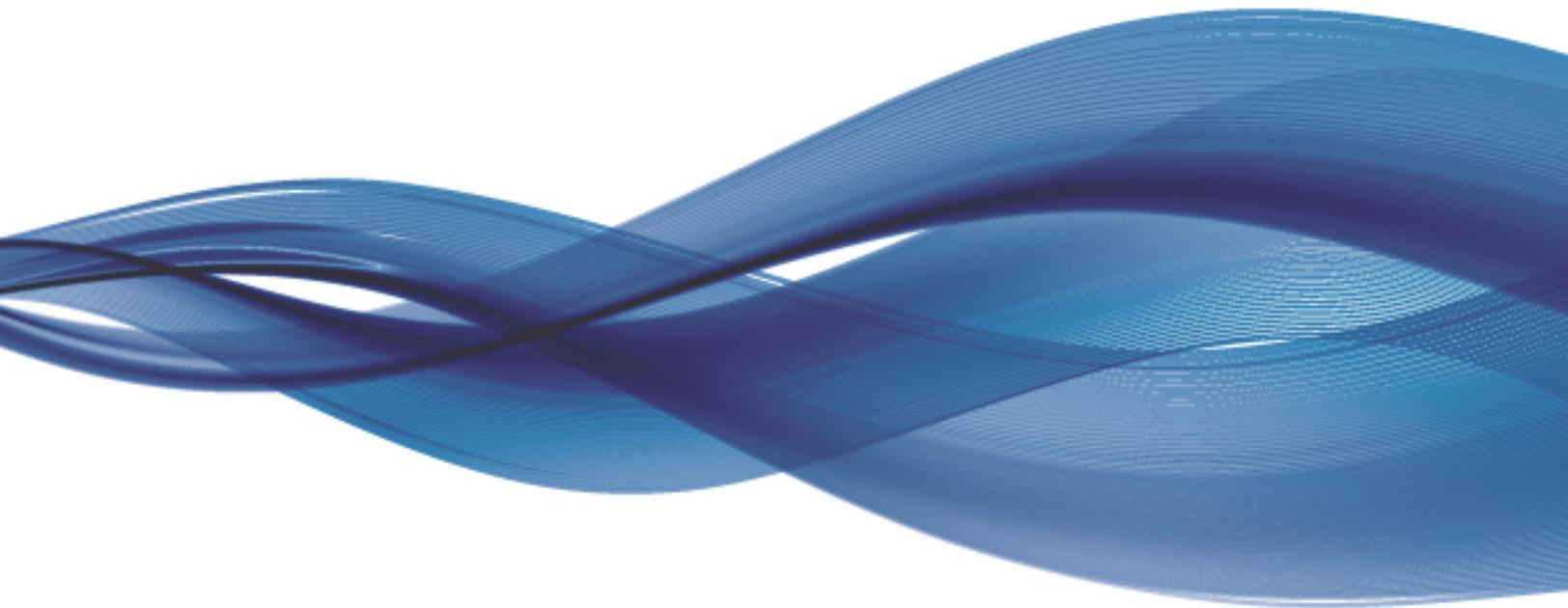


Readmission Reduction

A look at strategies for lowering hospital readmissions
across the continuum of care

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Introduction

The Affordable Care Act established the Hospital Readmissions Reduction Program (HRRP), which imposes penalties on hospitals deemed to have “excess readmissions.” Considering the bullets below, it’s easy to see why they took these steps:

- One in five elderly patients is readmitted to the hospital within 30 days of discharge.
- Avoidable readmissions cost Medicare \$15 billion per year.
- Medicare pays \$15,000 for an episode with no readmission and \$33,000 for an episode with one readmit.

For Fiscal Year (FY) 2015, the Centers for Medicare and Medicaid Services (CMS) has estimated that the total penalties will be approximately \$428M, up from \$227M in FY 2014. This will affect over 2,600 hospitals. No wonder that in the *Becker’s Hospital Review: 2014 CFO Survey*, 23% of hospital CFOs surveyed said readmissions reductions are top of mind.

Readmissions is a multi-dimensional problem. No single player or entity is entirely responsible for reducing excess readmissions. By improving our understanding of each touch point along the patient care continuum, strategies can be developed that ultimately reduce total readmissions.

