National Association of Public Hospitals and Health Systems

30 YEARS

Transforming American Health Care

DataBrief

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NAPH Members Focus on Reducing Readmissions

In late 2010, NAPH administered an online survey to quality directors (or their designee) at 101 NAPH member organizations to gather information about their ongoing activities to reduce readmissions. Respondents from 51 safety net facilities completed the survey, a group that is representative of all NAPH members on characteristics like bed size, geographic location, margin, and performance on publicly-reported readmission rates. However, compared to the average NAPH member the respondents are more likely to be academic medical centers and have slightly more inpatient discharges for patients covered by commercial insurance. The survey asked quality directors to describe how they are focusing their efforts to reduce readmissions, barriers to doing so, and strategies for success. The survey's findings presented in this data brief reflect safety net hospital commitment and allocation of scarce resources toward addressing readmissions for complex patient populations.

Prioritizing Readmissions

- Survey data indicated that executive leaders in 86% of the responding NAPH member hospitals have made reducing readmissions a priority as of October 2010. At that time, 73% of those same members had established readmissions as a priority within the past 18 months (chart 1).
- When asked who the hospital's executive leadership designated with primary responsibility for reducing readmissions, most respondents indicated that multiple groups of people were tasked with this responsibility. However, the quality/performance improvement department was named most frequently (chart 2).
- 78% of responding hospitals have established interdisciplinary teams to target reducing readmissions. The quality/performance improvement department, case managers, and physicians were most likely to be part of those teams (chart 3).

VISION STATEMENT

NAPH will be the nation's leading voice for safety net hospitals and health systems and the patients and communities they serve. NAPH's efforts will directly and substantially contribute to the ability of its members to meet the needs of the present and the challenges of the future, and to provide access for all to high-quality health care. To support the continued transformation of safety net systems into industry leaders in access and quality of care, NAPH publishes data briefs with key facts and information describing member achievements and progress.

- 59% have established goals for reducing readmissions. Of the members that have established goals, the majority benchmark themselves against a national average or state average rate, while 67% of them have specific internal goals (chart 4).

CHART 1 How long ago did executive leadership prioritize reducing readmissions? (as of October 2010)

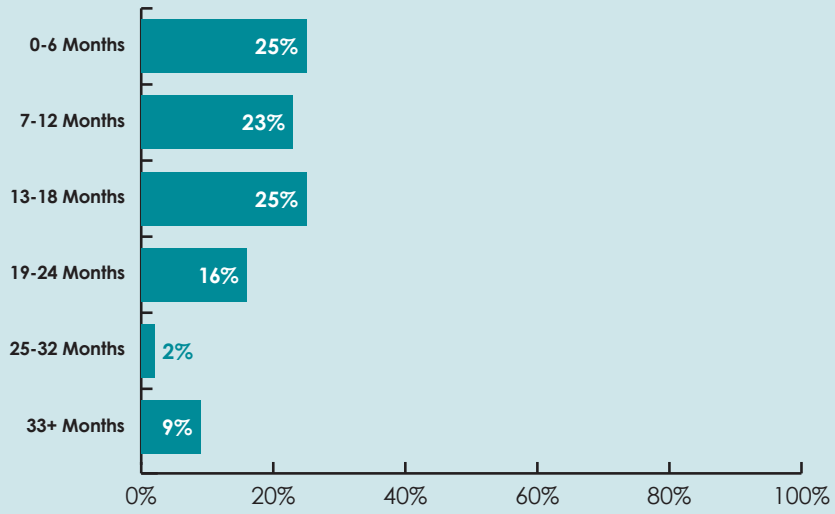
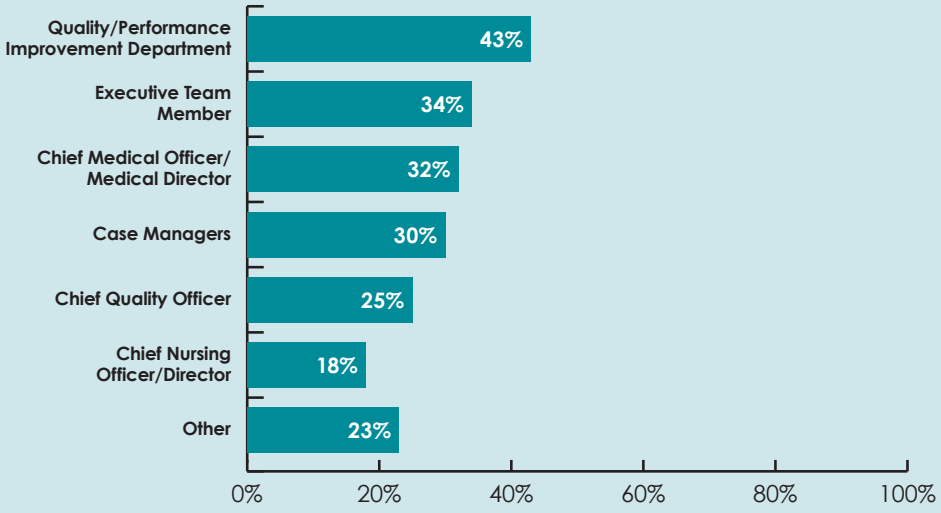


CHART 2 Who did executive leadership appoint with primary responsibility for reducing readmissions?



Executive leaders in 86% of the 51 NAPH member hospitals that answered the survey have made reducing readmissions a priority.

"OTHER" RESPONSES

- Nursing support staff
- Chief utilization officer
- Transition care team
- Chief of utilization management
- Chair of internal medicine and core measures multidisciplinary team
- Pharmacy, medical staff, and nursing
- Risk-assessment committee
- Chairmen of medicine, pediatrics, psychiatry, surgery, and obstetrics
- Social worker manager
- Director of case management and steering team

CHART 3 Who is part of your interdisciplinary team working to reduce readmissions?

