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Transforming American Health Care

Research Brief

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Reducing Readmissions in Safety Net Hospitals & Health Systems

Executive Summary

In view of increasing national attention around avoidable hospital readmissions, NAPH conducted an online survey of 51 member facilities, followed by in-depth interviews with eight respondents, to gather information about the strategies to reduce readmissions being implemented by safety net facilities.

Readmissions are a priority for NAPH members:

- Nearly 90 percent of respondents have made reducing readmissions a priority in recent years, motivated by a range of factors from patient satisfaction to cost reimbursement.
- 59 percent of respondents have established goals for reducing readmissions. Of the members that have established goals, almost all of them benchmark their rates against a national average or state average rate, while 67 percent have set specific internal goals.
- Although their methods of tracking readmissions vary, hospitals in the survey use the data they collect to drive improvement — almost 75 percent of respondents include tracked measures as part of a widely-shared dashboard or scoreboard and the vast majority share results with hospital leadership.

The most frequently cited significant contributors of readmissions are:

- Patient drug/alcohol abuse;
- Patients not following up with appointments; and
- Homelessness.

While there are readmission risk factors specific to safety net hospitals (such as substance abuse and homelessness), there are also common risk factors like heart failure that members also are working to address.

There are many barriers to reducing readmissions faced by the survey respondents that fall within four categories:

- **Health care system barriers** — widespread issues within the health care system that produce an environment in which readmissions occur frequently (e.g., lack of available outpatient care).
- **Hospital quality of care barriers** — systems or processes within a hospital that directly contribute to poor quality of care for patients. (e.g., poor coordination of care).
- **Hospital resource barriers** — barriers faced by those hospitals that lack access to important resources that enhance care provided to patients. (e.g., insufficient HIT resources).
- **Patient barriers** — characteristics belonging to particular patients that make them more likely to be readmitted regardless of the quality of clinical care they receive. (e.g., patients lacking family support).

The members in the study have implemented many strategies to address these barriers, including:

- Creating partnerships with community resources for low-income patients;
- Enhancing communication with patients and families;
- Establishing medical homes in outpatient clinics; and
- Using nationally recognized improvement models such as Project RED.

Hospitals will continue to work to drive down readmissions to best serve their patients in the most appropriate care settings. NAPH members are applying evidence-based practices and tailoring proven interventions to meet the needs of their unique patient populations, as they look toward the implementation of the federal readmissions reduction policy and others from states and private payers.

Introduction

A major goal of health reform is the reduction of avoidable hospital readmissions. Avoidable readmissions affect patients and other key players in the health care system, including hospitals. Patients who are readmitted soon after being discharged from the hospital may feel demoralized; hospitals with high readmission rates may incur high costs of providing care for readmitted patients. In addition, readmissions are becoming more common. On average, 18 percent of Medicare patients are readmitted within 30 days,[1] but that figure rises to 24 percent in some states.[2] These readmissions are also costly. Medicare unplanned readmissions were estimated to cost as much as 17.4 billion dollars in 2004.[3] A variety of patient factors are associated with readmissions, including low socioeconomic status, lack of a social support system, and limited access to care.[4,5,6] Finally, readmissions are sometimes indicators of poor quality of care. For example, patients who are discharged prematurely, experience medical errors during their stay, have trouble accessing follow-up care, or experience poor transitions in care settings are more likely to be readmitted.

For these reasons, readmissions are currently a major area of focus in the health care system. Reducing readmissions not only improves care but also saves money, which has made it a prime target for policymakers. Since 2009, the Centers for Medicare & Medicaid Services (CMS) has publicly-reported hospital readmission rates for heart attack, heart failure, and pneumonia with hopes of spurring improvement efforts. The Affordable Care Act of 2010 (ACA) promotes even more accountability by implementing payment penalties for hospitals with excess readmissions. Beginning in 2013, hospitals with higher than expected readmission rates will receive a reduction in their Medicare payments of up to one percent, increasing to a maximum of 3 percent in 2015 and beyond. Because NAPH members are increasingly concerned about these upcoming requirements, NAPH conducted a study to discover how our members are addressing readmissions, particularly in an environment of caring for complex patient populations.

NAPH Readmissions Study

In late 2010, NAPH administered an online survey to quality directors (or their designee) at 101 NAPH member acute care hospitals to gather information about their ongoing activities to reduce readmissions. Respondents from 51 safety net facilities completed the survey, a group that is representative of all NAPH members on characteristics like bed size, geographic location, margin, and performance on publicly-reported readmission rates. However, compared to the average NAPH member the respondents were more likely to be academic medical centers and have slightly more inpatient discharges for patients covered by commercial insurance. The survey asked quality directors to describe how they are focusing their efforts to reduce readmissions, barriers to doing so, and strategies for success.

Following the survey, we selected a quality director from eight member hospitals for phone interviews, to gain more perspective about the barriers they face to reducing readmissions, as well as their most successful strategies in addressing them. The hospitals we interviewed included both high and low performers on the CMS publicly reported readmission rates, as well as large, small, and geographically diverse hospitals. The survey and

interview findings underscore the many barriers that NAPH member hospitals encounter in their attempts to provide smooth transitions of care and their efforts in helping vulnerable patients access those clinical and non-clinical resources necessary for preventing readmissions.

Readmissions as a Priority

Reducing readmissions is a major priority for NAPH members. In the survey, 86 percent of the respondents indicated they had made reducing readmissions a priority and most had done so by the beginning of 2009. The member interviews produced four reasons why reducing readmissions is important to safety net hospital leaders:

- **Patient satisfaction:** NAPH members want to reduce readmissions because it is the right thing to do for patients. They are focused on customer service and believe that a patient should not have to return to the hospital unnecessarily.
- **Cost/Reimbursement:** Several members mentioned financial issues as a contributing factor for focusing on readmissions. Many of them understand that policies to reduce payment for avoidable readmissions will be implemented in the near future and are trying to prepare for these requirements.
- **Quality/public reporting of data:** Some hospitals were encouraged to improve their readmission rates after they became publicly reported by CMS.
- **Efficiency:** Ensuring that patients are treated in appropriate care settings based on their condition (e.g., preventing patients from using the hospital emergency department for primary care) is an example of how efficiency is driving their focus on readmissions.