This paper will explore the roles of patients and providers in reducing readmissions and review several strategies that each can implement to help reduce readmission rates.

Patients

Which patients are at high risk of hospital readmission?

Patient factors play a substantial role in the risk of hospital readmission. Many of these factors are outside of the direct control of the hospital, yet the hospital must work to manage the issues that arise as a result of patient characteristics.

Claims data and medical records for re-admitted patients offer a window into characteristics often associated with rehospitalization. Extrapolating from data across the Medicare population allows hospitals to identify high-risk patients who may benefit from more intensive discharge planning and follow-up. Additionally, socio-demographic and healthcare history characteristics likely also add risk of readmission to hospital patients more broadly.¹

Medicare Patient Characteristics Associated with Risk of Readmission²

Socio-demographic	<ul style="list-style-type: none"> • Gender (male) • Poverty • Age (Medicaid or uninsured) • Lack of stable living situation and/or support at home
Healthcare history	<ul style="list-style-type: none"> • Index admission for HF, AMI, PN or certain types of surgery • Recent admission(s) • Frequent ED visits
Disease burden	<ul style="list-style-type: none"> • Takes six or more medications • CHF, diabetes, COPD • Depression, psychoses • Cancer, renal or lung disease • Alcohol or drug dependency
Physical status	<ul style="list-style-type: none"> • Disabled • Frail • Signs of poor nutrition
Other	<ul style="list-style-type: none"> • Discharged during weekend or holiday

Certain patients may have a high propensity to be readmitted. This might depend on a number of factors as noted above such as the initial ailment the patient was suffering from, patient frailty and chronic health diseases which might increase the chances of readmission. For example it has been shown that patients over 65 years of age and suffering from heart failure had a 29 to 47 percent chance of getting readmitted within three to six months of initial discharge.

Inadequate post discharge treatment may lead to readmission of the patient. This could arise from a number of different elements:

- The patient may be provided with comprehensive verbal instructions and forget the instructions soon after discharge.
- Written instructions may be provided to the patient although, in the absence of a family member/friend, the information is not conveyed and may be forgotten after discharge.
- The patient may return home and become complacent after the initial few days of recovery. This is quite common and the patients may not complete the entire dosage of prescribed medicine primarily because they begin to feel better and they begin taking the treatment lightly and neglecting it.
- The patient may be unable to get a follow up appointment. This is common in over-crowded cities and hospitals where access to doctors or health care is difficult. Delay in follow up could lead to a deterioration of a patient's condition.
- Literacy rates and socio-economic status of the patient also plays a role in their readmission. Hospitals which primarily serve financially challenged neighborhoods often have high readmission rates primarily due to lack of knowledge among the patients admitted there.
- Ethnicity and gender can contribute to readmissions. Patients from different cultures may not express concerns, questions, or needs due to social mores. Men or women may perceive by virtue of their gender that they should not "require" assistance, education, or support post discharge.
- Spoken language could impact a patient's ability to understand discharge plans and education. Hospitals accredited by the Joint Commission are required to assess the patient's ability to understand based on their spoken language and utilize resources to support the patient's spoken language through the use of interpreters.

A variety of patient-specific factors can impact the propensity of readmission. It is paramount for the hospital to perform a comprehensive risk assessment and establish solutions to ensure viable reduction strategies.

Patients

Comprehensive Discharge Planning: A solution for patients at high risk for readmission

Comprehensive discharge planning significantly reduces readmission rates and may improve health outcomes without increasing costs.

Reducing preventable readmission is important not only to improve clinical excellence but also to ensure a hospital's financial success. Implementing best practices can help hospitals foster high patient engagement, improve patient education, and cut readmission rates.

A comprehensive discharge plan must consider the entire scope of a patient's health needs and should include input and feedback from both the patient and family. Optimal discharge plans should consist of written, visual or recorded information including follow-up appointments, medications, nutritional needs, family and patient support, transportation, health literacy, resources to call, social problems, and red flags.

Patient-centered discharge planning is the recommended practice today. Programs differ according to which patients are selected for intensive interventions, such as those with high-risk conditions like heart failure, and which disciplines or specialists are involved. Some hospitals are beginning to create a dedicated role for transitional care planning and support – the transitional care manager role is generally provided by a nurse.

