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Thinking Outside the Hospital Box Hospitalists, Other Initiatives Help Cut Readmissions

by Steve Raphael

Grappling with the dual challenge of improving quality and reducing cost, Medicare is zeroing in on lowering hospital readmissions as one way to do both. Readmission was once considered an inevitability – “frequent flyer” patients, as returnees were often dubbed. However, with Medicare approaching insolvency, the healthcare profession has begun exploring ways to reduce the number of readmissions.

The federal government, hospitals, and insurers are either in the middle of pilot projects or have already created programs. IPC The Hospitalist Company began 15 years ago to supply hospitalists to hospitals as a way to curtail costs.

The Office of Management and Budget says reducing hospital readmissions could save the healthcare system \$26 billion over the next 10 years. The Centers for Medicare & Medicaid Services (CMS) puts the cost benefit at \$17.4 billion. It's not surprising, then, that both the House and Senate healthcare bills have provisions that penalize hospitals for unnecessary readmissions by reducing their Medicare payments.

The April 2009 issue of the *New England Journal of Medicine* included a study that found one-fifth of all hospitalized fee-for-service Medicare patients were readmitted within 30 days of discharge and 34 percent within 90 days. Half had not seen a doctor since their release.

The medical profession is discovering that it takes a multi-pronged, common sense approach to keep patients from reentering hospitals needlessly. The approach includes educating the patient about taking his or her medicine, contacting a primary care doctor soon after discharge, and following dietary instructions.

All the approaches are based on one thing: communication. “That is really the gap that causes readmission – lack of follow up,” says Awo Osei-Anto, researcher for the Health Research and Educational Trust (HRET), an affiliate of the American Hospital Association (AHA).

“All too often, medical providers mistakenly assume that discharged patients are stable until they see their primary care physician or home care nurse,” says Dr. Adam Singer, Chairman and CEO of IPC. “In reality, the lack of communication between patients and providers during this time can result in setbacks for the patient, maybe even a re-hospitalization.”

HRET has developed a plan of action to aid hospitals that are trying to lower readmissions. The plan of action, called Effective Transition, spells out the steps that should be taken during three phases: while the patient is in the hospital, during discharge, and when finally at home. The hospital should create a team of nurses and other support personnel who can educate hospitalized patients about their diagnoses and emphasize that patients should communicate with their primary care doctors upon discharge. Discharge duties include scheduling and preparing patients for doctor appointments and assisting patients with their medications. In the post-discharge stage, nurses visit the patients at home, follow-up via telephone, and establish community support networks.

Other organizations have put their own programs in place, all employing similar strategies, including:

- CMS, in April 2009, launched a three-year Care Transitions Project with quality improvement organizations in 14 states to provide seamless transitions from the hospital to skilled nursing care or home healthcare. CMS says it is beginning to see readmissions

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decrease in all 14 states.

- STAAR, State Action on Avoidable Rehospitalizations, currently operates in Massachusetts, Michigan, and Washington State. STAAR was launched in May 2009 by the Institute for Healthcare Improvement (IHI) with a grant from the Commonwealth Fund. Organizations in the three states are bringing together local hospitals, physicians, and other providers to improve transitions of care.

- The Visiting Nurse Service of New York has designed and implemented interventions to improve care for its patients, both while they are hospitalized and post discharge. Called the Transitional Care Collaborative, the program relies on risk assessment tools and frequent follow-up visits by phone or in person from nurses and home health aides.

- The Society for Hospital Medicine's Project BOOST (Better Outcomes for Older Adults through Safe Transitions), begun in July 2008 at six sites, has expanded to 30.

Individual hospitals have developed their own programs. Virginia Mason Hospital in Seattle and insurer Group Health in Bellevue, Washington, have designed a new patient education program. Summa Health System in Akron, Ohio, targets low-income elders with chronic illnesses in community-based, long-term care facilities. Before discharge, hospital personnel perform risk appraisal and provide integrated medical and psychosocial care. The team employs an RN as care manager.

The AHA says it supports efforts to reduce preventable readmissions, but is concerned about expanding penalties. It argues that many factors outside of a hospital's control can lead to a hospital readmission. According to the AHA's Nancy Foster, Vice President

for Quality and Patient Safety Policy, hospitals have taken the lead to reduce readmissions, adding that the AHA is gathering best practice strategies from around the country to post on its web site.

IPC calls its program transition management. The hospitalist's role begins when the patient is admitted for the first time. The patient's primary care physician has the option of transferring patient care responsibilities to the hospitalist during the patient's hospital stay. Upon discharge, the patient returns to his or her primary care physician.

The company developed its own software, called IPC-Link, to manage patient care after discharge. Within minutes after a patient is discharged, IPC-Link automatically provides the primary care physician and any other physicians on the case with a comprehensive discharge summary, including medication list. The IPC Discharge Center contacts patients within 48 hours to 72 hours after discharge. If a patient reports an unexpected outcome, an IPC-registered nurse is prompted to intervene immediately. IPC now has more than 3 million patient encounters per year.

Hospitals employing the hospitalist model of care deliver better patient outcomes, according to a study published in the Fall 2008 issue of *Human Resource Management*. The study measured performance outcomes in more than 6,000 cases at Newton-Wellesley Hospital in Massachusetts. Compared to the traditional approach, researchers found that the hospitalist model decreased the patient's length of stay, reduced the risk of readmission, and improved coordination between physicians and other members of the healthcare team. □

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