HOSPITAL READMISSION CEU

STRATEGIES FOR REDUCING UNNECESSARY HOSPITAL READMISSIONS

JENNISE BEVERLY-CHAFFOLD

Strategies for Reducing Unnecessary Hospital Readmissions

Hospital readmissions are a serious problem that commands a heavy cost, not just to the individual patient, but also to the health system in general. According to 2011 data from the Medicare Hospital Compare website (most current data available), heart attack patients had a hospital readmission rate of 19.1%, heart failure patients had a readmission rate of 24.8% and pneumonia patients, 18.7 percent. Readmissions are defined as a hospital admission within 30 days of an index stay (past admission), whether it was to the same hospital or a different one.

According to an April 2014 statistical brief by the Agency for Healthcare Research and Quality, in 2011, readmissions cost US hospitals some $41.3 billion. Medicare accounted for the bulk of these costs, $24 billion, followed by Medicaid with $7.6 billion and private insurers, $8.1 billion. Uninsured patients accounted for $1.5 billion of readmission costs.

The three main causes of readmissions for Medicare patients were congestive heart failure, septicemia and pneumonia which incurred hospital costs of some $4.3 billion. For Medicaid, the three main causes were mood disorders, schizophrenia and diabetes, resulting in hospital costs of around $839 million. For privately insured patients, the main causes of readmissions were maintenance chemotherapy, mood disorders and complications resulting from medical or surgical care, which cost around $785 million. Many of these readmissions are the result of preventable causes such as medical errors or infections acquired in the hospital.

In an attempt to control costs related to preventable readmissions, the Affordable Care Act of 2010 mandated the Department of Health and Human Services to create a readmission reduction program. The program, which was implemented starting October 1, 2012, imposes escalating penalties reducing the total Medicare payments on erring hospitals. The penalties were imposed on hospitals with “excessive” readmission rates for acute myocardial infarction, congestive heart failure and pneumonia and were computed as a maximum of one percent of all Medicare payments in October 2012, two percent in October 2013 and three percent in October 2014. In 2015, additional conditions were added including readmissions following total knee arthroplasty, total hip arthroplasty, an acute worsening of chronic obstructive pulmonary disease and chronic bronchitis and other lung ailments.

The penalties seem to be having the desired effect. In October 2014, Medicare fined a record 2,610 hospitals in its third round of penalties, with penalties totaling around $428 million. Around three-fourths of hospitals that are included in the Hospital Readmissions Reduction Program are receiving penalties, with 39 being levied the highest penalty allowed. In 2012, readmission rates among Medicare patients fell to less than 18% which was lower than previous years, but still cost Medicare some $26 billion, of which $17 billion are believed to be from potentially avoidable readmissions, indicating that there is still a lot that needs to be done to prevent them.

Measuring the Risk of Readmission

There are a number of methods that are used to identify which patients are at the highest risk of readmission so that the right level of intervention can be applied. Many of these risk stratification methods use information from electronic medical records (EMRs) as well as self-reported patient data and administrative databases. These tools include:

- Probability of Repeated Admission (PRA) - This survey-based tool consists of a questionnaire as well as a software-based scoring formula. It is intended to identify those senior citizens who are at highest risk to make substantive use of health care services and are at high risk for recurring admissions. The PRA has identified eight risk factors including age, self-rated poor general health condition, more than six doctor visits over the past year, a history of coronary

artery disease, having been admitted to the hospital or have been suffering from diabetes over the previous year, of the male gender and the availability of an informal caregiver.

- LACE Index - This tool is intended to predict the rate of readmission or death within 30 days of patients. It uses the following parameters: Length of Stay, Acuity of Admission, Co-morbidities and visits to the Emergency Room within the past six months. Each of these factors is awarded points based on the value of each attribute and the highest possible point count is nineteen. The higher the LACE score, the higher probability that the patient will have an unplanned admission or will die within thirty days after discharge. A LACE score of ten and above is considered to be high-risk and requires early intervention.
- Community Assessment Risk Screen - CARS uses three factors to predict the probability of readmission: taking five or more prescription drugs, having two or more co-morbidities and having an emergency room visit or hospitalization in the past twelve months. Each of these variables is assigned a scoring system from 0 to 9 and patients are assigned to a low or high-risk category based on their score. Those scoring 4 and up are considered at greater risk of an emergency room visit, hospitalization, and higher charges per-member per-month.