Hospitals are formalizing and standardizing the discharge process to include documentation and patient education. The Joint Commission has also increased the focus on the preparation for discharge as part of hospital accreditation. This has provided a platform for work on readmissions and has certainly helped with improvements achieved in many hospitals.

A comprehensive discharge process includes:

- Assessment of the ability of the patient/family to provide care (includes problem solving, decision making, early symptom recognition and taking action, quality of life, depression and other cognitive and functional ability factors).
- Development of a comprehensive shared care plan using a shared decision making approach – consider patient values and preferences, social and medical needs.
- A complete and up-to-date discharge summary and medication plan.
- Preparation of the patient/family for the follow up visit (goals, questions, concerns).
- Initiating discussions for advanced directives and advance care planning as appropriate to patient needs and condition.

Preparing the patient and family for discharge is best initiated on admission and should include the following:

- Educate the patient and family about the diagnosis and care throughout the continuum of care.
- Employ the teach-back method to ensure patients/families understand the care plan, information and explanations given and that their questions are answered.
- Provide culturally and linguistically appropriate care.
- Ensure continuity in care in order to build trust.
- Use a shared decision making approach.
- Ensure enough time is available for consultation.
- Discuss with the patient any tests or studies that have been completed and who will be responsible for following up the results.
- Review with the patient appropriate steps of what to do if a problem arises.

The rate of readmissions can be reduced by improving core discharge planning and transition processes out of the hospital; improving transitions and care coordination at the interfaces between care settings; and enhancing coaching, education, and support for patient self-management.

Physicians

The physician's role in lowering hospital readmission rates

Engaging other providers and patients at each point along the care continuum to improve communication, coordination, and discharge planning is essential to decreasing inappropriate and costly hospital readmissions.

Physicians serve a pivotal function in helping to reduce excess readmissions. By providing expert care and counseling to their patients, they can reinforce positive patient behavior that can often prevent a return to the hospital. Additionally, diligent coordination with other physicians who are participating in the care continuum promotes patient-centered care.

Physician-to-Patients

An American Medical Association³ report highlights the critical role that physicians play in helping their patients make safe transitions after being discharged from the hospital. To help avoid rehospitalizations, physicians should:

- Keep organized information on patients' medical issues, health goals, functional and psychological status, and behavioral and social issues.
- Consider patients' acute, intermediate and long-term care goals.
- Be explicit with patients about social, economic, cultural and other factors that may impede their care.
- Use reader-friendly tools such as checklists and "red flag" lists to help patients and caregivers with self-management tasks.
- Use motivational interviewing and teach-to-goal methods to support self-care.
- Use pharmacy, patient and hospital discharge lists to ensure a fully reconciled and accurate medication list after discharge.
- Reinforce medication changes made in the hospital with patients, as appropriate.
- Use "pill cards" to help patients track drug changes.
- Allocate time to address care coordination tasks, using templates and checklists for specific tasks.

Physicians must invest the time it takes for patients to understand their medications, making sure that they have an appointment slip in hand when they leave the hospital and know what to do if worrisome symptoms or signs develop after they leave the hospital.

Additionally, timely follow up appointments are essential especially for patients suffering with chronic conditions such as heart failure and COPD. One study among Medicare patients requiring readmission within 30 days of discharge, identified that only 50 percent had seen a clinician for a follow-up appointment. Other studies affirm that patients who are scheduled or seen for follow-up appointments are less likely to be readmitted. Physicians should encourage their patients to make a follow-up appointment immediately upon discharge or ensure that one is made before the patient leaves the hospital.

Physician-to-Physician

Another key contributor to reducing readmissions is related to the communication between physicians. The hospital physician may not be the patient's primary physician. Hospitals are now relying on a fairly new trend of hospitalists - a term used for doctors who are specialized in the care of patients in the hospital. Hospitalist programs have been utilized for a variety of reasons: convenience, efficiency, financial and time constraints on primary care doctors, cost-effectiveness for hospitals, and the need for more coordinated care for hospitalized patients.

There is concern, however, that the provision of care by hospitalists disrupts continuities in the care continuum, both at the time of admission and discharge. Hospitalists may be unfamiliar with a patient's health and social history and, once a patient is discharged to the outpatient setting, the PCP may be unfamiliar with the rationale behind care provided in the inpatient setting. While hospitalists may try to contact PCPs to discuss care and discharge plans, they note that it is often difficult to communicate directly with community-based providers.

