Memorial Hermann leaders have been able to reduce preventable readmissions by closing care continuum gaps. They've tackled poor communication among disjointed or unaligned providers, a lack of systemic accountability and follow through, and inadequate human and IT resources.

Memorial Hermann in Houston is fortunate in some ways that it had a preview of the pain of readmissions almost a decade ago and decided to do something about it. Years before the Centers for Medicare & Medicaid Services started to penalize hospitals for preventable readmissions, Memorial Hermann had pain of its own: hundreds of millions of dollars in annual uncompensated care for a population that reached as high as 33% uninsured.

"We see a tremendous number of uninsured patients," says Memorial Hermann Chief Medical Officer Michael Shabot, MD. "We run 10 emergency departments, seeing over a half million patients a year, and we take care of everybody without regard to ability to pay. But what we found was that those individuals who weren't insured had a very high rate of readmission to the hospital or to our EDs or to observation. So we were actually paying for their admission and for every readmission. I mean literally just the hospital was paying for it."

It was decided that the right thing to do—as well as the most cost-effective—would be to undertake a comprehensive program to better manage high-risk patients. This program would close gaps in the care continuum that historically have led to readmissions: poor communication among disjointed or unaligned providers, a lack of systemic accountability and follow through, and inadequate human and IT resources.

The first step was to understand which patients were at higher risk for readmission. When the program began, risk stratification was based simply on a patient's number of previous hospital admissions. The team began to use a software program in conjunction with the Cerner-based electronic health record that scans the daily patient census and uses an algorithm to flag patients who may be at higher risk—based on their disease type or condition, as well as other demographic or clinical data. Those patients are added to a list that case management contacts for more follow-up.

The crux of Memorial Hermann's initial work in preventing readmissions has been in the expanded role of case management, which has evolved over the past seven years from a traditional inpatient episode role to one that takes a broad, continuum-spanning view of a patient's care. Pat Metzger, RN, chief of care management at Memorial Hermann, says the staff
case managers at the system's 12 hospitals follow up daily once the system has identified patients as a risk for readmission.

"At each of the campuses, the case management staff has what they call one-minute rounds," Metzger says. "They go up on the units each morning and they meet with the nursing staff to ask, 'Who have we got today that we need to consider as high risk for readmission when discharged? Who was the new admission? What are their care needs that are driving this hospitalization? Who do we have that we're planning on sending home today? Have they met all their milestones?""

The case manager makes certain that every discharged patient has a plan that maximizes the ability to avoid a readmission, Metzger says.

"No. 1, our case managers in the hospitals are focused on making sure that we're putting together a discharge plan that is the most cost-effective, but the least restrictive for the patients," Metzger says. For example, the case managers will review options for home health and other postacute providers that "we know we can trust to try to manage that patient in the ambulatory setting."

The staff case managers are "making every effort to get patients connected to the services that they're going to need back in the community before the patient leaves the hospital," Metzger says. Case managers will make the necessary doctor appointments for them, either within the Memorial Hermann physician staff or at area clinics. The case managers also coordinate with Memorial Hermann's ambulatory case managers to share care plans and to ensure there are no gaps in the care transition.

Case managers coordinate the discharge planning efforts, which are communicated via the health system's EHR platform.

"Our case managers do their discharge planning documentation right in … our electronic health record so that all the team members have access," Metzger says. "There's a particular folder in which they document interventions, such as who's going to be handling the patient, what arrangements have been made, or who the providers are so that anybody who accesses that patient's records can know where we are in the planning process and who are going to be the providers of services. The [time spent on] handoffs seems to get minimized because of the accessibility of the electronic data."

The organization is working to extend the accessibility of that data. Memorial Hermann owns many key pieces of the care continuum, including TIRR Memorial Hermann, one of the nation's leading rehabilitation hospitals, and its own home health agency. But for its readmissions program to be successful, the system had to find a way to work with a variety of community partners, says Carl Josehart, CEO of TIRR Memorial Hermann and System Rehabilitation Services.

"We're willing to share our data with them," Josehart says. "It's really being open about not only what we think they can improve, but also asking them if there was anything we did in our care that made it harder for them to receive our patient. We realized there are agencies in the
community [for which] we may not share ownership, but when we share our patients, we are really working together in partnership to close the gaps in care."

**In addition to discharge planning, the case managers also make certain that discharge education is tailored for the patient's situation, both clinically and at home.** Nurses and nurse educators provide the instruction to the patient, while the case managers follow progress to make sure the education happens when it should and involves the right people, Metzger says.

"They're communicating with the families about what the plan is," Metzger says. "The case managers work with patients and their families to decide whether they have the resources, skill, or desire to help manage the process once they leave the hospital. Is it the patient we have to teach? Is it the family member we have to teach? Do we need to look at a postacute provider as an interim step for this patient? So they're doing a lot of assessment about the readiness of the patient, the family, or significant others to assume responsibility posthospitalization for care, and then they'll involve the right people in that."

Enhancing case management, sharing data, and linking to community partners are some of the organizational improvements Memorial Hermann has made, but some of the largest gains involved closing the more practical gaps that can trigger readmission, such as those related to:

Durable medical equipment: Some patients with a catastrophic illness or injury may require a substantial number of durable medical devices, often for the first time. The team found that patients would frequently be sent home before the DME was ready, says Josehart—so rather than just making a DME referral, the staff now manages the transition.

"Our standard is that all the equipment needed to care for a patient in the home is in the home 24 hours prior to discharge so the family has a chance to make sure that it's there, that it's working, to test it, and if it's different from what they expected, to resolve that issue prior to the patient going home. That's something that we track in our internal quality metrics. Although it's a home thing, we see that as part of our commitment to making sure that we're handing off to a safe environment," Josehart says.

Medication reconciliation: Even before discharge, the nurses and case managers work to ensure that the patient and family understand their medication, even something as seemingly simple as recognizing changes in shape or color of a medication, Metzger says. Whenever there is a question, a staff pharmacist is brought in to explain the new medications and any potential interactions. The team also makes sure the patients have enough medication to take home with them so they don't have to rush out in those first few days to get a refill.

"We have a relationship with Walgreens so that when we have patients we know will be leaving the hospital with a new prescription, they can opt to have a Walgreens that is located on our campus bring those prescriptions directly to their room so that in fact they don't have to try to stop at the pharmacy or have something delivered to their home," Metzger says.

Discharge packets: One of the gaps that physician leaders noted in medication reconciliation failures was that patients did not understand their discharge instructions. That's no surprise,
considering the volume and complexity of the material given to them, says Keith Fernandez, MD, president of MHMD Memorial Hermann Physician Network. "Historically our patients might go home with 30 pieces of paper," he says.

"It was hard for the patient to determine which piece of paper was the most important. And even the important ones were hard to read and in language that the average patient could not understand," he says.

**A physician-led team spent a year organizing and editing down discharge instructions to a critical few and embedded those into the EHR.** Now, discharge instructions are distributed consistently to every patient based on that patient's specific condition. "The group came up with a very streamlined process for discharges," Fernandez says. "In fact, the discharge process probably would qualify for a discharge summary as well. So when the patient leaves, they take home a relatively clean sheet of information that has everything critical in that process for the patient to know—and only that."

The secret, if there is one, is in effort and attention, Metzger says.

"There is no magic to this," she says. "It's paying attention to the details and it's making sure that the patient and the family always understand where they are in a trajectory. It is constant, precise execution on those kinds of things every single day."

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