In order to ensure the most accurate results, a combination of methods can be used or the most appropriate measure be applied. They may be most appropriate for identifying high-risk individuals such as older adults and not for patients who have been readmitted for reasons such as chronic pain, mental illness or substance abuse.

The Society of Hospital Medicine has also identified eight characteristics of patients who are at high risk of readmission: multiple hospitalizations and emergency room visits over the past six months, poor health literacy, taking multiple medications, having problems with medication, depression, not having sufficient support, palliative care and certain principal diagnoses. In addition, the medical staff should also consider the patient's readiness to change unhealthy behaviors since this is an indication that he may need closer supervision in order to avoid readmission. You can also classify patients as to whether they are at high-risk or low-risk of readmission, so you can decide on the appropriate strategy for avoiding readmission.

Strategies for Reducing Hospital Readmissions

Here are some suggested strategies that may help in curtailing readmissions. These strategies are not one-size-fits-all answers but need to be applied in the appropriate context. They are designed to meet three essential goals for avoiding readmission: ensuring that the patient and his caregivers are empowered to take charge of his post-discharge care so that he can stay healthy; if the patient is unable or unwilling to take care of himself, to provide a more intensive intervention; and to avoid medical errors that can hurt the patient and result in a visit to the emergency room or a return to the hospital.

Improving Discharge Summaries

A hospital discharge summary is a document that is prepared when patients are discharged from the hospital and is intended to facilitate the patients' future care by ensuring that accurate information on their condition is provided to subsequent care providers. It should include their main complaint and the diagnosis that was made as well as what therapy they underwent while in the hospital and the medical recommendations when they were discharged including any medications they need to take and follow-up consultations with physicians.

According to a study by the Yale University School of Medicine, ensuring that a detailed discharge summary is generated in a timely fashion and is provided to the patient's primary care physician after discharge is vital to decreasing the chances they would be readmitted after 30 days. The study found that 8% of facilities studied did not have the summaries ready until some 30 days after discharge.

The Yale study also found that many discharge summaries were found to lack important information that could affect the patients' quality of care, such as any test results that are still pending, their condition when discharged, any medications they were prescribed and follow-up treatment recommendations.

What can be done to improve discharge summaries? One recommendation is for them to be completed within 24 to 72 hours of the patient's discharge, so they can be available to the patient's health care providers as soon as possible. Another is to ensure that discharge summaries are transmitted to the relevant practice or primary care physician once they are ready, something that many hospitals also neglect.
The timeliness of discharge summaries can also be ensured by taking advantage of the facility's electronic medical records system. The EMS can help to quickly transmit relevant information on the patient's follow-up care to his primary care physician. In addition, to make it easier to prepare discharge summaries, a template can be created that physicians and medical staff can easily fill in during the patient's stay. This would also help guarantee that any information relevant to the patient's treatment is documented and readily available to hospital staff.

Improving the Quality of Patient Handoffs

One of the major reasons for hospital readmissions is failed handoffs from hospital to home or other treatment setting that result in the quality of the patient's care being compromised. These transitions from the hospital care providers to the patient's primary provider fail for a variety of reasons, the main one being failures in the transfer of information between the patient's providers, which resulted in problems including mistaken diagnoses and incomplete workups. In the worst cases, the patient's condition degenerated and he/she had to be admitted to Intensive Care. What can be done to improve patient handoffs? Here are some recommendations:

