FEATURE

REDUCING READMISSIONS

# Telehealth programs aimed at reducing avoidable readmissions

It is no secret that governments and hospitals across the globe are struggling to keep up with a seemingly ever-rising demand, and often trying to do so with dwindling or stagnant resources. Hence the large volume of conversations asking the same question: how can we operate hospitals in a more efficient manner? Before Governments decide to increase funding there is a call to ensure that healthcare provision is a smoothly run, efficient model.

Unnecessary treatments, misuse of emergency departments, underuse of generic medication, inappropriate admissions and length of stay, poor communication, wasteful purchasing – these stories are familiar to all. The future of healthcare is as much about reducing unnecessary hospital use as it is about empowering patients to take more responsibility for their health.

Many countries are beginning to mobilise policy initiatives to tackle this problem by focusing on readmission rates. Readmission rates refer to the number of patients who experience unplanned readmission to a hospital a certain period (often up to 30 days) after a previous hospital stay. In the USA, the Affordable Care Act (2010) includes incentives for hospitals to implement strategies to reduce avoidable readmissions. According to the Agency for Healthcare Research and Quality (AHRQ) in 2011, there were approximately 3.3 million readmissions in the United States across at a cost of $41.3 billion.

In the UK, an average of 6.5 percent of patients were readmitted to hospitals within 30 days at a cost of about $2.4 billion (£1.6 billion) in 2011, according to Karen Taylor, Research Director for the Deloitte U.K. Centre for Health Solutions. To combat this, the UK also instituted a penalty for withholding funding to hospitals for readmissions within 30 days for the same condition.

ROBERT GRANT

**Care transition has become the focus in many programmes to reduce readmissions**

Readmission rates are a focus for reducing the burden on hospital use because they are a clear case of unnecessary and avoidable use of this service. Readmissions are often an example of an inefficiency in the system, which can be avoided with minimal restructuring. It affords an opportunity to make the most out of a point of contact between patient and provider, and through better organisation, management and communication ensure that patient needs are met.

Of course, not all readmissions are avoidable; some are unpredictable and unrelated to the previous stay. But, according to Dr Stephen Jencks, a former Senior Clinical Advisor to the Centres for Medicare and Medicaid Services, "readmissions are not primarily about people being re-hospitalised because of mistakes made in the hospital. Readmissions are about making transitions effectively".

Care transition has become the focus in many programmes to reduce readmissions. Given the fragmented and disjointed nature of healthcare, improving transitions between hospital and home, and coordinating care between various care settings is essential to lowering the burden on hospitals, reducing cost, and, improving patient outcomes.

To begin with, clearly articulating discharge instructions to patients while still in hospital, and ensuring the patient is fully educated about their responsibilities for ensuring recovery is essential to making effective transitions.

However, patients facing discharge after a procedure are in a particularly vulnerable state, especially elderly patients who can be fragile and disoriented after certain procedures and nervous about taking care of themselves. Add to this the fact that many hospitals are indirectly incentivised to discharge patients as quickly as possible in order to free up valuable space to treat new patients and there is a high risk of patients not quite being fully prepared to take the necessary steps in their recovery.

So even when the patient has left the hospital building, it is necessary to maintain communication with the patient in this vital period for recovery. Telehealth programmes, aimed specifically at patients being discharged from hospital, can be employed to extend the point of contact between patient and provider beyond the four walls of the hospital. Often known as Post Discharge Follow Up Programs, they can be used to smooth the transition of care and ultimately, reduce readmissions to hospital.

**How do they work?**

A team of dedicated Registered Nurses or Discharge Advocates operate from a clinical calling-centre, and proactively reach out to patients. Best-practice currently recommends a call within a 48-72 hour window after discharge. However, where specific departments identify peak readmission points, a call-ing program can be implemented to serve this population. In general terms, the call is used to discuss the patient's progress and recovery and address any concerns the patient might have.

Scripted questionnaires can be developed to suit the needs of particular patient populations and used to allow for data collection and population health management. The call is generally used to both reassure and educate the patient but also respond to the major causes of readmission. Specifically, they include: understanding and reinforcing discharge instructions, reminding patients about medication adherence, checking for new or worsening symptoms since discharge, establishing key readmission indicators for their condition, and scheduling follow-up appointments.

Where any clinical issues arise the patient is escalated to the relevant professional, who then assesses the patient through a clinical triage process based on clinical protocols which will deliver a recommendation to the patient. These recommendations can range from an immediate emergency department requirement to a transfer to a clinician for follow-up care.

Further integration of connected health solutions are also an option. For example, patients can be equipped with Remote Monitoring Devices which feed data back to the Nurses or Discharge Advocates about glucose levels or heart rate, for example, allowing them to make more informed decisions about the necessary next steps.

There have been several studies confirming the value of these kinds of programmes for reducing readmissions. One comprehensive example from 2013 found that of 48,538 Medicare members who received the intervention, 4,504 (9.3 per cent) were readmitted to the hospital within 30 days, as compared to 5,598 controls (11.5 per cent). Furthermore, although emergency department visits were reduced in the intervention group as compared to controls (8.1 vs. 9.4 per cent), physician office visits increased (76.5 vs. 72.3 per cent), suggesting the intervention may have encouraged members to seek assistance leading to avoidance of readmission. As a group, overall cost savings were $499,458 for members who received the intervention, with $14 million in savings to the health care plan. Telephonic support for patients after hospital discharge clearly affected hospital readmission and associated costs.

Another study found that receipt of a discharge call was associated with reduced rates of readmission; intervention group members were 23.1 per cent less likely than the comparison group to be readmitted within 30 days of hospital discharge.

We at RelateCare have run trials with the Cleveland Clinic in the USA – one of the leading hospitals in the world – and found that post-discharge calls not only reduce readmissions, but also improve patient experience and satisfaction.

In Ireland, Post Discharge Follow Up programs are limited in scope due to the lack of an Electronic Medical Record. Again, for the programme to be beneficial, it is necessary for the nurses making the call to have access to the patient's medical history, discharge instructions and future appointment needs. In many Irish health systems, we still send a discharge letter by post to the patient's GP or primary care doctor. This mode of communication is too slow to capitalise on that window of 24-72 hours where a timely intervention can mean readmissions can be avoided.

As we move into the future of healthcare delivery it is becoming more and more pressing to find ways to reduce the burden on our healthcare system. Technology and telehealth can play a role. But only when imbedded in organisational structures where it can be utilised to improve the connection between providers and patients and supplement the care received. Post discharge telehealth programs offer an example of this kind of integrated use. ■

> As we move into the future of healthcare delivery it is becoming more and more pressing to find ways to reduce the burden on our healthcare system