



Healthcare Association  
of New York State



Greater New York  
Hospital Association



# The Role of the Hospitalist in Reducing Readmissions

A NYS Partnership for Patients report prepared by the  
Healthcare Association of New York State and  
Greater New York Hospital Association

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# Introduction

The NYS Partnership for Patients (NYSPFP), a partnership of the Healthcare Association of New York State and Greater New York Hospital Association, facilitated the three-year Hospital Engagement Network from 2011 to 2014 to support hospitals' efforts to achieve the national goal of reducing preventable hospital-acquired conditions and readmissions. In 2014, NYSPFP convened a 15-member workgroup of hospital-based providers to explore the role of hospitalists in efforts to reduce avoidable readmissions.

The Hospitalist Workgroup comprised clinicians from 14 hospitals across New York State, ranging from large urban academic to small rural community hospitals. The Workgroup convened in person, via conference calls, and through email discussion between June and October. This document was developed through in-person meetings among hospitalists who participated as panelists at four regional NYSPFP Readmissions Conferences throughout New York State in October 2014. Workgroup members are listed on the next page.

The NYSPFP Hospitalist Workgroup's objective was to define the hospitalist's role in reducing readmissions and identify opportunities for hospitalists to participate in readmission reduction efforts.

Building upon the NYSPFP 2014 Preventable Readmissions Pilot, in which readmission reduction teams focused on testing and hardwiring improvements during three phases of hospitalization: upon admission, during hospitalization, and at the patient's discharge, the Hospitalist Workgroup subsequently added two more phases: the period before the decision to admit is made and the post-discharge time period.

The Hospitalist Workgroup also identified opportunities for improvement among three primary levels of change: actions an individual hospitalist could take to improve his or her daily practice; actions a hospitalist group practice could implement across all providers; and actions a hospital could implement to enable better practices in this domain.



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# The Role of the Hospitalist in Reducing Readmissions

Opportunities abound for hospitalists to meaningfully contribute to hospitals' efforts to reduce avoidable readmissions. Hospitalists are often referred to as the "quarterbacks" or the "captains" of hospital-based care. While these analogies can be helpful in describing a hospitalist's oversight and coordinating functions, the hospital readmission reduction team needs to know how to specifically engage hospitalists in these efforts. A hospitalist's participation as an active member of the readmission reduction team is critical to identifying and managing readmission risk.

The Workgroup categorized opportunities for hospitalists to reduce readmissions along the continuum of hospital-based care. These time points include:

- Prior to the Decision to Admit
- On Admission
- During Hospitalization
- On Discharge
- In the Post-Discharge Period

Some important responsibilities, such as medication reconciliation, patient and family communication, and establishing goals of care, are priorities at all points in a patient's hospitalization course. This report will address these high-priority activities in the context of one or more of these phases of hospital care.

## PRIOR TO THE DECISION TO ADMIT

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Efforts to reduce readmissions have traditionally focused on the transition from the hospital to the next setting of care. However, there are important opportunities to reduce readmissions by examining factors that contribute to the decision to admit—or readmit—a patient. These decisions are usually made in the hospital's emergency department (ED). Hospitalists have varying degrees of interaction with emergency medicine physicians. Workgroup members practicing at smaller hospitals reported having more interaction with ED colleagues than physicians at larger hospitals. Although the nature of the interactions between emergency medicine and hospital medicine groups varies, the Workgroup identified the following as feasible

opportunities to reduce avoidable readmissions before deciding whether to admit:

### Flag 30-Day Return Patients in the ED Record

Physicians would benefit from automatic prompts from the medical record to indicate whether the patient was recently seen in the ED or discharged from the hospital. When a clinician is aware that the patient has been recently seen in the ED or hospital, different questions arise and the patient's presentation can be assessed in a different context. Hospital information systems departments should consider implementing a flag system to alert providers when a patient has been admitted or seen in the ED within 30 days. Once a flag has been

created in the record, ED and hospital leadership should be sure to inform staff of the flag and develop processes in which this information can be used to assess the patient in a broader context of potentially avoidable utilization.