- Lengthening the process. Instead of speeding the patient through the discharge, the process should be done in a more meticulous fashion. For example, the different care providers take the time to talk to each other and share vital information. Documentation regarding future therapy should be carefully prepared to ensure that it is available as soon as the patient is ready to leave or shortly thereafter.
- Facilitating communication between the nurses and the primary care providers. Since the nurses are often the ones who spend the most time with the patient, they may make subtle observations that could prove to be vital to the patient's care since these could be early indications of problems which could eventually worsen. In order to avoid these problems, for example, physicians can take time to attend nursing shift changes so that they can confer with outgoing nurses. Or the nurses leaving their shifts can be encouraged to write down their observations as soon as possible and the physician can refer to their notes later.
- As much as possible, discharges should be handled on a face-to-face basis rather than through emails or written sign-offs. This can help ensure that the physician becomes aware of patient information that may not be noted in the paper record but which would prove to be vital in his care later. Face-to-face discharges can also be opportunities for physicians and nurses to have last-minute discussions with the patient and his caregivers, reminding them of what the patient needs to do and the medications he needs to continue taking.
- Cultivate a culture of carefulness. Physicians, nurses and other care providers should be aware of the ever-present possibility of errors so they should always be checking their information and develop strategies to ensure not just that patient information is accurate but also that the correct information is transmitted between the patient's health care providers.
- Work with the patient on the transition between hospital care to home care. The physician should empower the patient and his caregivers by providing them with the information that they need to continue his care at home. Doing so will help keep the patient informed about his condition so he can

discuss it with his primary care physician during follow-ups as well as being familiar with any medications he needs to continue taking.

Transitional Care Programs

To ensure that patients who are most at risk of readmission stay healthy, healthcare staff can make sure that they get the intervention they need. Staff can begin by segmenting them based on the level of post-hospitalization care they are expected to need as well as how vulnerable they are to being readmitted. For example, patients who are classified as low-risk and only require short-term intervention can receive periodic calls from hospital or social services staff asking them how they are doing and if they need anything, while those who need longer-term support can avail of the services of community-based health workers. Those who are at higher risk can receive short-term support from a transitional care team or longer-term care from specialized clinic services.

A member of the health care staff can be assigned to act as a transitional care coach for patients who are at highest risk of readmission. The coach meets with the patient and his caregiver before discharge to start a personal health record that will be provided to future care providers that includes information on their health conditions, symptoms to monitor as well as notes on allergies and any medications they need to take. The coach also schedules a post-discharge home visit.

During the home visit, which should take place no more than two days after discharge, the coach will discuss the patient's medication regimen as well as checking to see if there are any interactions with other medicines they may be taking; teach the patient how to communicate his needs to health care providers and review symptoms which may act as red flags, explaining how these can be managed and when a doctor needs to be contacted. Following this home visit, the transitional care coach will make a number of follow-up calls through phone or other methods to ensure that the patient's care regimen is being followed and he is taking his medications as instructed.

It should be noted that transitional coaches do not actually provide any hands-on care since their role is to teach the patient and his primary caregiver how to take charge of the process of providing the care needed. For example, they will listen in as the patient or his caregiver contacts the physician or pharmacist to ensure that it is being done properly. Of course, if emergency care is needed, coaches will step back into the role of nurse to provide it, but otherwise their role is to ensure the patient gets the care needed at home.

If more intensive intervention is required, then the Transitional Care Model can be followed. Unlike a transitional care program, the aim of the TCM is to manage the patient's health, rather than helping him and his caregiver take charge of the process. In line with this, the program is spearheaded by a Transitional Care Nurse who, while the patient is still in the hospital, gathers information such as the patient's health behavior and status as well as the level of social support that they can expect, and uses it to create a customized health care plan in partnership with the patient and his physicians. Once the patient has been discharged, the Nurse conducts regular patient visits as well as follow-up phone calls to monitor the patient's condition to ensure that the plan is being followed and the patient's health condition remains optimal.

During the follow-up visits, the nurse prevents health problems, if necessary, by working with the patient's physician to adjust treatment. In addition, the nurse accompanies the patient to his first follow-up visit to the physician to ensure that there is effective communication between the parties.

For patients who are at the highest risk of readmission, a multidisciplinary team can be assigned to provide post-discharge care. The team will consist of a nurse, a nurse care manager, social worker, community resource specialist, behavioral health specialist and pharmacist. This team will be tasked to provide the range

of services the high-risk patient needs including social, clinical and behavioral services. They will provide their services on a long-term (months) or even an ongoing basis.

