Reducing Readmissions by Improving Transitions of Care: Putting the Pieces Together

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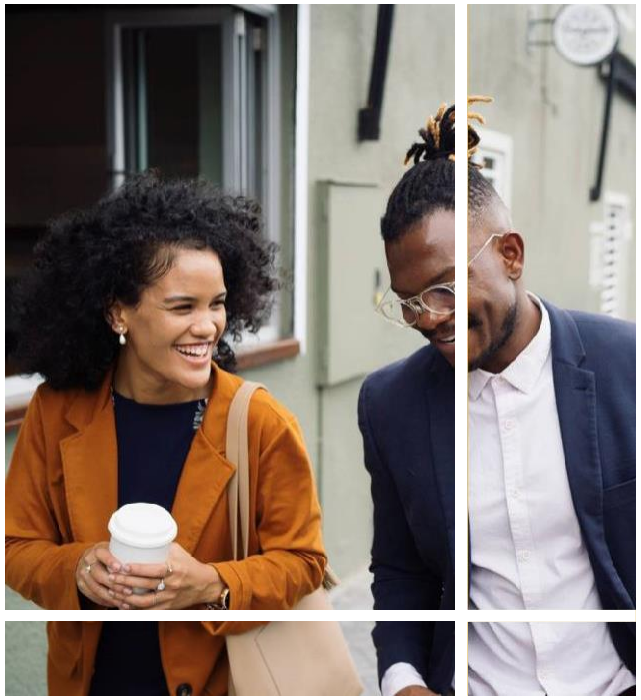
CME Disclaimer

In accordance with ACCME standards, the presenters have no relevant financial relationships to disclose.

Any potential conflicts of interest have been mitigated.



Before We Start Share Your Experience

- How does your clinic address transitions of care?
- What tools are used to support a patient's transition of care activities?
- Who do you rely on to ensure transitions of care activities occur?

