

BEST PRACTICES FOR REDUCING HOSPITAL READMISSIONS

Improve Discharge Planning

Plan at the time of the sentinel admission

- Require that a proper discharge plan is in place
- Refill prescriptions and schedule a primary care appointment prior to discharge







Identify high-risk individuals

- Target interventions towards high-risk individuals to allow payers and providers the opportunity for real impact
- Help the uninsured and underinsured obtain primary care through free clinics and prescription drug assistance programs
- Check in with high-risk patients after discharge and use telemonitoring devices that relay critical information





Schedule a Seven-day Follow-up



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- •CMS launched a pilot program from 2008-2010
 - •Hospitals aimed to lower hospital readmissions within 30 days of discharge by 2 percent.
- •Valley Baptist Medical Centers in Brownsville, and Harlingen, Texas
 - •Achieved 2.8% and 4.2% reductions in readmissions by working with physicians to ensure patients were being scheduled for follow-up visits within seven days



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Memorial Herman Memorial City Medical Center

- A 427 bed, private, nonprofit teaching hospital located in Houston Texas
- Approach:
 - Planning for discharge begins upon admission-- staff actively educating patients about their disease and connecting patients with a source of ongoing care
 - Implementation of "one-minute rounding": bedside nurses discuss what the patient was admitted for and the plan of care
 - Use of risk-assessment software to help case managers establish the appropriate level of care and assess a patient's readiness for discharge
- Results: The hospital has performed well above national averages on measures of AMI and pneumonia care, and is currently in the top 10 percent for these conditions

Readmission Rates						
	Average readmission					
	rates	Heart Attack	Heart Failure	Pneumonia		
National Average	N/A	19.7 %	24.7 %	18.5 %		
National Top 10%	19 %	17.9 %	22.5 %	16.7 %		
Memorial City						
Medical Center	18.62 %	16.1 %	21.9 %	14.4 %		

University of California, San Francisco (UCSF) Medical Center

A 559 bed academic medical center located in San Francisco, CA

Exhibit 7. Key Metrics of UCSF Medical Center's Heart Failure Program							
	Baseline 2006	Goals	2009	2010	2011		
30-day readmission rate for all-cause heart failure†	23%	16%	24%	19%	13%		
90-day readmission rate for all-cause heart failure†	45%	31%	40%	31%	26%		
Home-care referrals	n/a	90%	51%	63%	74%		
Scheduled follow-up appointments	n/a	90%	77%	91%	96%		

[†] Readmissions for any cause at UCSF Medical Center among patients age 65 and older admitted at UCSF with a primary or secondary diagnosis of heart failure.

• **Challenge:** The potential of less intensive approaches focused on improving patient education in the hospital and transitioning patients to post discharge care has not been fully explored

Approach:

- Conducted assessments for heart failure patients within 24 hours of admission
- Revised patient education materials and developed tools to promote health literacy
- Instituted a "hand off" procedure-- identified follow-up concerns for each patient

Results:

- Rates of all-cause heart failure readmissions declined by 46 percent within 30 days of hospital discharge and by 35 percent within 90 days
- From 2009 through 2011, scheduling of follow-up appointments at discharge increased from 77 percent to 96 percent for heart failure patients, while those scheduled to occur within seven days rose from 53 percent to 76 percent of the patients
- The average length-of-stay for heart failure patients admitted or readmitted to the medical center from 6.2 days before the intervention to 5.7 days in the second year of the intervention

McKay-Dee Hospital

	National Average	McKay-Dee Hospital
30-day readmission rate for heart attack	19.70%	18.20%
30-day readmission rate for heart failure	24.70%	20.10%
30-day readmission rate for pneumonia	18.50%	15.20%
Heart attack 30-day mortality rate	15.50%	15.80%
Heart failure 30-day mortality rate	11.60%	11.90%
Pneumonia 30-day mortality rate	12.00%	13.30%

- A 352 bed non-profit hospital in Ogden, Utah
- Challenge: McKay Dee hospital wanted to reduce hospital readmission rates
- Approach:
 - Staff identifies and educates all patients with heart-disease.
 - Nurses and doctors work closely with these patients and maintain check-ins and follow-up after discharge
 - Nurses call all heart failure, catheter, and hospitalist patients after discharge to identify and address problems before they are serious enough to require readmissions
- Results: McKay-Dee Hospital Center has readmission rates in the lowest 3 percent in all three clinical areas reported by CMS. October 2008 through April 2011 period



John Dempsey Hospital/University of Connecticut Health Center

- A 184 bed medical center located in Farmington, CT.
- Challenge: John Dempsey Hospital's 30-day readmission rate for Heart Failure patients in 2009 was 27.5%
- Approach: In 2010, a team was established in the hospital to help achieve the following goals:
 - Improve communication across settings
 - Standardize heart failure education across settings utilizing health literacy principles and cultural awareness
 - Share readmission reports including detailed chart reviews from all settings

Results:

 The overall 30-day readmission rate dropped from 27.5% (2008) to 19.1% (2011). The current heart failure 30-day all cause readmission rate for April 2011-May 2012 is 15.9%



