10 THINGS YOU SHOULD KNOW ABOUT CARE TRANSITIONS

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1 Hospital readmissions are a real problem.

All too often, patients find themselves back in the emergency room—or even a hospital bed—within weeks of going home. Almost one in five elderly patients released from a hospital is back within 30 days, and more than one in three are back within 90 days.[1] Many of these return visits could be avoided if doctors and nurses were able to coordinate patients' care better and if patients, caregivers, and hospital staff planned for the day the patient leaves the hospital well in advance.

$ 2 Hospitals are paying the price for readmissions.

The U.S. government estimates that avoidable readmissions cost Medicare more than $17 billion a year.[2] Under the Affordable Care Act, more than 2,000 hospitals faced penalties in October 2012 because too many of their patients were readmitted.[3] Hospitals will face higher penalties every year moving forward, unless they reduce their readmissions.

3 Patients and providers are both overwhelmed.

Every year, older adults with five or more chronic health conditions, such as diabetes or a heart condition, and their caregivers see 14 different doctors at 37 appointments and fill 50 separate prescriptions.[4] And on average, a primary care physician who treats elderly patients coordinates their care—such as sharing information and consulting—with 229 other physicians at 117 different practices.[5]

4 Hospitals and doctors' offices need to talk to each other.

When hospitals, primary care physicians, and specialists are not able to coordinate care and share important information, including test results, patients often wind up back in the hospital.[6] For more than four of every five patients admitted to the hospital, their hospital and primary care physicians have no direct communication after they leave the hospital.[7]

5 For patients, knowledge about their health = power.

More than half of patients can't state their diagnoses when leaving the hospital, and more than a third can't explain their medications.[8] Educating patients about why they were in the hospital, including their diagnoses and emergency warning signs, can help patients understand what to expect after leaving the hospital—and symptoms that are an emergency.

6 Patients need to continue care outside the hospital.

Patients in the hospital need to continue getting care after they leave. Three-fourths of patients with chronic conditions who leave the hospital wouldn't need a return trip if they had a plan for follow-up care.[9] But, in 2009, less than half of patients saw a primary care physician within two weeks of leaving the hospital after treatment for a medical condition, like a heart attack or pneumonia.[10] When hospital staff help patients set up follow-up appointments with the doctor or nurse they see regularly and any specialists, like a cardiologist, and call them as a reminder to keep appointments even if they feel better, it can help patients continue getting the care they need without returning to the hospital.

7 Discharge plans should come standard.

Getting continuous care also means taking care of oneself properly at home. One in five older adults with chronic health conditions who leaves the hospital will return within 30 days because they are not adequately prepared to take care of themselves or they do not receive follow-up care with their primary care physician or specialist.[11] By helping patients create a detailed, written plan—a discharge plan—before they leave the hospital, providers can help patients understand what they need to do to stay healthy after they leave. The plan should include any new equipment that patients need at home, such as a cane, wheelchair, or grab bar.

8 Medications are a major issue.

Patients leaving the hospital can be confused about their new medicines—and they don't always get it right. About one in five patients has an adverse event transitioning from hospital to home, and two out of three adverse events are related to prescriptions.[12] Patients who leave the hospital should have a medication list, which includes when to take each medicine and for how long, any possible side effects, and whether any new medicines are replacing old medicines. Patients should bring this list and all medications to follow-up appointments.

9 Caregivers are a crucial part of the equation.

Some family members may not know how to help provide care at home. When caregivers have copies of the discharge plan, test results, and all other materials about the patient's medical condition and medications, they can help their loved one follow the regimens that doctors have prescribed during their hospital stay.

✓10 Hospitals and other providers are making improvements.

The Affordable Care Act set aside $500 million for hospitals with high readmission rates to improve care transitions for Medicare patients.[13] When hospitals, physicians, nursing homes, pharmacists, and patients work together, avoidable readmissions can decrease.[14]

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