We also asked how leadership within member hospitals has demonstrated its commitment to reducing readmissions. In some cases, the hospital formed a multidisciplinary task force to examine the causes of readmissions and determine the best approach to addressing them. One NAPH member quality director described this approach as helpful because previous efforts to reduce readmissions were fragmented and required a coordinated approach that brought in all areas of the hospital. Other members indicated that allowing staff, especially nurses, dedicated time to working on readmissions projects demonstrated to them that leadership was focused on this priority. Finally, the creation of a department or a position within the hospital to take responsibility for reducing readmissions demonstrated leadership commitment.

Readmissions Data and Goal Setting

An important aspect of improving readmissions is setting goals and collecting, analyzing, and reporting

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Hospitals that have found differences by patient payer type have found that uninsured or patients covered by Medicaid are more likely to be readmitted.

data to hospital staff so they understand their current performance and can track trends over time. Research has shown that historical data is useful in setting appropriate and realistic goals. In addition, gathering data as close to real time as possible, measuring which interventions have had the most impact on readmissions, and following progress in attaining established goals is recommended in tracking performance over time.[7]

Hospitals that have electronic medical records or other health information technology (HIT) systems to help them with data collection are able to do so with greater ease and speed than hospitals that must rely only on paper records (like many under-resourced safety net hospitals).[8] About 25 percent of the survey respondents indicated they only collect readmissions data using HIT, while 14 percent only collect data manually through paper records; the majority of respondents use a combination of HIT, paper records, and assistance from outside vendors.

Some hospitals track their readmission rates by retrospectively reviewing charts from a specified period of time (for example the past 30 days) and establishing which patients were readmitted. Other hospitals, especially those with electronic systems, are able to determine in real-time if a patient was readmitted. The survey found that 46 percent of respondents only retrospectively track readmissions data; 34 percent both track data retrospectively and in real-time; and 18 percent only track data in real-time. Most of the hospitals that review retrospective data produce reports on a monthly basis. One member that looks at data in real-time has an automated process in which its case management team reviews a daily report on the readmissions that have occurred. They also review each readmission to determine if it was related or not to the initial hospitalization.

Reporting readmissions to hospital staff is a way to increase transparency and accountability. According to the survey, 73 percent of the survey respondents include readmission measures on a departmental or hospital-wide dashboard or scorecard. Sixty-five percent of respondents report readmissions data to the governing body of the hospital; 88 percent report it to the hospital's executive leadership, and 80 percent report it to physician leaders. Respondents tend to present high-level readmissions data to their governing body, such as the performance rates publicly reported on Hospital Compare, because hospital boards are interested in seeing how the hospital compares to others. Respondents use separate reports that are more granular for internal quality improvement purposes.

Sometimes readmissions are unavoidable, but determining if the readmission could have been prevented can be difficult. Half of the responding hospitals have a mechanism (such as a standard process or a designated individual) to determine which readmissions are avoidable or potentially preventable as opposed to unavoidable, but the other half do not have a standard method of

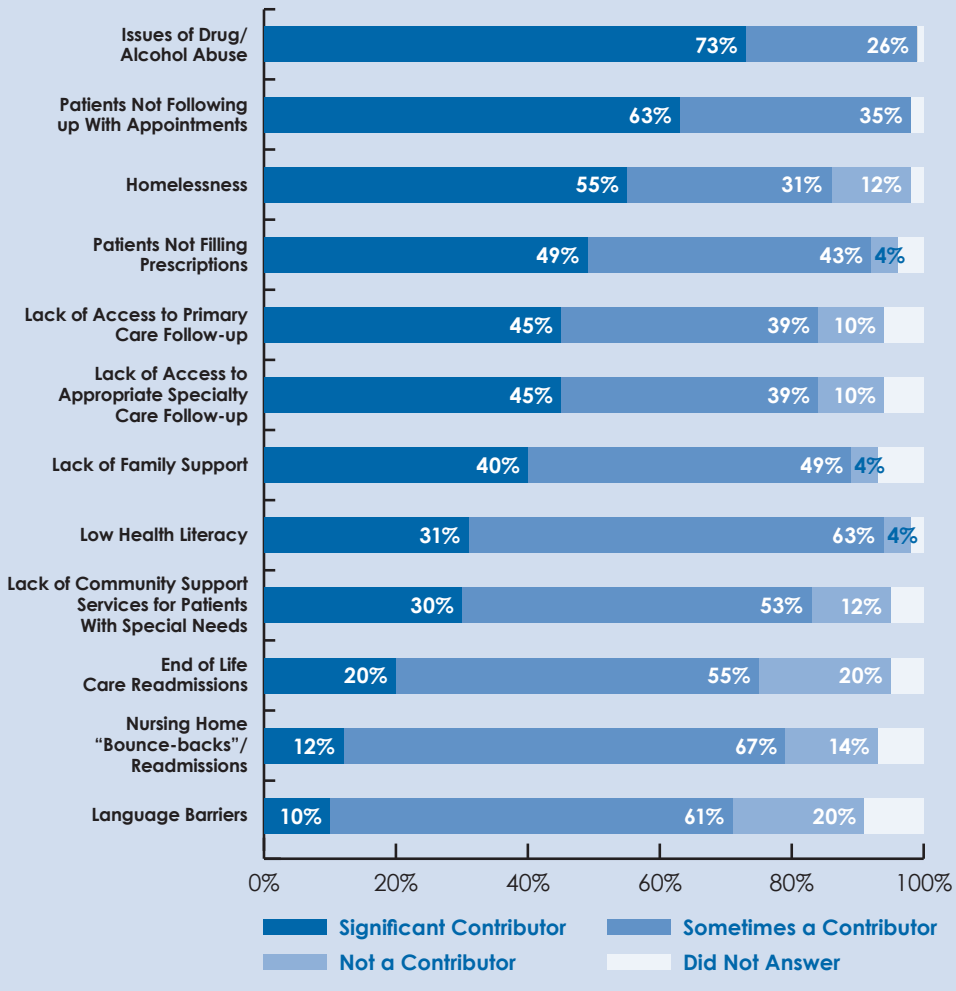
distinguishing the two categories. Of the hospitals that have a standard method for distinguishing avoidable versus unavoidable readmission, most (35 percent) interview the patient and record the findings in the patient's chart. One member noted that they use their patient interviews to understand the patient's perspective about what care providers could have done differently to prevent readmission. Another 15 percent of responding hospitals consider a readmission avoidable if the hospitalization occurred as a result of an ambulatory care sensitive condition (such as those identified by the Agency for Healthcare Research and Quality). The remaining hospitals in the survey use software or criteria developed by external consultants or organizations, such as 3M, Thomson Reuters, Milliman & Roberts, Canopy Systems, California Safety Net Institute, University HealthSystem Consortium, or the Institute for Clinical Systems.

