In August, CMS announced a few changes to the Hospital Readmissions Reduction Program (HRRP), changing how pneumonia readmissions are calculated and making excessive coronary artery bypass grafts readmission punishable. These seemingly small changes are expected to save CMS $538 million by increasing the number of hospitals penalized and the amount they’re fined. By the end of 2017, more than half the hospitals in the country will be fined for high 30-day readmission rates according to CMS projections.

There’s been much discussion between CMS, Congress, and hospital groups over how much control physicians actually have on readmission rates. While there is a bill that aims to include socio-economic factors to HRRP, it’s not guaranteed to pass and hospitals are still being fined in the meantime.

If you’re one of the estimated 2,588 hospitals expected to lose up to 3% of their Medicare payment next year, what can you do? What reduction methods are within your ability to make?

Plan discharge early and educate

Once a patient leaves the hospital, either they or a family member takes full responsibility for their care. And while a physician may work hard on providing quality care, if patients don’t maintain that care, they’re likely to be readmitted. It’s crucial for a patient to both understand their post-discharge instructions and know why they’re important. Despite this, many facilities wait until discharge day to create a post-discharge care plan and explain it to the patient.

To counteract this, Beth Feldpush, DrPH, senior vice president at America’s Essential Hospitals (AEH), recommends starting your discharge process the moment a patient is admitted. This gives physicians more time to create an effective post-discharge plan and patients more time to absorb it.

“[Discharge] planning involves identifying at an early stage the patient’s needs; both during their hospital stay as well as post-discharge,” she says. “For example, hospitals should try to employ culturally, linguistically, and educationally appropriate methods of communicating with patients about their diagnosis,
the care they are receiving while in the hospital, and
their discharge instructions to make sure patients
fully understand what care is being provided in the
hospital and what the patient needs to do once they’re
discharged to make sure they remain healthy.”

This early assessment can also find out if a patient will
need more support from community providers and social
service agencies once they are released, she says. Early
planning allows hospitals to reach out to said agencies so
they’re prepared to support patients shortly after discharge.

When talking with hospital staff and executives about
readmission, Joe Kiani, founder of the Patient Safety
Movement Foundation and chair and CEO of the
Masimo Corporation, says he hears most often about
patient education.

“If you look at 80% of everything that goes wrong
in a hospital, it’s due to poor communication,” he
says. “And the handover communication is not just
an issue between clinician to clinician; but clinician to
patients and their families during their hospital stay
and especially at discharge.”

One method he recommends is demonstrating post-
dischARGE instructions to patients while they are still in
the hospital. This gives patients more chances to learn
the correct steps and lets physicians know that the
patient is following them correctly.

“[Don’t tell them] just one time just before they leave,
‘Hey, let me show you how to do this thing.’ ” he says.
“But during their care, while they were there, repeatedly
use the same procedures that you expect the patients
to do when they get home, so that by watching they get
the knowledge of what to do on their own. I don’t know
about you, but I learn well after I’ve been introduced to
something three times, that’s when I finally get it. But
if you get introduced to an idea right before you leave,
amidst all that chaos of exit and worries, it’s probably
not the best time to go over material.”

Create a readmission reduction team

One of the reasons that hospitals struggle is that
the causes of readmissions are all over the map, says
Michelle Schneidermann, MD, a professor of clinical
medicine at Zuckerberg San Francisco General Hospital
(SFGH) and medical director of San Francisco’s Medical
Respite. There are system-level problems that are within
a hospital’s control, such as poor discharge planning and

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care coordination. Then there’s patient-level factors that hospitals can’t do much about, such as substance abuse or mental illness.

“Furthermore, I don’t think there’s clear consensus on what proportion of readmissions are even preventable,” she says. “Last I checked, the literature cites rates somewhere between 5% and 80%, and there’s more emerging evidence that it’s going to shake out somewhere in the 20% range. But it’s really hard to know how to benchmark this measure and I think it’s unfair for hospitals.”

To investigate the causes and solutions to readmission rates, SFGH created a cross-continuum task force that included frontline staff and clinical leaders from inpatient settings, primary care, nursing, and home healthcare. When the task force discovered how low the hospital’s timely post-discharge follow-up rates were, it created a new care model to make sure patients were getting their follow-up visits.

“But this isn’t as simple as it sounds,” she cautions. “Our primary care clinics had to do some real transformational work to create the capacity to see patients within seven days and this was supported by financial practice improvement incentives from one of the managed Medicaid plans, which was super helpful.”

The team also made clinics and primary care facilities responsible for making 72-hour post-discharge phone calls to patients, rather than SFGH. That way, she says, patients would naturally be brought back into primary care rather than the hospital.

“We also learn from small tests that clinics were having a hard time identifying patients for those [post-discharge] phone calls,” Schneidermann says. “So we worked with hospital [Information Services] to create a discharge database in our electronic medical record (EMR) which is accessible to the primary care clinics and can be sorted by date, primary care clinic, provider, and many other variables.”

