NEXUS Health Resources
Connecting People to Quality Healthcare

How to Reduce Avoidable Readmissions

Guidance for averting penalties and fostering healthier patients

A white paper by **Nexus Health Resources**
Dr. Virginia Feldman, Founder, President & CEO

THE PROBLEM

The world of healthcare has always been marked by unpredictable turbulence and frequent paradigm shifts. Medical facilities and professionals must adapt to rapidly shifting landscapes, economic highs and lows and new legislation, all while remaining dedicated to their principle mission – providing essential, swift and quality care to patients.

In the past two years, new legislation introduced as part of the Affordable Care Act titled the "Readmissions Reduction Program" has created an unprecedented modification in healthcare delivery, shepherding vast change with the ability to severely impact hospitals' bottom lines. Under these new regulations, hospitals that report above-average readmission rates for certain diseases within a 30-day window are subject to Medicare penalties from the Centers for Medicare and Medicaid Services (CMS).[1] Commercial insurance companies are following suit, imposing their own readmission penalties. According to government officials, approximately 12 percent of Medicare patients are readmitted for avoidable reasons. When compounded, these readmissions cost billions of dollars annually.[2]

12%
of Medicare patients are readmitted for avoidable reasons.

The CMS' plan to drive down readmissions by penalizing culpable hospitals was enacted in FY2012, taking shape as reductions to Medicare reimbursement. The first round of penalties slashed affected hospitals' Medicare reimbursements by one percent; the second round, two percent.[3]

At present, the diseases under the readmission microscope are Acute Myocardial Infarction (AMI), Heart Failure (HF) and Pneumonia (PN). The CMS uses a specific calculus to determine the excess readmission rates for these conditions. This data also informs the penalties hospitals face.[4] The CMS is currently tracking chronic obstructive pulmonary disease (COPD) and knee and hip replacement readmissions, too – and penalties for these will go into effect in FY2015. In the future, legislation will expand to include a broader suite of diseases and steeper penalties. Penalty rates will reach up to three percent in FY2015.[5]

If hospitals, skilled nursing facilities and other medical facilities are not nimble, and cannot adopt an appropriate care coordination response to combat these penalties, they risk dire circumstances. Between 2012 and 2013, more than 2,000 hospitals faced upward of $280 million in penalties.[6] When Medicare reimbursement costs are sapped, facilities encounter diminished earnings – affecting their ability to deliver quality healthcare to their communities.

---

1. *"Readmission Reduction Program," Centers for Medicare and Medicaid Services.*
2. *"The Revolving Door: A Report on U.S. Hospital Readmissions," Robert Wood Johnson Foundation.*
3. *"Focusing on the Patient, Not the Condition: What Hospitals Need to Know About Avoiding Medicare Readmission Penalties," Becker's Hospital Review.*
4. *"Readmission Reduction Program," Centers for Medicare and Medicaid Services.*
5. *"Focusing on the Patient, Not the Condition: What Hospitals Need to Know About Avoiding Medicare Readmission Penalties," Becker's Hospital Review.*
6. *"Medicare to Penalize 2,217 Hospitals For Excess Readmissions," Kaiser Health News.*

NEXUS Health Resources
Connecting People to Quality Healthcare

THE CAUSES

Several diverse causes lay at the root of avoidable readmission rates, all of which coalesce to create a complex problem. One cause is an **increasingly fragmented healthcare system.** Lack of communication between medical professionals, hospital administration and post-acute services creates a situation where specifics can slip through the cracks and errors can reign.[7] Too often, the experts who make hospitals tick work in silos, dedicating themselves to their expertise but not effectively communicating with colleagues in adjacent verticals, creating an experience that is neither integrated nor optimal.

Example: A cardiologist at Smith Hospital may treat patient John Brown, a 70-year-old man, for congestive heart failure. After having his illness diagnosed, Brown will be helped by other staff members and post-acute care professionals at Smith Hospital. But if Brown's cardiologist does not remain in constant contact with these professionals, the care plan risks breaking down. The cardiologist will not be aware of new developments, the additional staff members will not have access to the cardiologist's acumen and Brown may return to the hospital two weeks later due to otherwise avoidable circumstances.

A second root cause of avoidable readmission can be traced to **lack of communication between the hospital, patient and primary care physician (PCP).** In the event of an acute health issue – which can frequently stem from congestive heart failure or chronic obstructive pulmonary disease (COPD) – patients will likely seek help at hospitals' urgent care divisions. Although the patient's illness will be diagnosed and at least partially treated by medical professionals at the hospital, it is of utmost importance that the patient's PCP is brought into the conversation. Unfortunately, this frequently is not the case.[8] A PCP knows an individual patient's details better than an urgent care physician who is only treating a patient for the first or second time. Only together can the two professionals provide a comprehensive, well-informed care plan to avoid readmission.

