Patient care

Florida Collaborative Leads Charge in Reducing Readmissions

By Jennifer Hicks

Community-focused programs help keep patients from making return visits

With readmissions top-of-mind, Florida hospitals continue to make progress in reducing readmission rates in five focus areas: heart attack, heart failure, pneumonia, hip replacement and bypass surgery. Statewide, readmissions within 15 days of discharge fell by 11.1 percent from September 2008 to September 2010, according to the Florida Hospital Association. That translated into 1,500 fewer readmissions and a savings of $12 million.

One key to success has been the Collaborative on Reducing Readmissions in Florida. Launched by the FHA in 2008, the group's 108 member hospitals and health networks use face-to-face meetings and webinars to share best practices and interventions that have worked in their communities.

"All solutions have to be customized to the local level," so the collaborative facilitates an exchange of ideas," says Kim Streit, FHA's vice president of health care research and information services. Along with addressing established approaches, such as Boston University Medical Center's Project RED and the Society of Hospital Medicine's Project BOOST, collaborative members examine why patients are being readmitted and how hospitals can improve transitional care and patient communication.

Among hospitals that are dramatically driving down readmission rates, communication has moved well beyond simply handing over discharge papers with instructions for home care and follow-up. At Orlando Health, a readmission task force has implemented more than a half-dozen patient- and community-focused efforts that include a house calls program.

"Fifty percent of our readmissions occur within 10 days of discharge, and we found one reason is that patients don't get in to see their physicians soon enough," says David Sylvester, the health system's vice president of post-acute care and transition services. "So, our house calls program bridges that first week to make sure patients understand their medications and when to take them."

Sylvester also oversees efforts that include a visiting nurse program, an evaluation team that studies patients who have been readmitted within 30 days of discharge, an emergency department-based readmission prevention team and a bedside medication delivery program. The programs have uncovered some simple causes for readmissions, such as lack of transportation for physician follow-up. The initiatives have produced a 50 percent reduction in readmissions.

"Among Medicare patients with pneumonia, myocardial infarction and congestive heart failure, our readmission numbers were in the 20-24 percent range," notes Marvin Mengel, M.D., chairman of the Orlando Health Readmission Task Force, which launched in January 2011. "As our initiatives have taken effect, the readmission rate for that group has dropped to just over 10 percent" as of September.

Meanwhile, the collaborative has turned its attention to the launch of a care transitions program. "We're formulating how we're going to reach a goal of reducing readmissions by 20 percent" through improved transitions, says the FHA's Streit, a goal already identified for 2013 by the Centers for Medicare & Medicaid Services.

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