

PROFESSION

Quality initiative nets modest drop in readmissions

■ Providing clear discharge instructions and identifying patients at risk for adverse events at home can help prevent rehospitalizations.

By KEVIN B. O'REILLY ([HTTP://WWW.AMEDNEWS.COM/APPS/PBCS.DLL/PERSONALIA?ID=KOREILLY](http://WWW.AMEDNEWS.COM/APPS/PBCS.DLL/PERSONALIA?ID=KOREILLY)) amednews staff — Posted Aug. 5, 2013

A recent study found that a hospitalist-developed set of tools had success in preventing unplanned readmissions. The finding suggests that hospital-centered readmission-reduction initiatives can yield promising results, but health policy experts said that major cuts in rehospitalization rates may happen only when future efforts do a better job of addressing risk factors outside the walls of the hospital.

Researchers examined data reported by a varied, nationwide group of 11 hospitals that participated in Project Better Outcomes by Optimizing Safe Transitions — BOOST for short — between 2008 and 2010. Each hospital implemented BOOST tools in one medical-surgical unit while reporting readmissions outcomes for a matched unit that did not participate in the quality initiative. The project aims to help hospitals provide clearer written discharge instructions and patient-controlled transition records, improve use of "teach back," and identify and address readmission risk factors such as polypharmacy and poor cognitive functioning.

Overall, rehospitalization rates were 14% lower after 12 months in the units where BOOST tools were used, falling to 12.7% from 14.7%. Meanwhile, readmissions actually grew slightly, to 14.1%, in the units where typical care was provided. There was considerable variation in hospital results. One hospital saw its readmissions rate fall by nearly half to less than 10%. Two others cut their readmissions rates by 23% and 17%, respectively, with about one in seven patients being rehospitalized within 30 days.

Other hospital units that started with lower readmission rates saw slower progress. One unit that had an 8.1% rehospitalization rate at the start saw readmissions grow to 8.3% after a year of participating in Project BOOST. An additional 29 hospitals that took part in the quality initiative did not report outcomes data because they lacked matched-unit data or did not have the resources to gather the required information, said the study, posted online July 22 in the *Journal of Hospital Medicine*.

"For the cohort of hospitals that provided data, we saw statistically significant improvement, and I do believe that's real," said Luke O. Hansen, MD, MHS, the study's lead author and a hospitalist at Northwestern Memorial Hospital in Chicago.

Federal funds on the line

Getting the funds needed to work on reducing readmissions is less of a problem for the more than 140 hospitals now participating in Project BOOST. Starting Oct. 1, 2012, the Centers for Medicare & Medicaid Services began penalizing hospitals with high 30-day readmission rates, with cuts expected to reach \$280 million within the first year.

"The burning platform is much more evident now," Dr. Hansen said. "That creates a lot more opportunities for [executive-level] support, and that's essential. The more that this becomes a popular media issue, the more that front-line staff realize that this is important too. There were literally generations of people who thought of discharge as just the last page in the book, and we're evolving away from that."

CMS officials announced that the readmissions rate among Medicare patients dropped to 17.8% during the final quarter of 2012, down from a rate that ranged as high as 19.5% during the previous five years. But the Medicare Payment Advisory Commission and many other experts have noted sharply increased use of observation units to

triage patients and thus avoid inpatient admissions that would count as rehospitalizations.

Project BOOST is an initiative of the Society of Hospital Medicine, which represents more than 10,000 of the nation's 40,000 hospitalists, who specialize in providing acute inpatient care. The project is one of several quality interventions that hospitals across the country are using to improve care transitions and prevent unplanned readmissions.

For example, the University of Colorado Denver's Care Transitions Program involves "transitions coaches" who help patients and families take a more active role in preventing rehospitalizations. The coaching focuses on better medication management, use of personal health records, timely physician follow-ups, and teaching patients how to respond to red flags that indicate their conditions are getting worse.

"Kitchen sink" approach

At Yale-New Haven Hospital in Connecticut, physicians and other health professionals are using multiple methods to tackle the rehospitalization challenge. The hospital's readmissions results have not yet been published.

