CMS estimates that hospital readmissions for Medicare patients costs the American taxpayers more than $26 billion per year, more than $17 billion of which is avoidable. Approximately 18% of Medicare patients were readmitted last year, which is lower than in previous years. However, in 2015, 2,610 hospitals will lose up to 3% in payments for each Medicare patient they admit. Although CMS did not attribute a specific cause for the decline, Jonathan Blum of CMS stated that the drop is largely the result of penalties for high readmission rates, and funding for new efforts to reduce readmissions.

Causes of Readmissions


“Some return trips are predictable elements of a treatment plan. Others are unplanned but difficult to prevent: patients go home, new and unexpected problems arise, and they require an immediate trip back to the hospital. But many of these readmissions can and should be prevented. Many of these readmissions are caused by inadequate discharge planning, poor care coordination and communication between hospital and clinicians, and the lack of effective longitudinal community-based care. They are the result of a fragmented system of care that too often leaves discharged patients to their own devices, unable to follow instructions they didn’t understand, and not taking medications or getting the necessary follow-up care.”

The article goes on to say: “Hospital readmissions are sentinel events that often signal gaps in the quality of care provided to Medicare patients”.

CARE MANAGEMENT SERIES—Part 5
Preventing Readmissions
Strategies to Prevent Readmissions

There are numerous strategies to reduce readmissions in the literature. The following is an overview we hope you will find useful.

1) Discharge Planning Process

Obviously discharge planning is important – but do we do that now, right? Maybe it’s more of a question of not IF we are doing discharge planning, but IF what we are doing is effective.

Strategies to Consider

- Complete an enhanced, focused assessment of discharge needs at the time of admission. A little more time on the front-end is well worth the effort.
- Take a multi-disciplinary approach. Involve ALL disciplines including the pharmacist and the dietician. The literature suggests that two major causes of readmissions are medication management and diet.

2) Assessment of Readmission Risk

Complete a “formal” assessment of the risk of readmission so that interventions can be aligned to patient’s needs. Map questions to common causes like diet or lack of follow-up with primary care provider. Ask patient their thoughts on why they were readmitted. Cleveland Clinic Readmission Patient Interview, although it is copyrighted and I can’t reproduce, is an excellent example. The Patient Interview form can be accessed on The Advisory Board web site (advisory.com)

Strategies to Consider

- Develop a risk of readmission questionnaire
- Discuss the results of the questionnaire with the multi-disciplinary team, including providers, at discharge planning rounds
- Develop a specific plan that addresses each of the reasons for readmission
3) Medication Management

The literature on reasons for readmission has found that patients are frequently confused about which medicines to take after discharge.

When patients are admitted to the hospital, many stop taking their regular medicines and start taking new ones. Once the patient leaves the hospital, there is often confusion regarding which of the pre-hospitalization medicines should be continued. This may result in the patient failing to take needed medicine, taking duplicate medicine, or experiencing adverse drug events.

Strategies to Consider

- Ensure you have a reliable process for accurate medication reconciliation at admission
- Ensure you have a reliable process for medication reconciliation at discharge
- Provide patient education regarding discharge medications in a language and method the patient can understand. (Project RED has great patient-friendly resources.)
- Use teach-back to validate patient and caregiver understanding of medications
- Plan in place, prior to discharge, for patients to obtain medications after discharge

4) Patient Education

Often patient education is done the day of discharge – and THAT’S TOO LATE!

Patient education needs to be culturally sensitive, incorporate health literacy concepts and include information on diagnosis, symptom management, medication and post-discharge needs.

“The Revolving Door: A Report on US Hospital Readmissions”, states: “Many patients are discharged without understanding their illnesses or treatment plans, or inadvertently discontinue important medications.”

Strategies to Consider

- Develop patient friendly education materials
- Offer more intense education for any new diagnoses
- Review knowledge base / understanding of patients with chronic conditions and provide additional education focused on gaps in knowledge
- Use teach-back to validate patient and caregiver understanding
5) Primary Care Physicians

The patient’s primary care physician is an essential component of the care team, even though care in the hospital may have been provided by a hospitalist.

Strategies to Consider

- Identify a primary care physician for follow-up at discharge
- Make a follow-up appointment with the primary care physician prior to discharge
- If the primary care physician did not see the patient in the hospital, call the primary care physician directly and discuss the patient’s needs
- Send a copy of the discharge plan and discharge instructions to the primary care physician within 24-48 hours of discharge
- Expedite transmission of the discharge summary to clinicians accepting care of the patient within 24-48 hours of discharge

6) Collaboration with Community Providers

A strong relationship with community providers including skilled nursing facilities, home care, hospice, durable medical equipment providers are essential. Some facilities have quarterly meetings to discuss issues and problem solve.

Strategies to Consider

- Develop relationships with community based providers
- Consider regular meetings to discuss referral processes
- Call and discuss readmissions with community providers and problem-solve strategies to prevent readmissions in the future

7) Outpatient Follow-up

More than one-third of the patients who left the hospital in need of more care (e.g., lab tests or a referral to a specialist) failed to get that care. (Pasche et al.) Nearly half of the Medicare patients re-hospitalized within 30 days did not have a physician visit between the time of discharge and readmission (Jencks S.F., Williams M.V., Colman E.A.; NEJM 2009, 360:1418-1428). Arranging for follow-up care, prior to discharge, is critical to preventing readmissions.