Lack of communication between medical professionals, hospital administration and post-acute services creates a situation where specifics can slip through the cracks and errors can reign.

Example: Jane Brown receives care at an urgent care facility, where she is treated for acute symptoms relating to COPD. While medical records and Brown's input can inform her urgent care treatment, her primary care physician's wisdom and insight is required to ensure the treatment dovetails with her diet, lifestyle, and other medical issues. Without pairing their knowledge, Brown will likely end up back in the urgent care facility within weeks.

A third stumbling block for reducing avoidable readmissions is a **dearth of patient education pertaining to diseases, medications and readmission preventative measures.** Medical professionals provide the diagnosis, treatment and prescriptions that patients cannot, but a level of patient awareness is still required to avoid readmissions.[9] If a hospital acts detached – dispensing healthcare without detailing how and why it works, and why it is needed in the first place – they risk creating a disenfranchised patient population. Patients must play an active role in their treatment by bringing an understanding of their illness, the solution and avoidable readmission.

7. "Integrated Delivery Systems: The Cure for Fragmentation," The American Journal of Managed Care.
8. "Coordination Between Emergency and Primary Care Physicians," National Institute for Health Care Reform.
9. "Issues in Patient Education," Journal of Midwifery and Women's Health.

Example: John Brown is being treated for congestive heart failure. It is both his responsibility to understand, and his physician's responsibility to educate, that congestive heart failure is the leading cause of hospitalization for people over the age of 65; that it can be caused by high blood pressure, diabetes, or kidney disease; that regular blood tests and stress tests are recommended; and that lessened sodium intake and fluid balance are key to maintaining good health.

A similar catalyst for higher readmission rates is a **paucity of patient self-advocacy.** This cause is directly linked to education. A physician can diagnose and treat a disease, but the patient must first acknowledge the symptoms and proactively seek medical attention when necessary. From the first doctor appointment to follow-up care after discharge, a patient must be vocal about their condition and needs, advocating for the level of care they require.[10]

Example: Jane Brown is treated at a hospital for chronic obstructive pulmonary disease and is prescribed a course of pulmonary rehabilitation. Believing the doctor's regimen and an adherence to it is all that is required, Brown does not self-advocate when she experiences an uptick in shortness of breath and mucus production. As a result, Brown is unable to augment her regimen appropriately – and is readmitted to the hospital three weeks later.

A fifth cause of avoidable readmissions is unrealistic expectations of self-care. This concept also falls under the umbrella of patient education. It is paramount that patients understand the limits of care they are able to provide for themselves. Someone suffering from a chronic heart or lung diagnosis is able to take medications and carry out relevant lifestyle adjustments, but cannot administer all required care on their own. Only by working in tandem with the doctor and hospital can a patient successfully maintain an effective regimen and avoid unnecessary readmission.[11]

Example: John Brown returns home from the hospital, confident he can tackle care on his own without further professional guidance. But Brown is unable to adequately monitor his symptoms and provide changes to his care plan alone, and returns to the hospital within one week.

"It is paramount that patients understand the limits of care they are able to provide for themselves."

THE SOLUTIONS

The root causes for avoidable readmissions are varied and complex, and so too are the solutions. No single silver bullet possesses the ability to successfully reduce readmissions; instead, a carefully-crafted strategic plan with multiple tactics is required. At the heart of this strategy is the doctrine of care coordination – ensuring all pre- and post-discharge bases are covered.

The first solution is to **begin care coordination prior to discharge.** Either in-house care coordinators or third-party care coordinators should be delivering the patient's medicine to bedside and ensuring the patient is keenly aware of the drugs, dosages and timetables. Care coordinators should also ensure the patient's PCP and specialist are communicating, and that appointments are set up with each doctor before discharge.

10. "The Care Transitions Interventions: Results of a Randomized Controlled Trial," Archives of Internal Medicine.
11. "7 Methods for Reducing Avoidable Readmissions," Becker's Hospital Review.

Lastly, education should begin before the patient is discharged. Education should always incorporate the effective Teach Back method. Teach Back involves educating a patient on disease specific information, giving them a greater understanding of how to manage and look after their illness – having the patient recite this information in their own words helps to ensure their full understanding.

Example: Jane Brown is on bed rest at her hospital, and will not be discharged for three more days. But care coordinators begin to prepare Brown for her discharge early on, facilitating her medicine delivery to bedside and scheduling appointments for the coming months. Brown's care coordinator ensures she is well-versed in post-discharge care by having an interactive discussion. This conversation is facilitated by questions such as "Please explain to me why it is important that you take this medication and when you will be taking it," and "Many patients notice a change in their skin color or nail beds when their disease worsens. Let's discuss that and other symptoms you may typically have when your condition worsens. What should you do if these symptoms start to occur?"