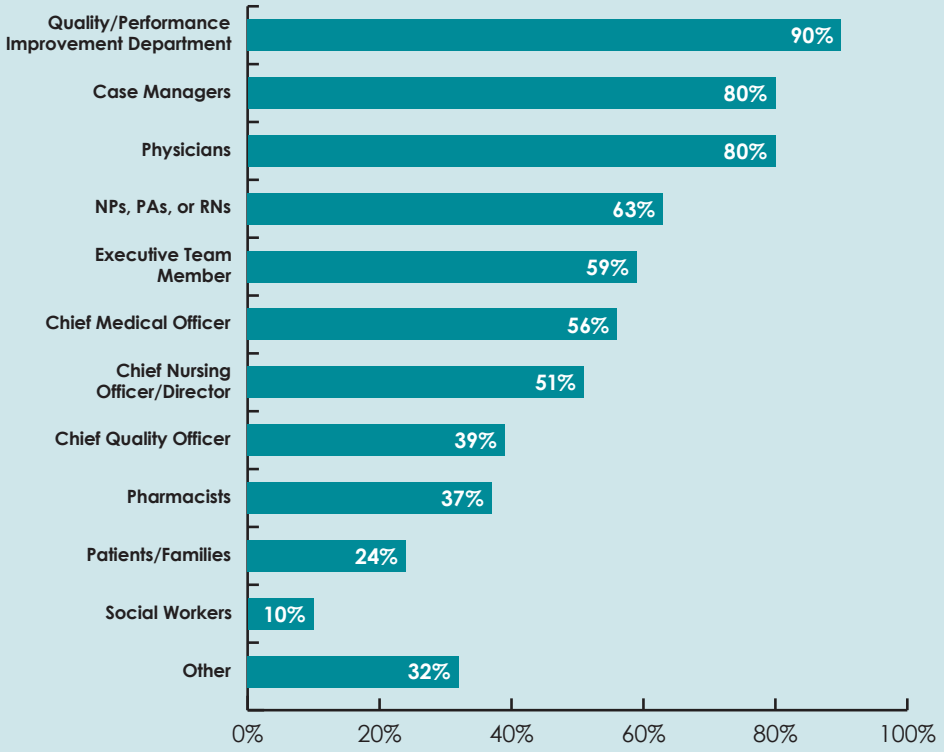
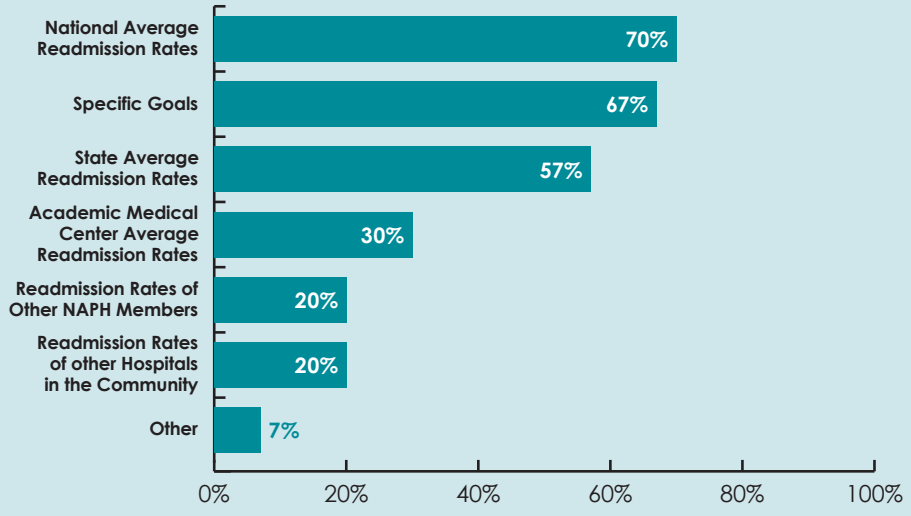


CHART 4 Which type of benchmarks/goals have you selected?



"OTHER" RESPONSES

- Discharge specialist RNs
- Staff nurses
- Patient safety officer, analysts, and interpreter services
- Heart failure educator
- Senior planning director and chief of staff
- Risk-assessment committee
- Research team
- Community-based care managers
- Senior services, medical director, case management, nutrition, physical therapy, and government affairs
- Utilization management
- Nurse educators, nurse program managers, performance improvement specialists, pharmacy representative called in as needed, creation of heart failure nurse position, and home visit physician
- Decision support department and finance

EXAMPLES OF SPECIFIC GOALS

- To be among the top 10% of hospitals in the nation
- Reduce heart failure readmissions by 50%
- Reduce 30-day readmissions by 30% and 90- and 180-day readmissions by 13%
- Within 18 months, reduce heart failure readmissions and readmissions for patients with short length of stay (i.e., 1 to 2 days) by 20%
- Reduce readmission rates to less than 10% by the end of 2011

Data Collection Methods

- 51% of responding hospitals have a mechanism (such as a standard process or a designated individual) to determine which readmissions are avoidable or potentially preventable as opposed to unavoidable (see chart 5 for more detail on methods used by the hospitals).
- 46% track only retrospective readmissions data; 34% track both prospective and retrospective data; and 18% track only prospective data (chart 7).
- 75% track length of stay; 71% track mortality; and 55% track ED visits following hospitalization data in conjunction with readmissions data to support their investigation of the issue.
- 73% include readmission measures on a departmental or organizational wide dashboard or scorecard.
- 33% provide feedback to individual hospital-based providers about their patient specific readmission rates to encourage improvement efforts.

CHART 5 If you have a standard method of determining which readmissions are avoidable, which methodology does your organization use?

Staff defines it based on review of patient's chart or interview with them	35%
3M's Potentially Preventable Readmission (PPR) methodology	19%
Hospitalizations that occur as a result of one of 15 AHRQ ambulatory care sensitive conditions	15%
Other	31%

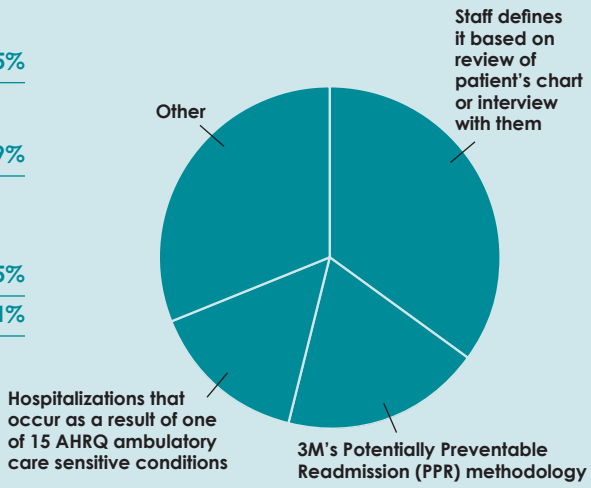
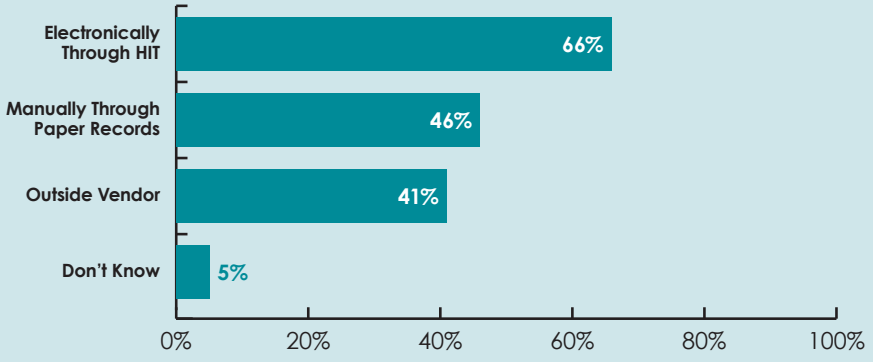


CHART 6 What system do you use to collect readmission data?



"OTHER" RESPONSES

- Thomson Reuters*
- Milliman & Robertson *
- Hospital readmission index developed by Canopy Systems Inc.*
- Criteria developed by California Safety Net Institute
- Institute for Clinical Systems Improvement (ICSI) methodology*
- Staff developed a scantron form to concurrently track and trend readmissions, which includes a chart review and patient interview portion to determine reasons for readmissions
- Criteria developed by the University HealthSystem Consortium

***External consultant to the hospital**

CHART 7 Do you collect readmissions data retrospectively or prospectively?

