Preventable Readmissions: Why the Answer to This Critical Issue Is (Literally) at Our Fingertips

Changes associated with the Patient Protection and Affordable Care Act—which requires hospitals to reduce preventable 30-day readmissions or face financial penalties—have increased our industry’s focus on this critical issue.

According to a January 2011 article in the *American Journal of Managed Care*, “Recent estimates suggest that almost one-fifth of Medicare beneficiaries discharged from a hospital are readmitted within 30 days, resulting in an estimated annual cost of unplanned readmissions of $17.4 billion.”

Many organizations have calculated what’s at risk for, let’s say, HCAHPS. Yet we find far fewer have fully realized the reality of what’s at risk for preventing readmissions.

But of course, for those of us in healthcare, preventing readmissions is far more than a financial issue. It’s about improving outcomes and providing the best possible care for patients. And because we know that mortality index rates go up in tandem with preventable readmission rates, it’s also about saving lives.

**Readmissions Right Now: A Stagnant Area for Our Industry**

As a nation we’ve shown little to no improvement in this critical patient care area. Data recently released by the Centers for Medicare & Medicaid Services (CMS) shows very little movement in performance on hospital readmissions for heart attacks, heart failure, and pneumonia.

The data found only small changes to the readmissions rate, according to Medicare, which compared data for the years 2007 through 2010 against data for the years between 2006 and 2009.

- The national 30-day readmission rate for heart attacks for the 2007-2010 years was 19.8 percent, compared with 19.9 percent for the prior period.
- The national 30-day readmission rate for heart failure between 2007 and 2010 was 24.8 percent, compared with 24.5 percent.
- The national 30-day readmission rate for pneumonia increased to 18.4 percent for the years 2007 to 2010 from 18.2 percent.

Mortality rates fared no better. While the heart attack death rate showed a slight decline, 30-day mortality for heart failure and pneumonia showed a slight increase. Besides being concerning from a mission perspective, this lack of improvement has financial implications: mortality rates are likely to impact reimbursement as an outcome measure in 2014.

In our research Studer Group® has found one tactic that significantly impacts both readmissions and mortality rates: post-visit patient phone calls.

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Post-Visit Calls Improve Outcomes and Save Lives

Post-visit calls enable us to extend care outside our hospital walls. When executed consistently and done right, post-visit calls reduce readmissions and save lives. They also create better clinical outcomes, decrease patient anxiety, and in general provide a better experience for patients. In other words, they allow us to better fulfill our mission of serving patients to the best of our ability.

Our data consistently shows that when patients do receive a post-visit call, they rank their care in the 90th percentile, on average. When they do not receive a call, they rank their care in the 30th percentile, on average.

Consider the following stories from our partner organizations:

I called a patient who is seen frequently in the Emergency Department at least two times a week, and this most recent visit was for abdominal pain. The patient was in our Emergency Department the night before, and since she is here so much, I almost didn't call her—but I'm glad I did. She was complaining of severe abdominal pain, wasn't taking anything to help, and had shaking chills. I told her she most likely had a fever and she replied, “No, I'm cold.” After much persuasion I talked her into returning to the Emergency Department. When she returned, she presented with a 102 temperature, and it was discovered that she had a ruptured appendix with a possible perforation of the bowel. The patient was transferred to our larger hospital for further specialized treatment, as she had a rare blood disorder.

I was so happy that I made that call because it reminded me of why we do them. It was also a good lesson for the Emergency Department because it becomes easy to not take our frequently seen patients seriously.

Janine Buckland, RN, ACC
Rochester General Health System

A few weeks ago we had an asthmatic patient. After he went home, the patient couldn't afford the new prescription he had been given so he simply didn't fill it. He ended up taking the newly prescribed dosage but with the old inhaler. One of our nurses called this patient a few days post-discharge, and discovered this had happened. She was able to get him back to his physician's office and also to get assistance with the prescription—a “continuum of care” intervention that may have saved a life.

Karen Fraser, RN, BSN
Roper St. Francis Healthcare

I wanted to share that the Emergency Department saved a life today with a post-visit phone call. One of our nurses called a patient seen in the Emergency Department, and the patient shared during the call that she had taken a large number of pills. The nurse immediately called 911 and police were sent to the home where the woman was found to have taken a large number of Ativan. The woman was brought to the Emergency Department for treatment. Without this post-visit call the outcome for this patient could have been fatal. Post-visit phone calls save lives!

Trish Gadberry, MSN, RN, CCRN
Administrative Director of Emergency Services and Evidence-Based Practice
Good Samaritan Hospital

Post-visit calls work. We hear stories like the ones above over and over again, stories that highlight the powerful clinical and human impact of post-visit calls. It's important that we as an industry do whatever it takes to hardwire this tactic so that calls get made with every patient, every time.
Why So Many “Sometimes” Callers?

Since we know post-visit calls work, why aren’t we seeing better results in our readmission rates? Quite simply, it’s because many hospitals that say they’re doing post-visit calls aren’t achieving the frequency required to get results. In other words, they haven’t hardwired the tactic effectively enough to move from being sometimes callers to always callers.