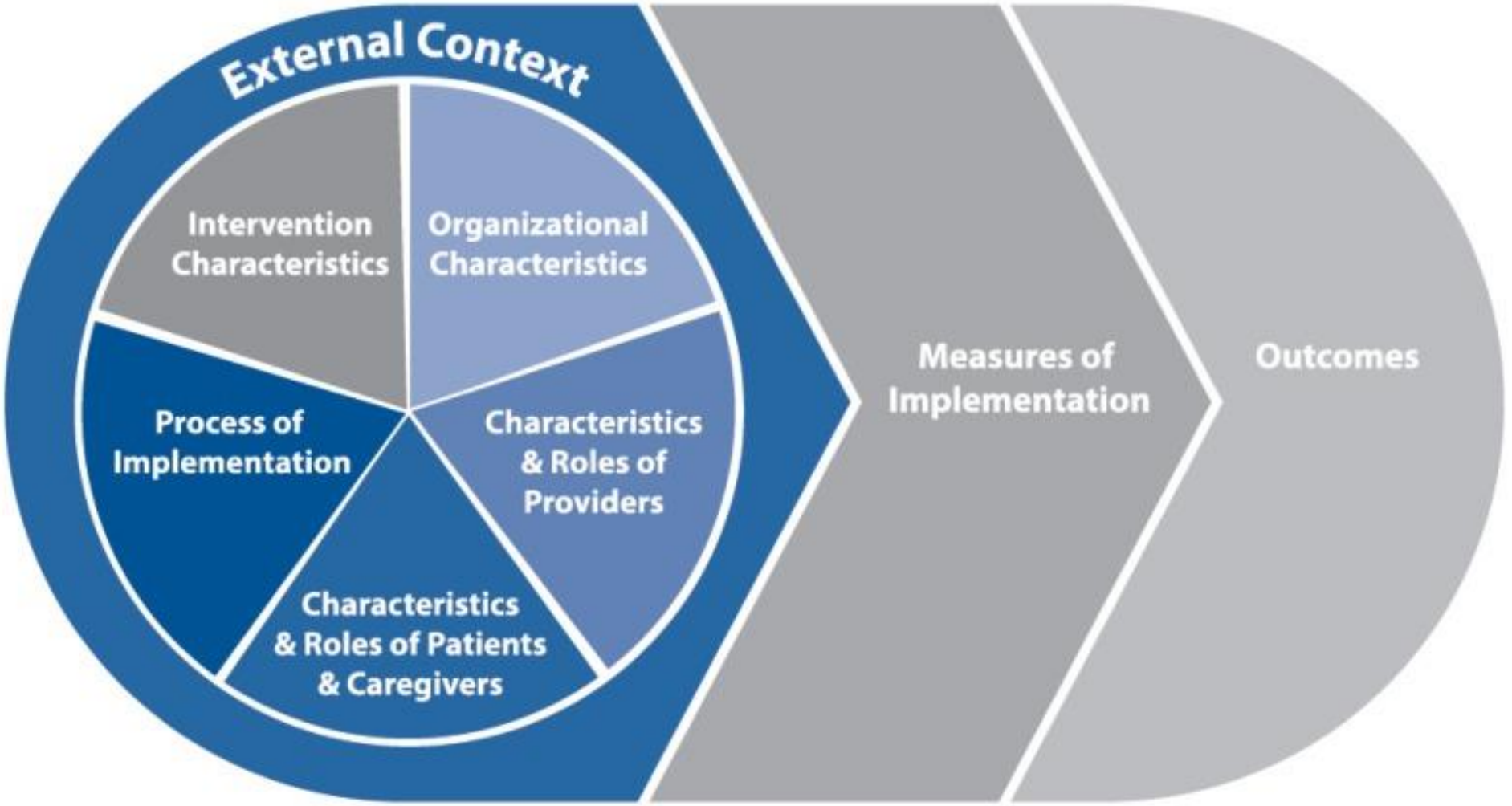
Learning Objectives

- Define transitions of care
- Discuss the importance of care coordination
- Describe the impact of care teams
- Explain hospital readmissions
- Identify four activities that impact readmission rates

Defining Transitions of Care

- Care transitions is the movement patients make between health care practitioners and settings as their condition and care needs change during a chronic or acute illness
- Interventions for transitions of care can involve. predischarge interventions in the hospital/skilled nursing setting, such as patient and caregiver education; post discharge support, such as outreach to patients and caregivers; and coordinating interventions.

Transitions of Care and Collaboration



Transition of Care Steps

- Pre-discharge planning and assessment
- Patient and family education – teach back and show back
- Review discharge plan – teach back and show back
- Five D's: Diagnosis, Drugs, Doctor, Directions and Diet
- Discharge summary completed with appropriate diagnosis and procedure codes selected
- Admission, Discharge and Transfer Notification

Issue of Concern

- A discharged patient is expected to be able to take medications as directed, continue to perform daily activities, and have the means to follow the plan for outpatient care, which may include rehabilitation programs, further testing, follow-up appointments, and/or lifestyle modifications.

https://www.ncbi.nlm.nih.gov/books/NBK557819/

Clinical Implications

- To discharge patients to their homes where they can heal and recover, it is important to perform an assessment of their home situation, caregiver support, and access to necessary follow-up care.
- By assessing their home situation, a member of the care team would factor in the patient's mobility, ease of food preparation, adhering to the medication regimen, toileting, and other activities of daily living.

https://www.ncbi.nlm.nih.gov/books/NBK557819/

Care Team Support

- Physicians or Advanced Providers (AP) are responsible for deciding whether the patient is safe for discharge, creating the discharge plan in conjunction with the rest of the team, and communicating instructions to the discharge coordinator or another member of the care team.
- Discharge planning may include nurses, therapists, social workers, patients, family members, physicians, occupational and physical therapists, caregivers, community health workers (CHW) and insurance companies.