Prospectively only	11%
Retrospectively only	46%
Both prospectively and retrospectively	34%
Don't know	9%

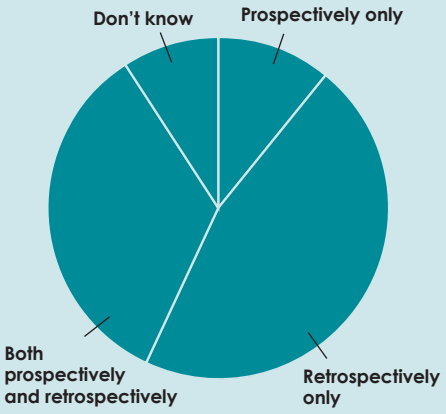


CHART 8 Do you track rates for patients readmitted within these time periods following discharge?

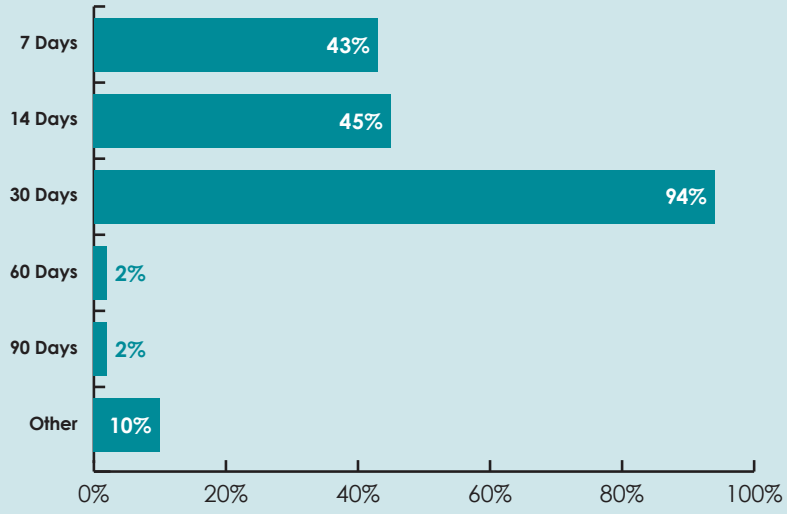
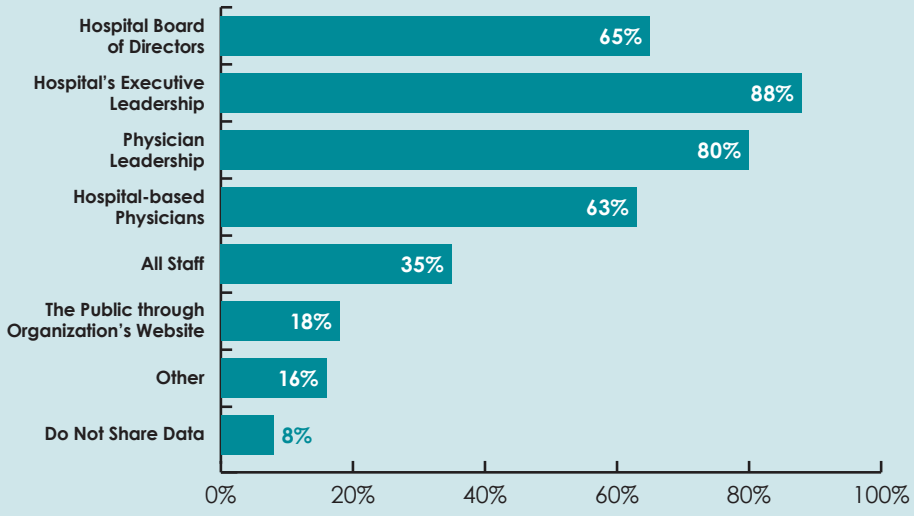


CHART 9 With whom do you share your organization's readmissions data?



