TRADITIONS HEALTH

READMIT RESCUE

Keeping patients healthy after hospitalization without question leads to good patient outcomes. Rehospitalization reduction methods that focus narrowly on the first 30, 60, or 90 days of care after hospitalization may ignore the patient's long-term care needs; therefore, patient care should be multifaceted and include care across the patient's care continuum.

The Crisis	The Barriers	The Solution
Key rehospitalization related statistics: More than 2,200 hospitals are penalized each year for Medicare rehospitalizations Financial penalties for impacted facilities exceed $320 million 1 in 5 Medicare patients are readmitted to the hospital within 30 days of discharge Two-thirds of these patients readmit within 15 days of discharge	Difficulty transitioning home can be related to: Taking medications appropriately Understanding complex discharge instructions Mobility limitations Social isolation Difficulty with coordination of care Increased risk for life-threatening acute episodes Need for additional psychosocial supports	Minimize the dangers of fragmentation by delivering collaborative care Daily patient or caregiver engagement during first 14 days of home health admission Engagement with patient, caregivers, and facility care team prior to facility discharge Identification of post-discharge resource needs for smooth transition Timely admission assessment in the home with provider collaboration for plan of care Individualized plan of care and assessment of risk for return to emergency department or hospital

Medicare introduced the Hospital Readmission Reduction Program (HRRP) to address the higher rates of readmission in six specific health conditions (acute myocardial infraction, chronic obstructive pulmonary disease, heart failure, pneumonia, coronary artery bypass surgery and elective primary total hip arthroplasty and/or total knee arthroplasty). Beyond the HRRP penalties for these specific diagnoses, however, readmissions increase the total cost of care for each patient.

The health care system and emphasis on specialization often results in referrals from provider to provider and transitions from one facility to another. Referrals and transitions can be frustrating and more costly in both actual expense and poor patient outcomes if not managed properly.

Traditions Health's Readmit Rescue program focuses on activities that emphasize collaboration of care with individualized goals and interventions to meet each patient's care needs. This involves a multi-disciplinary approach to care between acute and post-acute care facilities, physicians and non-physician providers, and the home health care team members.

PACE Model

The Traditions Health PACE Model helps enhance outcomes by improving patients' Psychosocial, Assessment, Continuity, and Education needs.

Psychosocial Factors

- Involves ongoing psychosocial assessment as the most fundamental element of the PACE Model
- Focuses on social determinants of health that influence health outcomes
- Emphasis on quality of life in the patient's preferred setting

Assessment

- Helps clarify and identify strengths, challenges, areas of support, and overall functioning
- Groundwork for identifying competencies and influences that could hinder the patient's or caregiver's abilities to adapt to changing health conditions and care needs

Continuity Factors

- Continuity of care is critical to achieving the best outcomes for each patient, especially for those with chronic or multiple medical conditions
- Focus is on establishing relationships between agency staff and the patient/caregivers to encourage communication and trust
- Involves engagement with other care providers, as needed

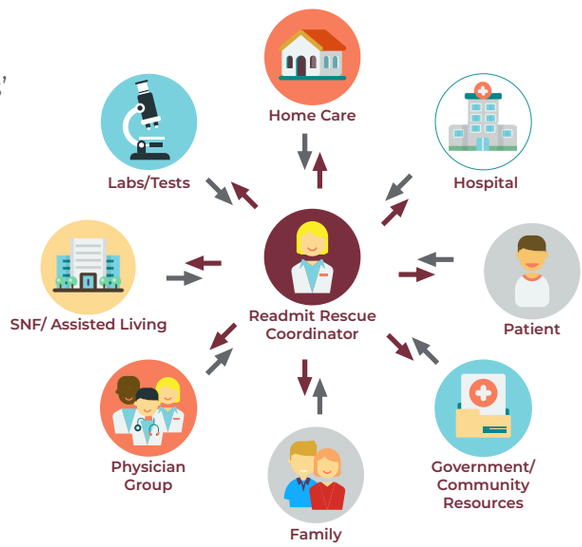
Education Factors

- An emphasis on education empowers patients and caregivers to play an active role in meeting the goals of care
- Focus is on providing accurate information in an easy-to-understand manner to encourage questions and compliance with the plan of care
- Traditions Health staff engage patients and caregivers in the care decisions to improve chronic care self-management and resulting outcomes

The Rules

Traditions Health achieves its stated objectives and abides by and supports well-established standards of care. Traditions Health follows the National Academy of Sciences' Standards of Care.

- Care is based on continuing healing relationships
- Care is customized according to patient needs and values
- The patient is the source of control
- Knowledge is shared and information flows freely
- Decision-making is evidence-based
- Safety is a system property
- Transparency is necessary
- Needs are anticipated
- Waste is continuously decreased
- Cooperation among clinicians is a priority



The Difference with Readmit Rescue Program

- Reduction in occurrences of rehospitalization
- Daily contact first 14 days and as needed
- Patient-centered and collaborative care
- Care across the continuum
- Psychosocial support as needed

For more information about the Readmit Rescue program, contact your local Traditions Health representative.

TRADITIONS HEALTH

Traditions Health | 2031 Arlington Street | Ada, Oklahoma 74820 | phone: 580-332-4888 | fax: 580-332-3102

traditionshealth.com

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