New Directions in Healthcare: Progress in Reducing Hospital Readmissions

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This is New Directions in Health Care, The Commonwealth Fund's podcast, and today we're talking about progress in reducing the costly problem of unnecessary hospital readmissions.

We begin our discussion with 71-year-old Harry Yowell who recently had knee replacement surgery. It went well, and two days later, he was discharged from the University of Virginia Medical Center.

"Good afternoon, Mr. Yowell. How are you doing today? How have you been feeling?"

To improve the odds that patients won't come back, the hospital works with a service that monitors patients.

"How are you doing with your pain meds? Just taking Tylenol. That's good."

Nurse Lisa Slate showed Yowell and his wife Barbara how to use simple equipment to check Harry's vital signs and transmit the data.

"What they measure specifically are their blood pressure, their oxygen saturation, their heart rate and their temperature."

Yowell said it was easy enough, and he was happy to be out of the hospital.

"Obvious reasons. I wanted to be home where I've got my TV, my remote control, my family and everything around."

Barbara Yowell found the service reassuring:

"It makes it easy. If anything came up, if Harry had any questions, we could call them."

And visiting nurse Angela Key-Kirby was on call to investigate any possible problems.

"Like when they are having a little bit of an elevated temperature, we'll go out and check and see if the wound looks different, if we're noticing any other symptoms, and then see if the patient can go to the doctor."

Even if things appeared to be fine, Slate made sure Yowell kept follow-up appointments.

"When they go home from the hospital and they don't see a physician in the next few weeks or so, that's when they're so much more likely to end up being readmitted."

Today, hospital administrator Maggie Short is happy to report readmissions are down.

"We've seen a 45 percent decrease in their readmissions."

The University of Virginia is not alone according to Douglas McCarthy, Senior Research Director for Tracking Health System Performance at the Commonwealth Fund. He shares data from the Fund's latest ***Scorecard on State Health System Performance.***

"Among Medicare beneficiaries we see a large drop in hospital readmissions in 2012 and continuing in 2013, which is the latest year of our data. We measure this rate as the number readmissions for every 1,000 Medicare beneficiaries, and this rate dropped about 10 percent in 2012 and by more than 12 percent in 2013."

One likely driver of change, he says, is fines assessed by the federal government against hospitals with excessive rates of readmission.

"In 2012 the federal government began financially penalizing hospitals with high rates of readmissions for certain common conditions such as heart failure and pneumonia, and this policy accelerated the trend toward lower readmissions that has continued."

Elizabeth Bradley agrees. She's a professor of public health at Yale University and the lead author of a study on national campaigns to reduce readmissions. Her team looked at heart failure patients treated at medical centers which were part of the STAAR or H2H initiatives. Researchers found several reasons why patients came back to the hospital when their medical conditions didn't warrant in-patient care.

"They may have actually not been given the clearest instructions about how to care for themselves, and that's where we really think we can make an impact. If there's a way to make people really connected as they get discharged—to the right medication, the right advice, someone they can call, they may be less likely to get readmitted."

No one knows how many cases involve stressful and unnecessary readmission, but Bradley believes the financial costs are considerable.

"If we could treat these readmissions more on the out-patient side and keep people home but more closely monitored in terms of their medications and what not, then we really don't have that large number of readmissions, which has been estimated might be costing us as much as $20 billion a year."

So how have the most successful medical centers reduced their rates of readmission? At The Commonwealth Fund, Douglas McCarthy says coordinating care is key:

"We did some case studies in leading communities around the country that have been able to see some changes in this area, and what they learned is that to be successful, this effort requires cooperation among all the providers, and this would include home health agencies,

skilled nursing facilities and even community organizations such as area agencies on aging that can play a role in helping seniors to be prepared when they get home to have a successful recovery."

Elizabeth Bradley's research shows that coordinated care is more effective when combined with at least two other strategies. Hospitals should, for example, make sure patients are scheduled for follow up visits with primary care physicians or specialists. They and their caregivers should receive clear instructions on taking medications and intensive education on what to expect once they leave the hospital.

"These are normal recovery symptoms, and here's a phone number you can call to get more advice if you're really nervous about it, but don't fret too much if you have these—heavy patient and family education. It takes a number of these, working in tandem, to really make a difference. Each piece is a little bit of an improvement, and in our studies we show that those hospitals that have three or more of these, those are the hospitals that have lower readmission rates."

Of course doctors, nurses, and other hospital-based providers are busy people, and making changes to their routines before discharging patients will involve changing habits and ways of thinking.

"It's almost like being in a new business. You're not just taking care of the patient during their acute stay while they're within your four walls, but actually you've got to think forward to even what their lives are like as they go out for the next month, and that requires nursing to think differently about what they do, it requires connections to the outpatient primary care physicians that were not always as robust as now they are starting to be. Sort of a new culture has to come about to have a hospital take charge of even patients who've been discharged a month ago."

Electronic medical records can help reinforce new hospital protocols when discharging patients, and Bradley says strong leadership was clearly a factor at the most successful medical centers she studied.

"At the end of the day the culture and the leadership of these hospitals and these physician practices and nursing homes is just fundamental. We see this again and again in our qualitative studies. No matter what strategies you undertake, at the end of the day if the senior teams and the senior, respected clinicians take this seriously, that we can, in fact, reduce readmissions, it makes a difference, and it really benefits clinical care."

Bradley adds that strategies should be tailored to the demographics and geographics of each medical center. Large urban facilities serving patients from around the world, for example, may do things differently than small, rural hospitals, but she and Douglas McCarthy agree that all can make substantial reductions in the number of unnecessary hospital readmission.

You've been listening to ***New Directions in Healthcare,*** The Commonwealth Fund's podcast. You'll find our latest ***Scorecard on State Health System Performance*** on our website, CommonwealthFund.org.