

## Readmission Prevention Tactics for Hospitals: Developing a Hospital Readmission Plan

The goal of this chapter is to provide acute care hospital executives with a road map for strategizing and developing an effective readmission prevention plan for their hospital. First, civic goals for developing the plan will be identified—goals beyond merely avoiding readmission penalties from the Centers for Medicare & Medicaid Services (CMS). Second, specific focus areas will be identified for different types of hospitals, including rural hospitals, urban hospitals, health systems, academic and teaching hospitals, safety-net hospitals, and critical-access hospitals.

### **FOUR OVERALL GOALS IN DEVELOPING A READMISSION PREVENTION PLAN**

Although the readmission penalties implemented by CMS in the Affordable Care Act (ACA) have prompted organizations to form work groups to address the preventable readmission problem, organizations committed to value-based care look beyond the penalties and aim for a true population health management

strategy. With that in mind, you should identify your organization's objectives and priorities before starting to develop a readmission prevention plan.

All hospitals should consider the following goals when developing a readmission prevention plan:

1. Admit only inpatients who cannot be cared for at a lower level of care.
2. Create a health information exchange (HIE) that is accessible to all community providers and caretakers.
3. Reduce improper admissions that lead to Recovery Audit Contractor (RAC) audit denials.
4. Reduce preventable readmissions and resulting penalties from CMS.

### **Goal 1: Admit Only Inpatients Who Cannot Be Cared for at a Lower Level of Care**

The ACA aims to position the hospital as the last resort in providing care to patients and keeping them well. When hospitals begin viewing themselves as the last resort in the new post-ACA delivery model, then and only then will they have clarity in designing an effective readmissions prevention program. The name of the game is not *readmission* prevention—it is *admission* prevention. That concept is a tough pill for hospitals to swallow because they are still reimbursed almost entirely for putting “heads in beds.”

Thus, implementing an effective readmission prevention program will require hospitals to implement criteria for inpatient admissions that rule out all lower levels of care when evaluating a patient in the emergency department (ED). This is a different approach for ED physicians than the methodology of the past, which, in short, was to run a series of tests and look for any reason to admit a patient to justify billing for reimbursement.

The ACA incentivizes hospitals and insurers to better coordinate care and prevent unnecessary hospital admissions. Note that it is prevent *admissions*, not *readmissions*. The goal is to make sure the right patients are being admitted at all times, not just when they are 30-day readmission candidates. Thus, it is important to have strict, up-to-date inpatient admission criteria that limit a hospital's liability and exposure to RAC audits and resulting reimbursement recovery from CMS.

If hospitals strive to admit only patients who cannot be cared for at a lower level of care, they will benefit from the financial incentives created by the ACA. In turn, an effective admission program solves the problems of readmission and a hospital's exposure to lost revenue in the RAC audit process.

## **Goal 2: Create a Health Information Exchange That Is Accessible to All Community Providers and Caretakers**

In 1996, HIPAA (the Health Insurance Portability and Accountability Act) was implemented as a means of ensuring privacy when exchanging personal health information. Just 13 years later, however, the passage of the ACA began a push for online universal information exchange—that is, online patient portals that are accessible to all caregivers and providers. Although access to personal health information will still require the patient's authorization, this authorization will likely allow more sharing with relevant parties.

The most effective way to make care decisions about a patient is by having an abundance of information about his individual history. This is particularly true in an evolving delivery model where the inpatient physicians are not the patients' primary care physicians but rather hospitalists and skilled-nursing specialists who are unfamiliar with the patients they are treating. Ultimately, a comprehensive HIE that includes electronic health record data and cloud-based (similar to text messaging) conversational data

and that stores both permanently at all points of care will become a physician's best resource. Keep in mind that under the new model, the delivery system also includes providers focused on wellness and healthy lifestyles. Thus, the portal would store input and data from all caretakers, including

- ◆ the hospital,
- ◆ doctor's office,
- ◆ nursing home,
- ◆ ancillary provider,
- ◆ assisted-living staff,
- ◆ pharmacist,
- ◆ home health provider,
- ◆ private duty nurse,
- ◆ senior center wellness caregiver,
- ◆ adult day care provider,
- ◆ healthy lifestyle providers (e.g., fitness gym), and
- ◆ individual patient and family input.