Collecting and analyzing data is also necessary for setting goals and measuring progress along the way. A majority of the respondents (59 percent) have established goals for reducing readmissions. Of the members that have established goals, most of them benchmark their rates against a national average or state average rate, while 67 percent have set specific internal goals. The hospitals that have set specific goals are trying to achieve one of the following: a percentage reduction in readmissions (such as reducing readmissions by 25 percent); a specific readmission rate (like having a heart failure readmission rate of 10 percent); or comparative advantage (for example, being in the top 10 percent of hospitals in the nation for pneumonia readmissions). Hospitals in the study vary in how they determine appropriate readmission goals. Some members found it necessary to set ambitious goals, while another member felt that staff were discouraged if the goal was too aggressive.

Causes of Readmissions in Safety Net Hospital Patient Populations

The literature has identified a variety of factors that lead to readmissions, including hospital practices, patient characteristics, and access to/quality of post-acute care. However, there are contributors to readmissions that may occur more commonly within safety net hospital populations (see Chart 1). About 73 percent of NAPH

CHART 1 Percent of NAPH members identifying an issue as a contributor of readmissions



respondents identified patient issues with drug and alcohol abuse to be a significant contributor of readmissions, closely followed by patients not following up with appointments (63 percent), homelessness (55 percent), and patients not filling prescriptions (49 percent). The interviewees provided more insight into these issues, including the fact that patients are much less likely to fill prescriptions because they cannot afford the medication and have trouble showing up to appointments because they lack access to primary care or transportation. Homelessness was mentioned as a major problem for many members because homeless patients often do not receive follow up care after being discharged, contributing to their readmission. In fact, homelessness is such a problem for some NAPH members that they have allocated extensive resources for homeless populations and participate with national homeless initiatives like the 100,000 Homes campaign.[9]

The survey also asked NAPH members to describe in detail the patient populations that are most at risk for readmissions in their organizations. After sorting their responses into categories to determine the most common high-risk populations, heart failure patients emerged as the most susceptible. But while there are common patient risk factors across safety net hospitals, there are also specific, targeted high-risk patient populations within each hospital.

Having access to electronic medical record (EMR) data has led several members to develop sophisticated models of predicting upon admission whether patients are at high risk for readmission. Researchers at Parkland Health & Hospital System in Dallas constructed and validated a model of 30-day readmission risk using real-time EMR admission data for patients admitted during a specified time period with a principal discharge diagnosis of heart failure. By basing the model on clinical, social, behavioral, and utilization factors, they found it was possible to predict heart failure patients' risk of readmission within 24 hours of their admission. Using this model allows clinicians to make more informed decisions about the course of care for their patients. For example, patients at high risk for readmission may be targeted for additional intervention services, whereas patients found to be at low risk could receive the standard recommended treatment. The ability to target high-risk patients can help clinicians and institutions target limited resources to those who need it the most. Parkland's model was recognized as one of the most promising in the field.[10]

Another member, Orlando Regional Medical Center, has developed a similar risk detection system that does not require electronic capability. Orlando created a Readmission Analysis Team, comprised of specially trained nurses and social workers, to interview patients rehospitalized within 30 days to determine likely causes of readmission. They work closely with discharge planners to incorporate information learned from their interviews into patients' discharge plans to lower their risk for future readmissions. They found that this process has provided a high level of patient and physician satisfaction.

Tracking readmissions data for differences is important for hospitals to better understand their patient populations, but few respondents are doing so because they do not have the ability to obtain data on patient race, ethnicity, or income. However, 43 percent of respondents track readmission rates by patient discharge location; 35 percent by presence of comorbidities; and 35 percent by payer status. Of the hospitals that track readmissions by patients with comorbidities compared to patients with none, 67 percent have found differences. Of those that track readmissions by payer type, 61 percent found differences. The hospitals that have found differences in patients with comorbidities have found that patients with a chronic disease like diabetes, respiratory issues, or behavioral health issues are more likely to be readmitted. Hospitals that have found differences by patient payer type have found that uninsured or patients covered by Medicaid are more likely to be readmitted.

