

The High Cost of Healthcare Readmission

It's hard to ensure quality care for a patient once he is discharged. Usually, caregiving falls to an untrained, unprepared family member. With the rise in families separated by geography, even these adult caregivers are often unavailable. Because of that, many seniors don't get the extended care they need after an injury or illness and end up back in your healthcare facility, costing you more resources.

There's a good chance that your organization has been negatively affected by readmissions. In the near future, those readmissions could come at an even greater cost. Starting in 2012, hospitals with a high percentage of avoidable readmissions will be heavily penalized, with some facilities risking the possible elimination of all Medicare payments. Participating in a program like RightTransitions will not only help you avoid these penalties, but also will save your facility money.



76% of readmissions are **preventable**.

Center for Technology and Aging

Preventable hospital readmissions **cost** the American healthcare system **\$25 billion** annually.

Pricewaterhouse Cooper's Health Research Institute

1 in 5 Medicare patients who leave a hospital will be readmitted within **30 days**.

Department of Health and Human Services



For more information
on RightTransitions
or other Right at Home
services, call us today.

877.697.7537

www.rightathome.net

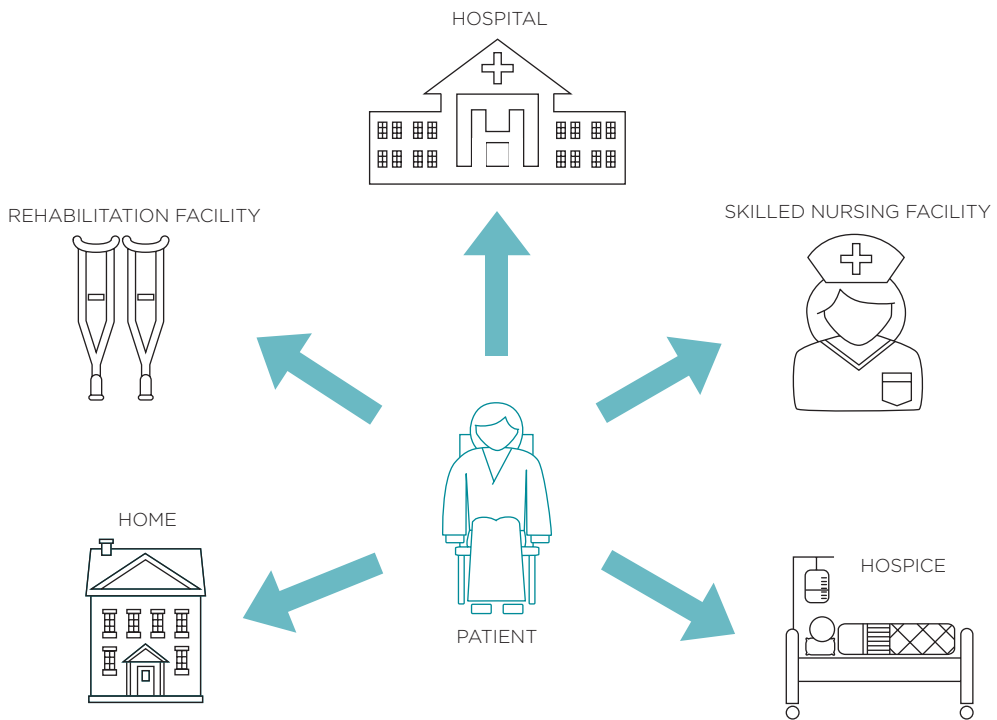
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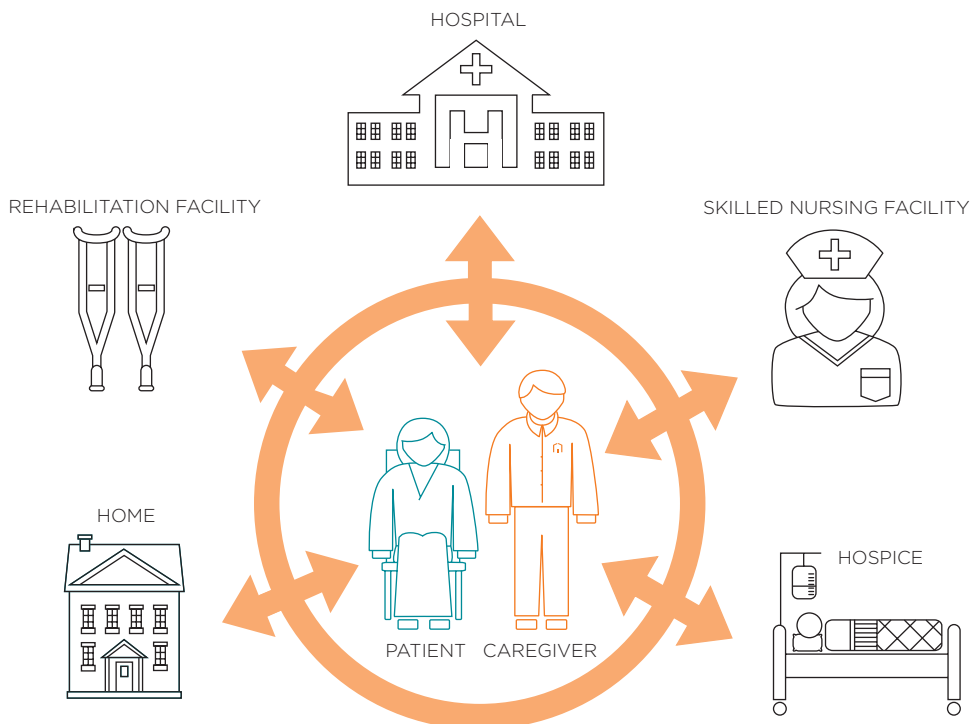
A Solution to Reduce Readmissions



