The FHA-led initiatives focused on two key areas in patient care:

FEWER READMISSIONS: Helping Patients Heal Sooner, Return Home Quicker and Stay Home After Treatment

The Collaborative on Reducing Hospital Readmissions

Goal

Understand readmission causes and adopt practices to significantly reduce the number of patients returning to the hospital after discharge, focusing on those most likely to be readmitted: patients experiencing heart failure, heart attack, pneumonia, hip replacement or cardiac bypass surgery. Readmission rates are a bellwether for successful coordination across the health care continuum – from hospitals to home to skilled nursing facility to the offices of primary care providers.

About

In 2008, Florida's hospitals became the first in the nation to publicly report readmissions data by hospital. Through that process, for the first time Florida's hospitals had access to actionable statewide readmissions data. Understanding avoidable readmissions drove the desire to work together to improve. In fact, data showed some patients may be readmitted to a different hospital for their follow-up care – further necessitating collaboration and underscoring the value of statewide data.

Launched in 2008, the two-year collaborative engaged 107 hospitals statewide, in partnership with Florida's Agency for Health Care Administration, two leading health information systems providers and quality-improvement expert Convergence Consulting.

The collaborative provided in-depth information and extensive opportunities for hospitals to learn from experts, and from each other, about why readmissions occur, policy and payment issues affecting readmissions, and methods shown effective in reducing them.

Florida Collaborative on Readmissions

- **15** percent fewer readmissions
- **1500** readmissions prevented
- **$25 million** saved in two years

Results

- Overall, readmissions decreased 15 percent among collaborative participants, resulting in 1,500 fewer readmissions and $25 million in savings. All five key focus areas saw a decrease in readmissions.
- Hospitals made gains by:
  - Making sure patients and caregivers understood their medications – and other care instructions – at the time of discharge.
  - Following up with a phone call or visit to patients to make sure their questions were answered.
  - Establishing partnerships among all providers involved in a patient's care, in order to improve handoffs and sharing of information.
  - Discharging patients to settings that could provide the care they need.
  - Scheduling follow-up visits with their physicians.
  - Evaluating the patient's end-of-life care wishes.
- A process for reducing readmissions after hip replacement operations was developed in collaboration with the Florida Orthopedic Society.
- Hospitals and the state's large health plans worked together to understand health plan services designed to keep people out of the hospital, establish standard methodology for measuring readmissions and explore principles for payment alignment.

What's next?

Work continues today through FHA's Partnership for Patients network – a nationwide project of the Centers for Medicare and Medicaid Services and coordinated through the American Hospital Association's Health Research & Educational Trust (HRET).

Through the HRET-FHA Hospital Engagement Networks, hospitals across Florida are working toward a goal of achieving a 20 percent reduction in readmissions by the end of December 2013. Resources are being devoted to creating hospital discharge advocates, providing medications to the patient prior to discharge and establishing strong partnerships with post-acute providers to ensure that patients are transitioned safely to the next level of care.

One specific project focuses on improving communication between hospitals and skilled nursing facilities – a critical link in reducing readmissions. A standard form is being developed to provide relevant medication and care information on patients transferring from a hospital to a skilled nursing facility. With clear information, facilities will be better able to care for newly arrived patients – and the need for re-hospitalization will be reduced.