Hospitals have a readmission crisis with sizeable percentages of patients who return after discharge for treatment of the same condition that initially brought them to the hospital. These repeat admissions rack up billions of dollars in potentially avoidable costs and affect the hospitals’ ability to receive reimbursement for services.

OVERVIEW
Each year, nearly 20 percent of Medicare beneficiaries being readmitted to the hospital within 30 days of discharge account for approximately $17.4 billion in additional bills for the government payer. And the average readmission rate across the country is 18.4 percent.

Through the Readmissions Reduction Program authorized by the Patient Protection and Affordable Care Act, the Centers for Medicare and Medicaid Services (CMS) is now attempting to slash those statistics by reducing reimbursement rates to hospitals with excess readmissions for specific conditions such as heart failure, heart attack, and pneumonia. The Readmissions Reduction Program began in October 2012 and will expand to include additional diagnoses in years ahead, resulting in increases in the potential financial penalties to be paid by hospitals.
In response, hospitals everywhere are developing and implementing processes and programs designed to lower 30-day readmission rates and preserve revenue streams. This white paper explores strategies and solutions that hospitals can adopt to help achieve these goals.

**The Readmissions Challenge**

CMS views readmissions that occur soon after discharge for the same condition to be potential indicators of low quality care, which could mean that during the initial hospital stay, the hospital failed to provide the proper treatment, healthcare providers committed medical errors, or physicians inadequately communicated post-discharge care instructions. By implementing a negative incentive (the reimbursement rate cut), the Readmissions Reduction Program aims to foster accountability, improve initial outcomes, and reduce costs associated with readmissions.

In the program’s first year, hospitals can face penalties of 1 percent of all Medicare reimbursement if CMS determines that they have an “excessive” readmission ratio. When CMS announced its first round of penalties at the start of fiscal year 2013, more than 2,200 hospitals were hit with cuts ranging from 0.01 to 1 percent of their Medicare revenue. On average, these hospitals’ penalties total in the low six figures, but for large hospitals subject to the maximum 1 percent penalty in 2013, the hit is closer to seven figures, and those dollar amounts could grow.

Looking ahead, the maximum penalties will increase to 2 percent on October 1, 2013 (FY 2014), and 3 percent on October 1, 2014 (FY 2015). For the 47 percent of U.S. hospitals in 2011 with a slim operating margin of just 2 percent, such a penalty could be significant.

**A Two-Pronged Approach**

To successfully improve outcomes, lower readmission rates, and avoid federal penalties, a two-pronged approach is needed and would include:

1. An optimization of internal processes and procedures to ensure high-quality care, clear communication, and positive outcomes during the patient’s initial stay.
2. Coordination and support of appropriate post-discharge care whether it’s self-care at home, supervision by a primary care physician, or admission to a post-acute facility.

When combined, these strategies can have measurable impact on the number of patients who return to the hospital within 30 days of discharge.

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**Two-pronged approach to successfully lower readmission rates and avoid federal penalties:**

1. **Optimize internal processes and procedures**
2. **Coordinate and support appropriate post-discharge care**

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**Inpatient Strategies**

Essential to a readmissions reduction strategy is a focus on the health providers’ care of and interactions with patients during the initial hospital stay. To ensure that both care and interactions are of the highest quality, hospitals may want to implement multidisciplinary bedside rounding. Multidisciplinary bedside rounding brings all members of the care team—the hospitalist, nurse, pharmacist, and case manager—into the patient’s room at the same time. The physician introduces the team, conducts the exam, and discusses the patient’s care concurrently and in collaboration with his team and the patient. This also provides opportunity for the physician and pharmacist to discuss the patient’s medications with each other and the patient, better ensuring the appropriate drugs and dosages are administered. All parties are also able to discuss the appropriate next steps in the patient’s care, and the patient is able to actively participate and ask questions as needed throughout the process.

Multidisciplinary rounding is much more collaborative and efficient than the traditional patient rounding protocol where each care provider (i.e., physician or hospitalist, nurse, pharmacist, and case manager or social worker) visits the patient individually and the later in the day gathering together to discuss the patient and create care plans prior to communicating the plan to the patient. The multidisciplinary bedside approach helps eliminate the “crosstalk” that can occur under the traditional rounding process.

Multidisciplinary bedside rounding helps ensure that every member of the patient’s care team, as well as the patient and the patient’s family, understand and agree with the care plan and can work together in a coordinated fashion.

Hospitals that have implemented bedside rounding have found that the improved process can help increase efficiency, reduce length of stay, improve patient satisfaction, and reduce the likelihood that patients will be readmitted due to issues such as medication errors.
Core Concepts
There are five core concepts—recognition, communication, intervention, education, and reconciliation—that if applied to each patient’s admission can help reduce the likelihood that the patient will need to be readmitted for the same condition.

Recognition
It’s critical for hospitals to recognize the potential issues that could lead to a patient’s readmission. According to the Society of Hospital Medicine, the eight characteristics of high-risk patients are: prior hospitalization, problem medications, depression, certain principal diagnoses, use of multiple medications, poor health literacy, poor patient support, and palliative care. Asking the right questions and reviewing patient information to identify these issues on the front end can help ensure that physicians provide the appropriate treatments to help avoid readmissions.

It is also equally important that physicians recognize and manage patient and family expectations for both treatment and post-discharge recovery. A patient’s or patient family’s misalignment or misunderstanding of treatment and post-discharge recovery expectations can lead to a lack of trust, which contributes to potential readmissions.

