Brownsville Hospital Success in Reducing Readmissions Highlighted in American Journal of Nursing

Work by TMF Health Quality Institute Helped Valley Baptist Medical Center Reduce Readmission Rates by 36 Percent

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Austin, TX – July 31, 2013 – As part of the Centers for Medicare & Medicaid Services (CMS) initiative in Texas facilitated by TMF Health Quality Institute, the state's Quality Improvement Organization, five hospitals in the Harlingen region of South Texas successfully reduced their 30-day all-cause hospital readmission rate. The article in the American Journal of Nursing focuses on how one hospital, the Valley Baptist Medical Center–Brownsville, drastically reduced their readmission rates compared to other participants in the project.
The project's goal was a two percent reduction in 30-day hospital readmissions, which the five participating hospitals matched exactly. Valley Baptist's individual rate dropped from 23.3 percent to 15 percent. This 8.3 point drop represents an impressive 36 percent reduction in hospital readmissions.

"The combined team of hospital staff and TMF consultants worked diligently to improve processes and enhance the quality of health care for patients," said Jennifer Markley, TMF quality improvement director. "We are pleased with the success of this initiative and happy this success is being recognized in the American Journal of Nursing as a guide for other initiatives."

With help from TMF, the five hospitals in the project, particularly Valley Baptist, identified several underlying causes of readmissions. These included fragmented discharge plans, miscommunication between caregivers and patients, inadequate care transition coordination and patients' lack of health literacy and self-management skills.

TMF introduced the hospitals and participating community post-acute care providers, such as nursing homes and rehabilitation clinics, to a strategic communications and process-restructuring model called Project Re-Engineered Discharge (Project RED).1 Valley Baptist precisely steered the expansion of Project RED within its departments over a two year span from January 2009 to January 2011.

Project RED, initially developed by researchers at Boston University Medical Center, created a model of interventions hospitals can implement in the areas of in-hospital patient education, discharge planning and post-discharge follow-up. The interventions involve educating patients on managing their conditions and medications. Internal communications with patients, documented follow-up with patients and increased coordination with after-care providers were critical to successfully reducing admissions.

Despite successful QIO projects like this one, readmissions remain a major concern to CMS, so much so it began a Readmission Reduction Program in 2012 to reduce payments to poorly performing hospitals. According to CMS, almost 20 percent of Medicare patients are readmitted within 30 days of hospital discharge. The annual cost of these largely preventable readmissions is a staggering $2.6 billion, or $1,000 per readmission.

Although the project's goals are complete, the hospital continues to implement new changes to further reduce readmissions. A palliative care program, continuing quarterly meetings with post-acute care providers and a redesign of the patient follow-up phone call process have all been put in place since the end of the formal project.

For further details on the successful initiative, please see the July issue of the American Journal of Nursing.

About TMF Health Quality Institute
TMF Health Quality Institute focuses on improving lives by improving the quality of health care through contracts with federal, state and local governments, as well as private organizations. For more than 40 years, TMF has helped health care providers and practitioners in a variety of settings improve care for their patients.

1Boston University School of Medicine, "Project RED (Re-Engineered Discharge),"
http://www.bu.edu/fammed/projectred/index.html.


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