Bray-Hall S, Schmidt K, Aagaard E. Toward safe hospital discharge: a transitions in care curriculum for medical students. J Gen Intern Med. 2010 Aug;25(8):878-81. [PMC free article] [PubMed] [Reference list]

Discharge Planning is Important

- The effectiveness of discharge planning is difficult to evaluate due to the complexity of inpatient interventions and the numerous variables involved.
- The quality of discharge planning correlates with a lowered 30 days readmission rate, which directly affects reimbursement from Medicare and Medicaid and value-based agreements.

Mabire C, Dwyer A, Garnier A, Pellet J. Meta-analysis of the effectiveness of nursing discharge planning interventions for older inpatients discharged home. J Adv Nurs. 2018 Apr;74(4):788-799. [PubMed] [Reference list]

A New Care Team Member

- A CHW is being integrated with greater frequency into a multidisciplinary team to help patients navigate social and health barriers.
- CHWs are frontline public health workers trusted by the community, acting as a link between residents and health or social services to improve access, health literacy, cultural competency and outcomes.
- They provide services such as health education, coaching, advocacy, and care coordination, and help ensure care plans are realistic and effective for the patient's life circumstances often times in the patient’s primary language.

Medicare Reimburses for CHW Services

- Medicare reimburses for CHW services through new Community Health Integration (CHI) codes, specifically G0019 and G0022, which went into effect on 1/1/24.
- These codes are for Medicare Part B and require an initial evaluation and management (E/M) visit by a billing provider to identify a patient's unmet social needs that interfere with treatment.
- The CHW or other auxiliary personnel can then deliver the services, and the billing provider is reimbursed for the time spent.
- Medicare Advantage plans were required to cover these services starting in 2025.

CHW Covered Services

- The services covered must address social determinants of health and include person-centered assessments, health system navigation, resource connection, care coordination, health education, and social/emotional support.
- G0019: Billed for the first 60 minutes of CHI services provided in a calendar month.
- G0022: Billed for each additional 30 minutes in the same month.
- Reimbursement is based on the total time spent on CHI services by a CHW in a month, not on individual visits.

New Partnership for Transitions of Care

- The Center for Medicare & Medicaid Innovation (CMMI) has also recently funded projects that integrate community-based organizations (CBO) and services into new care delivery models for Medicare beneficiaries.
- The inclusion of a strong community component to these models requires closer attention to interactions of organizational stakeholders.

What is a CBO?

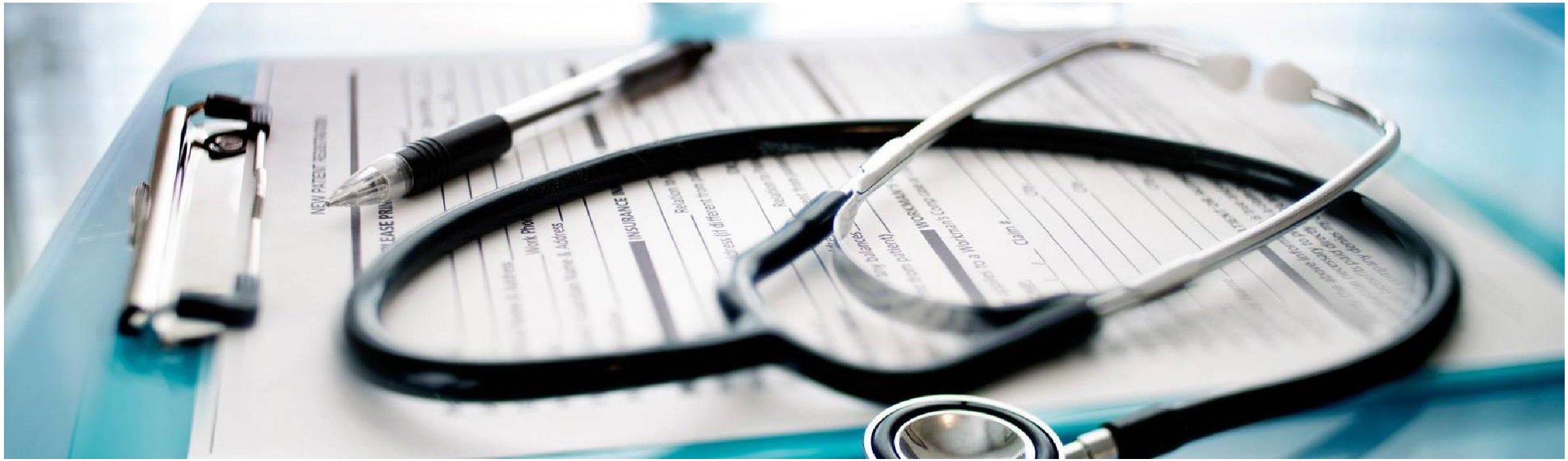
- A CBO does not only focus on charity and aid it may focus on the needs of the community such as education, social justice, health care, housing or human trafficking.
- The YWCA Kalamazoo provides individuals and families with victim-focused counseling and advocacy services as well as shelter for survivors of violence, transitional housing, and legal service plus maternal doulas.
- CBOs may receive funding from a variety of sources, including individual donations, grants from foundations or government agencies, and fundraising initiatives.