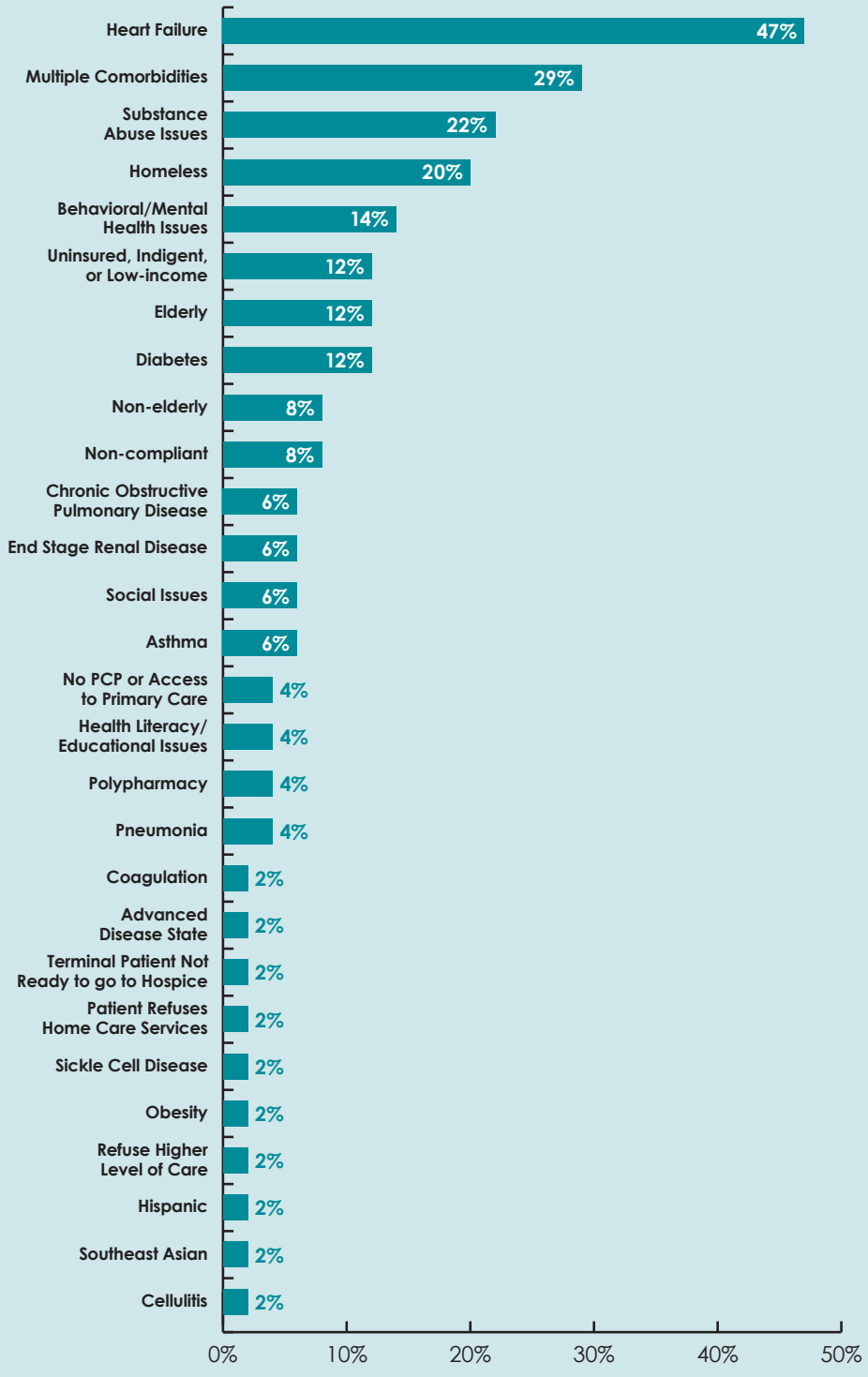
Causes of Readmissions

The survey asked NAPH members to describe in detail the patient populations that are most at risk for readmissions in their organizations. After sorting their responses into categories to determine the most common populations at higher risk for readmission, we found that heart failure patients were the most susceptible (see chart 10 and table 1). While there are common patient risk factors across safety net hospitals, there are also specific, targeted high-risk patient populations within each hospital.

TABLE 1 Examples of specific patient populations at high-risk for readmission in NAPH member hospitals

Elderly populations with multiple comorbidities who are not able to practice self management
Homeless patients with cellulitis
Heart failure patients younger than Medicare age with significant social, emotional, and/or mental illness issues
Young males with heart failure and comorbidities of drug abuse and/or morbid obesity
Renal patients requiring dialysis who are unable to receive it due to their immigration status and return to the hospital requiring readmission
Patients 50 to 60 years of age with heart failure and no health insurance
Patients with chronic medical conditions with co-occurring mental illness, substance abuse issues, and/or are homeless
Heart failure patients with underlying respiratory issues

CHART 10 Which patient populations have you found to be at higher risk for readmission?



Few respondents analyze and compare readmission rates of specific patient populations to discover disparities. However, 43% of respondents track readmission rates by patient discharge location; 35% by presence of comorbidities; and 35% by payor status. Of the hospitals that track readmissions by patients with comorbidities compared to patients with none, 67% have found disparities. Of those that track readmissions by payor type, 61% found disparities (chart 11 and table 2).

CHART 11 Do you track readmission rates for disparities, and if so, have you found disparities in your readmission rates?

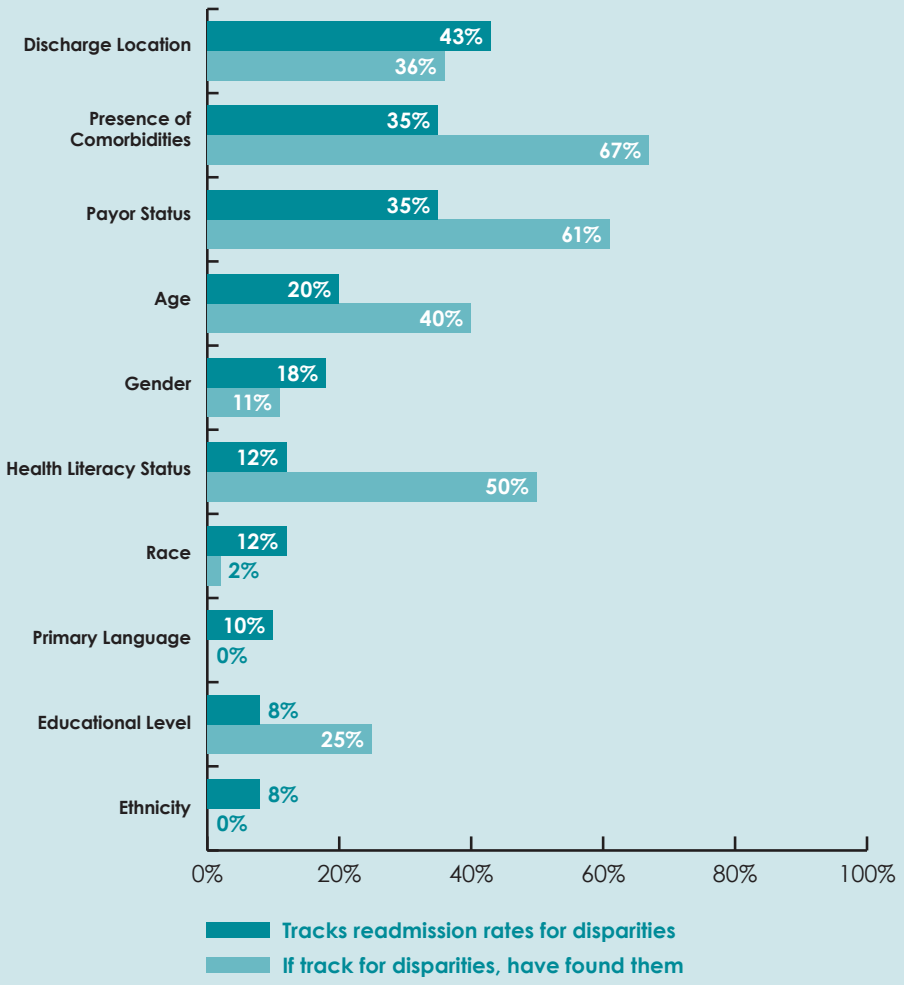


TABLE 2 Examples of readmission rate disparities members have found

Medicaid patients have higher readmission rates.
Indigent are more likely to return.
Patients are unable to pay for medications.
Uninsured and underinsured patients miss appointments and are less likely to follow medication.
Discharging patients to a homeless shelter leads to higher readmission rates.
Patients with little social support at home have higher readmission rates.
Patients discharged to a SNF have higher readmission rates.
Patients discharged to a home health agency have higher readmission rates.
Older population is less likely to practice self management.
The average age of readmitted patients is 54.9, lower than the expected age 60 or higher.
Hispanics have 50% fewer readmissions.
Heart failure patients with a behavioral health secondary diagnosis have higher readmission rates.
Patients with more comorbidities have higher readmission rates.
Younger patients with more chronic diseases have higher readmission rates.

73% of respondents identified patient issues with drug and alcohol abuse to be a significant contributor of readmissions, closely followed by patients not following up with appointments (63% of respondents) and homelessness (55%).

Strategies to Reduce Readmissions

- 38% assign discharge responsibilities to residents and 33% assign them to attending physicians (chart 13).
- 65% of respondents provide both an interpreter for oral discharge instructions and translated written instructions for limited English proficient (LEP) patients (chart 13).
- 71% follow up (by phone, email, or sharing of patient's electronic medical record) with skilled nursing facilities, 67% with rehab facilities, 65% with home health agencies, and 45% with patient's primary care physician (chart 15).
- 28% of respondents have created new positions within their organizations to facilitate the discharge process (table 3).

CHART 12 To what degree do you believe these issues contribute to readmissions in your organization?

