# Sharp Rees-Stealy Medical Group, San Diego
## Reducing Hospital Readmissions

### Background
Sharp Rees-Stealy (SRS), a non-profit, integrated delivery system with 70 percent of its revenue in capitated contracts, is organized and financially aligned to increase quality and decrease the cost of care for the patients it serves. The organization has many services already in place to coordinate patient care – for example, hospitalist teams, discharge planners and complex care managers supported by an electronic health record (EHR). In 2011, SRS made a series of incremental interventions to reduce its number of unnecessary hospital readmissions.

### Goal
Measure the impact of consistent, early follow-up medical appointments on patient readmission to the hospital.

### Target population
SRS analysts identified the following risk factors for readmission within its own patient population:
- Number of days until the patient’s follow-up appointment
- Length of hospital stay and number of ICU Days
- Whether the patient had an operating room procedure or received blood
- A creatinine level > 2.0

### Intervention
SRS implemented a standard EHR “discharge task,” which documents the reason for hospital admission, follow-up appointment recommendations and pending test results. A centralized Call Center schedules follow-up appointments to ensure that patients see their doctors within seven days of leaving the hospital. All patients who have been in the hospital or seen in the ED are followed by the Continuity of Care Unit, which employs nurses and health aids to call patients within 48 hours of discharge to review medications and the treatment plan, answer questions and make sure the patient has a follow-up medical appointment. In complicated cases, a care manager may be assigned. All senior patients are accompanied by a care manager at their first post-discharge visit in order to develop a care plan to help manage the patient’s condition and assist with care coordination.

### Results
In 2011, 84 percent of hospitalized patients were scheduled to see their health care providers within seven days of discharge, with an average of 77 percent keeping their appointments. Readmission rates dropped from a 2008 baseline of 15.63 percent in SRS’s senior population to 13.6 percent. However, further analysis reveals fluctuation in results.

### Recommendations/Observations
Reducing readmissions is more complex that it appears on the surface. Multiple factors must be addressed simultaneously to yield improvement.