Field Guide: Readmissions

Definition and Harm Impact

A readmission is a return hospitalization after discharge. The readmission rate is measured and tracked by Medicare, as an unplanned return to the hospital within 30 days of the initial hospital discharge date. California’s statewide 30-day readmission rate has remained relatively unchanged from 14.48% in 2016 to 14.6% in 2017, but is slightly below the national rate of 15.3% percent in Fiscal Year 2017.¹ Readmissions are costly, disruptive for patients and family members, and very often are 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.² 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. According to the Centers for Medicare & Medicaid Services (CMS) data, the Hospital Readmissions Reduction Program (HRRP) reduced reimbursement for 2,599 hospitals for fiscal year (FY) 2019, totaling $566 million, an approximately $2 million increase over FY 2018 penalties.³,⁴ A large percentage of California hospitals were impacted by Medicare reimbursement penalties due to underperformance on 30-day readmissions. In March 2019, it was estimated that of 292 California hospitals evaluated, 215 would sustain penalties.³,⁴

Engaging Patients and Families

Patients and family members are critical partners for addressing avoidable hospital readmissions.

Education points:

- Address patient and family/caregiver understanding of key events/diagnoses that occurred during the hospital admission and how each relates to their post-discharge care and recovery. For example, are they able to articulate understanding of a sepsis diagnosis?
- Provide comprehensive education for understanding how to respond to changes in patient’s condition. Use tools as decision aids, for example, the Zone Tools, post discharge.
- Encourage patient/family/caregivers to first seek treatment outside of the emergency room in non-life-threatening circumstances.
- Ensure patient understanding of timeframes for seeking outpatient care upon increase in worsening symptoms.
- Provide patient/family/caregiver with immediate contact from the inpatient stay should they have questions or concerns post-discharge.
- Reinforce with providers as well as patients the benefits of a Patient Discharge Survey process, and track and monitor actions.
- Use the Teach-Back method when giving patients and families instructions about their continued care.

Additional strategies to involve patients and families include:

- Recruit a patient/family patient family advisory council (PFAC) member to care coordination committee.
- Ask patients and families what is most important to them in maintaining their health and wellness to inspire activation for continued care.

Additional resources are available at: [www.hsag.com/hiin](http://www.hsag.com/hiin)
• Partner with patients and families in developing the post-discharge care plan to ensure understanding and successful follow-through.
• Assess with family/caregivers the patient’s risk for falls, adverse drug events, risk for disease-process exacerbation, etc., once they are discharged.
• Make the follow-up appointment with patients’ primary providers before they leave the hospital, and attempt to assure that patients will have transportation that day to the appointment.
• Consider a post-operative 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.
• Include a query about holistic and over-the-counter medications when conducting medication reconciliation.

**Hospital 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.

Known strategies for improvement are to:

• Identify causes for readmissions.
• Address potential readmissions during the hospital stay.
• Create a post-discharge plan.
• Address health literacy/disparities in care and patient-family engagement.

Other emerging strategies for addressing the care continuum include:

• Designing age-friendly health systems.
• Planning for post-discharge and future care for multiple co-morbidities and advanced disease care.
• Ongoing consideration and planning for variable social determinates and care needs.

**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.
Resources and Guides for Hospitals

- General Topic Information and Best Practice Sharing
  - Huddle for Care™—Offering transitions of care stories and solutions from healthcare professionals. Available at: https://www.huddleforcare.org.

- Specific Tools/Projects
  - The Care Transitions Program (Eric Coleman Model): Available at: https://caretransitions.org/.
  - Transitional Care Model (TCM) for in-hospital planning and home follow-up for chronically ill high-risk older adults hospitalized for common medical and surgical conditions: Available at: https://www.nursing.upenn.edu/ncth/transitional-care-model/.

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

- Supplemental
  - Pathway Health—INTERACT® communication and decision support tools for skilled nursing, assisted living, and home health: http://www.pathway-interact.com/interact-tools/interact-tools-library/interact-version-4-0-tools-for-nursing-homes/.
  - Administration for Community Living—Connected older adults and those with disabilities with community services: Available at: https://acl.gov/programs/connecting-people-services.
Additional resources are available at: www.hsag.com/hiin