# How Reducing Hospital Readmissions Benefits Patients and Hospitals

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Reducing hospital readmissions has been a longstanding goal for facilities across the nation. A hospital readmission is a patient who is readmitted within 30 days of being originally discharged, according to the Center for Medicare and Medicaid Services (CMS). Patients who are admitted to other acute care facilities also count as readmissions.

Hospitals and other health care facilities with high readmission rates experience a variety of negative impacts. They put an unnecessary strain on their nurses and physicians, waste time and health care resources, and have low patient satisfaction scores.  Readmissions are an ongoing

issue, which is why recently mandated health care reforms have been enacted to curtail repeat patient admissions in U.S. hospitals.

One of these reforms includes completing discharge reports shortly after a patient's release. Next, a detailed analysis of community hospital readmissions gives administrators insight into repeat visits. This information informs organizations where to place the focus in their quest to reduce hospital readmissions.

Resource expenditures are a telltale sign of high-risk clients. Due to the complex nature of service delivery, organizations sometimes deploy multiple readmission reduction plans. Improving the transition from the caregiving setting to clients' homes plays a critical role in most reduction processes. Once administrators develop a plan, cooperation with community health organizations considerably bolsters local wellness initiatives.

Professionals equipped with an advanced degree, such as a , can play an integral role in helping reduce readmissions.

## Benefits of Reducing Hospital Readmissions

High hospital readmission rates are challenging for health care workers, strain health care resources, and most important, are bad for patients. A focus on reducing readmission rates can yield numerous potential benefits.

First and foremost, reducing readmissions can improve patient outcomes. Readmission correlates with an increased risk of various adverse health outcomes, including increased patient stress and higher mortality rates. Conversely, reduced readmission rates are associated with greater patient satisfaction and improved outcomes.

Another key benefit of reducing readmissions is an overall reduction in spending on health care services. According to the CMS, Medicare will save approximately $521 million as a direct result of the Hospital Readmission Reduction Program (HRRP), which is a value-based purchasing program that seeks to cut down on patient readmission through improved care coordination and communication.

Better coordinated care, patient engagement, and communication mean patients will have a better understanding of their conditions and treatment plans. These strategies can also make the transition from hospital bed to home smoother, increasing overall patient satisfaction.

Patient satisfaction scores are crucial because under the Hospital Value-Based Purchasing Program, a portion of Medicare payments can be withheld if a hospital doesn't meet standards for quality of

care, including the patient experience. This has motivated many physicians and other health care workers to focus on care quality rather than on the number of patients they treat.

Another major benefit of reducing hospital readmissions is avoiding financial penalties. In 2021, Medicare reduced payments to 2,499 hospitals — 47% of all facilities — due to excessive readmissions, with projected penalties costing $521 million. Focusing on patient care and care coordination means hospitals can avoid penalties and dedicate resources to improving equipment and supplies, facilities, and staffing.

## Readmission Reduction in the United States

The Affordable Care Act (ACA) requires hospitals to reduce patient readmissions. The act defines a readmission as a repeated patient hospitalization within a 30-day period, with special amendments applying to conditions such as:

- Acute myocardial infarction (AMI)
- Chronic obstructive pulmonary disease (COPD)
- Heart failure (HF)
- Pneumonia
- Coronary artery bypass graft (CABG) surgery
- Elective primary total hip arthroplasty and/or total knee arthroplasty (THA/TKA)

The ACA provides an algorithm to assess readmission ratios in relation to national averages and outlines practices to adjust risk assessments based on client characteristics. Caregiving facilities must store and use three years of past data to calculate the readmission ratios.

Non-compliant institutions face significant financial penalties, while compliant organizations save expenses beyond those fines and improve patient outcomes. Before the ACA, more than 20% of all patients reentered care within 30 days, and almost twice as many returned in 90 days.

While care providers may find improving these outcomes challenging, they now recognize readmissions as a serious problem that warrants administrative attention. Readmission reduction is a large-scale initiative capable of saving medical institutions in the United States billions of dollars over time. Improving this circumstance is a boon for patients and caregivers.

The medical community is still discovering the best way to meet this goal. Among other practices, health care administrators are implementing the following seven steps to reduce preventable patient readmissions.

### Step 1: Deliver Discharge Information Faster

Caregiving facilities traditionally require discharge reports to be completed within 30 days after patient departure. Shortening the deadline from this standard interval to 24 hours drastically increases data relevancy and provides timely insights into readmissions.

With the lengthy 30-day deadline, caregiving facilities miss opportunities to reduce or eliminate issues leading to readmission. When patients leave a facility and have questions or concerns, they are likely to direct inquiries to their primary care providers. At this point, the patient begins treatment through an unrelated source, increasing potential medical errors.

Some modern treatments leave little room for error and misinterpretation. Patients and care providers need medical information quickly to avert readmission events. Additionally, readmission reduction initiatives typically focus on patient transitions from facilities to client residences. However, various facility readmissions originate for reasons occurring outside this window. For these conditions, such as chronic illnesses, readmission reduction efforts aimed solely at the discharge process do not improve patient outcomes.

Not all chronically ill patients seek medical attention outside of health-threatening events. These patients require separate, dedicated initiatives to identify and resolve trouble areas. Nevertheless, expedient discharge summaries also reduce errors and oversights leading to readmissions among chronic patients.

## Step 2: Review Current Data Stores

Intuitively, institutions begin reducing hospital readmissions by developing initiatives to generate financial rewards through the ACA. While legislators engineered the ACA to evoke this response, this practice does not fit every scenario. Incentive-based initiatives ignore definitive community readmission factors.