Preventing Readmissions: the Discharge Process & Care Coordination

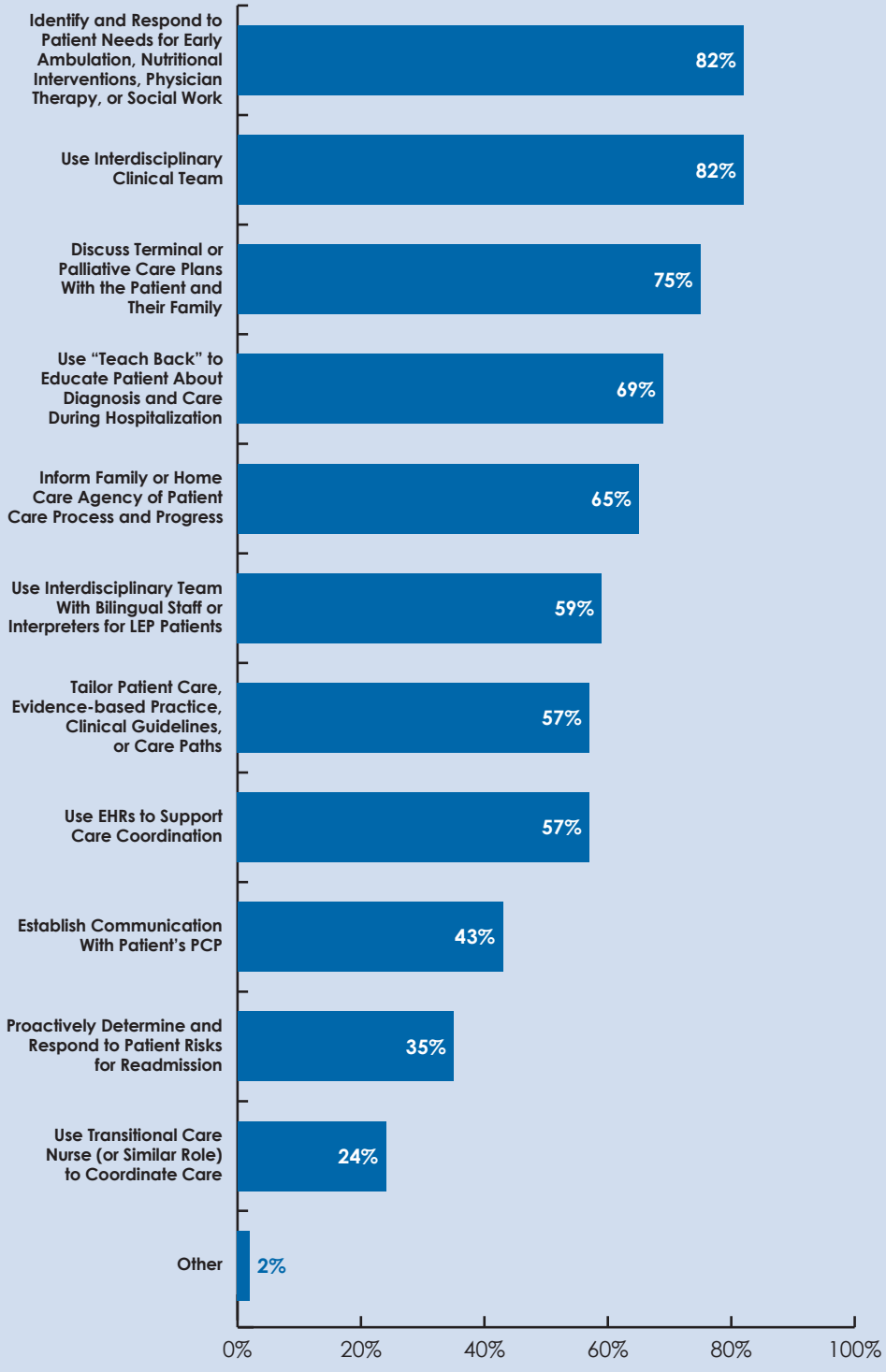
The hospital's management of the discharge process and transition of patient to home or another care setting can greatly influence whether

or not that patient is readmitted. The survey asked respondents to identify their standard discharge processes, as well as their attempts to improve them.

There have been many studies over the past several years that have determined important hospital processes for reducing readmissions. The Health Research and Education Trust (HRET) conducted a literature review of these studies and developed a set of key processes that hospitals should follow at different stages of the discharge continuum (pre-discharge, during discharge, and post-discharge). HRET published these strategies in the *Health Care Leader Action Guide to Reduce Avoidable Readmissions*.[11] We based a set of survey questions on the recommendations in HRET's action guide to find out whether respondents follow them as standard practice (see Charts 2, 3, & 4). The HRET action guide notes that the pre-discharge practices should be initiated by the hospital, while some of the discharge and post-discharge practices can be shared between the hospital and follow-up care providers. Not surprisingly then, the survey results show that NAPH members are doing more of the recommended strategies pre-discharge rather than during or post-discharge.

There was a mixed response in the survey regarding who in the hospital has primary responsibility for discharging patients. About 38 percent assign discharge responsibilities to residents, while 33 percent assign them to attending physicians and 17 percent to hospitalists. Enhancing

CHART 2 **Percent of NAPH members using recommended initiatives as standard practice during hospitalization (pre-discharge)**



NAPH members serve many patients who are limited English proficient (LEP), making it necessary to provide these patients with resources to help them better understand their discharge instructions. Not surprisingly then, 93 percent of respondents provide either an interpreter for oral discharge instructions or translated written instructions for LEP patients; 68 percent provide both services.

