



DELAWARE VALLEY HEALTHCARE COUNCIL  
of The Hospital & Healthsystem Association of Pennsylvania



THE HEALTH CARE IMPROVEMENT FOUNDATION  
*Building Partnerships For Better Health Care*

**FOR IMMEDIATE RELEASE**

CONTACT: Priscilla Koutsouradis  
(215) 575-3743  
(215) 906-2739 cell  
[priscillak@dvhc.org](mailto:priscillak@dvhc.org)

**PHILADELPHIA-AREA HOSPITALS REDUCE READMISSION RATE 7 PERCENT,  
PREVENT 400 UNNEEDED HOSPITALIZATIONS, AND SAVE \$3.8M IN 3Q 2011**

PHILADELPHIA, PA (December 13)—According to the [Transitions of Care Survey Summary Report](#) released today by [The Health Care Improvement Foundation](#), 29 area hospitals participating in the 18-month [Preventing Avoidable Episodes \(PAVE\) Project](#) showed significant improvement in their implementation of 21 out of 28 proven strategies to enhance transitions of care and prevent hospital readmissions. Of these 29 hospitals, [18 submitted monthly data on the number of patients readmitted within 30 days](#), demonstrating an aggregate 7-percent reduction in 30-day same-hospital<sup>1</sup> readmission rates, from a baseline of 12.2 percent in the second quarter of 2010 to 11.4 percent about a year later, in the third quarter of 2011. This reduction represents more than 400 patients who avoided being rehospitalized and more than \$3.8 million in savings on unnecessary health care spending for the quarter. The progress achieved through the PAVE Project should also help the region's hospitals avoid an estimated \$7 million in potential health reform-related Medicare penalties for higher-than-expected readmission rates in fiscal year 2013.

“Readmission rates are important indicators of the quality and effectiveness of health care,” said Kate Flynn, president of the foundation. “Many readmissions are unavoidable due to the complexity and severity of patients’ medical conditions. Nevertheless, each hospital discharge represents an opportunity to better coordinate prompt and effective follow-up care, keep patients from returning to the hospital, and save thousands of dollars in hospital costs,” said Flynn.

According to an analysis of data submitted by the 18 reporting hospitals, [Delaware Valley Healthcare Council of HAP](#), a partner in the project, found that these hospitals would have had 8,625 readmissions during the third quarter of 2011 if readmission rates had remained at baseline levels. Instead, the hospitals reduced their aggregate, average readmission rate for the

quarter to 11.4 percent, or about 8,220 readmissions, and more than 400 patients avoided rehospitalization. Based on the [Centers for Medicare & Medicaid Services' estimate](#) that each avoided readmission saves on average \$9,600, this reduction in readmissions saved \$3.8 million for the quarter or more than \$15 million annually.

“Anytime we can prevent an avoidable hospital readmission, it’s a positive step toward providing more affordable, better quality care and good news for patients,” said Richard Snyder, chief medical officer, Independence Blue Cross, which along with hospitals helped fund the PAVE Project. “We’re very pleased to see our area hospitals making significant investments to ensure patients follow through on the care plans and medical regimens established during hospital stays and devoting valuable resources to help patients get the health care they need after they leave the hospital,” said Snyder.

### ***More Hospitals Using Proven Strategies to Prevent Readmissions***

According to findings from pre- and post-project surveys, hospitals have adopted many measures designed to enhance communication with patients and families and make sure they understand health conditions and how to follow instructions for ongoing medical care. More than 90 percent of hospitals are now evaluating or implementing a screening tool to identify inpatients at high risk for readmission, so that patient education and other readmission-prevention efforts can be targeted accordingly. During discharge:

- The number of hospitals that have implemented improved processes to educate patients about their medical conditions has more than doubled.
- Most hospitals now have transition coaches or nurses to help patients and families understand ongoing medical needs and care.
- The number of hospitals that give patients check lists and other reminders has nearly doubled.
- All hospitals provide patients with detailed discharge plans.