By having extensive pertinent data available to caretakers at every step, particularly in the ED, physicians can make more informed care decisions based on the patient's personal history and immediate needs as opposed to a reimbursement model that no longer exists. In the old model, ED physicians relied almost entirely on the patient's input and social justification for visiting the ED. For instance, a patient could say she is having pain in her abdomen, and the physician would run tests on the basis of that information and then decide whether to admit her as an inpatient. Today, an HIE would provide the physician with additional information about the patient—and in an era where data rule, there can never be enough information when making an important decision. The importance of data is never clearer than when a patient visits the ED and a physician needs to decide whether to admit her to the hospital as an acute care inpatient.

### **Goal 3: Reduce Improper Admissions That Lead to RAC Audit Denials**

If an organization does an effective job of implementing a system for Goals 1 and 2, then the goal of reducing improper admissions that lead to RAC audit denials will be easily accomplished. By making those two operational changes, an organization will be well positioned to minimize the risk that it will have to return reimbursement funds to the federal government.

### **Goal 4: Reduce Preventable Readmissions and Resulting Penalties from CMS**

Much like Goal 3, if an organization does an effective job of implementing a system for Goals 1 and 2, then the goal of reducing preventable readmissions will be within reach. As discussed earlier, the true approach in the new healthcare delivery system is preventing avoidable admissions. Hospitals must implement protocols that ensure that patients who can be cared for at a lower level of care are not admitted as inpatients. Then a hospital will be well positioned to maximize financial efficiencies and reduce exposure to readmission penalties.

## **SAMPLE STEPS IN PLANNING AND IMPLEMENTING A READMISSION PREVENTION PLAN**

Once your organization has successfully identified goals, which would likely include some or all four of those listed here, the team can begin the necessary steps to develop a hospital-specific program for your organization. In some cases, the program might have more

of a community focus, if appropriate for the stakeholders involved. However, keep in mind that the hospital is the only entity subject to readmission penalties and therefore should take a leading role in the work group.

In the future, organizations will move closer to a patient-centered care model, which will widen the focus from readmission prevention to population health management. If done properly, your work group should be able to address both issues with the same solutions. Following is a list of simple steps in planning and implementing your readmission prevention plan. Although organizations may choose to implement multiple tactics listed in this chapter, the tactics were written as individual approaches, so implementing all of them is not necessary.

- ◆ *Form a team or work group.* Keep the team small but be sure to include the chief nursing officer or chief operating officer. The director of case management must also take an active role because if the case management and social services team does not support the changes, implementation is doomed to fail. A member of the information technology team should also be included in the work group.
- ◆ *Develop an effective implementation plan.* Your team's hours of work could be wasted if the organization does not develop an effective implementation plan. This process should start as soon as the work group is formed by making sure major stakeholders are involved from the get-go. If possible, the CEO should champion the effort because the entire leadership team needs to be behind it. If she is not in complete support, the entire plan is likely to fail. The team leader could be another high-ranking member of the administrative team, preferably the chief nursing officer or chief operating officer. Some organizations choose the chief strategy officer or vice president of post-acute care services to lead these efforts but run into roadblocks when changes start affecting inpatient operations, which is why involving the chief nursing officer

in the work group from the beginning is critical. Others have appointed the director of case management to lead these efforts but have learned that even when the director of case management is widely respected in the organization, someone from the administrative team needs to champion the readmission prevention effort or it will face operational roadblocks at some point.

