WHAT IS A KEY TO REDUCING READMISSION RATES? PATIENT ENGAGEMENT!

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As of last year, the era of healthcare reform was in full swing. The many changes that have emerged in this new landscape have brought uncertainty to healthcare providers, as well as patients.

The changes in quality measures and reimbursement were meant to bring about high-quality care at the lowest price. As we read, listen, and participate in meetings, many terms and buzz words are batted around to describe the changing landscape of healthcare, such as “continuum of care,” “collaborative care,” “transition of care,” and “value-based care.” But to most healthcare professionals and patients, the bottom-line concern is still how to provide time-efficient, quality care that protects patients from harm and decreases provider liability.

The challenge for most healthcare professionals is to identify and implement systems/processes to optimize patient care transitions and avert costly new penalties for Medicare readmissions. This can be accomplished through a team approach. A patient’s post-discharge team includes hospitals, hospitalists, primary care physicians, nursing and rehab centers, community health workers, family members—and last but not least, the patients themselves. This “team” must be on the “same page” to ensure compliance with some very important processes:

- Comprehensive written discharge instructions
- Complete medication list, instructions, and side effects
- Scheduled follow-up appointments
- Healthcare provider contact information for questions.

Recent statistics show that 71% of hospitals are receiving reduced Medicare payments because of readmissions. The lost payments nationwide amounted to $15 billion, and three-quarters of readmissions are preventable.1

When healthcare providers look for strategies to decrease readmissions and thus improve patient outcomes and quality, TeamHealth, a provider of hospital-based clinical outsourcing, offers five core concepts to reduce readmissions. They are:

- Recognition—recognize potential post-discharge issues that may cause readmission.
- Communication—active communication between team members, patients, and families.
- Intervention—continuously manage patient expectations. Every contact with the patient should include post-hospital care management.
- Education—empower the patient/family to actively participate in discharge planning.
- Reconciliation—continuous electronic health record medication reconciliation, at admission, discharge, and throughout the hospitalization.

Risk strategies
To minimize readmissions, healthcare providers can consider implementing the following:

1. The discharge summary should be complete and transmitted to the outpatient healthcare providers as soon as the patient is discharged. Like the admission note, the discharge summary is an important document.
2. Tell the patient whom to call for questions or problems. Designate an office staff member to field calls from newly discharged patients.
3. Office staff should be aware of patient discharges. Systems for following up with the discharged patient are valuable in preventing readmission.
4. Patients should never be discharged without adequate instruction and education. All inpatient healthcare providers should share in this responsibility.
5. Many medication errors occur at the transition points. Computerized physician order entry systems are useful for reducing errors in prescribing, but they cannot detect an error if the provider does not prescribe a medication that the patient was taking at home. Electronic medication reconciliation may reduce these unintended discrepancies.

Reference

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