"We are using the kitchen sink," said Leora I. Horwitz, MD, MHS, assistant professor of general internal medicine at Yale University School of Medicine, also in New Haven. "We do everything that we think will help. We make appointments. We communicate with primary care doctors. We communicate with the nursing homes. We try to get all of our ducks in a row."

In an editorial that accompanied the *Journal of Hospital Medicine* study, co-author Dr. Horwitz stated that better evidence is needed to evaluate how well Project BOOST works in cutting readmissions and whether it is cost-effective. The standard fee for hospitals participating in the project is \$24,000. In addition to help with implementing the tools and phone-call follow-ups, BOOST hospitals get on-site mentoring. More than 4,000 hospitals have downloaded the BOOST tool kit.

In the end, there may be a limit to how much readmission rates can be affected directly by the kinds of in-hospital efforts that are part of interventions such as BOOST, said Ashish K. Jha, MD, MPH, professor of health policy and management at the Harvard University School of Public Health in Boston. He co-wrote a separate editorial in the journal and also is a hospitalist in the Boston Veterans Affairs Healthcare System in Jamaica Plain, Mass.

"My take is that if you're a hospital focused on improving care transitions, then you should look at things like what's in BOOST and other programs and pick and choose things that make sense for you," Dr. Jha said. "But if the goal is really to lower readmission rates, you may find yourself very disappointed, because readmissions have so much to do with so many other things."

"If you want to really lower readmissions, it has to do with a whole series of different things, like investing in relationships with primary care doctors and ensuring that people get home visits," he added. "It requires a different approach to thinking about what the job of the hospital is, and it's much more expensive and much more difficult."

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ADDITIONAL INFORMATION

8 risk factors for readmission

A Society of Hospital Medicine screening tool identifies the "8Ps" that can raise a patient's likelihood of rehospitalization and should be addressed before discharge.

- 1 Problem medications:** Anticoagulants, insulin, oral hypoglycemic agents, aspirin and clopidogrel dual therapy, digoxin or narcotics.
- 2 Psychological issues:** Positive screen for depression or history of depression diagnosis.
- 3 Principal diagnosis:** Cancer, stroke, diabetes mellitus, chronic obstructive pulmonary disease or heart failure.

- 4 Polypharmacy:** Five or more routine medications.
- 5 Poor health literacy:** Patient is unable to do “teach back,” or reiterate the information that health professionals have provided.
- 6 Patient support:** Absence of a caregiver to assist with discharge and home care.
- 7 Prior hospitalization:** Hospital stay within the last six months for nonelective care.
- 8 Palliative care:** The patient has advanced or progressive serious illness, or the attending physician would not be surprised if the patient died within the next year.

Source: “The 8Ps: Assessing Your Patient’s Risk For Adverse Events After Discharge,” Society of Hospital Medicine Project BOOST ([link](#))

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EXTERNAL LINKS

“Project BOOST: Effectiveness of a multihospital effort to reduce rehospitalization,” *Journal of Hospital Medicine*, July 22 ([link](http://www.ncbi.nlm.nih.gov/pubmed/23873709): <http://www.ncbi.nlm.nih.gov/pubmed/23873709>)

“BOOST: Evidence needing a lift,” *Journal of Hospital Medicine*, July 22 ([link](http://www.ncbi.nlm.nih.gov/pubmed/23873749): <http://www.ncbi.nlm.nih.gov/pubmed/23873749>)

“BOOST and readmissions: Thinking beyond the walls of the hospital,” *Journal of Hospital Medicine*, July 22 ([link](http://www.ncbi.nlm.nih.gov/pubmed/23873761): <http://www.ncbi.nlm.nih.gov/pubmed/23873761>)

Society of Hospital Medicine's Project Better Outcomes by Optimizing Safe Transitions ([link](#): <http://www.hospitalmedicine.org/boost>)

“The 8Ps: Assessing Your Patient’s Risk For Adverse Events After Discharge,” Society of Hospital Medicine Project BOOST ([link](http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/PDFs/TARGET.pdf): http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/PDFs/TARGET.pdf)

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