Think About Your Clinic's Transition of Care Process

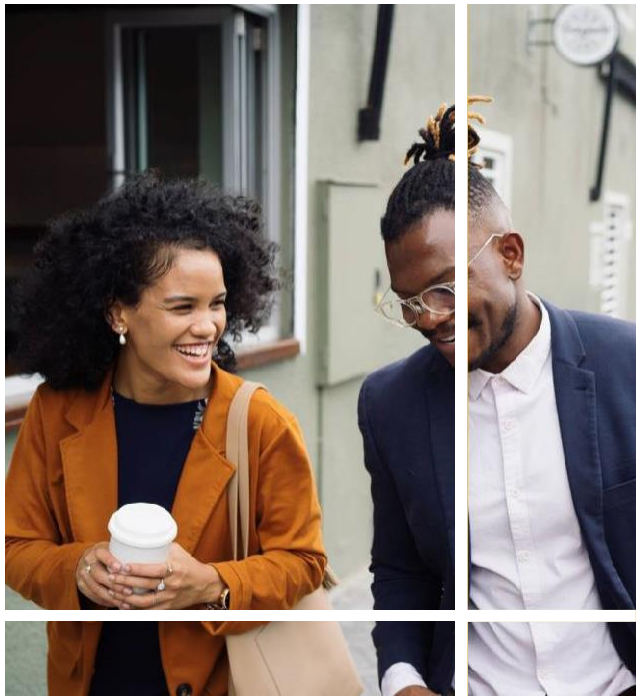
- Does a member of your clinic care team access ADT notifications daily?
- Who reviews the discharge summary and discharge instructions?
- Who contacts the patient within 48 hours of discharge?
- Who are your care team members?
- What trainings have your care team members completed?
- What questions should the care team member ask?

Transition of Care: Using the PDSA Method

- Aim: Identify the desired outcome and the specific problem the clinic is trying to solve
- Trigger: Identify the specific event that initiates the process
- Information and feedback from team: Identify information needed
- Documentation: Begin mapping the process
- Review and Sharpen-up: Assess the steps and refine as needed (Model for Improvement)



Transitions of Care and Readmissions



Before We Start…

- How does your clinic monitor high risk patients?
- What tools does your clinic utilize to track high risk patients?

Definition of Readmission

- CMS defines hospital readmission as an inpatient stay that occurs within 30 days of discharge from the initial inpatient hospitalization.
- This definition encompasses readmissions to the same hospital or another acute care facility, regardless of the reason for the readmission.

Quality of Care and Readmissions

- Hospital readmission is a critical indicator reflecting the quality of healthcare services and patient management post-discharge.
- Reducing readmissions is a priority for hospitals, health plans, policymakers and the physician community due to the considerable costs involved and the impact on patients' health.
- Readmissions often suggest unresolved health issues, inadequate discharge planning, or poor access to care.

