3 Key Strategies to Reduce Costly Readmissions & Medicare Penalties

According to the Agency for Healthcare Research and Quality, nearly 20 percent of Medicare hospitalizations are followed by readmission within 30 days. Ninety percent of these readmissions are unplanned, while 75 percent, or 4.4 million, may be preventable, according to the Medicare Payment Advisory Commission. Such readmissions hurt the bottom line – to the tune of $12 billion per year in Medicare spending.

It’s easy to point a finger at one group within the hospital for readmissions. However, it’s often process and communication failures throughout the entire health-care system that lead to avoidable readmissions and the costly penalties associated with them. For example, nearly 80 percent of medical errors involve miscommunications during patient transfers and handoffs. This illustrates the crucial need for effective, accurate and timely information at discharge to prevent wasteful spending and improve patient care.

A Hospital’s Evolving Responsibility

It used to be that hospitals were not held accountable for patients after discharge. However, that has changed as a result of the Hospital Readmissions Reduction Program and related regulations that started penalizing hospitals for preventable readmissions. In 2013, more than 2,200 hospitals were penalized $227 million in Medicare fines through HRRP due to excess readmissions. This amounts to 0.3 percent of total Medicare base payments to hospitals—a major hit to the bottom line—and a number that is increasing in 2014.

In addition, regulations outlined by CMS’ Meaningful Use incentives have underscored the need for hospitals to improve post-discharge communication. This requires hospitals to engage the patient and deliver a Transition of Care summary when the hospital hands the patient off to another provider or care setting—demanding more resources of an already strained system.

As CMS continues to intensify its initiatives, hospitals must actively seek ways to improve communication between and across settings to avoid steep financial penalties associated with preventable readmissions. By employing best practices during care transitions, hospitals can comply with new care model requirements and avoid increasing readmission penalties—ultimately protecting the organization’s financial health.

Preventing Readmissions through Effective Care Transitions

The following are three key strategies for framing care transitions to support robust patient care and improved efficiency across the continuum.

1. **Communicate more than just clinical information.**

   A key element in limiting readmissions is how well a hospital transitions a patient from acute to post-acute care, whether to the patient’s home, a rehabilitation or skilled nursing facility or other setting. Strong, interactive communication is therefore essential.

   Electronic health records (EHRs) and health information exchanges (HIEs) have improved communication efficiency across different settings; however, these tools focus on sharing clinical information—diagnosis, treatment plans, medication lists and so on. While necessary, clinical information alone may not be sufficient for a patient, family and post-acute provider to fully appreciate how to keep the patient on track. Families and providers need to understand more than just the medical aspects of the patient’s health to grasp the processes necessary to ensure the patient receives the care he or she needs.
For instance, through an EHR, a post-acute provider might know a patient’s medical history, current medications and when the hospital has scheduled a follow-up appointment. However, what the provider may not know is that the particular patient has a history of medication noncompliance and tends to skip follow-up appointments because she has no transportation to get to the pharmacy or the physician’s office. Without communicating these important processes and recommending interventions, the hospital puts the patient at substantially higher risk for experiencing a preventable readmission.

Finding ways to share information about care process needs, as well as clinical data, is key to supporting care transitions that set the stage for optimal patient care and reduced length of stay.

2 Expand reach to non-medical providers.

To effectively facilitate care transitions, hospitals may need to reach beyond traditional medical providers to make sure patients and post-acute care organizations have all the resources they need to complete care plans.

Referring back to the previous example, a home-bound patient without family support may need transportation to get to appointments or pick up prescriptions. Similarly, patients with diabetes or congestive heart failure may have specific nutritional needs that they cannot meet on their own; necessitating in-home, non-medical assistance with meal preparation or grocery shopping provided by an organization like Home Instead Senior Care.

Reaching out to non-medical providers to supply transportation, deliveries, cleaning and other services is an effective way to fill care gaps. Whether using manual methods of outreach or automated technology solutions, hospitals can coordinate essential nonmedical resources and services to ensure patients are able to effectively follow their care plans.

3 Leverage technology to manage large patient populations and maximize staffing resources.

To manage the discharge process for a large patient population, hospitals typically stratify patients by risk, including their risk for readmission. Many EHRs stratify risk based on conditions at the time of admission; however, this approach assumes care provided while in the hospital or following discharge has no effect on a patient’s readmission risk. Instead, hospitals should employ technology that provides a holistic view of the patient and recalculates readmission risk at the point of discharge and at different stages throughout the patient’s recovery.

For instance, a patient who misses a follow-up appointment 72 hours after discharge should be at higher risk for readmission than a patient with a similar diagnosis who attends the appointment and receives care from the physician. By identifying patients whose risk for readmission is increasing during post-acute care, providers are able to intervene appropriately and manage a larger population of patients. Likewise, if patients are following their care plans, their risk may decrease and therefore require less staff intervention from the provider.

Through risk stratification, hospitals can also direct highly technical, low-touch interventions to low-risk patients, while aiming low-tech but high-touch staff resources at higher risk patients.

Consider the 25-year-old woman who is being discharged from the hospital, expected to make a full...
recovery and going home to a supportive family. The hospital has identified her as low risk for readmission. By leveraging an automated discharge process or using technology solutions such as texting or direct messaging, the hospital can effectively engage the patient without consuming staff resources. Conversely, a 90-year-old high-risk patient with little family involvement who is being transferred to a skilled nursing facility is less likely to engage in high-tech, low touch solutions. The best way to reach this patient is through a care provider, family member, phone call or personal visit—all of which require staff intervention.

Technology that Improves Efficiency, Drives Down Costs
With staffing shortages and an influx of medically complex patients, there often aren’t enough care coordinators or discharge planners to efficiently manage care transitions, leaving some patient populations vulnerable to preventable readmissions and other negative outcomes. By employing technology solutions that maximize resources and streamline communication during care transitions, hospitals can ensure vital care needs follow patients throughout their care journey. This not only enables better continuity of care and patient outcomes, but reduces the risk of avoidable readmissions and associated penalties.

About Wayne Sensor
Wayne offers his visionary insights from the lens of a life-long career in health-care leadership as the CEO of a 10-hospital system in the Midwest. As a senior advisor at Leavitt Partners, he gained a deep public policy view of the industry while advising large health systems. Passionately driven by his own ailing mother’s challenging discharge, Wayne understands the urgency to improve patient care coordination across the health-care continuum.

The penalties don’t just apply to avoidable readmissions but to a hospital’s entire Medicare volume. Initially a 1 percent penalty, it’s now 2 percent of a hospital’s Medicare payments and next year it will be 3 percent. To put that in context, this year there will be about a $280 million reduction in payments to hospitals due to avoidable readmissions. The financial viability of our institutions depends on us figuring out a solution.”

-Wayne Sensor, Ensocare CEO

Sources

According to a study, nearly 80% of serious medical errors involve miscommunications during patient transfers or handoffs.