ExcelCare
HOME HEALTH

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Preventing Re-hospitilizations, Part 1

One of the greatest opportunities for our home health care agency today is to reduce hospital re-admissions. ExcelCare Home health seizes the opportunity to partner and build relationships with hospitals, rehab centers and ACOs to help alleviate the penalties hospitals face for patients being readmitted within 30 days of discharge.

These readmissions can costs the healthcare system up to $41 billion in hospital costs every year. ExcelCare Home Health is perfectly positioned to prevent these readmissions by recognizing the signs that could lead to re-hospitalization, and sometimes even perform some of the same tasks that can be done in a hospital. All while keeping the patient in the comfort of their own home.

Some of the most usual suspects that drive hospital readmissions are:

- Acute myocardial infarction
- Heart failure
- Pneumonia
- Chronic obstructive pulmonary disease (COPD)
- Hip and knee replacement
- Coronary artery bypass graft

And patients who require even more intense monitoring include those with multiple co-morbidities such as of heart failure, diabetes, COPD, hypertension and Alzheimer's disease.

As clinicians, it is our honor and duty to be good stewards of healthcare dollars and to do all within our power to keep patients comfortable, which usually means keeping them out of the hospital.

Decreasing the burden of the cost of hospital re-admissions and improving our patient's experience under our care is of paramount importance. These information will explore how we can work with the discharging hospital and our home health staff to be effective members of the care transition team.

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Preventing Re-hospitilizations, Part 2

This is the second part is exploring how we can work with the discharging hospital and our home health staff to be effective members of the care transition team.

ExcelCare Home Health and their facility partners must develop a more effective and shared responsibility for a patient's transition to home. Agencies can assist with the initial transition of the care process, by ensuring certain things are accomplished prior to the patient's discharge from the facility and admission to homecare. It is the duty of the management staff to no longer think about patients being discharged from the hospital but transitioned to home, which suggests equal responsibility.

Here are some tips to help to ensure a smooth transition of care.

(1) Educate partners in the facility about the concept of care transition instead of discharge. The facility and the homecare agency should work together, sharing responsibility for the care of the patient and proactively prevent readmissions.

(2) Ensure the patient's medications are ordered prior to leaving the hospital or any other inpatient facility, and that the medications are covered by insurance and/or affordable for the patient.

(3) Contact the patient's primary care physician. Send information and setup follow-up appointment upon discharge, while identifying any barriers to getting to the appointment.

(4) Request a discharge summary if the facility does not automatically provide them. This will give you all the pertinent information about the patient's current health status and need for home care.

(5) Identify the programs in place for your hospital referral sources. (Do they have transition nurses that go out to the home? Will a clinician monitor the patient's outcomes?) These efforts assist the home health admitting clinician in setting up services and frequencies.

(6) Identify other ways to improve communication at time of patient transition of care and proactively identify any potential readmission risks.

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Preventing Re-hospitilizations, Part 3

Of course, once the transition has gone smoothly from the hospital to the home care agency, it's up to the home care providers to keep the patient from being re-hospitalized. Below is a list of best practices that home care clinicians can follow to improve the patient's outcomes and reduce the risk of readmission.

(1) Review the care plan with the patient until he or she completely understands it, and attends all follow-up appointments with his or her primary physician.

(2) Ensure that both the patient and the caregiver recognize signs and symptoms that are new or worsening and how to respond to them and who to contact.

(3) Confirm that the patient has personal health records to facilitate communication between all providers. Some hospitals offer these patients "life packs." Your agency may develop these resources as a great tool for the patient.

(4) Ensure patient/caregiver has proper medication regimen and that medicines are set up correctly.

(5) Continually educate and engage the patient in their care. Teach them in easy to understand terms what they can do to mange their own care and improve their outcomes.

(6) Identify and encourage support systems for the patient. E.g. family members, outside caregivers, or support groups.

(7) Identify patient comorbidities. Certain conditions, such as heart failure, make readmissions more likely. But more often the readmissions occur due to comorbidities.

(8) Front-load visits in the first 72 hours after discharge, and continue phone monitoring as visit frequency decreases.

(9) Encourage the patient to visit urgent care centers instead of an ER when incidents are not life threatening. This will not reflect negatively on your outcome measures, and it will save the patient money.

Medicare patients report greater dissatisfaction related to discharges than to any other aspect of care that CMS measures. The Medicare Payment Advisory Commission estimates up to 76% of readmissions within 30 days of discharge may be preventable.

Ultimately, in an effort to turn this unnecessary spending around, home healthcare will play a major role in care transitions, functioning as the transition coordinator for hospitals. Their attention to detail will help reduce the number of readmissions, and ultimately lead to improved patient outcomes.