Top Ten 30-day all-cause Adult Hospital Readmissions

- Septicemia
- Heart failure
- T2D with complications
- Acute and unspecified renal failure
- Schizophrenia spectrum and other psychotic disorders
- Pneumonia
- COVID-19
- Cardiac dysrhythmias
- COPD
- Respiratory failure, arrest

https://hcup-us.ahrq.gov/reports/statbriefs/sb307-readmissions-2020.jsp

Findings

- In 2020, septicemia was the top principal diagnosis at admission with the highest number of 30-day all-cause readmissions regardless of payer.
- Among adult hospitalizations with an expected payer of Medicare, septicemia had the highest number of readmissions (207,300) in 2020, accounting for 10.4 percent of adult Medicare readmissions.
- Septicemia was also the top condition with the highest number of readmissions for stays with an expected payer of Medicaid (54,200), private insurance (39,600), or self-pay/no charge (9,600), constituting nearly 8 percent of all adult readmissions for each of these expected payer.

https://hcup-us.ahrq.gov/reports/statbriefs/sb307-readmissions-2020.jsp

Findings

- Schizophrenia and alcohol-related disorders were among the top five conditions with the highest number of readmissions for stays with an expected payer of Medicaid or self-pay/no charge.
- Among adult hospitalizations with an expected payer of Medicaid, schizophrenia admission ranked the second highest and alcohol-related disorders ranked the fifth highest in 30-day all-cause readmissions.
- For adult hospitalizations with an expected payer of self-pay/no charge, alcohol-related disorders at index admission ranked the second highest and schizophrenia ranked the fifth highest in number of readmissions.

https://hcup-us.ahrq.gov/reports/statbriefs/sb307-readmissions-2020.jsp

Findings

- Both conditions also had one of the highest readmission rates—schizophrenia: 23.1 and 18.0 per 100 index admissions, respectively, for stays with an expected payer of Medicaid or self-pay/no charge; and alcohol-related disorders: 22.8 and 18.7 per 100 index admissions, respectively, for stays with an expected payer of Medicaid or self-pay/no charge.
- Behavioral health conditions were three of the top five conditions with the highest number of readmissions with an expected payer of self-pay/no charge: alcohol-related disorders, depressive disorders, and schizophrenia.

https://hcup-us.ahrq.gov/reports/statbriefs/sb307-readmissions-2020.jsp

Attempts to Reduce Avoidable Readmissions

- To address the rate of readmissions, CMS has established financial incentives in the form of penalties for hospitals and skilled nursing facilities.
- While readmissions have decreased since the implementation of readmission reduction programs, the highest readmission rates are still among Medicare patients.

PCP Strategies to Reduce Avoidable Readmissions

- Accurate information on the discharge summary that includes diagnoses
- Heightened focus on medication management
- Enhanced patient education
- Improved care coordination
- Timely follow up care
- Emphasis on social determinants of health

Know Your Hospitalist

- Accurate information on the discharge summary that includes diagnoses.
- Review the discharge orders.
- Review the social determinant of health assessment tool.

Medication Management

- According to the World Health Organization, medication errors cause at least one death every day and harm approximately 1.3 million people annually in the United States alone.
- Develop check lists and utilize teach back and show back strategy.
- Upon discharge from the hospital complete a medication reconciliation activity.

https://www.who.int/news/item/29-03-2017-who-launches-global-effort-to-halve-medication-related-errors-in-5-years

Enhanced Patient Education

- Patient and care giver education should begin in the inpatient setting.
- Information provided should be in the primary language of the patient.
- Access to an interpreter to ensure the discharge orders are understood; patients who understand their condition and care requirements are better equipped to manage their health at home.
- Education should be reinforced during the PCP care team members outreach efforts 48 hours post discharge.
- Self management skills are monitored using the brief action plan method.

