2014 Healthcare Benchmarks

Reducing Hospital Readmissions

Note: This is an authorized excerpt from *2014 Healthcare Benchmarks: Reducing Hospital Readmissions.*
To download the entire report, go to http://store.hin.com/product.asp?itemid=4786 or call 888-446-3530.

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2014 Healthcare Benchmarks: Reducing Hospital Readmissions

116 healthcare organizations describe how they are working to reduce hospital readmissions, including the tools used to identify individuals most at risk for returning to the hospital, the targeted conditions and populations, the most successful strategy to reduce readmissions, and more.

"Predicting heart failure, acute myocardial infarction and pneumonia using DRG codes and discharge data will be part of our [readmissions program launching in the next 12 months]."
> Specialist provider

"[Our partnership with post-acute care is helping to reduce hospital readmissions] by utilizing a transitional care program to engage with the patients while in the facility, and to continue to follow up with in-home visits after discharge to continue education and teach-back as well as monitor and oversee the patient's progress."
> Transitional care organization

"Screening for high-risk patients during hospital admission is our [most effective protocol in reducing hospital readmissions]."
> Hospital/health system

"[To prepare for increased CMS scrutiny of 30-day hospital readmission rates in 2014 and 2015], we are working on ensuring PCP follow-up within seven days of discharge as well as case management improvement between the patients and the PCP."
> Independent practice association

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2014 Healthcare Benchmarks: Reducing Hospital Readmissions

This special report is based on results from the Healthcare Intelligence Network's fourth annual survey on reducing hospital readmissions conducted in December 2013.

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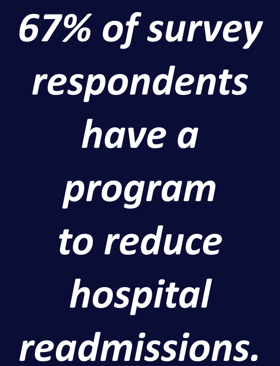
About the Healthcare Intelligence Network

The Healthcare Intelligence Network (HIN) is an electronic publishing company providing high-quality information on the business of healthcare. In one place, healthcare executives can receive exclusive, customized up-to-the-minute information in five key areas: the healthcare and managed care industry, hospital and health system management, health law and regulation, behavioral healthcare and long-term care.



Executive Summary

Development of post-acute partnerships with home health, skilled nursing facilities (SNFs) and hospice is emerging as a key strategy to stem hospital readmissions, according to new market data from the fourth annual Healthcare Intelligence Network (HIN) Reducing Hospital Readmissions Survey.

More than half of survey respondents participate in post-acute partnerships, with home health collaborations the most common (79 percent). These partnerships serve to streamline processes and care transitions, educate and align staff, and implement changes of value to patients, respondents say.

Looking at more conventional approaches, medication reconciliation and telephonic monitoring of patients post-discharge emerged as frontrunner strategies to curb readmissions. Moreover, the 2013 survey revealed significant upticks in the use of each tactic over 2012 levels: medication reconciliation is now conducted by 73 percent of respondents, versus 54 percent in 2012, while the use of telephonic monitoring jumped from 48 to 71 percent over the same 12-month period.

In other new data, almost half of respondents — 47 percent — aim programs at individuals already assessed at high risk for readmission as well as the traditional Medicare (53 percent), Medicaid (28 percent) and high utilizer (23 percent) populations.

"Outbound calling for patient follow-up will be included in our future readmissions program."

Survey Highlights

- ✓ Two-thirds of respondents to HIN's December 2013 Readmissions e-survey have a program to reduce readmissions.

- ✓ In a new metric from the 2013 survey, more than half — 52 percent — aim readmission reduction efforts at individuals with diabetes.

Using This Report

This benchmarking report is intended as a resource for healthcare organizations searching for comparable data and means to measure implementation and progress. It is also a helpful planning tool for organizations readying initiatives in this area.