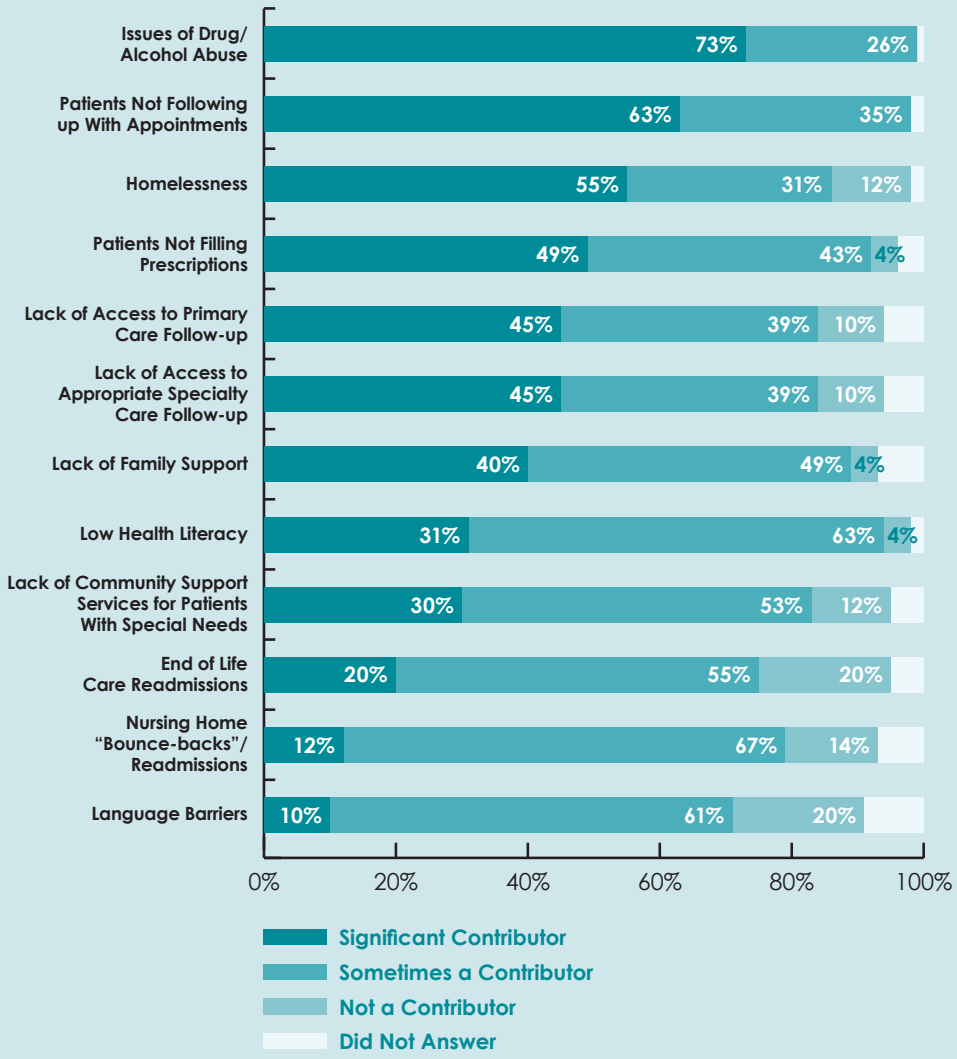


CHART 13 Who has primary responsibility for discharging patients?

Residents	38%
Hospitalists	17%
Attending Physicians	33%
Patient's Private Physician	4%
Other	7%
NPs/PAs	2%

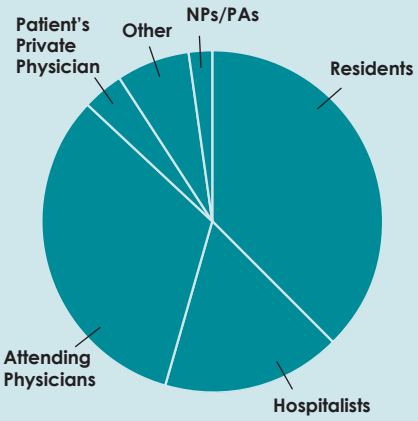


CHART 14 Do you have the following discharge processes in place for Limited English Proficient (LEP) patients?

Provide Written Discharge Instructions in Patient's Preferred Language Only	10%
Provide Oral Discharge Instructions With the Use of an Interpreter Only	18%
Both	65%
Neither	6%
Other	2%

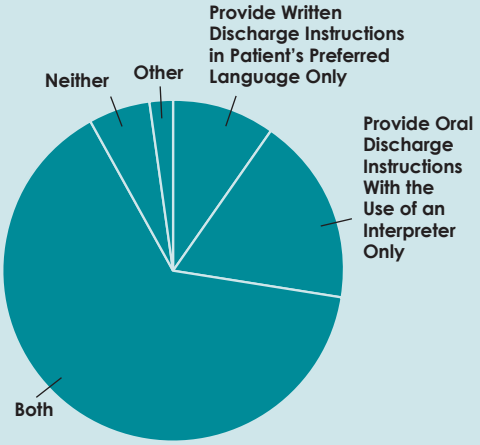


CHART 15 Which modes of communication do you employ to communicate with patients' community providers?