These changes, plus a few others such as a post-discharge for those without regular primary care and a transitional care nursing program, have made a major impact for SFGH. A year after this care model was implemented, the hospital’s 30-day readmission rate fell from 13.1% to 10.3%, and the percentage of patients attending follow-up visits with seven days of discharge went from 38% to 51%. Of patients who actually attended their follow-up appointment, only 6% needed to be readmitted to the hospital.

Collect data and interview patients

Even with the strides that SFGH has made, Schneidermann says there are still a few significant barriers.

“We don’t currently have a systematic way to predict which patients are at the highest risk for readmissions,” she says. “We definitely have a good sense of who’s at risk based on many deep dives into our population data, but we haven’t figured out how to apply that ‘Spidey-sense’ in an automated and effective way.”

The Parkland Health & Hospital System in Dallas and its nonprofit affiliate, the Parkland Center for Clinical Innovations (PCCI), have been working on new ways to lower readmission rates. Using PCCI’s analytic tools and predictive modeling, the system has been able to identify patients with the highest readmission risk factors. PCCI Medical Director Vibin Roy, MD, MBA, says that combining analytics with a strong hospital team has been extremely effective at reducing readmission rates.

“Based off of that [data] we’re able to alert a team of nurses and case managers who are called the transitional care unit [TCU] at Parkland,” he says. “They’re able to provide some high-level interventions; [they] go and talk with those patients and try to see what potential barriers [patients] have when they get up and out of the hospital, what are some of the issues they may have, making sure they receive increased education and access to resources.”

Many trends and patterns can be gleaned from patient data as a whole, he says. And feeding that information into a predictive model allows facilities to figure out how to best allocate resources to most at-risk patients.

Marilyn Callies, RN, BSN, MBA, senior vice president of transitional and postacute services at Parkland, says when it comes to data collection, it’s also important to get feedback from patients.

“Interview the patients; find out from their perspective why they were readmitted to the hospital,” she says. “Because some things—especially if it’s associated with their index submission and there is some clinical component to it—are easier to define than the ‘all cause’ readmissions. [And] even
with that I would say interview the patient. Because some of the hypotheses that we had for why patients were generally coming back to the hospital for readmission were totally different from the patient’s perspective.”

**Communicate with discharged patients**

Callies adds that the TCU team stays in contact with patients up to 30 days after discharge.

“They are making phone calls to see if [patients] have any questions, are they following their medication regime, if they have any transportation issues to their next appointment,” she says. “Another thing that Parkland has done is implemented acute response clinics that can see patients within one to two days of discharge. Normally a follow-up appointment can take up to two weeks or more. But since opening these clinics in the community, they are able to be seen in a few days.”

To start, TCU teams only followed patients diagnosed with heart failure. Parkland has since phased in other populations and has expanded the program to four of its off-site clinics.

“We really started out looking at patients with congestive heart failure, trying to see if this model would work,” Roy said. “What we found was that this can be an effective model, so we’re expanding it to other conditions and are using analytics to better understand these issues. We’re continuing to build upon each phase of our prior work and prior successes here.”

Kiani also supports keeping patients in contact via phone or electronic messaging after discharge, though he doesn’t think it’s a common practice yet. He notes that many hospital systems and ACOs have been attempting to create better contact with patients and their families through telepresence.

“Unfortunately, many times patients in affluent neighborhoods have more communications with their primary physicians and care providers after surgery that helps them stay on course,” Kiani says. “But in less affluent neighborhoods they don’t have that support system and some tools like telepresence and monitoring are ways that people are looking at to bridge the gap.”

The numbers don’t look too good right now, he says, with between 20–25% of hospitals having an effective telepresence system. While there are challenges to an effective telepresence program, he points out that today’s technology is both getting cheaper and more robust.

“If they tried to do this 25–30 years ago with modems and fax machines and trying to get dial-up, you couldn’t do it,” Kiani says. “But today there’s amazing internet infrastructure out there keeping communications going with patients; it’s getting so much easier. My hope, and maybe it’s not my guess, is that within five to 10 years [telepresence] will be ubiquitous and any patient at risk will definitely be in constant communication with their care providers.”

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**The upside of ISO certification**

**Quality management with ISO 9001:2008 and DNV-GL**

In August, Morehead Memorial Hospital of Eden, North Carolina, became the 150th hospital in the United States to receive ISO 9001:2008 certification from DNV-GL Healthcare. To earn it, Morehead had to undergo four years of preparation and surveys from the DNV, in addition to meeting CMS requirements.

However, DNV-GL doesn’t require that hospitals get ISO certification for accreditation. Which raises the question: Why should a hospital expend the effort for a voluntary certification?

**What is ISO 9001:2008 certification?**

The International Organization for Standardization (ISO) is an independent group based in Switzerland, with members in 163 countries. Founded in 1946, ISO’s goal is the promotion of internationally recognized quality standards for every industry. To date, it has more than 21,000 international standards covering fields from technology, agriculture, food safety, and healthcare.

ISO’s 9001:2008 certification isn’t industry specific and is recognized in over 176 countries. To achieve it, an organization has to show its quality management