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Lowering Rehospitalization Rates through Seamless Transitions

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Our nation's healthcare system is currently faced with many challenges, including the need for high-quality care and cost-effective strategies. It's also tasked with meeting the needs of a growing population that is living longer, and with higher rates of chronic disease.

Recently, there has been widespread attention and effort across healthcare providers to lower rehospitalization rates due to the growing prevalence of readmissions, as well as new financial penalties.

Medicare beneficiaries contribute most to high hospital spending on readmissions, accounting for an estimated $17.4 billion annually. In fact, one in every four Medicare patients with a chronic disease is readmitted within 30 days of discharge.

When properly integrated into the continuum of care, home health becomes a critical part of ensuring patients discharged from hospitals or inpatient settings don't suffer relapses that require hospitalizations.

Recent data from health insurance company Paramount shows that patients who utilize home health services within 14 days of discharge from an acute care facility are more likely to avoid a readmission in the 30 days after discharge.

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“Overcoming readmissions really starts with collaboration,” said Kristi Wimberly, vice president of care transitions at Enhabit. “By taking a coordinated team approach to care, we give patients a safe and effective transition from the inpatient setting to the home.”

Twenty five percent of care transitions fail for a variety of reasons. According to a study published in the New England Journal of Medicine, 67% of Medicare readmissions are due to medication noncompliance. Other factors include underdeveloped discharge plans, complex discharge instructions, unprepared family members and insufficient home environments.

Inadequate communication with physicians also plays a critical role in unsuccessful transitions. Fifty percent of Medicare patients who are readmitted have no interaction with a physician between discharge and readmission, according to a study published by JAMA.

Many primary care physicians (PCP) also don’t have access to their patients’ discharge summaries, proving that lack of collaboration between hospitals and physicians is a common barrier to quality patient care.

Our home health services can help fill the gaps between settings by providing fully integrated transitional services. Partnering with discharge planners, performing on-site patient visits and coordinating follow-up appointments with the patient’s PCP are solutions that positively impact continuity of care.

“Working with the patient’s entire team of experts helps us provide a post-acute solution for our hospital partners and get the patient on the right service, at the right time,” Wimberly said.

Patients nearing the end of life also experience multiple transitions between health care settings, including high rates of preventable hospitalizations. These transitions can disrupt the delivery of care and create burdens for patients and families.

Sixty percent of spending among Medicare beneficiaries occurs during the final 30 days of life. Ensuring patients effectively transition home can result in significant savings, as the cost of in-home hospice services is significantly less than end of life care in the hospital setting.

As healthcare providers, prioritizing the collaboration of care creates seamless transitions between settings, resulting in lower rehospitalization rates and associated costs, as well as improved patient outcomes and patient satisfaction.