- ◆ *Establish clear goals.* The work group's goals will often be identified by the administrative team but may be delegated to the work group. In any case, it is wise to start with the four goals identified earlier in this chapter and build from there by adding further goals if necessary.
- ◆ *Implement an HIE and/or electronic health record.* Connectivity and access to information are critical in developing an effective readmission prevention plan and population management strategy. The first goal is to collect all the data you can while the patient is in the hospital. The second goal is to connect as many community providers as possible so you have as much information as possible at your fingertips if the patient returns to the ED.
- ◆ *Alert your team when a potential readmission shows up.* When it comes to pure readmission prevention, the administration's main role is to alert ED physicians and staff (as soon as possible via text or e-mail) when a patient is a readmission candidate per CMS penalty guidelines.
- ◆ *Evaluate inpatient admission criteria for all ED patients.* Having appropriate criteria for inpatient admissions—specifically, by ruling out the possibility that the patient's needs could be met at a lower level of care—is the most effective tactic in running an efficient hospital. In addition, it will allow you to minimize unnecessary readmissions.
- ◆ *Establish, implement, and operate an ED case management system.* The hospital's ED case managers must take an active role in any readmission prevention plan and must support the process for it to succeed.

- ◆ *Prioritize patient education.* Patient self-management is the single most effective way to solve the readmission problem. Consistent patient education is the most efficient way to improve self-management. The importance of self-management will be discussed in greater detail later in the book.
- ◆ *Use internal resources.* The ultimate objective of an organization and business is to develop and maintain a profitable business structure. Regardless of an organization's mission, if it does not remain profitable, it cannot continue to operate. With that in mind, as your work group assembles the readmission prevention plan, focus on business opportunities and new revenue streams. Organizations that have a home health agency or skilled-nursing facility (SNF), including an SNF distinct part (an SNF unit or subacute care unit located within the walls of an acute hospital), are well positioned to generate additional revenue while improving their ability to manage the patient outside of the acute care setting. In fact, home health is the one entity that allows a hospital to monitor a patient in the home while still being reimbursed for delivering healthcare services.
- ◆ *Consider community resources.* All community resources should be considered when developing a readmission prevention plan. Community resources might include transportation, adult day programs, and access to grants. Some hospitals have included representatives from community resources on their work team. However, invitations to people outside the hospital should be discussed. The goal of the hospital work group is to develop a plan that meets the needs of the hospital and the patients it serves. When outside representatives are included in the work group, the clarity of objectives may be compromised and goals, even when clearly outlined, may be influenced and questioned by the outside parties.
- ◆ *Explore technology solutions.* Technology solutions for managing patients outside of the hospital are developing rapidly. Genetic testing, for instance, is an emerging way to improve patient care, reduce medication errors and costs, and give

physicians and pharmacists a specific game plan that best meets each patient's needs. Personal DNA mapping, which is covered under Medicare Part B, is becoming imperative for patient care. Remote monitoring, another technological innovation, allows hospitals to discharge patients home sooner while still being able to monitor them around the clock from a skilled-nursing, assisted-living, or home environment. Remote monitoring capabilities were previously limited to intensive care or telemetry units in acute care hospitals. Hospitals should not delay in implementing such technologies—not only do they reduce the cost of healthcare delivery and improve care, but they are also reimbursed in many cases.

- ◆ *Communicate options for follow-up.* One of the most critical issues in patient education is making sure patients know what their options are if they experience pain or discomfort after discharge and wonder if they should return to the hospital. Ensuring that the patient understands the proper telephone numbers to call, including the primary care physician's office, urgent care clinic, follow-up clinics, ancillary providers, senior centers, or other practitioners at different levels, is one of the most critical factors in avoiding unnecessary readmissions. The hospital needs to go to great lengths to make sure the patient knows what his options are other than returning to the ED.
- ◆ *Identify new revenue streams.* The ACA was a big blow to hospitals in terms of profitability. The balance of power in the delivery system shifted even further away from hospitals and physicians and gave more influence to health plans and insurers. The changing delivery model has already resulted in lower admissions nationwide and will continue to affect profitability as hospitals receive less reimbursement as a result of lower censuses. Many hospitals that have been successful are now faced with the challenge of identifying new revenue streams to survive. As your team develops your readmission prevention plan, profitability and new revenue streams should be at the forefront of every decision made.