A lack of communication, seamless information exchange, and relationships between inpatient and outpatient providers, as well as PCPs and specialists, inhibit providers from delivering high quality, patient-centered, and coordinated care. Engaging providers and patients at each point along the care continuum in efforts to improve communication, coordination, and discharge planning is essential to decreasing inappropriate and costly hospital readmissions. Even within the context of the current delivery system, adopting and promoting a sense of "systemness" through mechanisms such as team-based care and electronic medical records (EMRs) would be a distinct improvement.

Communications

Optimizing communications between providers

The single biggest problem in communication is the illusion that it has taken place
- **George Bernard Shaw**

Effective communication means that the message you want to send is received by your intended audience without any discrepancy in the meaning. Not understanding the important role communication plays in reducing hospital readmissions can impact hospitals financially, through imposed Medicare penalties and in the quality of patient care. Communication between care providers is often inconsistent. Poor communication has been well documented as a barrier to effective discharge planning.

Health care providers must use effective spoken and written communication methods to convey the patient's short- and long-term treatment and discharge plans.

The communication flow begins at the initial point of access, whether in the clinic or Emergency Department (ED), transitions to the acute care setting, and continues with the primary care provider and venues of care following hospital discharge. Communication handoffs involve numerous people: the primary care provider (PCP); the ED staff; the inpatient care team, including hospitalists, nurses, case managers, social workers and pharmacists; and the post-acute care providers.

Strategies to Prevent Readmissions⁴

In the acute care setting, communication strategies include multidisciplinary care progression rounds, patient and family education, meetings for patients at high risk for readmission, medication reconciliation, and discharge planning with the post-acute venues of care.

Patient education is essential for improving self-care and lowering readmission risk. Providers may use a variety of teaching tools such as teach-back, in which the patient demonstrates knowledge by teaching the clinician; computerized learning and testing; and group sessions to help improve self-care. Providing continued patient education throughout the inpatient stay helps patients retain knowledge and prevent confusion at home.

Medication reconciliation is comparing the medications the patient is taking at admission with the medications prescribed at discharge. Encouraging the patient to participate in medication reconciliation helps improve self-care, as it provides patients with a list of pre-hospital medications that should be discontinued when they leave the hospital, and reminds them of any changes in the dose or frequency. It also highlights the medications patients should continue as well as over-the-counter medications they should avoid.

It is critical that these instructions be provided in the language the patient speaks and in a format that can be provided to caregivers in the next venue of care.

A **Patient-friendly discharge plan** is key as the patient is being prepared for discharge from the acute care setting. A nurse should provide a clear, easy-to-follow plan that outlines the post-discharge plan of care.

Key components of the plan should include:

- the reason for hospitalization;
- medication reconciliation;
- pending tests and results;
- post-discharge services needed;
- reference to post-discharge resources to support health improvement and maintenance;
- symptoms that indicate the patient should contact the PCP;
- the post-hospitalization appointment with the PCP; and
- important contacts and phone numbers.

Post-discharge intervention is necessary to minimize recidivism. The patient care manager or primary nurse should schedule a home visit in the first 48 hours of discharge, followed by a PCP office visit within the first two to five days post-discharge. Patients at moderate or low risk may require a home phone call within 48 hours and an office visit five to seven days post-discharge.

Effective communication means that the message you want to send is received by your audience without any distortion in the meaning. Communication methods can lead to success or failure of any project or program.

When patients and care providers are well-informed about discharge processes and see their role as part of a team, they tend to develop a higher confidence level. The increased confidence level will foster comfort regarding the discharge and their role and will also alter their attitudes on a positive note. Molding patient and care providers attitudes will ensure that they provide their best to the effort of improved health.

Transitional Care

Building patient-centered transitional care models to reduce readmissions

Readmissions is a community-wide issue requiring hospitals to partner with local community resources in an effort to reduce readmissions.

Transitional care interventions, which aim to improve care transitions for patients moving from the hospital to the home, help reduce hospital readmissions rates in the intermediate-term (31-180 days) and long-term (181-365 days) intervals after the discharge of a patient with chronic conditions, according to a study in the December 2014 issue of *Health Affairs*.

