2014 Benchmarks in Reducing Readmissions

Brought to you by the Healthcare Intelligence Network

www.hin.com
Reducing Readmissions
Benchmark Data

- While great strides have been made in the reduction of 30-day all-cause hospital readmissions, CMS still penalized more than 2,200 hospitals in 2013 for exceeding 30-day readmission rates for heart failure, pneumonia and myocardial infarction.

- In its **fourth annual** Reducing Hospital Readmissions e-survey conducted in December 2013, HIN captured the latest initiatives and programs to reduce readmissions by patients with these costly conditions and others by more than 100 healthcare organizations.

- This presentation contains highlights from those responses.
Reducing Readmissions

Benchmark Data

- **Figure 1** - Have Program to Reduce Readmissions
- **Figure 2** - Targeted Populations
- **Figure 3** - What’s Done for Patients Upon Discharge
- **Figure 4** - Most Successful Strategy to Reduce Readmissions
- **In Respondents’ Own Words:** Most Successful Workflow, Processes and Tools
- **Sources**
- **For More Information**
- Two-thirds (67 percent) of respondents have a program to reduce readmissions.
- This is a slight decrease from the 72 percent in 2012.
- Medicare is the population most targeted by programs say 53 percent.
- Following the Medicare population are the high-risk (47 percent), ‘all’ (40 percent) and Medicaid (28 percent) populations.
- Upon discharge, 87 percent of respondents review medication plans with patients as a strategy to reduce readmissions.

- Furthermore, 81 percent go over discharge instructions and 79 percent confirm follow-up appointments.
The most successful strategies to reduce readmissions include case management (27 percent), telephonic monitoring (11 percent), post-discharge coaching (11 percent) and improving instructions (9 percent).
In Respondents’ Own Words

Most Successful Work Flows, Processes and Tools

- “Use of smart phones and tablets to convey relevant information and reminders to both the patient and the designated care partner.”
- “Screening for high risk on admission.”
- “Follow-up with patient post-facility discharge by case managers embedded in our physician practices.”
- “Engaging transitional care organization early in admission to establish a relationship with the patient and caregivers.”
Sources

- See *2014 Healthcare Benchmarks: Reducing Hospital Readmissions*, available at store.hin.com

- Responses and data were derived from HIN's fourth annual survey on Reducing Hospital Readmissions conducted in December 2013.
For More Information

- Visit www.hin.com
- Call (888) 446-3530
- Follow @H_I_N on Twitter
- Like us on Facebook: www.facebook.com/TheHealthcareIntelligenceNetwork
- Connect with us on LinkedIn: www.linkedin.com/company/healthcare-intelligence-network