A community-specific response requires in-depth analysis generated from local data. This kind of detailed research produces actionable information relevant to specific care networks and typically requires a dedicated, month-long initiative.

This stage begins with a current readmission volume review. Health care administrators begin the process by sourcing information from internal data, patient interviews, and third-party partners, as well as any sources producing relevant data. This information provides insights into specific patient readmission factors.

Health care administrators source third-party information cautiously, as the provided data does not comprehensively represent the entire readmission population. Therefore, initiatives require critical internal data evaluations. When executing this step, it is important to focus on opportunities for improvement rather than on departmental shortcomings.

## Step 3: Identify Readmission Characteristics

Before launching any readmission reduction initiative, it's vital to identify where to focus organizational efforts. Health care administrators divide readmissions into three broad classifications, which are:

- Chronic conditions
- Poor transitions
- Readmissions due to complications

Readmissions due to chronic conditions comprise the most frequent recurrences. The medical community recognizes this small but costly client population as a high-risk group. They require "enhanced services" to ensure their well-being after discharge. These services require organizations to reallocate resources to prevent readmissions, and include:

- Family/caregiver consulting
- IT readmission warnings
- Managed care services
- Pharmaceutical reevaluations
- Research
- Training

Enhanced service offers value to care providers by reducing costs compared to readmission occurrences. Health care administrators consider this savings when evaluating enhanced service financial viability. By providing this feature, organizations meet objectives supporting new payment models designed to improve service delivery cost-effectiveness and patient outcomes.

## Step 4: Classify Readmission Candidates

Readmission reduction initiatives target high-risk patients who consume the most organizational resources. The American Academy of Family Physicians (AAFP) offers a popular framework for classifying the high-risk patient population into six numerical categories, with category number six representing the most at-risk population. The process of classifying high-risk patients is time-consuming and typically takes around six months to complete. However, Medicare provides financial incentives to help organizations manage service delivery among chronically ill patients.

Using this framework, health care administrators classify clients as low, moderate, high, or extremely high resource consumers. Under each tier lie six risk levels. Care providers devote resources to patients based on their risk level, such as support staff and longer physician sessions.

After identifying these high-risk groups, health care networks implement programs to educate patients on wellness matters. The programs cover topics such as chronic illness management or available outpatient resources. As more organizations implement strategies similar to the AAFP framework, the results reveal classification effectiveness.

## Step 5: Build Applicable Strategies

Some organizations adopt multiple strategies to reduce hospital readmissions because it's difficult to definitively pinpoint the reasons behind readmissions or predict how solving one problem may create another. Multiple strategies increase the probability of achieving readmission reduction.

Health care administrators determine whether this strategy is necessary after amalgamating data from all available sources. By examining how current readmission reduction practices perform, health care administrators determine appropriate program objectives and responses. Organizational objectives, in part, define these criteria.

This information clarifies the variables contributing to readmissions and helps administrators interpret the appropriate organizational response. After formulating a strategy, administrators calculate how the overall initiative improves operations. This estimate consists of improvements produced by all combined strategies.

## Step 6: Reform the Client Transition Process

Improving patient transitions contributes to reducing hospital readmissions. The emergency room is a prime department to establish alerts when patients return more than once in a 30-day period. Due to high patient volume, this department requires a dedicated readmissions specialist to monitor for, and liaise with, emergency room clients requiring high-level service.

Readmission specialists clearly identify and record patients returning within a 30-day period and the reason for the return visit. The specialists also identify readmission risk candidates during the client intake interview and investigate whether clients have visited the ER in the past six to twelve months.

The specialists document all factors contributing to readmissions, monitor patient records internally and externally, and inquire about external issues that limit a client's ability to maintain their health.

Specialists also identify patient and caregiver needs. The specialists are expert communicators and ensure information flow to and from the client with clarity and comprehension. When necessary, readmission specialists secure translators to ensure effective communication and confirm that at least one capable external care provider receives pertinent information.

## Step 7: Develop Community Support

Collaboration among multiple disciplines reduces patient readmissions. Health care administrators begin this process by reaching out to large community groups. These groups include insurers, government agencies, labor unions, civic associations, and other enterprises that promote community well-being. After establishing alliances, provider networks reach out to individuals in the organizations to work together in developing group care plans, such as formulating discharge procedures to help reduce readmissions among group members. Collaboratively, these relationships form a network that improves population well-being and reduces hospital readmissions.

Health care organizations maintain relationships with these partners through regular meetings to discuss the current status of community readmission and evolving group needs. As a best practice, a designated individual within each organization facilitates this ongoing professional relationship. By building local connections, care providers develop community resources that are vital to reducing hospital readmission rates.

### The Keys to Reducing Hospital Readmissions

Legislators developed the readmission reduction agenda to improve patient outcomes and reduce caregiving expenses. Caregiving organizations must comply with this agenda to avoid financial penalties.

Health care administrators begin compliance initiatives by drastically shortening patient discharge summary deadlines. They then perform a detailed discharge history review, which identifies the patients who most frequently return for health care services. These high-risk candidates consume the bulk of institutional resources.

When high-risk clients fall under numerous classifications, health care administrators pursue multiple strategies to reduce readmissions. These efforts reduce costs and improve service quality for patients and medical institutions. Health care administrators also enhance readmission reduction strategies by working with local civic organizations.

As the demand for health care services continues to rise, readmission reduction will continue to play a crucial role in making the best use of limited caregiving resources in the United States.

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## Recommended Reading

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How to Become a Health Informatics Specialist

Online Master of Health Administration Resources

**Sources:**

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