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## Reducing Readmissions: A New Sense of Urgency

By John Rossheim  
February 22, 2011

The importance of reducing readmissions is well-documented, but with a looming deadline next year that impacts Medicare reimbursements for the lowest-performing 25 percent of hospitals, case managers and discharge planners find themselves in key roles to drive better financial and clinical outcomes.

On Oct. 1, 2012, the start of federal fiscal year 2013, The Patient Protection and Affordable Care Act mandates that acute-care hospitals with higher-than-expected readmissions will receive lower Medicare payments. This payment reduction under PPACA Section 3025 is estimated to reduce Medicare payments by a collective \$7.1 billion over 10 years.

In the first two fiscal years, the reduced payments will apply to readmissions related to heart failure, heart attack and pneumonia. In the third year, the policy expands to include other diseases and procedures. Another new requirement is that HHS will post on the public [CMS Hospital Compare](#) site the readmission rates for identified conditions. Hospitals must supply this data to CMS directly or through the relevant state agency.

### Speedy Conveyance of Patient Information Is Critical

So what are hospitals doing to make sure they're ready for the implementation of PPACA Section 3025? Key to holding down readmissions is the efficient dissemination of patients' medical records, especially at discharge.

"Information is at the heart of improving care transitions, including goals of care and what we anticipate for the patient trajectory," says Amy Boutwell, MD, director of health policy strategy at the [Institute for Healthcare Improvement](#) in Cambridge, Mass. "We need patients and their families to have this information and know what to do with it, and the same holds for discharge planners."

Patient-transition technology thus becomes more important than ever. Tools that give the hospital a better profile of the patient will ultimately lead to more accurate placements and reduced readmissions.

"With a short length of stay, hospitals have to create a patient profile very quickly," says Eileen Zenker, a director at home-care provider SeniorBridge and a former social work executive at New York University Medical Center. "The discharge planner will make recommendations based on that profile."

A Critical Care Business Challenge

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With a larger percentage of older patients with conditions that require acute care, the challenge to reduce readmissions becomes more complex. The nation's 80 million baby boomers began turning 65 on Jan. 1. "The boomers coming into Medicare mean more people living longer with more medical conditions and frailty," says Boutwell.

And as the population ages and the number of prescriptions and their interactions multiply, medication management becomes much more complex. Half of Medicare participants take eight or more prescription medications regularly, according to a [statement](#) by the National Council on Aging and CVS/Caremark. The effective distribution of medication data to all of the patient's care providers can help maintain treatment without interruption and thus reduce readmissions.

"Communication breakdowns often lead to adverse events," says Ellen Kurtzman, MPH, RN, an assistant research professor at the School of Nursing of George Washington University. Whether the patient is discharged to post-acute institutional care or home care, lax communication about medication status is one of the first things that can go wrong.

"Inadequate medication reconciliation is a huge piece of readmissions that can be avoided," says Zenker. "Patients don't always understand medication orders, and doctors don't always know their patients' insurance coverage."

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*John Rossheim is a writer and editor who covers information technology, careers and other topics in health care. This article reprinted with permission. See the [original article](#) on the Curaspan site. Or visit the main Curaspan site [here](#).*

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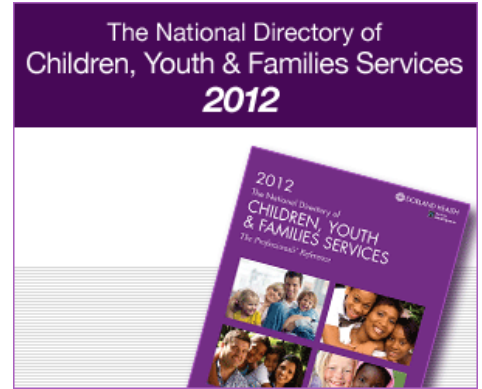
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