Hospital Readmissions Reduction Strategies: The Impact of the Hospitalist

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As penalties associated with avoidable readmissions continue, hospitals across the country are attempting to identify the most effective approaches to tackle this challenge in order to limit monetary as well as reputational losses. While the solutions required will likely be as multi-faceted as the problem itself, one specific group that can play a pivotal role in reducing readmissions are the hospitalists. Hospitalists play a central role in process improvement within hospitals, which gives them a head start in tackling the readmissions challenge. However, in certain cases, overemphasis on length-of-stay (LOS) reduction may contribute to the problem, which can lead to higher readmissions, patient dissatisfaction, and increased liability for the physicians and the hospital. Thus, the hospitalists and the hospital leadership need to develop a proactive, coordinated set of strategies to achieve the desired results of efficient care as well as reduced readmissions. Use the following ten tips to support your organization’s coordinated strategy.

1. Promote a Team Approach

Reducing readmissions requires a team effort with other physicians, nurses, care coordinators, case managers, family members, and post-acute providers. Hospitalists typically work in a team-based environment and are used to playing “quarterback” to a multidisciplinary team of healthcare professionals to improve inpatient processes and quality, and thus are best qualified to lead efforts to reduce readmissions. Because many of the areas that can impact readmissions are outside the immediate purview of the hospitalists (e.g., case management or post-acute care), some organizations utilize a dyad approach where the hospitalist co-chairs the taskforce with an administrative leader.

2. Coordinate Discharge Planning

Hospitalists are often asked to balance hospital efficiency (e.g., through managing LOS and cost per case) while ensuring that the patient receives appropriate care in the most appropriate setting. Hospitalists can manage this balancing act by working with case managers and care coordinators to develop a plan of care starting on the first day of admission. The tasks of planning post-discharge care, coordination with the Primary Care Physician (“PCP”), specialists, and communication with family should be initiated as early as possible.

3. Improve Patient Education

The best preventers of readmissions are often the patients themselves. If properly educated on symptoms, medications, warning signs, and need for follow-up with PCPs, many of the most common problems that result in readmissions can be prevented. While it certainly depends on the ability of the patient to follow instructions, hospitalists can lead the effort by providing written as well as verbal instructions in an easy to understand way. Depending on the situation, it may be appropriate to engage family members. Additionally, deploying a patient education specialist or case manager to follow-up with the patient to make sure they understand the hospitalist’s recommendations and plan of care identifies areas where patients may be unclear and resolves those issues before discharge. This also serves as a vehicle to improve patient experience. Optimally, patients should be given a phone number to call should they have questions after their discharge. That number should be given by the hospital, hospitalist, case manager or in coordination with the PCP.
4. Strive for Smoother Hand-offs

Transition from the inpatient setting to post-acute or home setting is a critical step in preventing adverse outcomes and potential readmissions. Effective communication about the needs of the particular patient applies to not just the inpatient stay, but to the discharge process and post-discharge environment. Hospitalists need to pay particular attention to effective and timely communication with the PCPs or post-acute providers. While a letter or faxed copy of discharge notes is common practice, it is usually not sufficient; phone calls can be much more effective in relaying important information and developing a game plan, especially for complex patients. Additionally, electronic exchange of health information and shared viewing of the electronic patient record is optimal. This often remains a challenge due to lack of integration between inpatient and ambulatory records.

5. Schedule Follow-up Appointments

Patient follow-up appointments should be scheduled with the PCP before discharge, and an appropriate outreach and communication process should be structured so that patients who miss their follow-up appointments are identified. This requires a tightly coordinated effort between the hospitalists, the hospital and the patient’s PCP or other relevant specialty provider. Further, home health agencies can support the transition to home with home visits to assess the patient’s condition, home environment, and ensure compliance with medications. Hospitalists should drive the communication with the PCP and coordinate efforts with internal hospital departments to ensure appropriate post-discharge visits are arranged.

6. Improve Medication Reconciliation

Multiple studies have demonstrated that proper medication reconciliation can result in a significant decrease in readmissions and adverse events. Hospitalists can take a leading role in improving medication reconciliation through a coordinated effort with the pharmacist, pharmacy technicians, and nursing staff. Depending on the approach, the process may require additional staffing resources, and the hospitalists can spearhead the task of communicating the expected benefits to administrative leaders. Further, medication reconciliation doesn’t stop within the hospital walls. Ensuring that the PCP is updated regarding changes in medications while in the inpatient setting and the ambulatory record is updated are pertinent; as is coordination with post-acute care providers.

7. Utilize Post-Acute Care

As the healthcare system moves to an integrated delivery model, hospitalists can play an important role in the post-acute arena to improve care coordination. Several organizations now send hospitalists to round in skilled nursing facilities (“SNFs”) and nursing homes to ensure a safe transition and follow-up. Some organizations have dedicated physicians to the SNF setting, often referred to as “SNFists.” For less acute patients, several programs offer post-discharge clinics that are staffed either by hospitalists or through a partnership with the PCP. While utilizing hospitalists or advanced practice professionals with hospitalists’ oversight, outside of the inpatient setting, may require financial support from the organization, the benefits from reduced readmissions, lower costs, and higher patient satisfaction can be significant.

8. Identify Those at Greatest Risk for Readmissions

Hospitalists are in the best position to identify patients that are at greatest risk for readmissions. Using data analysis to provide a greater level of detail and feedback to hospitalists is important to overall success, as is instituting a feedback process to account for the hospitalist’s identification of high risk individuals, processes and conditions. Utilizing a risk stratification tool and arming hospitalists with information from that tool at the time of admission are recommended.

9. Encourage Communication between Admitting and Discharging Physicians

Studies have shown that often there isn’t communication between the admitting and discharging hospitalists regarding patients that are readmitted. While basic information is often exchanged, there isn’t a tightly coordinated effort to discuss readmitted patients between the physicians that are involved in the care. Closing the communication loop between hospitalists could provide valuable information and lessons learned and ultimately reduce readmissions as well as improve quality and support a team-based environment.

10. Design Incentives Models that Matter

Having clear guidelines and processes that should be followed by the hospitalist program are important. Additionally, since the readmission penalty is structured to only impact the hospital at this time, and hospitalists are still compensated
for seeing readmitted patients, creating an incentive model methodology that bonuses the hospitalists for improving or maintaining a given readmission rate may help align overall incentives in the program and engage hospitalists in the process. Hospitals should work collectively with the hospitalists group and other stakeholders to design effective incentive models.

Readmissions reduction requires a well-coordinated approach among many providers along the continuum of care as well as with the patient, family, and other participants. Hospitalists can play a critical role in the development of a culture of safety that improves patient outcomes, reduces penalties for the hospitals, and also minimizes the medical-legal risk exposure. Readmissions reduction is a clear first step in transitioning to a more value-based delivery system, and hospitalists can and should play a critical role in this process.

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