Hospitals	Health Plans
Telephonic Outreach	Follow-up calls to caregivers, families	Follow-up within 7 days
Discharge Instructions	Intense self-management instructions; Patient/caregiver education/prevention efforts (meds, DM, etc.); Both pre- and post-discharge management	Case manager involvement; Proactive case management;
Home Visits	Fall prevention programs; Relationships with post-primary providers; Increased home health referrals;	Home health monitoring; Partner with providers to ensure follow-up visits;
Other	Case management review of readmission stats by physician, diagnosis, etc. Incorporating prevention at the public health level	Hospitalists; Utilization management; Relapse prevention technology; Provider team-developed action plans to keep patient at home

Source: HIN January 2007 e-survey, "Reducing Hospital Readmissions"

The Hospital Stance

Of 54 hospital survey respondents, slightly fewer than 70 percent are actively working to improve their ratings in this area. Half of the remaining hospitals say they will address this in the year ahead. Nearly 60 percent say they see a reduction in readmissions, with just under 10 percent saying there's no change in rates and 32 percent saying their efforts are too new. To scale down the number of patient readmissions, hospitals are employing one or more of the following tactics:

- ✓ Eighty-four percent provide departing patients with improved discharge instructions.
- ✓ Almost 60 percent schedule follow-up visits.
- ✓ Forty-eight percent offer telephonic support.

The Health Plans React

Eighty-three percent of 47 responding health plans are trying to reduce hospital readmissions. Slightly more than 40 percent say they are succeeding, while 35 percent say it's too early to tell and 25 percent say their efforts have had no effect.

What's Working for Others

Some organizations are taking telephonic outreach one step further. A home health organization has launched a "Call Me First" campaign, providing patients with written and verbal instructions upon admission and at each visit to teach them when to contact hospice care instead of emergency services.

In another venture, a healthcare communications company says it is "beginning to design programs for both post-hospital discharge outreach (24-48 hours post discharge) and daily call outreach to those who have a history of several recent admissions."

The patient's home is often the platform around which these initiatives are constructed. Besides remote monitoring, there are a growing number of home-based initiatives designed to keep patients from reentering the hospital. A provider of wound services has a "strong home-based program designed to keep patients from being reentered or entered in the hospital in the first place." This provider is in constant communication with network healthcare providers to resolve patients' wounds.

Prevention of falls among the elderly, a frequent factor in hospital readmissions, is getting a fair amount of attention. An adult day care facility collaborates with a group of internists to complement care with non-medical in-home services so that patients can be safe at home.

Related Resource

Care transitions — when patients move from one care setting to another — are prime opportunities to provide the continuity required to reduce hospital readmissions. The Healthcare Intelligence Network offers a number of resources in its *Managing Transitions to Care* series, including:

Managing Transitions to Care for Medicare Patients to Avoid Costly Inpatient Admissions: This 90-minute audio conference on CD-ROM examines how to predict which Medicare patients are most likely to experience problems during care transitions that can lead to higher costs of care and strategies for alleviating these problems. For more information, please visit **http://store.hin.com/product.asp?itemid=3542**.

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1. The Commonwealth Fund Commission on a High Performance Health System, *Why Not the Best? Results from a National Scorecard on U.S. Health System Performance* (New York: The Commonwealth Fund, Sept. 2006).

2. Journal of the American Medical Association, February 27, 2007