- ◆ *Have measurable goals.* The work group should clearly identify and communicate measurable goals to the whole organization, along with the importance of the initiatives, timeline, and how the program's success is anticipated to affect the organization. This message should be repeated and updated regularly—monthly, or at a minimum quarterly—so that the entire organization can be kept up to date on the success of the implementation. As always, objectives should be measurable.

Although this list of recommended steps to develop an effective readmission prevention plan is by no means complete, it serves as a viable template or starting point for any organization, along with the specific tactics to implement for each phase described in Chapters 3–5. These four chapters should be consulted when you select the tactics to be implemented for your hospital-specific readmission prevention plan. In addition, the Perspective at the end of this chapter describes how improved communication among ED physicians, hospitalists, primary care physicians, and patients' families can prevent the discharge process from breaking down.

## **DIFFERENT TACTICS FOR DIFFERENT TYPES OF HOSPITALS**

Readmission prevention tactics will depend on the setting and type of hospital. The following sections look at readmission prevention tactics specific to different types of hospitals. Some tactics will be more effective than others for each hospital type.

### **Rural Hospitals**

Rural hospitals share certain characteristics that should be considered when developing a readmission plan. One of the most relevant

data points that CMS shares with hospitals annually is the same-hospital readmission rate. A hospital with a same-hospital readmission rate lower than 60 percent is at risk for a readmission penalty because more than half of the patients return to another hospital. If this is the case at your hospital, then emphasizing patient education and access is critical. Same-hospital rates are even more relevant for rural hospitals because there are fewer hospitals in rural areas, and tracking your own readmission data is the biggest indicator of an overall problem. Rural hospitals often do not communicate with other hospitals in neighboring areas, and there may not be the consistent relationship and communication between hospitals that one often finds in metropolitan areas.

A rural setting provides an increased opportunity for collaboration between the acute care hospital and post-acute care providers because often there is only a small number of providers. Such opportunities range from the hospital's providing SNFs with clinical support and education to a coordinated community transition program. Many rural communities have already proven that these programs can be successful with the appropriate stakeholders.

## **Urban Settings**

Access and convenience most often drive healthcare decisions in an urban setting. For example, patients often seek healthcare after they get home from work for the day, and they go to the ED because they assume they do not have any other choice after hours. Yet most metropolitan areas now offer several different access points to care after hours, and many health systems have teamed up with physicians to ensure that patients have access to physicians after hours. This has required creative solutions, and physicians who were historically competitive are now learning to work together.

Urban areas often present additional challenges to the same-hospital readmission rate. For example, when I was CEO of Western Medical Center Anaheim, a 188-bed acute care hospital

near Disneyland, five competing acute care hospitals were located within five miles of our campus. Educating patients to always return to the same hospital was not likely to be effective, so other solutions needed to be considered, in particular connecting health-care providers via the HIE. Connecting a community via the HIE requires acute care hospitals that have traditionally competed to share data through the HIE. Though it may take several months of planning, a truly connected community benefits the patients and the hospitals.

Urban hospitals have access to extensive community resources, and any hospital or health system that does not thoroughly investigate all available community resources is limiting itself. An organization that has extensive community resources at its disposal can capitalize on them to reduce costs and sometimes even get reimbursement while preventing readmissions.

## Health Systems

Identifying specific tactics that a health system should implement to reduce readmissions is difficult because each health system is unique. However, the one tactic all health systems should consider is creating an HIE that is accessible by all providers and facilities in the network.