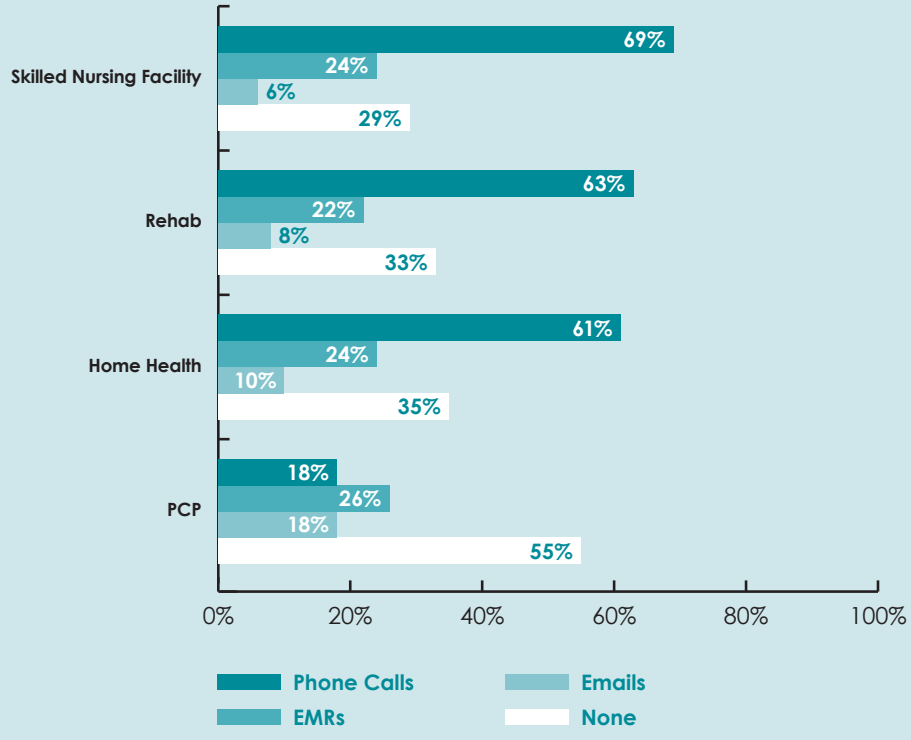


TABLE 3 Examples of discharge coordinator position responsibilities

A discharge coordinator position provides discharge education to cardiac surgery patients and monitors the patient for up to 30 days post-discharge through follow up phone calls.
Case manager identifies heart failure patients and ensures discharge medications, teaching, and follow-up clinic appointments are scheduled. Pharmacists ensure patients have a 30-day supply of meds and are taught about medication compliance.
Transition planners act under direction of social worker or case managers to carry through transition plan.
Hospitalist program admits patients when the resident program is capped and a discharge lounge facilitates the patient vacating the actual bed on the nursing unit.
A team that includes a social worker, RN, and a clerical associate are responsible for patients with complex medical conditions and/or readmissions by facilitating decreased length of stay and gaps in care, as well as transition of care, for patients post-discharge. This includes a 48-hour post discharge phone call, home care referral, and primary care appointment and referral to outpatient care manager.
A designated "discharge nurse" reviews the discharge instructions with the patient and/or family or caregiver. These instructions include educational material, follow-up appointments (if indicated), and prescriptions.
A clinical nurse dedicates time to follow and discharge heart failure patients either in person or by phone to make sure they are aware of risk factors and are compliant with instructions. Medication schedules can also be modified through coordination with a physician.
Discharge RN completes discharge paperwork, discharge education, compliance with core measures, and medication reconciliation.

CHART 17 Have you attempted to create partnerships with these community organizations to improve care coordination?

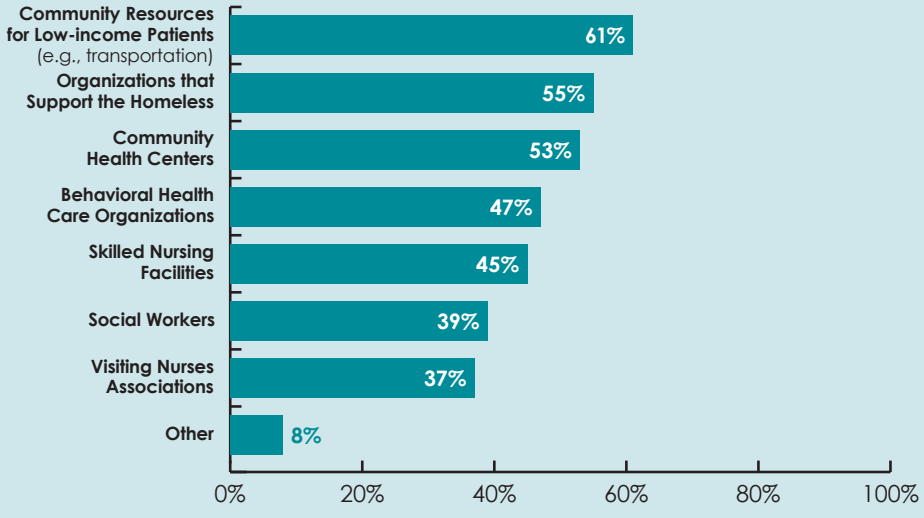
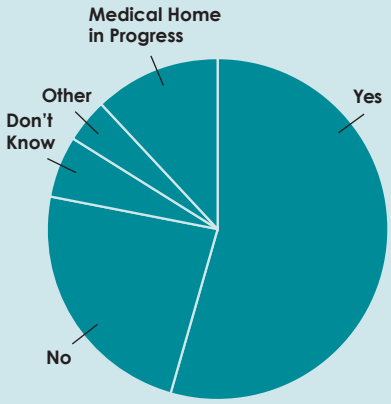


CHART 16 Has your organization established patient-centered medical homes in any of its outpatient clinics to improve care coordination and/or reduce readmissions?

Yes	55%
No	24%
Don't Know	6%
Other	4%
Medical Home in Progress	12%



NAPH based a group of survey questions on a document published by the Health Research and Education Trust (HRET) called the *Health Care Leader Action Guide to Reduce Avoidable Readmissions*.[1] This action guide provides strategies for hospitals to follow at different stages of the discharge continuum to reduce avoidable readmissions: pre-discharge, during discharge, and post-discharge. The survey asked respondents to identify which strategies they use as standard practice during these three key time periods (see charts 18, 19, and 20).

CHART 18 **Have you implemented any of the following processes as standard practice during hospitalization to prepare patients for discharge?**