Improved Care Coordination

- Communication, communication, communication!
- The hospital discharge planner should debrief with the PCP's care team.
- A warm hand off is recommended.

Timely Follow-Up Care

- A study in the Journal of the American Medical Association (JAMA) found that patients who saw their provider within 7 days of discharge had a 12-24% lower risk of 30-day readmission.
- A care team member reviewing the ADT notification should ensure a post-discharge appointment has been made.
- The PCP may create a check-off list for the care team member performing the outreach activity.
- The patient portal or text messaging system could be beneficial, depending on the age of the patient.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2924440/

Emphasis on Social Determinants of Health

- Create a checklist to ensure social needs are identified.
- A neutral elevator speech to discuss SDOH information.
- Clinic should have a binder with community organizations and contact information.
- Clinic should be familiar with 211.
- Care teams should be familiar with motivational interviewing techniques.
- Care team member should not only make the appointment, arrange for the service but also have a process to ensure timely follow-up.

Summary

- Transitions of care activities require a process, a workflow.
- The transitions of care workflow will undergo changes once the process is tested.
- Communication is a key component of care coordination.
- Clinics should have well trained care teams who know how to utilize motivational interviewing techniques.
- Care teams are comprised of both licensed and unlicensed health care professionals.
- Care teams should know their community of care and strive for continuous quality improvement.
- Reducing readmission rates is a team sport.

Discussion

References

Birkmeyer JD, Barnato A, Birkmeyer N, Bessler R, Skinner J. The impact of the COVID-19 pandemic on hospital admissions in the United States. Health Aff (Millwood). 2020;39(11):2010-7. https://doi.org/10.1377/hlthaff.2020.00980.

Ghoshal S, Rigney G, Cheng D, Brumit R, Gee MS, Hodin RA et al. Institutional surgical response and associated volume trends throughout the COVID-19 pandemic and postvaccination recovery period. JAMA Netw Open. 2022;5(8):e2227443. PMID 35980636.

Jiang HJ, Hensche M. Characteristics of 30-Day All-Cause Hospital Readmissions, 2016-2020. HCUP Statistical Brief #304. Rockville, MD: U.S. Agency for Healthcare Research and Quality; September 2023. www.hcup-us.ahrq.gov/reports/statbriefs/sb304-readmissions-2016-2020.pdf.

Weiss AJ, Jiang HJ. Overview of Clinical Conditions With Frequent and Costly Hospital Readmissions by Payer, 2018. HCUP Statistical Brief #278. Rockville, MD: U.S. Agency for Healthcare Research and Quality; July 2021. www.hcup-us.ahrq.gov/reports/statbriefs/sb278-Conditions-Frequent-Readmissions-By-Payer-2018.pdf.

AHRQ PQI Technical Documentation, Version v2023. Rockville, MD: Agency for Healthcare Research and Quality; August 2023. https://qualityindicators.ahrq.gov/measures/pqi_resources.

Data Source

The estimates in this Statistical Brief are based on data from the Healthcare Cost and Utilization Project (HCUP) 2020 Nationwide Readmissions Database (NRD). For additional information about the HCUP NRD, please visit https://hcup-us.ahrq.gov/db/nation/nrd/nrddbdocumentation.jsp.

References

Hines, A. L., Barrett, M. L., Jiang, H. J., & Steiner, C. A. (2014, April). Conditions With the Largest Number of Adult Hospital Readmissions by Payer, 2011. Retrieved October 1, 2025, from https://www.hcup-us.ahrq.gov/reports/statbriefs/sb172-Conditions-Readmissions-Payer.jsp.

Collective Medical helps rural hospital decrease all-cause 30-day readmissions by 78%. Retrieved October 1, 2025 from https://collectivemedical.com/case-study/collective-medical-helps-rural-hospital-decrease-all-cause-30- day-readmissions-by-78/.

Helping Providers Establish Better Home Health Care. Retrieved October 15, 2025 from https://collectivemedical.com/case-study/helping-providers-establish-better-home-health-care/.

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