Your Guide to Consumer Information

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# Reducing readmissions

## How to stay out of the hospital

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### The problem

Every year, Minnesota hospitals admit approximately 570,000 people at an average cost of $10,000 each. For some conditions, up to one in five patients is readmitted to the hospital within 30 days after being sent home (i.e., discharged). Many of these readmissions could be prevented by proper follow-up care.

### Causes

There are five factors known to increase the likelihood that a patient will be readmitted within one month of discharge: inadequate discharge planning; a patient's inability to manage medication; lack of patient/family engagement in self-care; insufficient transition planning; and poor transition communication between different settings of care, such as the hospital and an assisted living center.

A hospital's attention to these factors helped one patient avoid being readmitted to the hospital. After being hospitalized with a leg fracture, worsening depression, and other chronic health problems, the patient left the hospital ahead of her scheduled discharge. The physician called in her prescription to the pharmacy but when the hospital's discharge advocate called the patient the following day to check up on her, he found that the patient was not doing well and had not started her medications. The discharge advocate strongly encouraged the patient to take her medications, to keep her doctor appointments, and to attend the transitions group meeting that was part of her medication therapy management program. The discharge advocate also visited the patient at her home, where he additionally encouraged the patient, reviewed her appointments, and made a referral for a visiting nurse to check up on the patient.

Without this timely intervention, the patient likely would not have started her medications and her condition would have worsened. Without the follow-up phone call and home visit, she may have missed key follow-up appointments and have been readmitted to the hospital. Efforts such as these are critical to helping patients spend more nights at home in their own beds.

*Visit your primary care physician within five days of being discharged.*

### Addressing the problem

The statewide RARE (Reduce Avoidable Hospital Readmissions) campaign, involving more than 80 hospitals and 95 community partners across the continuum of care, is working to lessen the burden that avoidable readmissions place on patients and their families. RARE is coordinated by the Institute for Clinical Systems Improvement (ICSI), the Minnesota Hospital Association, and Stratis Health (www.rarereadmissions.org).

## RESOURCES

**Asking Questions to Get the Care You Need.**
www.ahrq.gov/news/columns/navigating-the-health-care-system/video-questions/index.html

**Honoring Choices Minnesota. Downloadable advance health care directives.** www.honoringchoices.org

**Taking Charge of Your Healthcare: Your Path to Being an Empowered Patient. Guide for patients and families to use before leaving the hospital.**
http://www.patientsafetysummit.org/_assets/documents/checklists/Consumers Advancing Patient Safety - Hospital Exit Checklist.pdf

**Tips for Taking Medicines Safely.** www.ahrq.gov/news/columns/navigating-the-health-care-system/video-medicines/index.html

**Minnesota Senior LinkAge Line (800) 333-2433**, www.mnaging.org/advisor/SLL.htm

## Solutions

***The patient's role.*** Visit your primary care physician within five days of being discharged. Ask your hospital if it offers a transition program or transition coaches to help ensure this follow-up visit happens.

Coaches encourage patients to recognize their own needs, set their own health care goals, and access needed services. Patients are coached to understand the reasons to take, and possible side effects of, each medication they are prescribed. Coaching helps ensure patients have a reliable system to make sure medications are taken on schedule. In addition, coaching helps ensure that discharged patients keep a personal health record, schedule and keep follow-up doctor visits, can recognize if their condition is worsening, and know what to do so they don't end up back in the hospital unnecessarily.

***Ask, share.*** Good care following a hospital stay takes teamwork. Your medical team will share a lot of health information that you'll need to know in order to stay healthy. As part of the team, you need to ask questions until you understand your condition and how to better manage your health at home. It's very helpful to have a family member or friend with you at the hospital who also can listen to instructions.

*Ask how your current medications might interact with new ones.*

Care is a two-way street, so you need to share information with your medical team. Share your medical history, diet, lifestyle, whether prescriptions and other expenses for your care fit into your budget, and any other factors that affect your health and ability to stay out of the hospital. Share what quality of life means for you with your family and primary care doctor. Talk about your goals, like fishing at the lake next summer or dancing at your son's upcoming wedding, and what you need to do for your health to achieve those goals. Discuss health-care treatment options: which options are right for you now and, in the event you can no longer make decisions for yourself, who is best able to make decisions that respect your life goals and personal treatment preferences. These thoughts should be recorded in a document called an advance health care directive.

A 2004 report in the Journal of the American Medical Association showed that hospitals that improve patient education at the time of discharge reduce the chance of a patient returning by 25 percent. While many hospitals have patient engagement and education programs, patients and their families who understand the patient's condition and ask questions to better manage their own care can greatly decrease the risk of a quick return to the hospital.

***Medication management.*** Make a list of all the prescription drugs, over-the-counter drugs, vitamins, and supplements you were taking before you were admitted to the hospital. Review this list, as well as any new prescriptions you receive, with your doctor or other care provider. Make sure you understand three things about any new medication: **what it is, what it is for, and how to take it.** Ask how your current medications might interact with new ones. Know what to do if you have questions or problems.

***Self-care.*** Having a support system for daily activities is important. Ask your health care provider when you'll be ready to do activities such as climbing stairs, cooking, shopping, and house cleaning. If you will need help bathing, dressing, using the bathroom, getting to doctor appointments, or picking up prescription drugs, make sure you have help ready—family caregiver, personal care attendant, etc.—and involve them in your self-care education so they understand your specific needs.

Ask your health care provider to teach you and your caregiver any tasks that require special skills, like changing a bandage or giving a shot. Then, practice in front of the provider to make sure you can do these tasks correctly.

Finally, write down a name and phone number of a contact person at the hospital whom you can call if you need help after leaving the hospital. Managing your own care after being in the hospital can be difficult. Your hospital, your doctor, and the rest of your care team want to help you care for yourself—so we all can sleep more peacefully.

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