Strategies to Consider

- Make appointments for follow-up care (e.g., medical appointments, post discharge tests/labs) before the patient leaves the hospital
- Ensure there is transportation available for primary care appointments and any testing that has been ordered
- Assign staff to follow up of results from tests or labs that are pending at discharge
- Call the patient to ensure they kept their scheduled appointments
8) Phone Follow-up

A phone follow-up with patients shortly after discharge can identify any issues or unmet needs the patient may be experiencing “early”. Use the call to reinforce components of the hospital discharge plan using teach back.

Strategies to Consider
- RN Follow-up call with patients 24-48 hours post-discharge
- Document issues / concerns and any follow-up actions taken

9) Community Case Management

There are some patients in which the strategies outlined previously to prevent readmissions, even when executed perfectly, are not sufficient. Community Case Management is a strategy that can be effective for very high risk or complex patients. Unfortunately, unless the program is associated with an organization like a Medical Home, there is minimum to no reimbursement. For acute care hospitals however, the cost of the program may be offset by reducing or eliminating the payment reductions for readmissions.

The Collaborative Case Management Journal, Winter 2014 edition, has an excellent article on one hospital’s experience in developing a community case management program. The criteria they used for inclusion of patients in the program were: Five or more hospital admissions within a year, Several chronic, complex comorbidities (such as COPD, CHF), Co-recurring mental health issues, Psychosocial barriers, Drug abuse, Limited access to funding.

Strategies to Consider
- Identify high-risk patients that may be appropriate for case management
- Develop a cost-benefit analysis of developing a case management program

10) Develop a Plan

The most important thing you can do to reduce readmissions – is to have a plan and execute it. Just wishing that readmissions are going to get better isn’t going to work. Here’s some steps:
1) Identify the team (include providers) -- Consider your utilization review committee
2) Review current performance
3) Develop a readmission reduction goal
4) Agree on a definition for readmissions
5) Review the literature
6) Use LEAN methods and tools
7) Gain consensus on strategies – include all stakeholders
8) Implement strategies
9) Measure and report results
10) Celebrate success
The Role of Data

An essential element of improvement is using DATA! To improve you will need to be able to answer these four questions:

1) Where you are now (baseline)?
2) Where do you want to be (goal)?
3) Why aren’t you achieving your goal?
4) How are you going to measure success?

The following data elements are key in both initially analyzing root cause of readmissions as well as measuring ongoing performance.

- Medicare Readmission Rate
- Medicaid Readmission Rate
- Readmission rates by primary diagnosis
- Readmission rates by diagnosis: CHF, Pneumonia, Acute MI, COPD, Total hip arthroplasty, Total knee arthroplasty
- Readmission rate by primary care physician
- Readmission rate by primary care physician by diagnosis
- Length of Stay for admission prior to readmission
- Discharge disposition (prior admission)
- Emergency Department visits prior to readmission (# and reason)
- Reason for Readmission

And as you drill down to determine WHY a readmission occurred, look at the process measures that the literature has shown are predictors of a readmission occurring.

- Appointment made with physician prior to discharge
- Days until patient saw primary care provider
- Days until patient saw Specialist (if recommended)
- Discharge summary sent to primary care physician within 24 – 48 hours
- Outpatient Laboratory tests drawn as ordered
- Laboratory tests pending at discharge sent to primary care physician
- Evidence in medical record that patient received focused education including diagnosis, diet, medication, etc. including evidence of patient understanding
- Medication Reconciliation completed at Discharge
- Patient followed diet as ordered
- Patient took medications as ordered
- Discharge phone call within 24-48 hours of discharge with FU on any issues identified
Gaffey Healthcare, a partner with HTMS, has a new product called AlphaAnalytics. The AlphaAnalytics product has the ability to capture readmission data already in your system, and turn it into useable information. You can build queries, trend data over time and build reports including dashboards. An example of a very simple report is shown in the screen shot below.

If you are interested in more information about this product, please contact me and I will be glad to set up a demonstration for you.
**Resources...**

As you develop your Readmission Reduction strategies, the following resources may be helpful.

1. Project Red (Re-engineered Discharge)  
   www.ahrq.gov/professionals/systems/hospital/red/toolkit/index.html
2. Project BOOST (Society of Hospital Medicine)  
   www.hospitalmedicine.org/BOOST
3. Health Care Leader Action Guide to Reduce Avoidable Readmissions (Health Research and Education Trust)  
   www.rwjf.org
5. Institute for Healthcare Improvement – Targeting Patient Transitions to Reduce Readmissions  
   www.ihi.org
6. The Advisory Board Company – Readmission Reduction Toolkit (Note: full access is restricted to members but there is still valuable information available)  
   www.advisory.com

HealthTech hopes that the information contained herein will be informative and helpful on industry topics. However, please note that this information is not intended to be definitive. HealthTech and its affiliates expressly disclaim any and all liability, whatsoever, for any such information and for any use made thereof. Recipients of this information should consult original source materials and qualified healthcare regulatory counsel for specific guidance in healthcare reimbursement and regulatory matters.

If you have questions or comments about this newsletter, please contact Carolyn St.Charles, Regional Chief Clinical Officer.  
Email: carolyn.stcharles@ht-llc.com. Office: 360-584-9868 Cell: 206-605-3748