Ensure Medication Reconciliation

One of the most serious avoidable treatment errors that can affect a patient's health and cause readmission are medication errors. These errors result from inadequate reconciliation of a patient's medication record as they transition from admission to transfer and discharge. In fact it is believed that some 40% of medication errors result from these transitions, of which some 20% result in harm to the patient. For example, the patient may be prescribed two drugs that would result in an adverse reaction when taken together. What are the most common reasons for medication errors?

- Lack of communication between the patient's health care providers
- Lack of communication between the patient and his provider
- Medication names that sound alike and can result in the wrong drug being given

These errors can be avoided by ensuring accurate medication reconciliation. This is the process of generating a comprehensive and accurate list of the medications the patient is currently taking and comparing it to those in his medical record or prescription orders. Reconciliation is done to create an accurate list in the hope of avoiding common medication errors such as duplications, omissions, negative drug interactions and mistaken dosing. There are five steps in medication reconciliation:

- Create a list of the patient's current medications
- Create a list of medications that will be prescribed as part of the patient's current therapy
- Reconcile the two lists
- Make clinical decisions based on the reconciliation
- Transmit the new list to the patient and his health care providers and caregivers

Since patients under treatment may constantly undergo changes in medications they are prescribed, medication reconciliation needs to be an ongoing effort. This means that at every stage where there is a medication encounter where drugs may be changed or added, regardless of the setting, reconciliation should take place. In addition, to ensure that any negative interactions are avoided, the medication list must include not just any prescription and over-the-counter drugs the patient is currently taking, but also any vitamins and other supplements as well as herbal and home remedies, as well as dosing information. The process of medication reconciliation must also be multidisciplinary, involving not just the physician and nurses but also pharmacists, staff of other health care settings where the patient is being treated (i.e. eldercare facilities) and any other health care providers with which the patient is interacting.

Another consideration is if the patient is taking any medication that he does not want to be generally disseminated to parties other than his primary care physician. In this case, the physician should take pains to reassure the patient that any information shared with him will only be shared with his other health care providers and will not be included in any lists of medications that others may see. The physician should provide this information to other health care providers through private conversations and only after getting the permission from the patient to share this information. To ensure adequate documentation, these drugs should also be noted in the physician's private notes.

How can the process of medication reconciliation become more accurate? Here are some suggestions:

- Design a safe medication reconciliation process with clearly defined goals and expectations. The physician's team should also be organized to ensure that the process is smoothly implemented, with each team member having a role based on their specialization and the needs of the patient.

- Establish a culture in which health care staff is free to report errors without fear of reprisal. For example, if a nurse finds a mistake, she should not be afraid to talk to the physician to correct it. In addition, there should be a process for improving the medication reconciliation system in which it is regularly reviewed, results are analyzed and constantly look for new ways to enhance it. The system should not be set up and then allowed to work without periodic review.
- Make sure to always involve the patient and his caregivers in the process of medication reconciliation. This involves educating the patient in what medications he needs to take and what conditions they are expected to treat so that he can be empowered to be an active participant in his treatment. The physician or nurse should always take the time to discuss the patient's medication list with them rather than just giving it to him and telling him that this is what he needs to take.
- Ensure that information on the patient's medication be freely accessible to all parties participating in his care. This includes information from all sources, including other care providers and pharmacies.
- Regularly review the patient's list and make sure that any unnecessary medications are discontinued. The patient's medication regimen should also be simplified not just by minimizing the drugs he needs to take, but also making sure that dosing information is clear and concise.
- Give nurses the lead role in medication reconciliation. Since nurses have the primary responsibility in providing the patient with his medicine while he is in the hospital, it makes sense that they should also take the lead in reconciling the patient's list of medications. For example, in a study conducted by Johns Hopkins, the process of medical reconciliation started with the physician taking a medication history when the patients were admitted. Nurses tasked with medication reconciliation then interviewed the patients to compile a list of medications they were taking at home; if the patients could not recall all of them, the nurse would either consult electronic medical records to check what medicines they were prescribed upon a past discharge, if applicable, or contacted family or care providers to get the information and confirmed it with the patients. If the nurse finds discrepancies between his/her list and the list compiled during admission, he/she would consult with a pharmacist to check if the differences were intentional; if the discrepancy was due to a mistake, the nurse can get in touch with the physician to correct the error.

