Definition and Harm Impact

A readmission is a return hospitalization after discharge. The readmission rate is measured and tracked by Medicare within 30 days of the hospital discharge date. In 2014, nearly 250,000 patients in California were readmitted within 30 days of discharge. In fiscal year 2016, the national readmissions rate for hospitals was 18.35 percent. Readmissions are costly, disruptive for patients and family members, and very often preventable. Unplanned readmissions have been associated with ineffective discharge processes including discharge planning, medication reconciliation, failed handoffs to post-acute care providers, and insufficient patient education. In addition to concerns regarding quality, readmissions are also very costly for the healthcare system and for patients. Hospitals are now financially penalized by Medicare through the Readmissions Reduction Program for higher-than-expected readmission rates. In fiscal year 2017, total Medicare penalties assessed on hospitals will total $528 million nationally. In California alone, 255 hospitals are expected to be penalized an average of 0.55 percent of their Medicare payment during fiscal year 2017 for readmissions that occurred through 2015.

Measurement

The Hospital Improvement Innovation Network (HIIN) goal for the reduction of avoidable readmissions is a decrease of 12 percent from the baseline rate. For the purposes of the HIIN, the readmissions rate is measured as the number of inpatients returning as unplanned inpatients to any acute care hospital within 30 days of date of discharge from any acute care hospital over the total number of inpatient discharges from any acute care hospital (excluding discharges due to death) multiplied by 100. Included in this measure are all unplanned readmissions regardless of relationship to the discharge diagnoses. Although patients from all payer types can be readmitted, for the HIIN, this measure will be pulled from Medicare Fee-for-Service claims and focus on the Medicare patient population.

Known Improvement Strategies

Integral to addressing readmissions is working across the continuum of care, following a patient from the initial decision to admit through the discharge planning process to post-discharge follow-up care in the community. Successful strategies in the work toward reducing readmissions include:

- Identifying causes for readmissions.
  - Conduct a data analysis drill-down on readmitted patients (e.g., by diagnosis, discharge disposition, race, ethnicity, and ZIP code).
  - Interview readmitted patients and family members (e.g., looking at previous hospitalization discharge planning, keeping follow-up appointments, filling prescriptions, and taking medications as prescribed).
- Addressing potential readmissions during the hospital stay.
  - Conduct a readmissions risk assessment on admission.
Begin discharge planning at the time of admission and standardize the process.
Work with emergency department staff members to identify patients who are possible readmits.

- Creating a post-discharge plan
  - Coordinate follow-up appointments with care providers or call patients who do not have a follow-up appointment within 72 hours.
  - Develop a post-discharge care plan to be shared with primary care providers and family members.
  - Partner with community providers (primary care clinics, skilled nursing facilities, home health agencies, federally qualified health centers, and palliative care organizations).
  - Partner with community organizations (church groups, pharmacies, community groups, and meals on wheels).

- Addressing health literacy/disparities in care.
  - Use a formal health literacy screening tool.
  - Adapt educational materials and resources to the patient’s language and level.
  - Use teach-back strategies to validate patient understanding prior to discharge.

Engaging Patients and Families

Strategies to actively engage patients and family members in the prevention of readmissions include:

- Involving patients and families in developing the post-discharge care plan to ensure understanding and successful follow-through.
- Making the follow-up appointment with patients’ physicians before they leave the hospital and attempting to assure that patients will have transportation that day to the appointment.
- Using the teach-back method when giving patients and families instructions about their continued care.
- Considering a post-op visit (rather than a call) to observe the patient and family environment (e.g., checking for safety of the environment, assessing for food insecurity, etc.). This might be done in conjunction with continuum-of-care partners.
- Including a query about holistic and over-the-counter medications when conducting medication reconciliation.
- Asking patients and families what is most important to them in maintaining their health and wellness to inspire activation for continued care.

Resources and Guides for Hospitals

- General Topic Information and Best Practice Sharing
  - Huddle for Care: [https://www.huddleforcare.org](https://www.huddleforcare.org)

- Specific Tools/Projects
  - The Care Transitions Program®: [http://caretransitions.org/](http://caretransitions.org/)
Project RED (Re-Engineered Discharge): http://www.bu.edu/fammed/projectred/index.html

- Readmissions Reduction Program
  - QualityNet: www.qualitynet.org
  - Medicare FFS Readmission Reduction Program: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html

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2 Quality Innovation Network-Quality Improvement Organization National Coordinating Center January 2017 Quarterly Scorecard