The next step – and one of the most paramount – is **continuing care coordination for 30 days after discharge.** Experienced care coordinators should shepherd patients through their first month out of the hospital – this is when most avoidable relapses and readmissions occur. A robust schedule should be established that includes: regular phone calls; confirmation that all the proper medicine and durable medical equipment is in order; reminders for doctor appointments; facilitation of transportation to and from doctor appointments, orchestrated well ahead of time; establishing the importance of communications with the PCP; and ongoing education reinforcement.

Example: John Brown was discharged from the hospital four days ago. Today, his care coordinator phoned to remind him of tomorrow's check-up appointment, and to confirm his transportation. It is then discovered that the transportation Brown had originally arranged while in the hospital is no longer available. After speaking with Brown about other options and discovering that his neighbor may be able to help, Brown's care coordinator facilitates the rearrangement of his transportation with Brown and his neighbor.

Another important tactic for reducing avoidable readmissions is **proactive health seminars for at-risk individuals in the community.** Care coordination should always be proactive, as evidenced by the previous two solutions. In providing free seminars for community members, hospitals and care coordination agencies can educate potential patients before they experience any health issues. Seminars and lectures can focus on disease-specific information, like the causes and symptoms of congestive heart failure and chronic obstructive pulmonary disease. The forums can also inform viewers about the major shifts in the healthcare world, and how care coordination is now more important than ever.

Example: Jane Brown is a healthy 67-year-old. However, Brown knows – given her age and medical history – she may be at risk for congestive heart failure. She learns of a free seminar at a nearby hospital that spotlights the warning signs of, and proactive treatments for, congestive heart failure. Brown attends the seminar and gleans seminal information, helping her to lead a healthier lifestyle going forward. The seminar also highlights care coordination and patient education – should Brown ever be hospitalized, she is now well-versed in how to stay healthy post-discharge.

Another tactic for alleviating avoidable readmissions is to **boost communication for all post-acute partnerships,** and to **compliment internal readmissions systems.** Hospitals and other medical facilities benefit greatly from working alongside third-party care coordination agencies, but only if the two entities work in tandem. Much like specialists and PCPs must maintain an open line of communication, so to must hospitals and care coordination agencies. Both parties should stay abreast of each other's operations and activities, and liaise regularly about patients who are most at-risk for an avoidable readmission.

Example: Smith Hospital enlists Nexus Health Resources to assist with reducing avoidable readmissions. To ensure the partnership is as effective as possible, Nexus Health care coordinators regularly discuss patients and cases with their contacts at Smith Hospital. As a result, Nexus Health is able to provide outstanding pre- and post-discharge care to John Brown, who remains healthy after his hospital stay and is not readmitted.

The final tactic for successfully reducing avoidable readmissions is not clinical, but clerical – specifically, **using software, data analysis and integration with hospital systems** to ensure patients' needs are being met. Digital assistance offers peerless record-keeping and data parsing abilities to help care coordinators remain up to speed on patients' schedules and diagnoses, along with greater trends in the healthcare realm. Detailed data analysis further assists by providing medical centers with meaningful data for actionable decision making.

THE CONCLUSION

As the healthcare landscape becomes increasingly punitive toward avoidable readmission, hospitals and other medical facilities must implement comprehensive strategies, or risk steep Medicare and commercial insurance penalties that will impact their bottom line. Only by assessing the situation with a bird's-eye-view, carefully meting out the best fixes and implementing extensive solutions can hospitals ensure they retain adequate Medicare funding and foster healthier patients.

REFERENCES

Adamopoulos, Helen (February 5, 2014). "Focusing on the Patient, Not the Condition: What Hospitals Need to Know About Avoiding Medicare Readmission Penalties," Becker's Hospital Review.

Coleman, EA et al. (September 25, 2006). "The Care Transitions Interventions: Results of a Randomized Controlled Trial," Archives of Internal Medicine.

Enthoven, AC (December 15, 2009). "Integrated Delivery Systems: The Cure for Fragmentation," The American Journal of Managed Care.

Feldman, Virginia (June 10, 2014). "7 Methods for Reducing Avoidable Readmissions," Becker's Hospital Review.
Freda, MC (May/June 2004). "Issues in Patient Education," Journal of Midwifery and Women's Health.
Rau, Jordan (August 13, 2012). "Medicare to Penalize 2,217 Hospitals For Excess Readmissions," Kaiser Health News.
(August 4, 2014). "Readmission Reduction Program," Centers for Medicare and Medicaid Services.

(February 2013). "The Revolving Door: A Report on U.S. Hospital Readmissions," Robert Wood Johnson Foundation.

(February 24, 2011). "Coordination Between Emergency and Primary Care Physicians," National Institute for Health Care Reform

"Reducing Hospital Readmissions With Enhanced Patient Education," Boston University/Krames Patient.