Patient Education

Empowering the patient to be able to take charge of his own care after he's been discharged is key to avoiding readmission. An Agency for Healthcare Research and Quality-funded study found that patients who understood clearly how to take care of themselves after discharge, including when they should schedule follow-up visits and how to take their medicines, are 30% less likely to visit the Emergency Room or be readmitted. The study found that a large number of hospitalized patients received no education at all about how to take care of themselves once they got home before they were discharged.

Here are some of the important aspects of successful patient education programs:

- Identifying the "key learner(s)" so that education efforts can be targeted toward them. The key learner is defined as the individual or group of people who is responsible for the learning process, and which may or may not include the patient. For example, the patient's primary caregiver may be the key learner. To identify the key learner, the patients are asked questions such as who takes care of them at home, who ensures they take their medications and who accompanies them when they go to their doctor's appointments.
- Evaluating how effectively the "key learner(s)" understood what they've been taught. One effective strategy that has been adopted is known as "teach back" and encourages the key learners to show how effectively they've learned by expressing the lesson in their own words.

For example, the staff can ask the key learners about the symptoms that they need to report to their physician during follow-ups or the names of the medications they need to take. To ensure better results, a different set of teach back questions should be asked every day.

- Creating a culture that supports patient education. One of the common complaints about implementing patient education is that it is time-consuming. While it is true that the process takes up the staff's time, when the process is managed properly, it does not take as long as expected.
- Adopting systems to support it. To make implementing patient education easier, the hospital can adopt various high-tech and low-tech strategies. For example, some hospitals have added teach-back sessions along with providing the patient his medication. On the other end of the scale, virtual educators are being tested that allow the patient to take charge of their teach-back session, providing them with particular information about their care and medications as well as allowing them to proceed at their own pace. Unlike a person, the virtual software allows the patient to go over the lessons methodically to ensure that the patient learns them.
- Providing patients with well-prepared educational materials to take home. The materials should be targeted towards laymen and use language that is easy to understand. For example, the patient can be given a list of medications that includes both the brand name and the generic name as well as what the drug is supposed to do and how the patient should take it.

Ensure the Patient Takes His Medications

Although data on the subject is limited, it is widely believed that medication nonadherence is a factor in hospital readmissions. There are a number of reasons behind patients not taking their medications as directed, including not believing that the medicine is beneficial, limited access to medication, insufficient financial assets to purchase medicine, complexity of the drug regimen and cognitive or psychiatric impairment. Here are a number of strategies that can help the patient adhere to his medication regimen:

- Identify those who are at the highest risk of nonadherence. This can include those with poor health literacy skills (see below), those with complex drug regimens and those with severe symptoms.
- Simplify schedules. For example, instead of spreading dosing schedules from two to three times a day, let the patient take all his medicines first thing in the morning or last thing at night. By making regimens more convenient, you can greatly improve adherence. In addition, compliance may be enhanced by aids such as pillboxes with sections divided into days of the week.
- Ensure that patients meet their follow-up consultations. Those who miss their doctor's appointments are more likely to not follow their drug regimen. If required, hospital staff may need to provide assistance with scheduling follow-ups and arrange transportation to the doctor's office.
- Improve patient education. The patient and his caregivers should be educated about the effects of his medications and the importance of taking them. Written materials can also be provided to supplement verbal education as well as serving to remind patients of how to take their medication.
- Avoid polypharmacy. This is a term that refers to taking multiple medications to treat a single condition. The practice has been associated not only with nonadherence to drug regimens but also adverse drug interactions.
- Help make drugs more affordable. To help patients with limited financial resources, hospitals can help reduce copayments to ensure that they can afford to buy them.

- Provide the most at-risk patients with a month's supply of medications. Although most hospitals may find it difficult to implement this strategy due to distinctions between payments for Medicare Part A & D, it may be worth it for them to absorb the cost of at least thirty day's worth of medications rather than risk being penalized.