### Promote Collaboration Between Emergency Medicine and Hospital Medicine Clinicians

The decision to admit often rests with the emergency medicine physician; however, the Workgroup agreed that a formal or informal collegial norm of clinical collaboration between emergency and hospital medicine physicians could greatly improve the assessment of whether a patient requires admission. Hospitalists may have important information to add to an emergency medicine physician's assessment of whether an admission is appropriate. A hospitalist's background and training in inpatient and outpatient medicine, orientation toward longitudinal trajectory, and insight into what the hospital plan of care would be for a patient, including whether a hospitalization would benefit the patient, could be helpful in the assessment. Hospitalists can contribute to the emergency medicine physician's admission decision by evaluating the patient in depth before the decision to admit is made. In some cases, low-acuity admissions may be averted with the benefit of the hospitalist's perspective after an in-depth evaluation of the patient.

Additionally, hospitalists frequently manage all or part of a patient's observation status care. They may be best positioned to determine whether a patient can be safely stabilized or treated at that level of care. That option is an important part of collaborative ED-hospitalist decision-making.

### Collaborate with Referring Community Providers

If the opportunity exists to collaborate on the decision to admit the patient, the hospitalist should call the referring provider to clarify the concern regarding the potential need for acute care. A well-vetted example of this practice is from the INTERACT (Interventions to Reduce Acute Care Transfers) Program,<sup>1</sup> which some skilled nursing facilities (SNFs) use. By encouraging providers to send a succinct "reason for transfer"

statement along with the referring clinician's name and number, INTERACT has helped improve communication between the two settings when a patient is transferred from a SNF to an ED.

This practice is especially pertinent for patients presenting from SNFs, and is also applicable to any referring provider, such as a home health nurse or primary care physician. Often, the referring provider may want "another set of eyes," or a set of labs or imaging done in the ED, or help with short-term stabilization of the patient (e.g., diuresis or hydration). In such instances, the provider would reassume care in the community if the evaluation did not suggest a clear indication for acute-level admission. Without such cross-setting communication, ED and hospital medicine physicians may incorrectly assume that the referring provider is not able to care for the patient in the community.

### Form a Joint Quality Improvement Committee Between ED and Hospital Medicine to Review Low-Acuity Admissions and Readmissions

A practical way to build a culture of collaboration and educate both ED physicians and hospitalists about alternatives to (re)admission is to host inter-departmental reviews of low-acuity admissions and all readmissions. The decision to admit has traditionally been guided by a clinical norm of exercising "an abundance of caution," or presuming outpatient care has not been successful. The transition to a patient-centered focus, with a goal to provide the least-intrusive intervention possible, and a new expectation of value-based utilization, will require extensive clinician re-training. Reviewing the clinical course, successes, and opportunities of low-acuity (re)admissions together can promote collaboration on the decision to admit and provide training in avoiding unnecessary (re)admissions.

## ON ADMISSION

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Intensive attention is given to every patient at the time of hospital admission. In the context of readmission reduction efforts, several opportunities exist to improve the information, assessments, and communication that occur when the hospitalist admits a patient. The Workgroup identified ways in which the focus and intent of the admission process can be strengthened to incorporate a perspective of readmission avoidance.

### Assess the Patient While in the ED

Hospitals differ as to whether the admitting physician evaluates the patient in the ED or waits until he or she reaches the nursing unit to conduct the assessment. Assessing the patient while still in the ED benefits a number of essential readmission reduction practices that start at the time of admission. Specifically, paper-based information—such as medication lists or referring provider documents—may not be reliably captured into the electronic or paper record on the patient care unit. Patients often provide their paper-based medication lists to the emergency medical services or ED provider, and these are frequently not communicated in the transition from ED to floor. In addition, caregivers are typically present with the patient while in the ED, but may leave once the decision has been made to admit the patient. Interacting with that caregiver and the patient at the point of admission in the ED can provide a valuable opportunity to collect a complete medical-psycho-social-functional history and serve as the first opportunity to discuss goals of care, alternative approaches to care, or provide anticipatory guidance regarding what to expect from the hospitalization.