For health systems that have multiple hospitals in the same metropolitan area, many of these tactics can be implemented from one hospital to the next, regardless of which hospital the patient visited for the index stay. A true population management strategy would have similar or identical admitting criteria in each hospital and ED, and the focus would extend well beyond simple readmission prevention to include population health management.

For health systems that have hospitals spread out throughout the country, in urban areas or in both rural and urban areas, creating a system-wide approach would be wise to allow connectivity and create an alert system when patients are readmission candidates.

## **Academic and Teaching Hospitals**

A unique characteristic of academic and teaching hospitals is that they usually have access to additional research dollars or grants that can help drive innovation in the areas of population health management and readmission prevention. Although the tactics to prevent readmissions in this setting are largely the same as in other hospitals, these additional resources and tools can be used to identify and study patients who are readmitted to the hospital unnecessarily.

## **Safety-Net or County Hospitals**

I spent seven years operating safety-net hospitals as a CEO and took great pride in caring for underserved populations. In these safety-net hospitals I had no budget to address population management or readmission prevention—and on many days I had no operating cash in the bank. Yet even with such challenges, it is important to look beyond mere survival and identify effective readmission prevention tactics.

For example, an automated telephone system that calls high-risk patients after discharge is an effective tool for a safety-net hospital with a small budget. Several vendors offer this technology for a modest monthly fee, including Cipher Health, one of the leaders in this area. The patient is required to answer three questions by pressing a number on the phone. Questions are simple, such as, “Are you feeling better or worse than you did yesterday? Press one for better, two for the same, or three for worse.”

Most hospital executives assume there would be a low response rate to this technology, but the opposite is the case when case managers and social workers educate patients before discharge to expect this call and emphasize the importance of taking two minutes to answer the questions. If the patient does not answer any of the questions, an alert is triggered to the hospital ambulatory case manager, and high-risk patient protocols are put into action.

## Critical Access Hospitals

Although critical access hospitals are not subject to readmission penalties, they would still be wise to connect electronically with high-volume hospitals in the same region. Then, when a patient is admitted to a critical access hospital, the nurses and physicians would have access to the patient's medical history and be better prepared to address the patient's needs. In the post-ACA environment, healthcare providers at all levels should continue to move toward an integrated HIE so that the patient's medical history and genetic map can be referenced in his best interest.

## SUMMARY

Regardless of the type of hospital, the future of healthcare is patient-centered care delivered in a value-based model. Creating a model where hospital admission is a last resort, reserved only for those who truly need acute care, takes two key commitments from providers. First, development of a comprehensive HIE allows providers at all levels to share as much data as possible about the patient (with the patient's consent). Second, physicians and hospitals alike must commit to using inpatient admission criteria that rule out all other options and are not financially motivated.

When health systems can commit to a minimum of two of the initiatives described in this chapter—sharing data and admitting patients only when truly necessary—the US healthcare system will finally reflect the model the ACA set out to create. Although progress is slow, the goal remains for healthcare organizations to convert from a fee-for-service model to a value-based model.

## **PERSPECTIVE**

### ***A Hospitalist's Perspective on Readmission Prevention***

*By Hassan Alkhouli, MD*

*Chief medical officer, Garden Grove (California) Medical Center*

According to the Centers for Medicare & Medicaid Services (CMS), about 20 percent of Medicare patients are readmitted within 30 days of discharge from a hospital, most typically within the first 7 or 8 days of discharge (Jencks, Williams, and Coleman 2009). CMS also reports that half of these patients do not see a primary care physician for follow-up after their discharge. In 2004, unplanned readmissions cost Medicare approximately \$17 billion, and the cost for potentially preventable readmissions was \$12 billion. As many as 90 percent of these Medicare readmissions were unplanned.