Arrange Patient-Friendly Follow-Up Plans for the Patients Before They are Discharged

Before patients are discharged, the hospital staff should create a treatment plan for patients that is easy for them to follow. The plan should be written down in clear language and should at least include the following:

- The reason the patient was hospitalized
- A list of medications that the patient needs to take which should be checked for accuracy
- Any pending test results
- Post-discharge services required
- Symptoms that the patient should watch out for which indicate they need to get in touch with their primary care physician
- The day and time of the first follow-up appointment with their primary care physician
- A list of post-discharge resources that the patient can avail of to support health maintenance and improvement

If necessary, the medical staff can arrange follow-up appointments with the physician on the patient's behalf. The staff should provide a written copy of this schedule to the patient as well as impressing on him the importance of meeting his appointments and, if necessary, assuring that the patient has the means to get to the physician's office. The staff should also make follow-up calls with the physician to ensure that the patient has met his appointments. In addition, a staff member can be tasked to follow up on test results to ensure that they are delivered to the patient's primary care provider.

Explore Using Technology to Keep in Touch with the Patient

To ensure continued monitoring of the patients, particularly those who are deemed at high risk for readmission, health care staff should consider using various ways to communicate with them. For example, for patients who have access to computers and an Internet connection, they can talk regularly using Skype. They can not only follow-up but also monitor the patient's vital signs daily. For example, if the patient has access to electronic blood pressure monitoring machines, he can do regular testing and then communicate the results to the staff member when they call.

But if wireless technologies are not available, simple phone calls may be sufficient if the staff is able to establish bonds of trust with the patient so that he would be forthcoming with them about what is going on with his health. Health care staff may also be able to get in touch with patients using mobile phones, smart phones and other portable devices that they can keep on their person at all times. This may provide a quicker way for patients to get the information they need to help them stay healthy by clarifying care issues.

Improving Staff Behaviors

A recent Gallup poll showed that hospital staff may be remiss in providing discharged patients with the information they needed to stay healthy and avoid readmission. As a result of the survey results, here are some recommended responsibilities that staff members need to fulfill to their patients:

- Provide them with complete explanations of what medications they need to take and what they do, as well as the consequences of not taking the medicine as prescribed.

- Engage the patients in discussions of what they need to do at home post-discharge, particularly the areas that they are directly responsible for. In addition, as much as possible, the patient's family and caregivers should be included in these discussions.
- Customizing post-discharge plans rather than using 'one-size-fits-all' ones in order to better engage the patient in actively participating in his own care as well as empowering them to stay healthy.
- Informing patients of alternative therapies, if available. Doing this also serves to make patients more likely to adhere to a treatment plan by giving them choices.

Focus on Palliative Care

Often elderly patients with chronic diseases and patients with terminal conditions who are facing end-of-life issues don't want to be readmitted to the hospital. In this case, a palliative care approach may be appropriate. Palliative care is a specialized type of care that focuses on improving the patients' quality of life by alleviating their symptoms and providing relief from pain and suffering. It is distinct from curative care which focuses on curing the illness. An important part of palliative care is accepting death as normal, and stresses the integration of spiritual and psychological care along with physical treatment. The basic principles of palliative care include:

- Advance care planning through the patient preparing advanced directives for his care via a living will or health care proxy and end-of-care planning that defines what goals a patient wants (i.e. longevity, comfort care or functional preservation).
- Symptom and pain management
- Caregiver support.

Research has shown that terminally-ill Medicare-age patients who consulted with an interdisciplinary palliative care team that included a doctor, nurse and social worker were less likely to be readmitted. But palliative care does not have to be delivered in the hospital. Palliative-care services delivered at home or at a hospice were also seen as effective in helping avoid readmissions.

Palliative care helps to prevent readmissions by providing the patient with the appropriate level of care that he needs. In addition, patients who suffer from chronic pain can avoid hospitalization by managing their symptoms. Thus, their pain can be controlled so that it does not become unbearable and require them to avail of Emergency Room services or be admitted to the hospital. In fact, it is so-called "frequent flyers" that are constantly in and out of the hospital who are the target of palliative care.

One example of a palliative care model that has been shown to be successful in reducing readmissions is that developed by integrated health delivery system Kaiser Permanente which delivered in-home palliative care. Under this model, patients were provided with nurse visits every week and ongoing doctor visits every two to three months. As a result, utilization of emergency room services and readmission were not only substantially decreased but patient satisfaction was greatly improved.

