Why Reducing Readmissions is Critical For Overall Outcomes

Hospitals, health systems, and health plans are increasingly focused on minimizing avoidable readmissions.

CMS mandates that hospitals reduce avoidable readmissions within 30 days of patient discharge from the hospital. The Hospitals Readmissions Reduction Program (HRRP) has been in effect since 2012.

Avoiding Penalties

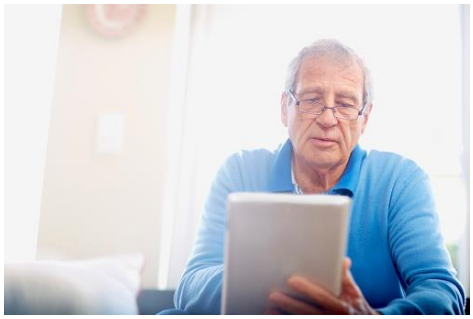
In order to reduce healthcare costs and improve patient outcomes, Medicare and private insurers use penalties and incentives to try to reduce readmissions, often targeting the 30 days after discharge. According to the Center for Health Information and Analysis, the estimated annual cost of this problem for Medicare is $26 billion annually and $17 billion is considered avoidable.

Minimizing Patient Risk

Readmission risk is not necessarily related to the initial cause of hospitalization. Hospitalization can induce significant stress in patients which may have unfortunate lasting effects. An article in the New England Journal of Medicine indicates that patients may experience the following at the time of discharge: impaired physiological systems, depleted reserves, and less ability to defend against health threats.

Reducing Readmissions

A comprehensive transition program which engages patients (and their respective caregivers) can help reduce readmissions.



Engaging Patients

Engaged patients are less likely to be readmitted. In a pilot with >350 chronic heart failure patients, a Philadelphia hospital was able to reduce its 30-day readmissions by 10% by using email and text message reminders with patients for follow-up appointments.

Including Caregivers

Including patients' caregivers into the discharge process can minimize hospital re-admittance. In a study published in the Journal of the American Geriatrics Society, integrating caregivers during discharge planning resulted in a 25% reduction in the risk of elderly patients being readmitted to the hospital within 90 days of discharge and a 24% reduction in the risk of readmission within 180 days.

Virtual Care and the Transition from Inpatient to Outpatient

Virtual care is increasingly being used as a viable and valuable way for providers and medical staff to conveniently remain in touch with discharged patients and their caregivers. Upon discharge, the medical staff should clearly set expectations for how/when patients can use virtual visits to facilitate follow-up care.

Travel time and expenses can be saved for all involved. Instead of needing to drive (or arrange for a ride) to a follow-up appointment, patients can participate in their follow-up care from the convenience and comfort of their home. Instead of needing time to drive to various patients' homes throughout the day, case managers can "see" and support more patients from one location. Our virtual visit solutions are designed for your medical staff to monitor and motivate patients – as well as quickly access needed specialists (such as a pharmacist) post discharge.

To learn more, visit our website at www.synzi.com