### Capture the “Story Behind the Story”

In the course of conducting root cause analyses, it is recommended that readmission reduction teams look well beyond the discharge and readmission diagnoses to capture the “story behind the story” of a readmission event. Patients and their caregivers have made a set of decisions amidst a set of circumstances that led them to seek care in the ED and thus present for admission. Those decisions and circumstances—in the context of their history, symptoms, and findings—prove most

helpful in developing a robust transitional care plan and effective teaching messages for patients to prevent readmissions. Hospitalists can expand their history-taking to inquire about these issues, especially for frequently admitted or readmitted patients. A patient- and family-centered approach to patient interviews, focused on what is important to the patient and family, rather than just the patient’s medical condition, can provide invaluable information to support education, preparation, and adherence to the care plan.

### Adopt an “Any Risk” Approach to Identifying Readmission Risk

Many hospital readmission reduction teams are learning that identifying “any” readmission risk is central to successful efforts to develop a robust transitional care plan.<sup>2,3</sup> Any number of issues can represent a risk of readmission, and moving beyond screening patients for a narrowly defined set of readmission risk factors is proving a successful strategy. Hospitalists review a large amount of information about patients during the admission process. Hospitalists can capture the issues that arise during the admission process, not only in the context of the medical decision-making, but also to inform transitional care planning and to initiate appropriate referrals for social work, nutrition, pharmacy, palliative care, physical or occupational therapy, case management, or other consults to address all needs early during the hospital stay. Hospitalists can ensure the appropriate team is working on patient preparation, education, and mitigating any hospital-acquired deconditioning from admission.

### Obtain an Accurate Home Medication List

Medication reconciliation is a complex process fraught with challenges. Hospitalists play an essential role during admission to ensure an accurate list of the patient’s current medications is obtained. Hospitalists can directly own this responsibility, or indirectly oversee a pharmacy technician, nurse, resident, or other individual who is charged with this task.

Whether the hospitalist is directly or indirectly involved with obtaining the home medication list, he or she can ensure best practices are used to increase the accuracy of this task. These include:

- Asking the family to bring in a bag of all medications taken by the patient.
- Asking the caregiver who dispenses medications to report on home medications.
- Calling the post-acute or home health agency to obtain the patient's most recent medication list or administration records.

Hospitalists should not complete the admission process without ensuring that best practices have been implemented to obtain the most accurate home medication list that reflects what the patient is actually taking.

### Notify Community-Based Providers on Admission

Notifying outpatient providers about their patients' admissions is part of a comprehensive strategy to improve transitions in care, ensure timely follow-up, and increase continuity and collaboration across care settings. Hospitalists can ask about and confirm the name and location of a patient's outpatient physicians—including relevant specialists—during admission. It is important for the team to know if the patient does not have or cannot identify his or her outpatient provider so that linkage to community-based care can be prioritized before discharge. Transitional care teams have found that when the practice is aware that a patient is hospitalized, efforts to arrange timely post-discharge follow-up appointments are more successful, perhaps even scheduled at the time of notification, if possible.

## DURING HOSPITALIZATION

Each day of a hospitalization must balance a day-to-day assessment of the acute clinical issues with an understanding of the whole-person needs post-hospitalization. Considering post-hospital longitudinal needs, working to mitigate risks, and articulating a specific post-hospital care plan might be viewed as a fairly new expectation of hospitalists. Some hospitalists may seek professional development or peer mentorship in this area. For a variety of reasons, such as length of stay and readmission avoidance, hospitalists need to be prepared to articulate not only the short-term goals for the hospitalization, but also to communicate and coordinate a robust post-hospital plan of care with the patients, caregivers, and the internal and post-hospital teams. Equally important are actively preventing deconditioning and raising awareness of new risks that present during hospitalization. Like those that were present on admission, these new risks must be mitigated.<sup>4</sup>

### Discuss Goals of Hospitalization and Goals of Care

Hospitalists should work with patients and caregivers to understand their concerns and goals for the hospitalization, and to articulate the clinical goals in the context of that understanding. Hospitalists can reinforce this mutual understanding by articulating daily goals for the hospitalization during rounds, using the white board, and communicating those goals to the inter-professional team. In addition, the hospitalist and the inter-professional team can identify when a discussion about global goals of care is indicated.

Readmission reduction efforts rely on the appropriate leadership of hospital-based clinical teams to use hospitalization or a repeated hospitalization to engage the patient and loved ones in considering both care goals and the risks and benefits of repeated hospitalization in the context of life-limiting illness or undertreated symptoms that could be better managed through effective palliative care.