The report, entitled “*Transitional Care Interventions Prevent Hospital Readmissions For Adults With Chronic Illnesses*,” also found that only high-intensity interventions seemed to be effective in reducing short-term readmissions (occurring 30 days or less after discharge). To boost the effectiveness of reducing readmissions, the report suggests that transitional care strategies should comprise high-intensity interventions that include care coordination by a nurse, communication between the primary care provider and the hospital, and a home visit within three days after discharge, according to the abstract.

More importantly, facilities are becoming increasingly aware that readmissions indicate problems for patients, and that improving transitions from acute care to other settings holds the potential to enhance patient outcomes.

In an atmosphere of patient-centered care, readmissions is not and should not be a hospital problem. It is a community-wide issue requiring hospitals to partner with local community resources in an effort to reduce readmissions.

Hospitals can begin by reaching out to nursing homes and home health agencies to facilitate smoother transitions, overcome system issues and ensure patients have arranged follow-up appointments. Both patients and staff must understand the discharge plan.

Brian Contos, executive director for strategic research at The Advisory Board Company in Washington, D.C., agrees that preventing readmissions requires a community effort, saying, “Implementing strategies to reduce unplanned readmissions requires that hospitals broaden their accountability beyond the acute-care setting, a theme that applies to larger care delivery and payment reforms underfoot. Efforts must include strategies within the hospital’s four walls and beyond.”

The Commonwealth Fund and Health Research & Educational Trust (HRET), an affiliate of the American Hospital Association, published the *Health Care Leader Action Guide to Reduce Avoidable Readmissions* in January 2010, suggesting that hospitals examine their readmis-

sion rates, assess priorities, develop an action plan of strategies to implement, and then monitor progress. The authors cited four interventions that have strong evidence of reducing avoidable readmissions. They include:

- Boston Medical Center's Re-Engineered Discharge/RED.
- Eric Coleman's Care Transitions Program, with coaches.
- The Evercare Care Model, a care coordination program for people who have long-term or advanced illnesses.
- The Transitional Care Model, developed by Mary Naylor, Ph.D., FAAN, RN, at the University of Pennsylvania School of Nursing, which provides comprehensive in-hospital planning and home follow-up for chronically ill, high-risk older adults hospitalized for common medical and surgical conditions.

The goal of transitional care is to develop patient-centered models to ease the transition back to home or the community. There is no one best method and what may work for one hospital may not work for another. It is important for hospitals to evaluate resources and develop a program that meets the needs of the patient population it serves.

End Of Life Planning

Compassionate conversations can yield lower readmissions

Healthcare organizations must be prepared to have difficult conversations, employing those with compassion and knowledge to provide palliative care services.

A large majority of patients discharged from the hospital fail to receive the basic and necessary planning and preparation. These gaps lead to readmission in a surprisingly large number of cases. The costs associated with hospitalization consume nearly one third of the total dollars spent on healthcare in the United States.

Other studies have examined the low rates of referral and utilization for hospice and palliative care services during the last phase of life.⁵

When patients desire and are referred for hospice services, hospitalization rates in the subsequent 30 to 180 days are decreased by 40% to 50%, as demonstrated by Casarett and Gonzalo.⁶

Providing post-discharge care and support is very resource-intensive. One of the biggest challenges is matching discharged patients with the most effective set of interventions to provide care and support.

The Agency for Healthcare Research Quality Research (AHRQ) has found that most patients have not participated in advanced care planning, yet many are willing to discuss what they want when encountering a serious illness and end-of-life care.

A recent American Hospital Association study regarding patients' wishes at the end of life revealed that 80 percent of patients wish to avoid hospitalization.⁷

Patients who have advance care planning involvement spend 10 fewer days in the hospital during their last two years and have fewer readmissions than those without as many elect to spend the time at home with family. When patients are involved with and educated on end-of-life care outside of the hospital, hospitalization rates in the subsequent 30 to 180 days are decreased by 40 to 50 percent.⁸