Another palliative care model that can be adopted is that developed by the Coleman Foundation. This consists of four pillars:

- Medication Management. This is designed to ensure that the patient is getting the correct medication and knows how to take it properly. It consists of medication reconciliation performed by a pharmacist, using the "teach back" method to educate the patient on how to properly take his medication, 24/7 availability to a registered nurse and a "sick day plan" that helps the patient and his caregivers deal with days when he is sick.
- The creation of a personal health record. This consists of information that the patient and his caregiver needs to manage his care, and includes a list of people to contact, Red Flag symptoms to monitor and a list of medications that the patient needs to take. In addition, it can also include information about the patient's advance planning regarding his care.

- Educating patients about Red Flags. Health care staff should have discussions with the patient about his diagnosis and the nature of his illness, provide him with a checklist of symptoms that he has to look out for and when he should call his primary care physician, as well as specific contact numbers.
- Scheduling follow-up appointments. Hospital staff can assist in making post-discharge appointments with the patient's primary care physician and work with the caregivers and family members to ensure that he makes his date.

In addition, hospitals should consider setting up an in-house multi-disciplinary palliative care team since these can not only contribute to lowering readmissions but also help improve patient outcomes.

Improving Health Literacy

Health literacy is defined as possessing the basic reading and numeracy skills to be able to take ownership of our own health care. Some studies have shown that as many as one-third of English-speaking patients had poor health literacy skills. In addition, there are seen to be links between low health literacy and poor health behaviors such as medication nonadherence, worse self-reported health and increased hospitalizations.

Identifying the level of a patient's health literacy can be difficult since physicians and other health care providers may be embarrassed to ask the patient about his reading skills. In turn, the patient may be too embarrassed to admit that he has trouble reading any instructions that are provided to him by health care providers. And it is worth keeping in mind that even people with fairly good health literacy may also have difficulty in filling up complicated forms or understanding directions that are written in technical language.

How can you identify patients who have low health literacy or are experiencing difficulty reading and understanding instructions given to him? Here are some assessment questions that you can ask:

- Are you happy with the way you read?
- Do you ask others for help in reading prescriptions, filling out insurance forms and reading and understanding information sheets?
- What do you like to read and how much time do you spend every day reading?
- Do you have trouble reading and understanding health information because you find it too hard?
- How do you prefer to learn new information: by reading, asking others to explain it to you or though media such as TV or the radio?

There are also some behavioral clues that can help you identify patients with poor health literacy:

- They make excuses when they are asked to read an information sheet or prescription or fill out forms.
- They may submit incomplete medical histories or check "no" in order to avoid having to provide further information.
- They may display signs of nervousness, frustration or confusion when in the doctor's office and be very uncomfortable when presented with a situation in which complicated learning is required.
- They may make mistakes regarding their drug regimen or miss appointments.
- They may give wrong answers when asked about something they have read.
- They may move their finger along the text when reading or lift the text so it is closer to their eyes.

Once you have identified patients with poor health literacy skills, it is important that you not make them feel embarrassed about it and provide a supportive environment. In addition, you should also make them feel that they are not being disrespected. Some things that you can do to help these patients include providing them with assistance in filling out forms and make sure that forms are written in simple language using layman's terms. Any assistance you offer should be offered in a confidential manner, making sure that you are not in a public area where others may overhear.

When the patient is referred by his primary care provider to another doctor or asked to take another test, it may be difficult for him since he may have trouble reading the referral form and understanding the directions. To make it easier for the patient, the physician can ensure that the instructions he gives are as simple as possible and, if necessary, go over them with the patient. Review what you have discussed with the patient to ensure that he understands. You should also help the patient with filling out insurance forms and dealing with other insurance-related issues.

Finally, the physician or health care staff can prepare patients to take charge of the care process by telling them to bring in a list of their medications or the physical bottles (these should include everything they are taking including supplements, vitamins and herbals) as well as any recent test results that have been requested by other health care providers they have been seeing and, if available, a personal health record, and to report any new symptoms that they have been experiencing or if they are feeling anything that seems out of the ordinary. They should also prepare a list of questions that they want to raise. If a caregiver or family member is available, they should accompany the patient to the physician's office to help them remember any directions that were given to them and write these down.