CHART 3 Percent of NAPH members using recommended initiatives as standard practice during discharge

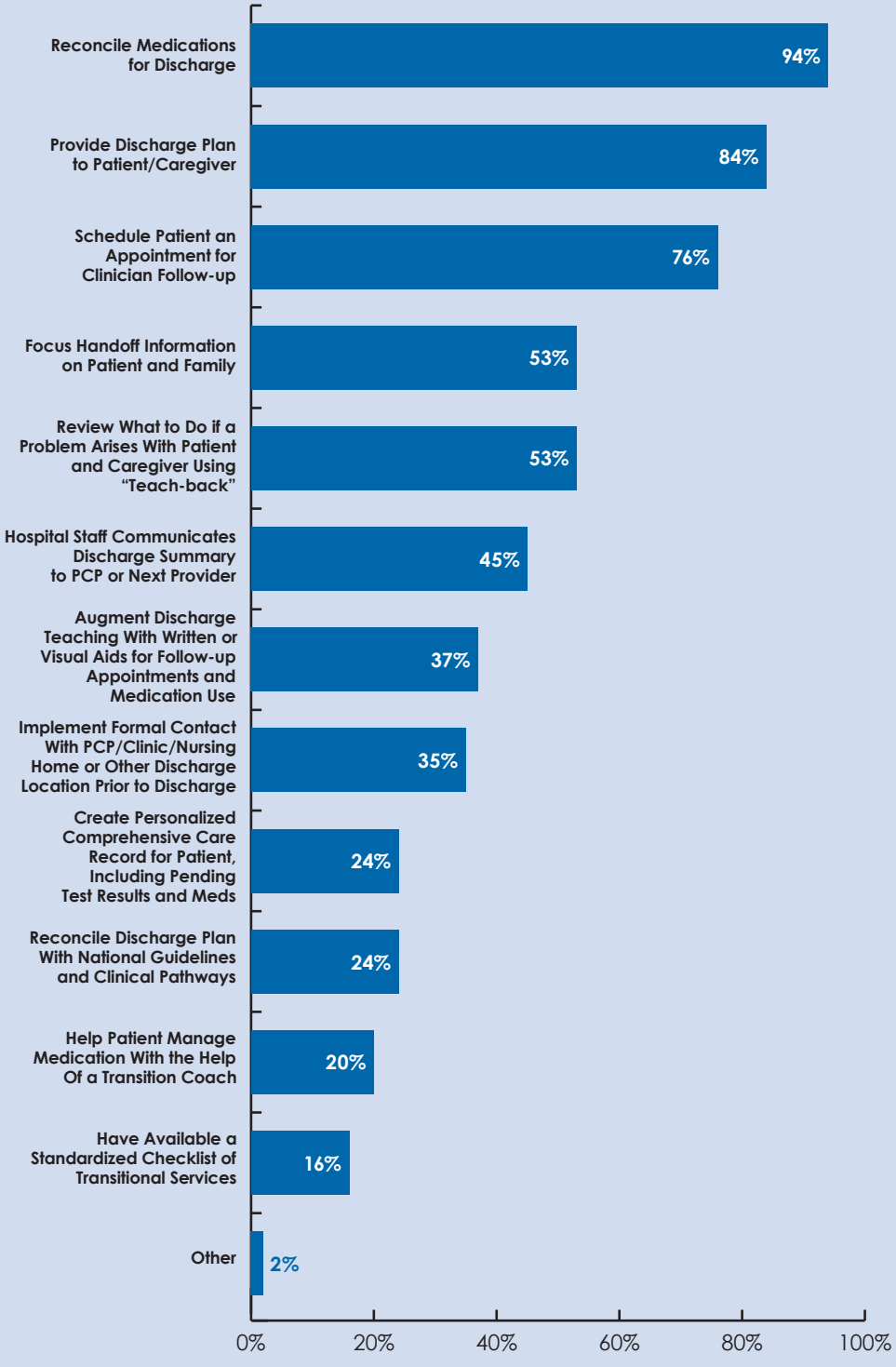
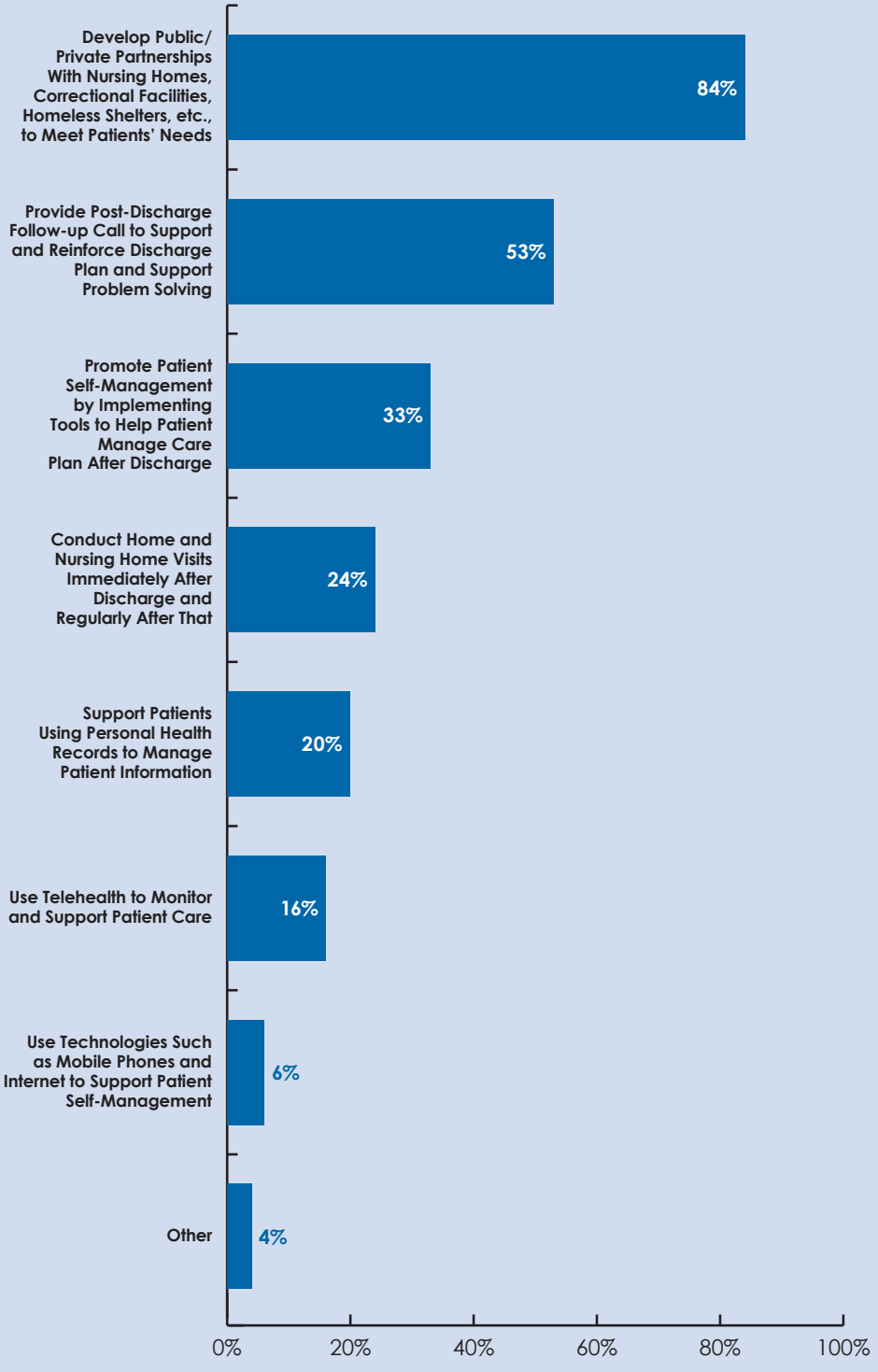