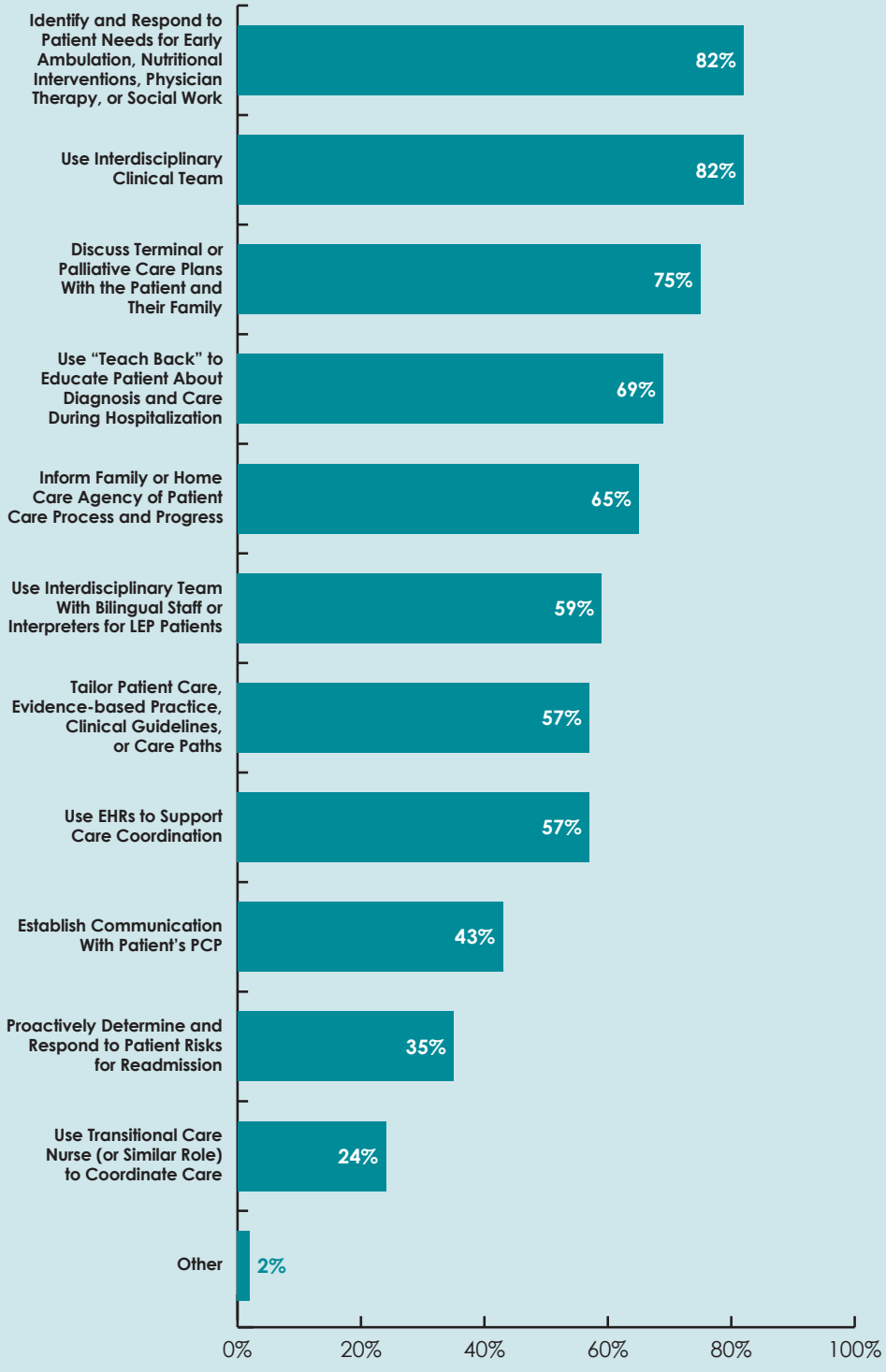
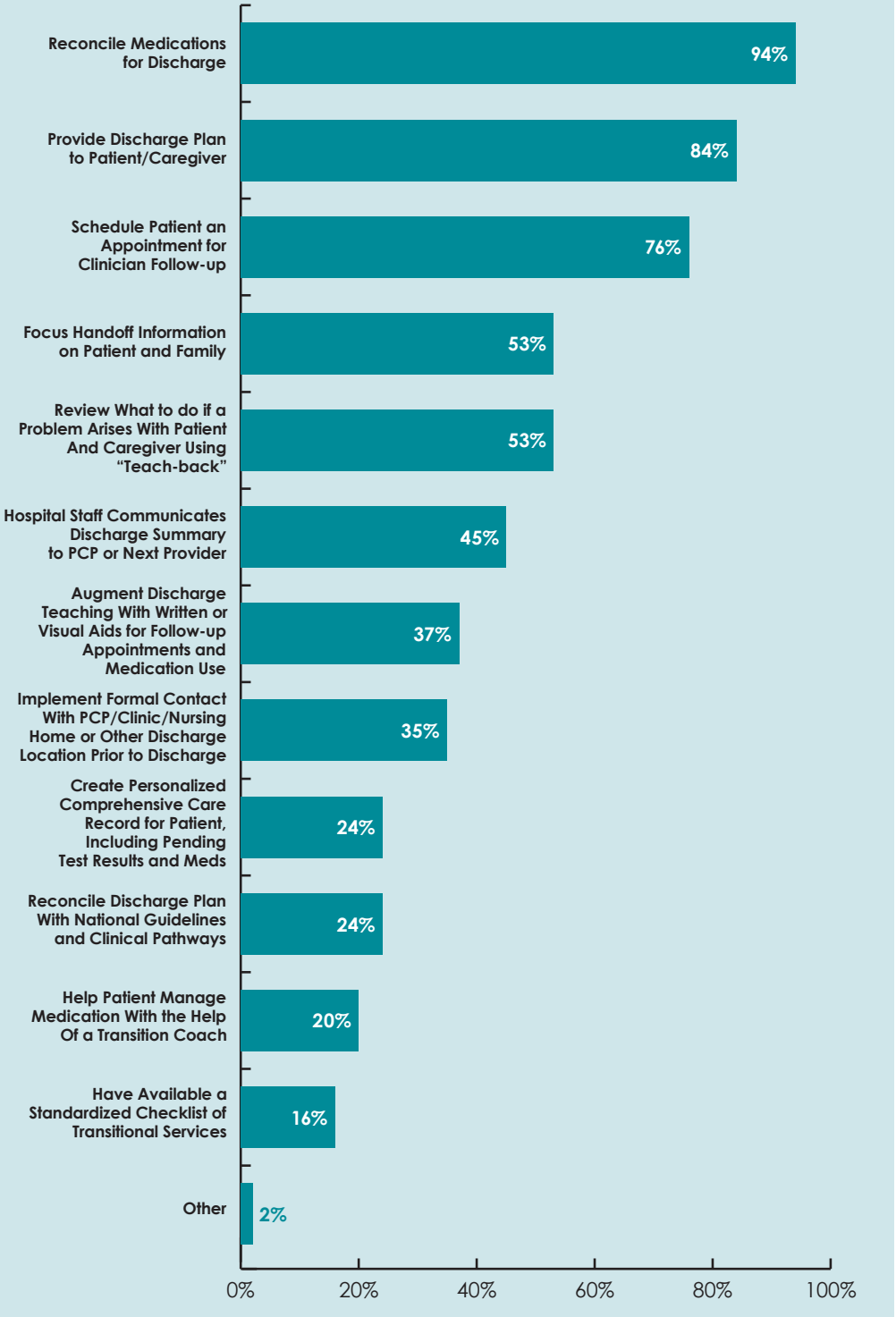
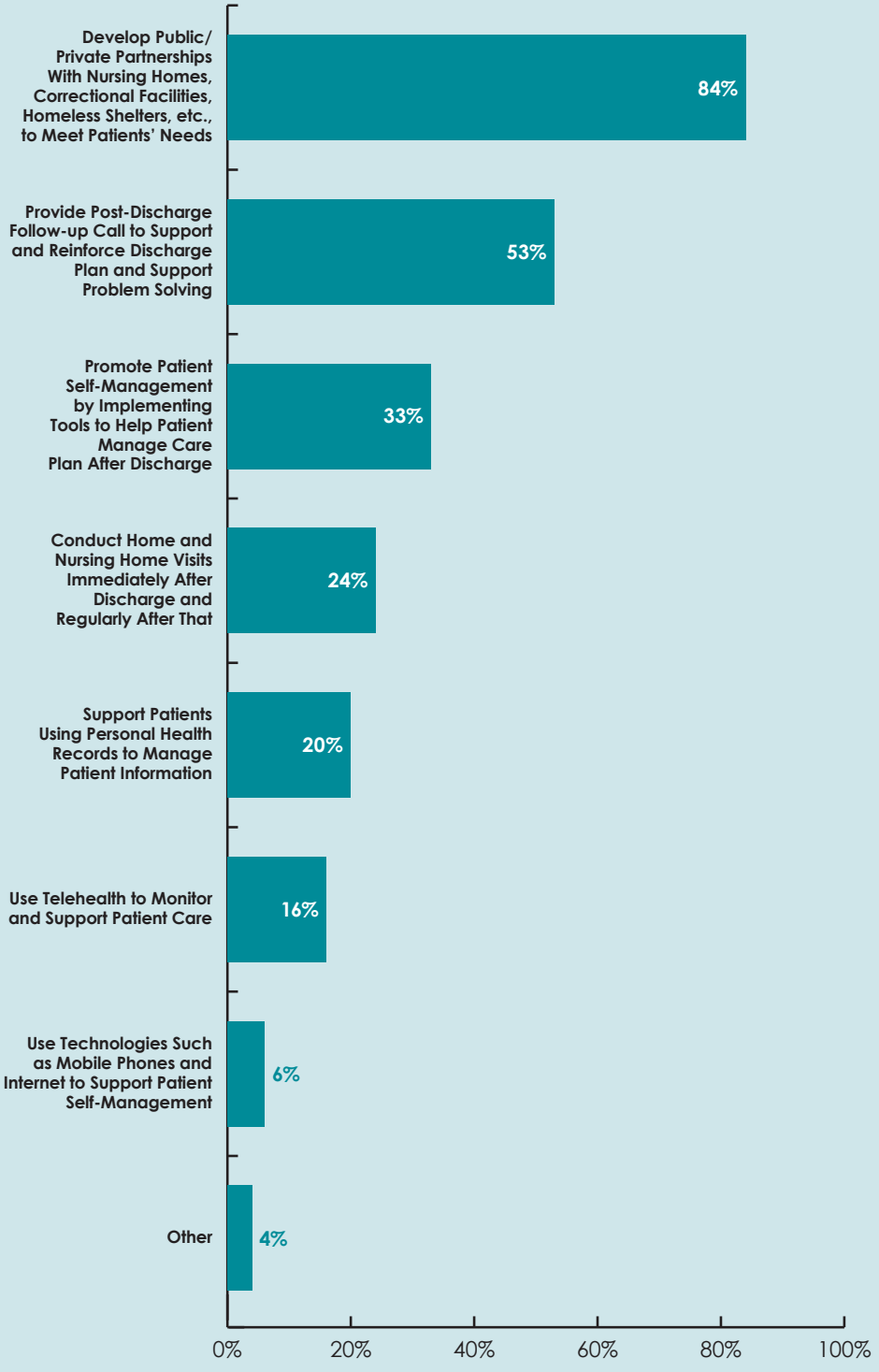