### Anticipate Discharge Date and Clinical Milestones Daily

Although it can be difficult to state with certainty an expected date of discharge, patients and the inter-professional care team look to hospitalists to identify the expected clinical milestones during a hospital course and to provide a working estimate of a discharge date. It is important for the patients, caregivers, and other professionals involved in ensuring an effective transition of care to know how much time to expect before the transition occurs. Professional colleagues can reassure hospitalists that these estimates are just that—estimates—and that everyone on the care team understands that unforeseen complexities can arise during a hospitalization.

Communicating to the patient and caregivers that the hospitalization will be on the order of a few days, for example, is important for setting an expectation that the patient will progress from the acute setting to another setting to convalesce and recover after the acute hospitalization. More importantly, it allows the caregivers time to make arrangements and prepare for the patient's discharge.

### Actively Participate in Inter-Professional Care Planning

Hospitalists are often referred to as the “quarterback” or “captain” of the inpatient care team. This is especially true for the need to communicate and collaborate with the inter-professional care team. Some hospitalists may have difficulty envisioning attending “multidisciplinary rounds” in the context of their current workflow patterns.

However, numerous mechanisms exist for hospitalists to coordinate with the full care team to ensure comprehensive transitional care planning and effective linkage to post-hospital care and services are underway. Inter-professional collaboration can occur at the bedside, by using shared documentation, or during scheduled morning huddles or planned multidisciplinary rounds. This can occur whether the hospitalist is regionalized by unit/floor or not. NYSPFP hospitals demonstrated during the 2014 Preventable Readmissions Pilot the feasibility of successfully including the hospitalist in multidisciplinary rounds.

Pilot participants discovered that formalized inter-professional rounds or care planning meetings greatly decreased the number of pages hospitalists received, increased collaboration, and improved workflow efficiency, eliminating re-work and delays.

### Use Teach-Back Methods or Support the Use of Teach-Back

Hospitalist Workgroup members identified patient education as an important component of their patient care responsibilities. In addition to providing patient education directly using the teach-back technique, some hospitalists said they work with staff who will provide patient education to identify the key messages a patient needs to review. Hospitalists should collaborate with nursing, nutrition, respiratory therapy, and other departments to develop standardized teach-back scripts for common conditions.

## ON DISCHARGE

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*“Hospitalists play a crucial role in the discharging process; they are the leaders of the team that coordinates care and transitions patients safely to their primary care physicians.”*  
—Workgroup Co-Chair Cristina Topor, M.D.

The day of discharge can be stressful for providers, staff, patients, and families. Hospitalists can contribute in meaningful ways to ensure that patients, families, and receiving providers are prepared for and feel confident that the transition from the hospital to the next care setting is well-planned and effective. The patient's and caregivers' planning needs to include a clear understanding

about the hospitalization, follow-up care and plans, and ensuring that appointments and services are in place before the day of discharge. The hospitalist's role on the day of discharge is to ensure these important communication and coordination elements are in place, and that there is clarity about and confidence in the plan.

### Provide Simple, Clear Instructions to the Patient and Caregiver

Despite an increasing understanding of literacy and health literacy, hospital-generated discharge instructions do not always provide the clarity that patients and

Patient-centered information provided on the day of discharge should include the following components written in a clear, easy-to-understand, cultural and literacy-appropriate way:

- Updated and confirmed medication list
- Description of the reason for hospitalization
- Self-care instructions for the next three to five days until physician follow-up
- Brief description of symptoms to report to their primary care physician
- Pending and follow-up testing
- Telephone number to call with questions

caregivers need to successfully assume self-care after a hospitalization. Workgroup members agreed that hospitalists play an important role in directly working with the patient and caregivers, and the nursing and case management staff to ensure there is a clear understanding of the post-hospital care plan on the day of discharge.

While the hospitalist may not generate or produce this information, he or she should work with the patients and caregivers to ensure understanding; with the inter-professional team on the floor to clarify and align teaching; and with hospital administration to improve the quality, clarity, and customization of electronically produced instructions.