The initial charts and graphs presented represent results from all respondents; images in subsequent sections depict data from high-responding sectors. (Figure titles begin with the segment they represent; for example, All, Health Plans, Hospitals, etc.)

Often, one of the largest responding sectors is composed of respondents identifying their organization type as “Other.” In general, we do not depict results from this segment because it represents a wide range of organization types, including consultants and product vendors. However, you will always find a graph indicating the demographics of respondents.

Here are some additional tips for using this report:

- ✓ See how you measure up: Scan this report for your sector, and see how your program compares to others. Note where you are leading and where you are behind.
- ✓ Evaluate your efforts: Think about where you have been focusing your efforts in this area. Look for trends in the data in this report. Look for benchmarks set by your sector and others.
- ✓ Set new goals: Use the data in this report to set new goals for your organization, or to raise the bar on existing efforts.
- ✓ Use it as a reference book: Keep this report accessible so you can refer to it in your work. Use these data to support your efforts in this area.

If you have questions about the data in this report, or have feedback for our team, don’t hesitate to contact us at info@hin.com or 732-449-4468.

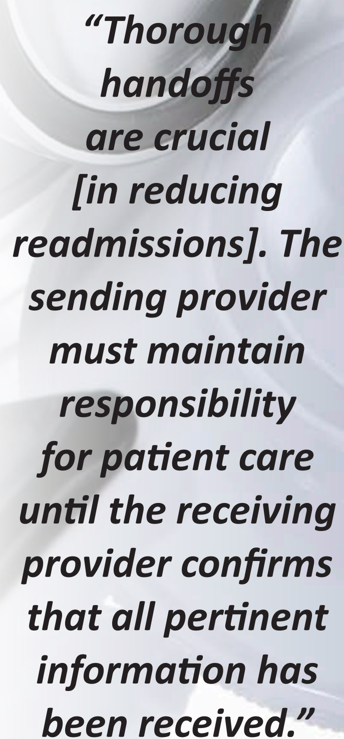


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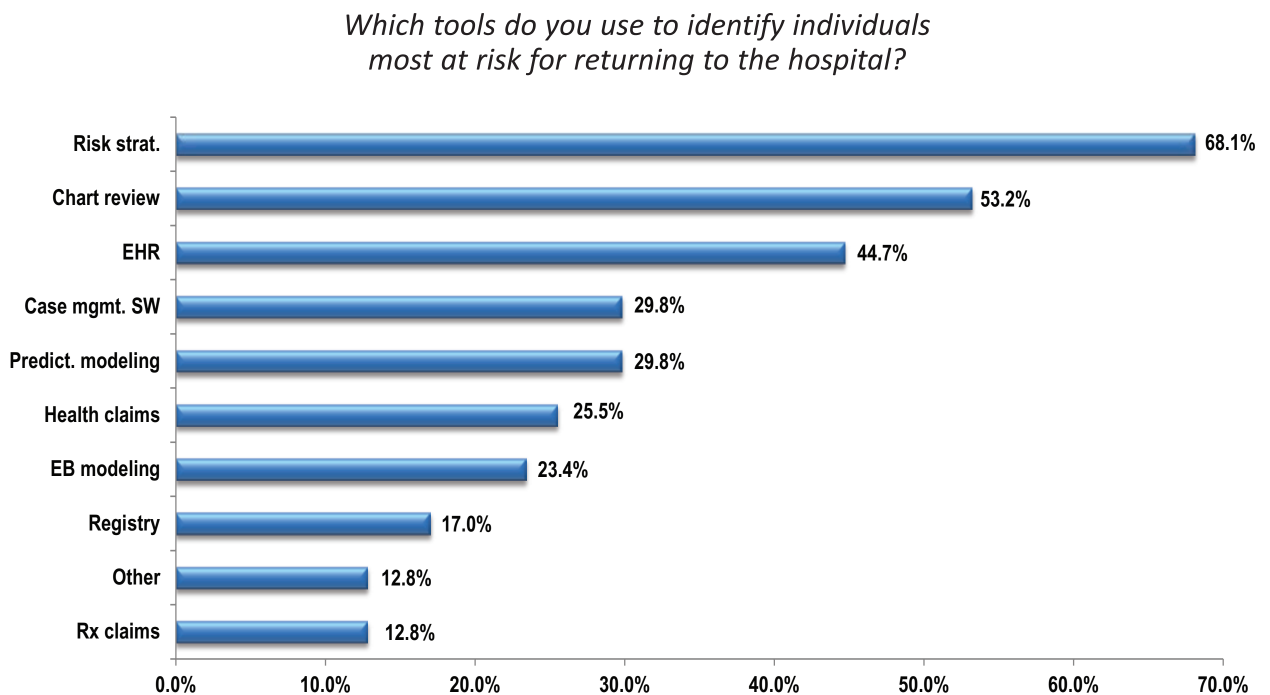
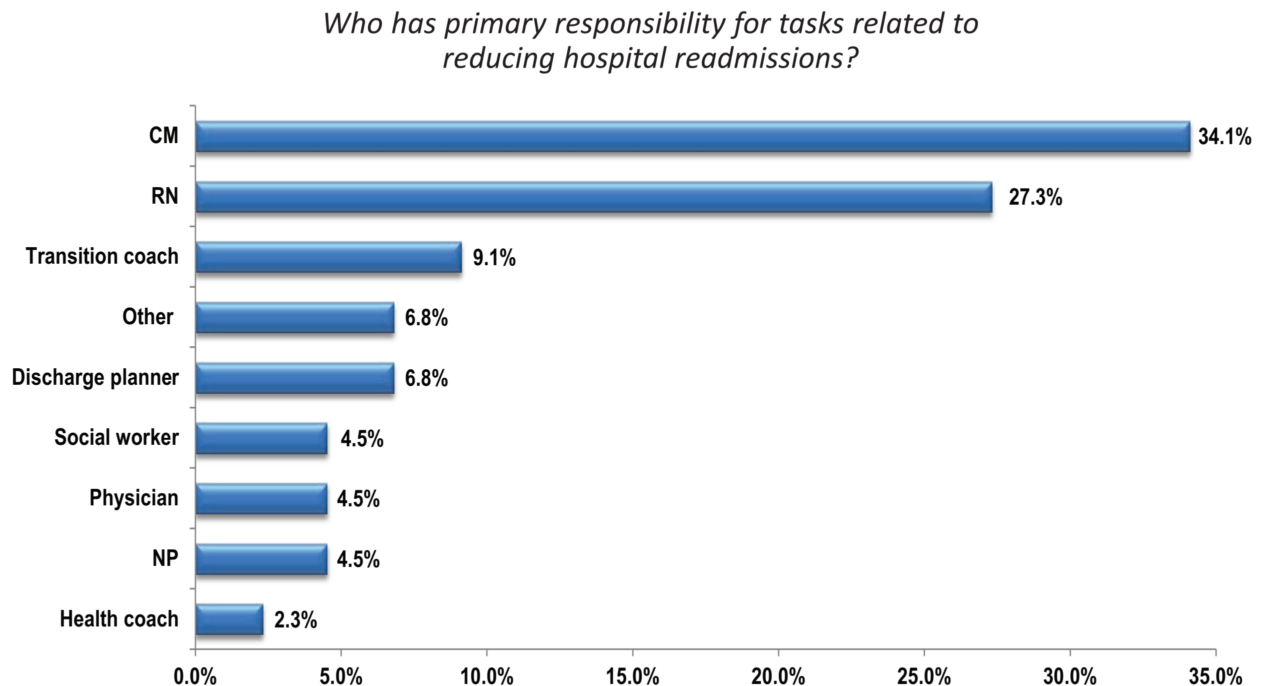
Figure 3: All - Identifying Individuals for Readmissions



HIN Reducing Hospital Readmissions in 2013 Survey
December, 2013

Figure 4: All - Responsible for Reducing Readmissions



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