Unplanned rehospitalizations for some of the most common diagnoses (e.g., heart failure, septicemia, simple pneumonia, dehydration, renal failure) are almost always critical emergencies, and although the patient's comorbid conditions play a role in readmission causes, most cases are the result of systems failures in ensuring appropriate transition to another source of care. Patients who are older than 80 years and have a history of depression, end-stage renal disease, or five or more chronic conditions pose the greatest risk for readmission, but that risk can be mitigated by recognizing their risk score early and tailoring a discharge plan that is most appropriate for their condition, including hospice and palliative care.

The primary contributor to the high readmission rate, however, is the breakdown of the discharge process. Historically, many patients who are readmitted to the hospital do not see their primary care physician within 7 to 14 days of discharge as recommended (American



Hospital Association and Health Research and Educational Trust 2014), even though many of them require additional outpatient workup. Often, discharge summaries are not readily available to primary care providers at the time of the postdischarge appointment, and even when the discharge summaries are accessible, most lack an accurate description of the hospital course of events, discharge medications, or any pending tests that may need further investigation. Patients are often not educated about the purpose of the drugs they are prescribed or about potential side effects. As a result, patients may not know the warning signs that could alert them to seek early medical advice.

Information technology–based improvements may help reduce rehospitalizations. Discharge summaries generated from the hospital database may include such important information as the physical exam, test results, pending results, and medications. Use of a discharge planner may also decrease readmission rates and, potentially, mortality rates.

Preventing readmissions is a challenging task because many internal and external factors contribute to the problem. However, improvement is possible with the implementation of changes in four areas:

1. *Communication among members of the care team:* Communication among the team members, including the hospital, primary care physician, specialist, patient, and transitional care specialist, can be anything from a simple phone call to an e-mail or a fax after the patient's discharge—when clear communication is key. The Society of Hospital Medicine ([www.hospitalmedicine.org](http://www.hospitalmedicine.org)) has developed a discharge checklist that can be used to identify elements to include in a discharge summary and information →

that needs to be communicated to the primary care physician after the patient becomes an outpatient.

2. *Medication reconciliation*: Reconciliation ensures that an accurate, up-to-date list of medications is maintained and is consistent with the patient's care plan. Regulatory agencies require this reconciliation to occur at discharge. The inpatient team needs to develop a standardized approach for reconciliation and education, whether provided by a physician or a nurse. The process can also be automated or involve the use of clinical pharmacists. Involving clinical pharmacists in the medication reconciliation process at discharge can lead to fewer adverse drug events after discharge and can reduce readmissions. In many of the more robust pharmacist-based programs, patients are called after discharge to troubleshoot medication problems.
3. *Pending tests and labs*: Many patients are discharged with laboratory and other test results pending. Physicians are often unaware of tests requiring review and follow-up after hospital discharge. Although automated mechanisms to track pending results are the ideal, they remain uncommon. Creating checklists and extra layers of safety for important results (i.e., having more than one follow-up appointment scheduled with the care provider) and communicating what action should be taken in response to the pending test result will help ensure that important results are not overlooked.
4. *Patient- and family-empowerment discharge coaches*: Involving the patient or family in the discharge process has been associated with improved outcomes by providing an extra layer of safety for follow-up of test results pending at discharge and communicating important events that occurred during the

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hospitalization. Encouraging patients to take a more active role in their care and providing tools and guidance in the form of transition coaches can lower hospital costs and readmission rates for elderly patients. This patient-centered approach is a useful strategy to improve care transitions.

In conclusion, communication should not be restricted to simply the doctor–patient relationship but should encompass the relationships between the emergency department physician and hospitalist, the hospitalist and the primary care physician, and the primary care physician and the family. Proper documents, including laboratory and diagnostic test results and discharge summaries, should be readily available to all care providers. The healthcare community at large can also play a role in making transitional care more efficient among the local population. Partnerships may be built between hospitals and other healthcare providers and community agencies to facilitate easy access to patient documents, allowing direct lines of communication between facilities and supplying healthcare providers with critical information regarding their patient population.

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