When a patient moves from one facility to another, it's hard to coordinate information about the patient's treatment.



With RightTransitions, a Right at Home caregiver can help coordinate communication between providers regarding the patient's care, helping to avoid a preventable readmission.



Right at Home's Supervised Care Transitions is an Option

There is an alternative that will enhance your current discharge practices.

Many healthcare facilities recognize the value of supervised care transitions provided by trained, reputable providers to safeguard against unnecessary readmissions.

Right at Home is at the forefront of these providers. Our RightTransitions program is structured to work with you, other healthcare providers, your patients and their families. We work to reduce your readmission rates, lower costs associated with readmissions and enhance your reputation for providing quality patient care. Whether you currently have a transitional care program or not, our caregivers can improve your patients' recovery, as well as improve your bottom line.

Our non-medical care model includes services necessary to help patients transition safely out of your facility, including:

Frequent follow-ups with families and discharge planners

Medication reminders

Coordinating communication between providers

Transportation to physician appointments

Preparing meals

Running errands

Keeping homes clean and safe

“Working with Right at Home reduced readmissions within this program by 53 percent. Just as importantly, though, they provided the quality of care our patients expect from us. They're an asset to our patients and our business.”

*Crystal Redding,
Director of Case Management*

*Forsyth Medical Center,
Winston-Salem, NC*

A recent survey showed **100 percent** of patients that benefited from the RightTransitions program were **satisfied** with Right at Home.

How RightTransitions Improves Patient Outcomes

Enhanced Communication Between Care Providers and Patients

While HIPAA laws protect patients from breaches of privacy regarding their medical records, for healthcare providers they have hindered communication because of a lack of portability. There is no simple solution when it comes to the issue of securing medical records passed from one provider to another.

Right at Home can help coordinate communication between care providers and the patient by helping the patient follow the Care Plans prescribed by healthcare providers. Right at Home caregivers work with patients to help ensure they comply with providers' recommendations.

Follow-up and Transportation to Physicians

Patients are regularly scheduled for follow-up appointments with a primary care physician or specialist before they're ever discharged. Many never make it to their appointments due to a lack of transportation, or they simply forget about their scheduled visit.

Right at Home works with care providers, patients and their families to ensure the patient makes these critical follow-up appointments. We coordinate with a patient's support system to ensure they have a ride to providers' offices, and we transport patients ourselves whenever it's necessary.

Clear Instructions on Post-Discharge Care and Medications

Many seniors contend with multiple chronic diseases, disorders and conditions that require an array of medications. The discharge instructions that pertain to their medications are often confusing, and many patients are readmitted soon after discharge due to medication errors and mismanagement.

Right at Home advocates for your patients when it comes to Care Plans. We provide them with medication reminders to help ensure prescriptions, OTC medications and nutritional supplements are taken on time and refilled when needed.

Provide Proactive Solutions

No two patients need the same kind of care. We coordinate between providers and patients to ensure patient needs are met. Your patients may need meals prepared for certain dietary restrictions. We can easily help them prepare those meals. Perhaps they need ambulatory assistance to lessen the likelihood of a fall that could lead to a re-injury and readmission. We do this every day. Regardless of what your patients need to ensure they are safe and healthy outside of your care, there's a good chance it's something we provide to thousands of people every day.