Communication
At every level of patient care, communication is vital. After providers fully understand a patient’s diagnosis and treatment plan, the caregiving team must work to avoid communication breakdowns. That means relaying important information among providers and creating thorough documentation, including a detailed and complete discharge summary.

Surprisingly, some 41 percent of inpatients are discharged with test results pending, and 25 percent of discharged patients required further work-up—all are likely the result of poor communication. Physicians should also provide “downstream alerts,” when appropriate, to other providers within the hospital who may be handling part of the patient’s care. The more information these providers have, the better prepared they are to provide the best care.

Communication diligence also applies to ensure that no communication breakdowns occur with patients and families. This means speaking to patients and families at the appropriate level for their healthcare literacy and, in many cases, identifying a single family spokesperson to whom the physician can provide updates and information to be relayed to other family members. Physicians who do not share the patient’s native language should enlist the help of translators.

Intervention
Every point of contact with a patient is an opportunity to take appropriate action. Don’t put off providing necessary care, and don’t assume another care team member will handle a task. When a provider notices a potential problem, he or she should immediately seek resolution in order to improve patient outcomes and reduce the likelihood of complications that could lead to a readmission.

Education
Hospital physicians can write prescriptions and prepare careful discharge plans, but when the patient leaves the hospital, the physician loses control of the patient’s care. Perhaps the patient doesn’t know there are resources available to help with medication expense, or perhaps his or her benefits don’t cover home health care. Or the patient and family may not fully understand post-discharge instructions or dietary limitations.

It is crucial to appropriately tailor discussions with the patient and family to ensure that any social and cultural traditions or differences that might interfere with a patient’s care are taken into consideration.

The “teach-back” method can be very effective here. That is, when the physician explains the post-discharge instructions, have the patient or family member repeat the instructions back to the physician. This will help reveal the level of understanding about the patient’s post-discharge care, and help physicians know whether more education is needed. This continuous education approach helps patients and families better understand what to expect and helps physicians feel confident that they have done everything they
could to educate and empower the patient and his/her family.

Reconciliation
While in many ways Electronic Medical Records are immensely helpful, this technology has certain drawbacks. If one caregiver enters data or medication information incorrectly, that information will be considered correct by other providers who view the record. Therefore, to ensure optimal care, it’s important to reconcile errors and confirm EMR records on a regular basis.

Post-Discharge Care
After a physician has written the prescriptions and provided post-discharge instructions, when the patient leaves the hospital, numerous things can happen in the community that are incongruent with the physician’s orders. The physician can’t follow his patients around to ensure that they’re following his care plan; maybe the patient can’t afford the medications and doesn’t know where to find resources that could help with the costs; perhaps the patient just stops taking the medication. The physician may not be consulted prior to a nursing home sending a resident patient to the hospital because the patient complained of pain or discomfort and nursing home staff was unaware of or did not understand the care that the patient underwent while in the hospital.

The readmissions crisis cannot be solved by hospital efforts alone. Readmissions are challenges for the community as a whole, and the solution requires coordination among hospital departments, post-acute care providers, patients, and families.

However, hospitals can take a number of steps to circumvent such problems. One measure is to implement education programs for healthcare providers and care organizations and facilities, such as home health agencies, nursing homes, and physician offices, to discuss the importance of reducing unnecessary readmissions and how the hospital and outside care providers can better communicate and coordinate care for each patient. In many cases, outside agencies may be unaware of the hospital’s financial risks associated with readmissions and would be open to increased collaboration, especially when the hospital is a significant referral source.

Similar efforts are needed in hospital emergency departments. Because unnecessary readmissions are harmful to a hospital’s financial health, hospital administration and the emergency department leadership should discuss and explore care options available in the hospital as well as in other care settings prior to a patient being admitted to the hospital. In addition to providing the patient with the best level of care, this collaboration and possible referral from the ED to care settings other than readmission to the hospital has been seen to help to forge partnerships between the ED and home health agencies. When appropriate, this process helps take the patient from an admission situation to receiving care at home.

Finally, and perhaps most importantly, hospitals must take an active role in the transition of care from the acute setting. Studies have shown that the high prevalence of issues related to discontinuity of care from the inpatient to the outpatient environment is associated with increased risk of hospitalization.

Some hospitals are creating new positions that are responsible for coordinating patient care from the inpatient to outpatient settings. This position ensures that patient instructions, discharge summary, and other needed patient information are communicated directly to the patient’s next caregiver. He or she determines who (e.g., nursing home provider, rehab facility, primary care provider) needs to have the patient’s records and discharge information and in some cases may schedule the patient’s appointment with that provider. This process ensures that when the patient is released from the hospital, he or she is already scheduled for follow-up care to ensure that recovery is going as expected and that the patient’s primary care physician or nursing home understands the care the patient received at the hospital and the hospitalist’s post-discharge instructions and that there are no gaps in understanding or interpretation.

This open exchange of information helps the patient continue to receive the care he or she needs and helps reduce the likelihood of a readmission. If a patient does not have a primary care physician, the hospital should refer the patient to a physician in their area or to a local clinic to ensure proper follow-up care occurs.
CONCLUSION
With implementation of the Readmissions Reduction Program, hospitals are at risk for losing valuable reimbursement dollars if too many patients return to the hospital within 30 days of discharge. To effectively minimize readmissions, hospitals must take a two-pronged approach that includes improving processes and care during the inpatient stay and improving care coordination after discharge.

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