

Hospital Readmission Reduction

Hospitals have a lot to lose, if patients are readmitted not long after discharge. Preventable readmissions are of critical concern for hospitals, not only from a quality-of-care perspective, but they are expensive to hospitals and are costing healthcare a lot of money. Therefore, to incent hospitals to reduce preventable admissions, Medicare's value-based purchasing programs offer financial incentives.

What has not been as clear is who is responsible and how we can motivate them to reduce readmissions. Of course, the lack of care coordination inside the hospital and transition errors can result in fragmented health care, treatment errors, cost increases and preventable hospital readmissions. This cause of readmissions is within the hospital's ability to address with increased focus on patient engagement and satisfaction, coupled with better ensuring that patients understand the instructions of how to care for themselves after discharge. However, the greatest cause of hospital readmissions is poor care navigation/coordination, post-discharge.

At Preservant, we are aware that the source of a readmission can be found at any point, once the patient is discharged.

Some examples include:

- Home – lack of patient compliance management and lack of patient and caregiver training and support.
- Primary care – considered by most to be the primary source of readmissions.
- Nursing homes and rehab facilities – case management frequently comes up short and there is inadequate coordination of care and efforts to reduce errors.
- Pharmacies – where counseling and reviewing drugs with patients is often pro forma,
- Home health agencies – failures to create and execute a care plan are the most common

The variety of providers that patients may use after hospitalization is not designed to keep the overall safety of the patient in mind and creates fertile ground for error. Supporting the best patient experiences with outpatient organizations requires

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creating a seamless communication workflow that supports all types of visits and patient preferences.

At Preservant, our innovative SpecNav health risk reduction and care navigation services help to reconcile the hospital readmissions–profit loss dilemmas. Our, patient-centered, SpecNav care navigation services are designed to reduce preventable health deterioration after the release from the hospital by better ensuring access, safety and quality of care, both in the home and across the entire healthcare continuum. This results in reduced readmissions.

The benefits to patients:

- Enhanced patient and caregiver engagement and patient-centered care, while in the hospital
- Improved post-discharge to the community by enhancing communication, care coordination and navigation, across the entire healthcare continuum
- Medication management in the home
- Lessen the occurrence of declines in the health
- Assurance of adequate caregiver quality post-discharge from the hospital and the implementation of caregiver regulations and oversight
- Improved safety in your home

Our care healthcare navigators will accompany patients, either virtually/remotely or in-person, on their journeys from the hospital, into their homes and across the entire healthcare continuum.

Engaged patients pick less expensive treatment options, are more thoughtful about what's really important, and tend to have fewer readmissions to the hospital. We encourage and support active patient participation along the continuum of care to promote healthy lifestyle choices and improved patient outcomes. This translates into reduced readmission and medical malpractice rates.

Our innovative SpecNav health risk prevention and care navigation services reduce low-profit medical inpatient admissions.

Amid an ever-changing healthcare regulatory landscape, there is one thing hospital administrators can count on – reimbursement models are going to continue becoming more closely tied to value and cost consequences to readmissions will also. Our, patient-centered, SpecNav care navigation services are designed to

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reduce risk and protect revenue at hospitals by improving the quality of care received by patients, once they are discharged from the hospital.

Preservant's health risk reduction and care navigation services complement the hospital's strategies to improve patient engagement and satisfaction, in their efforts to reduce readmissions. We are the hospital's post-discharge handoff to assure that patients are both safe and focused, during the 30-day discharge period.

We bridge the gap between provider services and patient satisfaction.