As part of PAVE, hospitals have also worked to improve coordination and communication across the continuum of care, so that physicians, nursing homes, home health agencies, and insurers have the information needed to provide patients with the best possible health care—and the best chance of avoiding readmission. The proven strategies adopted include:

- Almost all hospitals now coordinate with patients while they are still in the hospital to make follow-up physician appointments; more hospitals are coordinating follow-up testing.
- Nearly 50 percent of hospitals send patients' discharge summaries to patients' primary care physicians; more than 40 percent of hospitals are evaluating and implementing ways to share summaries with primary care physicians.
- Nurses at nearly 60 percent of hospitals are doing nurse-to-nurse handoffs when discharged patients transition to nursing homes or other care settings; the remaining hospitals are evaluating or implementing such handoffs.

“Preventing readmissions takes the concerted effort of patients and absolutely everyone who takes care of them in any capacity, not just hospitals,” said Patricia Yurchick, PAVE program director. “A crucial aspect of the project was bringing together stakeholders from the various provider segments of our too-often fragmented health care system, to break down barriers and develop a shared appreciation of how important effective communication and coordination are to the well-being of our patients,” said Yurchick.

### ***Engaging the Entire Continuum of Care***

The PAVE Project involved 150 health care professionals representing [47 organizations](#), including consumer advocacy groups, primary and specialty care physician practices, hospitals and health systems, nursing homes, home health agencies, pharmaceutical manufacturers, and insurers. Participants served in three main workgroups charged with developing tools to improve key aspects of readmission prevention: medication management, care transition, and personal health management.

To strengthen coordination among health care providers as patients transition between care settings (for example, from nursing home to hospital to physician's office), the workgroups created a suite of passport documents designed to encourage the consistent communication of crucial health information. The [Medication Passport](#) outlines a set of standards to help providers across the continuum of care reconcile and share information about patients' medications. The [Hospital Discharge Passport](#) incorporates the crucial components of effective transition at hospital discharge. The [Hospital Care Transitions Passport](#) provides hospital contacts to facilitate the sharing of patient information. A Personal Health Tracking Form is also being created.

The PAVE Project was conducted as part of the Partnership for Patient Care, a collaborative, multiyear patient safety initiative funded by Independence Blue Cross and the

region's hospitals and health systems. PAVE began in May 2010, and has included work sessions and seminars to train health care providers on the 'teach back' method of communicating important health information to patients; to share best practices for preventing readmissions; and to foster collaboration among health care providers across the continuum of care.

**Delaware Valley Healthcare Council of HAP** advocates for southeastern Pennsylvania hospital and health care-related organizations including more than 50 acute and specialty care hospitals and health systems, 30 facilities providing inpatient behavioral health services, and 20 facilities providing rehabilitation.

**The Health Care Improvement Foundation** is an independent nonprofit organization that leads health care initiatives aimed at improving the safety, outcomes, and care experiences of all patients, residents, and consumers across the Delaware Valley. The foundation is dedicated to the vision that, through an engaged, collaborative community, the region benefits from a high-performing health care delivery system demonstrating enhanced measures of safety, quality, and effectiveness.

**Independence Blue Cross** is a leading health insurer in southeastern Pennsylvania. Nationwide, Independence Blue Cross and its affiliates provide coverage to nearly 3.1 million people. For 73 years, Independence Blue Cross has offered high-quality health care coverage tailored to meet the changing needs of members, employers, and health care professionals. Independence Blue Cross's HMO and PPO health care plans have consistently received the highest ratings from the National Committee for Quality Assurance. Independence Blue Cross is an independent licensee of the Blue Cross and Blue Shield Association. Visit us at [ibx.com](http://ibx.com). Fan us on [Facebook](https://www.facebook.com/ibx). Follow us on [Twitter@ibx](https://twitter.com/ibx).

**The Partnership for Patient Care** is a collaborative dedicated to the advancement of patient care by accelerating the adoption of evidence-based clinical practices. Funded by Independence Blue Cross and the region's health systems, the partnership achieves its goals by pooling the resources, knowledge, and efforts of local health care providers.

<sup>1</sup> The 30-day, same-hospital readmission rate is based on hospital readmission data submitted to the Delaware Valley Healthcare Council of HAP's web-based, monthly utilization reporting system. Every month hospitals enter the number of patients who were readmitted for any reason, including planned readmissions, within 30-days of discharge from that same hospital. Individual hospitals cannot track discharged patients who are readmitted at other hospital facilities.

###