CHART 19 Have you implemented any of the following processes as standard practice at the time of discharge to prepare patients for discharge?



While there are common patient risk factors across safety net hospitals, there are also specific, targeted high-risk patient populations within each hospital.

CHART 20 Have you implemented any of the following processes as standard practice post-discharge?



NAPH members are forming partnerships with community organizations to improve care transitions.

Respondents were asked to identify strategies they implemented that had an impact on reducing readmissions within their organizations and reported 55 total strategies, which we grouped into seven categories (see table 4).

TABLE 4 | What strategies have you implemented that have reduced readmissions in your organization?

Category (55 Total Strategies)	Example of Strategies
Increased support & communication with patients/family (14 strategies)	Nurse and social worker teams provide wrap-around support
	Purchased scales for all patients discharged with heart failure
	Provide telehealth for heart failure patients
	Heart failure team has been addressing readmissions with discharge teaching by RN
	Nurse managers call patients to assess understanding of instructions and follow up reminders
	Advanced practice RN for cardiology visits patients in house prior to discharge, calls patient to remind of follow up appointment, and assesses level of compliance to plan
	Focused on the discharge process and educational information given to patients to reduce children's asthma readmissions
	The nurse on duty the night prior to discharge discusses discharge plan with patient
	Find group homes for homeless
	Implemented intensive case management and follow up with patients at home by phone
Improved processes care delivery (11 strategies)	Internal medicine residents have reduced heart failure readmissions through 100% compliance with core measures
	Physicians adopted a team approach to discharge
	Unit nurses changed process for daily weights instead of using bed scales
	Implemented disease-specific pathways and review of evidence-based measures and standardized order sets
	Made enhancements to electronic medical record
	Brought together a multidisciplinary group from across the organization (hospital, clinics, long-term care)
	Created discharge standards for skilled nursing facility discharges to avoid rushing paper work
Increased communication between inpatient providers & other providers (9 strategies)	Referred appropriate heart failure patients to inpatient medical detox unit and outpatient substance abuse referrals
	Ensure heart failure patients have follow up appointments in hand
	Partner with hospice
	Partner with county health department to serve as medical home
	Systematic hand-off communication via comprehensive care plan that goes home with patient and is referred to by primary care and follow up providers
	Have a designated nursing home in the community
	Focused process for skilled nursing patients to ensure a smooth transition of care
Addressed medication needs (8 strategies)	Fill prescriptions prior to discharge
	Decreased readmissions in newborns by implementing bilirubin protocol
	Give patients a list of local pharmacies
	Pharmacist calls patient ready to be discharged to ensure understanding of medication instructions
	Social workers identify and assist high risk population for readmissions by helping them enroll in hospital's pharmacy discount program
	Modulate medication dosages in the outpatient setting

TABLE 4	What strategies have you implemented that have reduced readmissions in your organization? (continued)
Implemented a specific improvement model (6 strategies)	Implemented a disease management program
	Currently working on heart failure readmission rate through the development of a chronic care model coordinated with hospital care
	The patients that are currently being seen for Project Red have had a very successful low readmission rate for heart failure
	Heart failure readmissions implemented best practices from American College of Cardiology Hospital 2 Home initiative
	Interventions implemented as a result of the Readmission Value Stream Breakthrough Events (LEAN) has produced a 10% decrease in readmissions
	Lean Kaizen methodology
Identified high-risk patients/contributing factors to readmission (4 strategies)	Collect information prospectively on the causes of each readmission
	Produce a daily report of all readmissions with case review to identify contributing factors
	Cardiology PCC visits patient to assess risk for readmission
	Unit discharge facilitators conduct assessment if patient is a readmission, patients are readmitted back to discharging unit
Developed a heart failure unit (3 strategies)	Developed a chest pain unit to address patients who frequently go to the ED because they were unable to get into hospital's primary care system.
	Chest pain admissions and readmissions using an "observation unit" based on the Australian Model

Conclusion

Although safety net hospitals have focused on reducing readmissions for the past several years, the problems associated with readmissions are complex. A national policy that will require hospitals to meet specific hospital readmission rates or face financial penalties will soon be implemented, making sustained improvement in readmission rates even more crucial for safety net hospitals. Implementing, measuring, and analyzing evidence-based or innovative strategies within safety net hospitals and sharing success stories with colleagues can help to address the issue. NAPH offers multiple resources for members that facilitate the exchange of successful strategies, such as webinars, conference presentations, and publications. The NAPH website highlights innovations developed by members, as well as other evidence-based tools and programs for reducing readmissions (http://naph.org/Main-Menu-Category/Our-Work/Quality-Overview/Reducing-Readmissions.aspx). To display an innovation related to readmissions from your hospital, please contact Katie Reid, Research Associate at NAPH (ksreid@naph.org). ■

Notes

1. Osei-Anto A, Joshi M, Audet AM, Berman A, Jencks S, *Health Care Leader Action Guide to Reduce Avoidable Readmissions*. Health Research & Educational Trust, Chicago, IL. January 2010.