CHART 4 Percent of NAPH members using recommended initiatives as standard practice post-discharge



the discharge process has become more common for those hospitals focused on reducing readmissions. One strategy for improving the discharge process is dedicating staff to the process. One-third of respondents created new positions within their organizations to facilitate the discharge process. Most of these hospitals use a designated nurse to act as a discharge coordinator, who educates patients about their condition, medication and self-management. Many of the hospitals also ensure the patient has a follow-up appointment scheduled and their medications in hand to increase compliance with their discharge instructions. Some of the nurses also follow up with the patients by phone after they leave the hospital to address any issues and help patients manage the crucial period following their hospitalization.

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An important part of the discharge process is coordinating patients' care with their outpatient providers. Of the respondents, 71 percent follow up (by phone, email, or sharing of patient's electronic medical record) with skilled nursing facilities, 67 percent with rehab facilities, 65 percent with home

health agencies, and 45 percent with patient's primary care physician (Chart 5). Coordinating patient care is a major barrier for most hospitals, particularly with community providers. Therefore, many members have attempted to create partnerships with community organizations to bridge these communication gaps. More than half of the respondents (61 percent) have attempted to access community resources like transportation for patients, while 55 percent have partnered with organizations that support the homeless; 53 percent with community health centers; 47 percent with behavioral health organizations, and 45 percent with skilled nursing facilities (see Chart 6).

Barriers to Reducing Readmissions

The eight member interviews provided additional information about the many barriers faced by safety net hospitals in reducing readmissions, grouped into the following categories:

- **Health care system barrier** — widespread issues within the health care system that produce an environment in which readmissions occur frequently.
- **Hospital quality of care barriers** — systems or processes within a hospital that directly contribute to poor quality of care for patients.
- **Hospital resource barriers** — barriers faced by those hospitals that lack access to important resources that enhance care provided to patients.
- **Patient barriers** — characteristics belonging to particular patients that make them more likely to be readmitted regardless of the quality of clinical care they receive.

Some of the barriers can be classified as more than one type (see Table 1). For instance, a lack of resources for limited English proficient patients is a hospital resource barrier, but it can also be a hospital quality of care barrier if the hospital providers are unable to effectively communicate discharge instructions to the patient.

Strategies to Reduce Readmissions

NAPH members have implemented many strategies to address all of the barriers outlined above. These include the following types of strategies:

- **Increasing support and communication with patients and families** Many of these strategies involved training nurses to more effectively communicate with patients about their follow up care prior to leaving the hospital, including the use of "teach-back" to further ensure patients comprehension of specific treatments, medications or next steps. There were also some strategies implemented to address the post-discharge period in which a nurse, social worker, or case manager followed up with patients by phone, through telehealth technology, or by conducting home visits to assess patient progress and address any of their questions. One

hospital had social workers find group homes for homeless patients.

- **Consistently delivering evidence-based practices**
  Several strategies focused on standardizing processes, such as implementing disease-specific pathways and standardized order sets, and using evidence-based measures. Others focused on ensuring that core process measures for heart failure patients were met, which they found decreased heart failure readmissions. A few hospitals redesigned their care by adopting a physician team approach to the discharge process. One hospital strategy for improving care coordination and reducing readmissions is establishing patient-centered medical homes in outpatient clinics, which 55 percent of the respondents have done with another 12 percent in the process of doing so.
- **Increasing communication between inpatient providers and other providers**
  Many hospitals have also attempted to improve communication with other providers in the community. For example, some implemented policies that ensure a patient has a scheduled follow up appointment before leaving the hospital. Many hospitals improved communication with skilled nursing facilities to ensure smoother transitions of care. Another hospital worked with their county's health department to enroll patients in a medical home.
- **Addressing medication needs**
  As noted earlier, a major barrier for safety net hospital patients in

CHART 5 Percent of NAPH members employing modes of communication with other providers