### Ensure the Discharge Medications Are Accurate and Can Be Obtained

The patient's entire medication regimen should be reviewed and confirmed for accuracy prior to discharge, including psychiatric medications and controlled substances. This is especially true when patients are transitioned to home-based providers so the medication list is complete, accurate, and comprehensive. Furthermore, some patients revert to their prior medications or dosages because they have filled prescriptions at home, and the copayment or logistical challenges of filling a new prescription create a barrier to adhering to a newly prescribed medication regimen. Hospitalists can complete the medication reconciliation or work with the nurse, physician extender, or pharmacist to do so. It is important that the medications, titration, and any patient concerns be communicated to the primary care

provider to avoid adverse drug events that can lead to readmissions.

### Ensure Follow-Up and Services Are in Place

Early and consistent communication with the inter-professional care team will greatly facilitate early discharge planning to ensure that follow-up appointments with primary care and relevant specialists are in place prior to discharge—and scheduled for a time convenient for the patient and caregiver within five days of discharge. The hospitalist should review and confirm that services, such as physical therapy, home health, durable medical equipment, coaching, disease management education, or social service supports are in place with a contact name, service start date, and telephone number provided to the patient and caregiver.

### Communicate with the Receiving Provider

To enhance communication and care transitions, hospital readmission reduction teams are encouraged to implement a “warm handoff” process, which can offer an important opportunity for provider-to-provider clarification. This is especially true for managing a patient's care and conveying general impressions that are not written. Communicating with the receiving provider can take many forms and should be customized to the circumstance. For example, nurse-to-nurse warm handoff (e.g., telephone conversation) to SNF providers may achieve the core function of communicating with the receiving provider. In other cases, a physician-to-physician communication via e-mail, text, or secure portal to briefly indicate the patient is being discharged, any major new

diagnoses or issues, and a reference to where to access the discharge summary, can also achieve the handoff communication function without trying to get two busy physicians on the phone at the same time.

One Workgroup member found that a brief “heads up” hospital page was all that was needed at the time of discharge. Hospitalists should consider reaching out to their local referring primary care colleagues to ask them—the “receivers”—how they would like to receive real-time notifications of discharged patients.

### Dictate an Informative, Concise Discharge Summary

Many hospitalists were trained to dictate a discharge summary that served as a historical record of the hospitalization. The discharge summary’s utility is evolving,

and it now needs to serve as a handoff communication tool across settings. The discharge summary should be produced as close to the time of discharge as possible. The same day or within 24 hours of discharge appear to be the emerging new norms. In addition, hospitalists are revising the discharge summary format to better serve as a clinical transition of care document by highlighting new diagnoses; tests, procedures, and their results; medication changes; and pending items for follow-up. This information appears early in the document, to better serve as an “executive summary” for the receiving providers. Hospitalists can work with their receiving providers in the community and post-acute care settings to identify the most important information and prioritize those in discharge documentation.

## IN THE POST-DISCHARGE PERIOD

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Hospitalists may feel their clinical obligation to the patient ends at discharge from the hospital, or that there are barriers to being available to respond to or follow-up on issues in the post-discharge period. The NYSPFP Hospitalist Workgroup agreed that there is a level of accountability for exchanging patient information past the discharge day. Several examples exist to illustrate how hospitalists can arrange systems to be responsive to recently discharged patients, their providers, and ensure follow-up on hospital-ordered testing.

### Provide a Hospital Medicine Contact Number

Daytime, evening, and overnight work across rounding, admitting, consulting, and other hospital duties make it very difficult for any one hospitalist to commit to individual availability, especially when rotating “off service.” It is not necessarily essential for the individual to be available, but rather that a mechanism is provided by which patients, caregivers, or providers can call the group, department, or floor with questions in the immediate hours and days after discharge.

For example, patients receive the telephone number of the floor charge nurse, post-hospitalization “hotline,” director of care management, administrator of the hospi-

tal medicine group, or the “triage” hospitalist. Patients, caregivers, and providers (especially home health nurses and skilled nursing facilities) have questions that the hospital medicine team can readily explain, clarify, or confirm, even if the specific discharging physician is not available. Many of these questions typically raised are about discharge medications—omissions, duplications, missing prescriptions, etc.—issues that arise almost immediately in the next setting of care. Having a representative of the hospital or hospital medicine group available to readily clarify these questions can avert an avoidable return to the ED and readmission.