Access to Mobile Health Care

If applicable, health care staff can provide patients with the contact information for mobile-based health care providers in their area. These providers go to the patient's home in order to provide them with the health services they need including monitoring their health condition and helping to make them more comfortable. Mobile health services are particularly vital for patients who are bedridden or cannot leave their homes since they are too sick, as well as for those who cannot drive and have no reliable access to transportation to care providers.

Mobile-based care providers can provide invaluable non-emergency health care services, which include home visits and providing the patient with transportation to the pharmacist, a clinic or his primary care provider. When they arrive for home visits, they can assess the way the patient is taking care of his health, such as how closely he is following his home care therapies and if he is taking his medicines regularly and as directed. They may also provide primary care services such as drawing blood for tests and injecting vaccines.

Hospitals should take the opportunity to partner with these mobile care providers to ensure that unnecessary readmissions are avoided. At present, many of these organizations have to pay out-of-pocket to provide these services. Hospitals can share some of these costs as well as offering whatever other support these care providers require.

One example of a successful model that can be emulated is that implemented by the Carmel Fire Department in Indiana. Under their Mobile Integrated Health Care Program, firefighters with paramedic training check in regularly on patients, particularly those who are classified as "frequent fliers" or those who avail of emergency room services regularly. Some of these patients would call for mobile emergency services to take them to the hospital as frequently as dozens of times monthly. Of the eighty patients who have participated in this program, only two have called emergency services again for the same health program they were reporting.

What YOU Can Do

Much of the information contained in this CEU may be new to some of you, a reminder for others, or perhaps you find yourself and your workplace already implementing some of these hospital readmission strategies. Regardless, there is no question that "it takes a village" to ensure that our elderly patients are receiving the best care possible both in the hospital setting and in the place where they are transitioning. In the coming months, we want to hear from you about your success stories. What are you doing to make a difference in the lives of your Medicare patients as it relates to hospital readmissions? Thank you in advance for sharing and for all you do for the elderly! hiscornerstone@gmail.com

Resources:

1. White, Jess. Three Unique Ways to Prevent Readmission. http://www.healthcarebusinesstech.com/prevent-readmissions/
2. Tips for Identifying and Addressing Health Literacy Issues, http://www.hpsm.org/documents/Tips_for_Identifying_Health_Literacy_Issues.pdf
3. Clark, Cheryl. 12 Ways to Reduce Hospital Readmissions, http://www.healthleadersmedia.com/page-5/QUA-260658/12-Ways-to-Reduce-Hospital-Readmissions
4. Snyderman, et al. Strategies to Help Reduce Hospital Readmissions. http://www.jfponline.com/fileadmin/qhi/jfp/pdfs/6308/JFP_06308_Article2.pdf
5. White, Jess. Keys to Better Patient Discharge Summaries. http://www.healthcarebusinesstech.com/patient-discharge/
6. Rizzo, Ellie. 4 Staff Behaviors That Help Lower 30-Day Readmission Risk. http://www.beckershospitalreview.com/quality/4-staff-behaviors-that-help-lower-30-day-readmission-risk.html
7. Improving Medication Adherence and Reducing Readmissions, NEHI Issue Brief October 2012, http://www.nacds.org/pdfs/pr/2012/nehi-readmissions.pdf
8. Reducing Hospital Admissions with Enhanced Patient Education, https://www.bu.edu/fammed/projectred/publications/news/krames_dec_final.pdf
9. Fernandes, Olavo A. Medication Reconciliation. https://bcpsqc.ca/documents/2012/09/Fernandes-Medication-Reconciliation-Practical-Tips-Strategies-and-Tools-for-Pharmacists.pdf
10. Axon, A. Neil. Preventing Avoidable Readmissons Together: Improving Discharge Summaries. http://www.scha.org/files/documents/improving_discharge_summaries.pdf

Written by Jennise Beverly-Chaffold, MBA, Speaker, Author, Coach