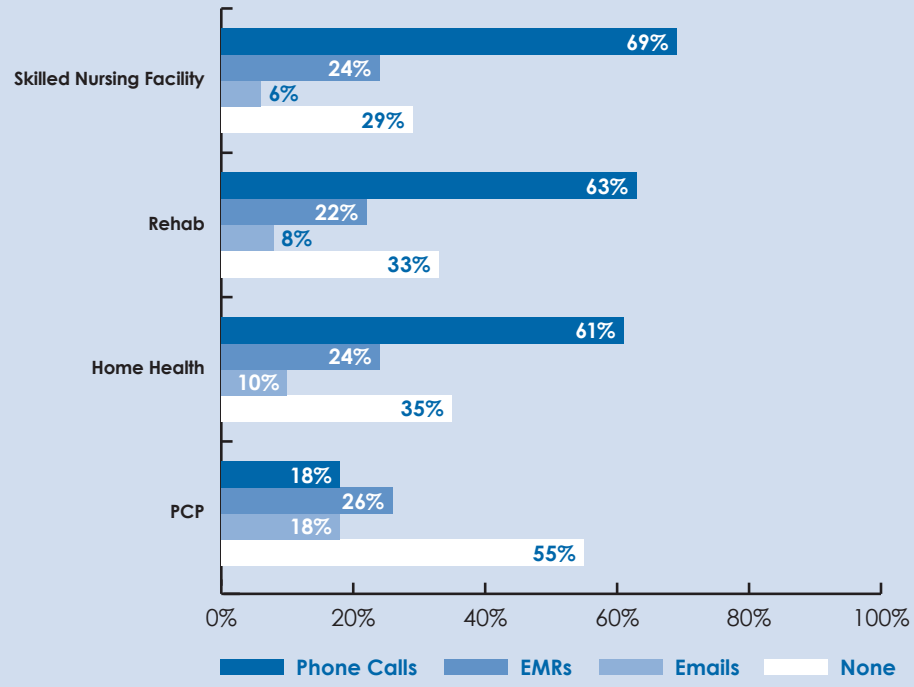


CHART 6 Percent of NAPH members that have created partnerships to improve care coordination

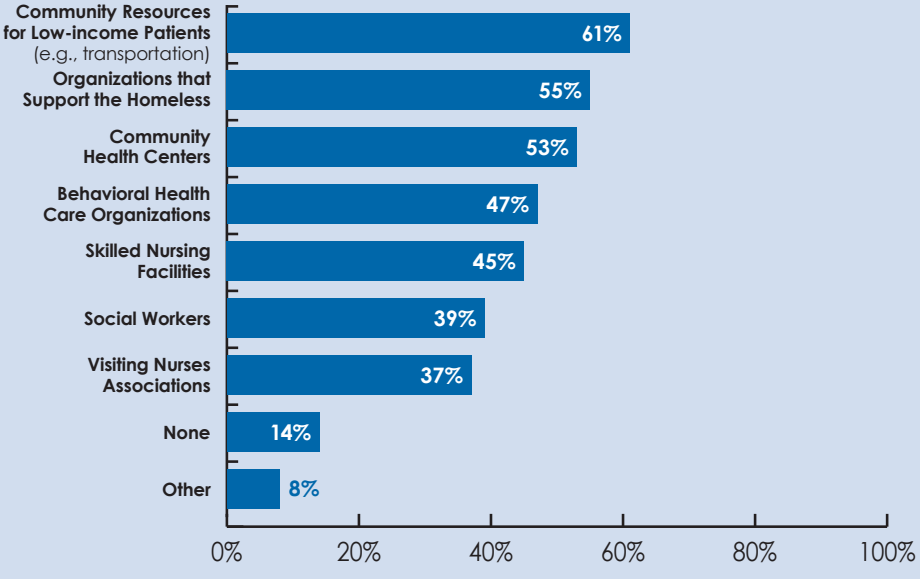


TABLE 1 | Common Barriers Faced by NAPH Members

	Health Care System Barrier	Hospital Quality of Care Barrier	Hospital Resource Barrier	Patient Barrier
Limited access to community outpatient care Outpatient providers in the community are unable to accept their discharged patients. If patients are discharged without the hospital making a follow-up appointment, patients are unlikely to obtain an appointment for months and many times end up in the ED. One hospital mentioned that patients without insurance cannot access rehab care and another noted the lack of psychiatric care available for patients.	X			
Lack of hospital HIT resources NAPH members observed that a major barrier to collecting and analyzing data is the lack of HIT available in the hospital, including EMRs and personal health records. HIT also helps hospitals more easily identify high-risk patients for readmission.			X	
Lack of hospital resources to support enhanced discharge process In addition to HIT resources, several members encounter problems obtaining resources that would help them enhance the discharge process, such as dedicated staff time or money to fund a discharge coordinator role.			X	
Limited patient financial resources Finding transportation to appointments or money to pay for medications, lack of a permanent home, or other obstacles can negatively impact recovery following a hospitalization.	X		X	X
Insufficient support structure for patient Some NAPH member patients do not have a strong family or friend support system to help them care for themselves following an admission, which is a significant barrier for these patients.				X
Lack of resources for Limited English Proficient (LEP) patients Several of the NAPH member hospitals demonstrated a lack of resources (e.g., interpreters or patient tools translated into languages other than English) to help them better communicate with LEP patients.		X	X	
Access to care for undocumented immigrants A major barrier for safety net hospitals involves providing preventive and follow up care for undocumented immigrants. One hospital mentioned that many of their patients requiring dialysis will not access the system's free clinic because of their immigration status, so they go to the ED or are readmitted to the hospital with major complications.	X		X	X

TABLE 1 | Common Barriers Faced by NAPH Members (continued)