### Have a System for Following Up on Results

Processes need to be formalized to follow up on test results that are pending at the time of discharge. Many hospitalists assume this responsibility at the individual level; others have a practice-wide system for tracking and reporting patient test results as they come back after discharge. Hospitalists cannot assume this will be accomplished by the primary care physician—especially if there is inconsistent detailing about pending diagnostics or further testing needed in their discharge summaries. This communication can be even less reliable if the patient’s outpatient care team is not part of the

same electronic medical record as the hospital. The Workgroup participants identified this as primarily a safety issue and gave examples of their individual ways of following up on pending results. As a safety issue, the Workgroup recommended that hospitalist practices develop a reliable system that does not risk being subject to variation in individual practice.

### Ask for Feedback from “Receiving Providers” and Review Issues that Arose on Post-Discharge Calls

In addition to tracking readmission data as an indicator of the effectiveness of these efforts in reducing avoidable readmissions, hospitalists and readmission reduction teams should be sure to “listen to the customer”: the patients, their caregivers, and their receiving providers. Many hospitals make post-discharge follow-up telephone calls. Workgroup participants noted that hospitalists do not receive any feedback on the content of these calls, including what questions and issues arose during the calls. This information can become a valuable source

of feedback to hospitalists and the inter-professional team: understanding the most frequent and concerning questions that arise during these calls can help the inpatient staff more consistently or clearly address those issues prior to discharge.

In addition, hospitalists and readmission reduction teams can query a variety of “receiving providers” in the community, such as affiliated primary care providers, non-affiliated primary care providers, specialists, home health providers, and skilled nursing facility providers to understand the information elements that were helpful and those that are consistently missing. Adding this to the department and readmission team’s quality monitors will help continuously improve the quality and usefulness of hospital handover communication and cross-setting collaboration. The support and involvement of hospitalists in requesting and reviewing this feedback is essential to fostering meaningful improvement.

## CONCLUSION

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The insight shared by the NYSPFP Hospitalist Workgroup provides a good foundation for identifying specific, practical ways in which hospitalists can meaningfully contribute to readmission reduction efforts in hospitals of every type. The Workgroup identified opportunities for hospitalists to improve their individual practice, the group’s practice, and to strengthen and improve hospital-based systems of care. Many more meritorious opportunities for practice change and participation in readmission reduction activities exist.

*“This product guides hospitalists to do the right thing at the right time, from admission to discharge. As a Workgroup, we recommend improving communication at all levels and involving the patients and their families in the care. I am certain that if hospitalists can implement some of these recommendations in their busy daily work, they will enjoy the benefits of not only improved readmission rates, but also overall improved quality of care.”—Workgroup Co-Chair Nejat Zeyneloglu, M.D.*

## END NOTES

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# Summary: The Role of the Hospitalist in Reducing Readmissions

There are many specific ways in which hospitalists can contribute to hospitals' efforts to reduce readmissions. Hospital readmission reduction teams should explore engaging their hospitalists in contributing to those efforts in the following ways:

## PRIOR TO THE DECISION TO ADMIT

- Flag 30-day return patients in the ED record.
- Promote collaboration between emergency medicine and hospital medicine clinicians.
- Collaborate with referring community providers.
- Form a joint quality improvement committee between ED and hospital medicine.



## ON ADMISSION

- Assess the patient while in the ED.
- Capture the "story behind the story."
- Adopt an "any risk" approach to identifying readmission risk.
- Ensure an accurate home medication list is obtained.
- Notify community-based providers on admission.



## DURING HOSPITALIZATION

- Discuss goals of hospitalization and goals of care.
- Anticipate discharge date, hospital, and clinical milestones daily.
- Actively participate in inter-professional care planning.
- Use teach-back methods or support the use of teach-back.



## ON DISCHARGE

- Provide simple, clear instructions to the patient and caregiver.
- Ensure the discharge medications are accurate and can be obtained.
- Ensure follow-up and services are in place.
- Communicate with the receiving provider.
- Dictate an informative, concise discharge summary on the day of discharge.



## IN THE POST-DISCHARGE PERIOD

- Provide a hospital medicine contact number.
- Have a system for following up on results.
- Ask for feedback from "receiving providers," and review questions that arose during post-discharge telephone calls.





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