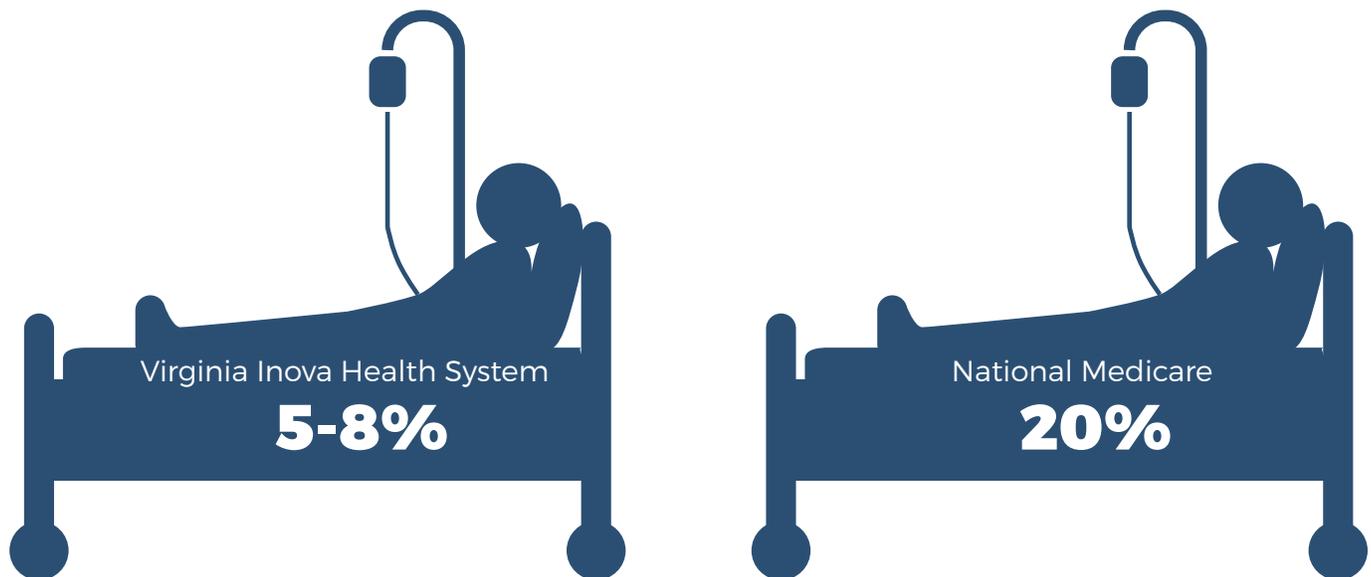
Researchers sponsored by AHRQ suggested a five-part process that physicians can use to structure discussions on end-of-life care:

- Initiate a guided discussion.
- Introduce the subject of advanced care planning and offer information.
- Prepare and complete advanced care planning documents.
- Review the patient's preferences on a regular basis and update documentation.
- Apply the patient's desires to actual circumstances.⁹

The most proactive approach is through standardization of four on-going conversations:

1. Initiating Advance Directive discussions while people are still healthy – encouraging conversations with family members and writing those wishes down.
2. Discussing Advance Directives after terminal illness diagnosis and updating Advance Directives based on current diagnosis.
3. Initiating Physicians Orders for Life Sustaining Treatment (POLST) and updating Advance Directives as part of ongoing care for chronic conditions and aging.
4. Ensuring that POLST moves with the patient between settings; helping patients understand the limitations of POLST (not the same as an Advanced Directive).

Readmission Rates



At Virginia's Inova Health System, patients who receive palliative services have lower readmission rates at 5 percent to 8 percent, compared to the national Medicare average of 20 percent. The hospital screens all patients at admission to identify high-risk patients for readmission, ensuring that palliative care specialists are part of the planning process, according to an AHA-CAPC report.¹⁰

To reduce readmission rates, particularly among the elderly, healthcare organizations must be prepared to have these difficult conversations, employing those with compassion and knowledge to provide this important information and valuable tool.

Conclusion

It's clear that no single strategy can reduce excess readmissions. Healthcare providers should use a data-centered approach to identify which patients, conditions, physicians and other factors affect their readmissions and then select interventions with the greatest potential for long-term impact.

Lowering readmissions takes time and persistence. Beyond improving overall patient care, hospitals have an economic incentive to lower their readmissions to keep pace with the growing demands of Medicare's Hospital Readmissions Reduction Program. Hospitals that maintain a status quo position may find themselves with higher readmission rates relative to their peers and thus be subjected to higher penalties in the future.

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Is your hospital one of the 2,610* receiving reduced Medicare payments in 2015 due to excess readmissions?

*Source: Kaiser Health News

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