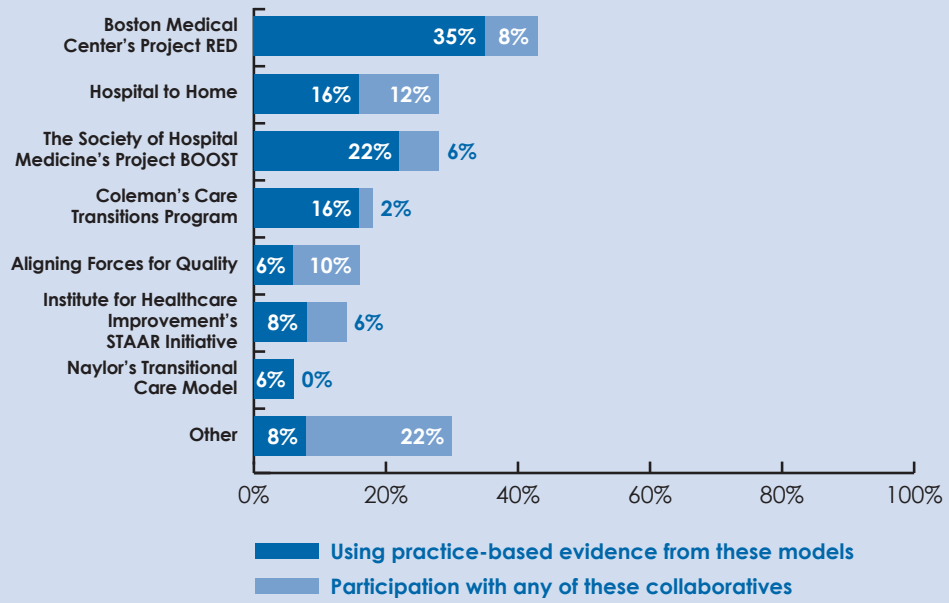
	Health Care System Barrier	Hospital Quality of Care Barrier	Hospital Resource Barrier	Patient Barrier
Ineffective emergency department and hospital flow Emergency department flow is an issue for some hospitals due to overcrowding and issues with throughput which can impact the discharge process. Streamlining the flow of patients may free up resources and ensure a more comprehensive and efficient discharge process that prevents patients from coming back to the hospital.		X	X	
Lack of a formal discharge process Another barrier to readmissions for some safety net hospitals is having a proper discharge process that incorporates evidence-based practices, training for staff, and assessment of staff compliance — all of which requires tremendous resources.		X	X	
Lack of hospital palliative care One academic medical center observed a problem with end-of-life patients being readmitted into the hospital. This medical center is attempting to implement a palliative care program but is struggling to raise funds so it can be implemented.		X	X	
Poor coordination of care within the hospital system Coordinating care for patients throughout the hospital's own system is a challenge for many safety net hospitals. They struggle with linking hospitalized patients to outpatient physicians in their system, either due to error or the hospital's clinics being over capacity. Patients that are scheduled follow up appointments with hospital clinic providers sometimes have extremely long wait times.		X	X	
Poor coordination of care between hospital and external providers In addition to coordinating care within the hospital system, hospitals also face barriers in coordinating patient care with providers not affiliated with the hospital. Poor communication between hospitalists and PCPs is common. Frequently, hospitalists and PCPs are unaware of medications ordered by other physician specialists involved with patients care.	X	X	X	
Inefficient hospital utilization Some hospitals struggle with treating patients in the appropriate setting. For example, some patients use the ED for primary care.		X		X

The majority of NAPH members have been engaged with reducing readmissions over the past several years. There are readmission risk factors unique to safety net hospital populations (substance abuse, behavioral health, homelessness, etc.), as well as common risk factors like heart failure that all hospital have to address.

particular is obtaining medications and complying with prescription instructions. Some hospitals are helping patients with getting their meds by filling their prescription for them before they leave the hospital, enrolling patients in the hospital's pharmacy discount program, or providing patients a list of local pharmacies. Hospital pharmacists also work with patients before they are discharged on understanding medication instructions.

- **Implementing a specific improvement model**
  Some of the strategies included the implementation of existing models that include evidence-based practices for reducing readmissions. Several hospitals implemented disease management or chronic care programs to better manage patients with chronic conditions and keep them from coming back to the hospital. Others worked to implement Lean methodology. The survey asked hospitals whether they are participating in any national collaboratives or using evidence-based practices from recently developed models (see Chart 7). The respondents were most likely to incorporate elements from Project RED, which was developed by Boston Medical Center, also a NAPH member.
- **Identifying high-risk patients and/or contributing factors to readmissions**
  As mentioned previously, some hospitals are identifying patients

CHART 7 Percent of NAPH members using nationally recognized improvement models for readmissions



at high risk for readmission early in their hospital stay so they can provide a greater concentration of resources on these patients. One hospital started a policy of assessing whether each admitted patient is a readmission, and if so, admitting them to the unit they were previously discharged from so they can be cared for by the same providers.

- **Developing a heart failure/chest pain unit**
  Since patients with heart failure are at high risk of being readmitted, strategies that target this population are also commonly implemented. Developing a chest pain unit is one strategy that helps prevent emergency department physicians from unnecessarily readmitting patients with chest pain. Having a chest pain unit helps the physicians, who may not feel the need to admit patients but also feel uncomfortable sending patients home, by providing them an area where patients can be monitored to ensure no further complications arise.

Summary

Although there have been other studies on hospital readmissions, this is the first one that comprehensively explores the NAPH member experience in addressing readmissions. The majority of NAPH members have been engaged with reducing readmissions over the past several years. There are readmission risk factors unique to safety net hospital populations (substance abuse, behavioral health, homelessness, etc.), as well as common risk factors like heart failure that all hospital have to address. This highlights the importance of establishing comprehensive data systems and learning about patient populations as much as possible. In addition, the study points to the fact that safety net hospitals have had more success in opening lines of communication with skilled nursing and home health services rather than primary care physicians.

Hospitals will continue to work to drive down readmissions to best serve their patients in the most appropriate care settings. The incentives put forward in the ACA to reduce readmissions will motivate hospitals to accelerate their improvement even more rapidly. NAPH members are applying evidence-based practices and tailoring proven interventions to meet the needs of their unique patient populations, as they look toward the implementation of the federal readmissions reduction policy and others from states and private payers. ■

Notes

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