The graphic at right shows the results of a recent survey of webinar attendees we conducted:

We regularly hear comments like:

- We do make calls, just not consistently—OP Surgery always makes calls, IP units do when they have time, and ED never does, for example.

- We don’t know what to do with the feedback. How do we improve processes and get the info back to staff and units?

- Accountability is an issue. We don’t have a verification process to ensure these calls are always made. We find we don’t have a way to break down highest contact rates to see what success looks like, so it’s hard to move the will and the skill of callers.

- We can’t decide whether centralizing resources is better, or if spreading them to individual areas is better, so we didn’t do anything.

The key, of course, is not simply doing post-visit phone calls, but doing them effectively. Studer Group has worked with partners since 2000 on this critical patient care tactic, and over the years we’ve gained valuable insights on how to make it more impactful.

Aiming for Always: Post-visit Calls Done Right

We at Studer Group recommend that hospitals aim for always. We recommend that they attempt to call 100 percent of inpatients discharged home. Attempting to call everyone doesn’t always mean reaching everyone—depending on the department, anywhere from 70 percent to 80 percent is acceptable—but it’s the consistency and the contact rates that move results.

In fact, according to a 2010 *Journal of Emergency Nursing* article written by Stephanie Baker, contacting 50 percent of eligible Emergency Department patients will move results. Just this past quarter, a new partner increased consistency in making calls from their Emergency Department. Contact rates improved by 40 percent, and readmissions were reduced from 8 percent to 5 percent.

The most effective way to implement post-visit calls is via a centralized system in which all the data feeds to one collection point. This allows hospitals to hit the “breaking point” faster because of the accountability factor. The breaking point in this case is reaching enough of the right patients in order to reduce readmissions for certain populations while improving HCAHPS results overall. A central system helps organizations benchmark results and determine which departments are performing best with the calls and contact rates (which, in turn, helps move best practices). Best of all, they see an impact almost instantly.

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A Few Tips for Hardwiring Post-Visit Calls:

• **Move post-visit calls from a “nice to have” to a “must have.”** This is an attitude shift that begins at the C-suite and cascades throughout the organization. Don’t wait until the organization as a whole can start the tactic; instead, choose a few pilot areas and get it right. Prove the concept prior to requiring the tactic for all departments. We find the phased approach works best. With the dollars ultimately at risk, “nice to have” will no longer be the reality.

• **Link the outcome of this tactic into leader evaluations.** If a leader has a goal to improve HCAHPS or reduce heart failure readmissions and she has “skin in the game” to achieve it, she is more likely to hardwire post-visit calls. This quickly moves the leader’s mindset from, “We make calls when we have time,” to, “I know I have to reach 80 percent of my patients discharged from this unit in order to move my results.”

Roper St. Francis Hospital is a master at rolling out post-visit calls across their system. Their effort is entirely quality focused, and leader evaluations are tied to the quality measures that calls improve. They’ve also realized they have $972k at risk due to unnecessary reimbursements if they don’t reduce readmissions.

• **Look closely at who is making the calls.** Who is doing a good job and who is not? Are some nurses getting better contact rates than others? Are they getting better outcomes? Drill down into what might be making them more effective. Is it the time of day they call? Is it the words they say? Is it that some callers are just more dedicated? Maybe they try each number several times and end up getting better contact rates? It’s often something as simple as finding it’s better to call an 80-year-old patient at 7:00 a.m. and a 30-year-old patient at 7:00 p.m.

• **Reward and recognize those who have the best contact rates and outcomes, and share the stories of clinical saves.** One of Studer Group’s partners has a chief nursing officer who holds a weekly huddle with all nurse managers. At that meeting, managers are asked to share a “win” (i.e., a staff member a patient identified on a post-visit call as providing great care), a clinical intervention (an example of a patient receiving a better clinical outcome due to the call), and an insight they gained on how to provide better care. In an inexpensive 30-minute meeting, recognition happens and accountability is reinforced. Another organization updates a board with all of the positive physician feedback obtained during calls.

We find that when a nurse is able to help a patient or save a life, she will never again be reluctant to make post-visit calls…because she sees that they really do make a difference.

• **Don’t let the “clinician vs. non-clinician” debate be a barrier to making calls.** The most important thing is that a patient gets a call to ensure he is complying with medications and discharge instructions, and that organizations have a process to intervene clinically should they need to do so.

You might consider asking nurses who work in the area where patients stayed to make the calls, due to their stronger connection and level of expertise. One organization had non-hospital employees making calls to Emergency Department patients, and they sat around the 10th percentile. Once their own nurses started calling, results moved up to the 70th percentile almost immediately.

In healthcare we tend to get the hard things right. (We do sophisticated brain surgery and heart transplants, after all!) Unfortunately, we don’t always follow up with the smaller things that really connect the dots with patients. That’s a shame, because it’s often the last 5 or 10 percent that makes the most impact.

Post-visit calls seem like such a simple tool, and yet we know from a patient care perspective that there are significant benefits. When we do them correctly they yield major return on investment. Not only do they help us maximize reimbursement, they keep patients safe at home and on the road to recovery. They serve as a touchback that moves results in all key areas, and they’re a win-win for everyone.

To learn more about the power of post-visit calls, please visit www.studergroup.com.