The Challenge of Hospital Readmissions

Hospitals today face the challenge of reducing hospital readmissions for Medicare patients with complex and chronic conditions. Knowing that an excessive number of readmissions could result in serious financial penalties, it is increasingly important for hospitals to establish effective systems for continuity of care that can prevent and minimize the types of health crises that result in emergency room visits and hospital readmissions.

A Proven Solution

Liberty Healthcare Corporation has created a transitional and coordinated care system that can be fitted to your hospital and its local resources. We work collaboratively with each hospital to establish the components that help patients safely achieve independence in the crucial period of transition from the hospital to outpatient care.

Beginning at the point of discharge, our designated Care Coordination Nurses (CCN) communicate with the physicians and care team to remove potential for conflicts or misunderstanding of discharge plans and medical information. We help link patients with needed community resources to address the functional and economic needs that can directly impact health. Our CCNs provide personalized hands-on support to ensure that patients attend follow-up doctor visits and to help organize medication administration to prevent errors and ensure safety in the home.

Benefits of Transitional Care

• Avoidance of hospital readmissions for primary and complicating conditions
• Reduction in the number of days spent in the hospital when readmissions are necessary
• Improvements in health outcomes, functional status, and quality of life after hospital discharge
• Enhancement in patient and family caregiver experience and satisfaction with care
• Reduction in overall health care costs for high-risk patients, making these services essential for ACOs managing the health of large Medicare populations

FACTS:

1. About 20% of older Americans (more than 10 million Medicare beneficiaries) are living with five or more chronic conditions and account for 75% of total Medicare spending.

2. Nearly 18% of Medicare enrollees are readmitted to the hospital within 30 days, and up to 75% of these readmissions are preventable.

3. Most TCM programs achieve reductions in readmissions of at least 25% to over 50%, depending on the baseline readmission rate. (source: Perspectives Online Research Journal)

4. Approximately $355 billion in healthcare spending is wasted each year in the United States as a result of failures of care delivery, poor care coordination, and overtreatment, including up to $44 billion attributable to unplanned hospital readmissions. (source: Online Journal of Public Health Informatics)
Liberty’s Coordinated Care Program

Liberty’s COORDINATED CARE PROGRAM was developed with the University of Pennsylvania using UPenn’s empirically-based Transitional Care Model (reference, 2014) and includes the following:

Using Liberty’s Risk Level Assessment tool, the Care Coordination Nurse (CCN) assesses each patient’s level of risk for acute relapse of illness, injury, and/or rehospitalization.

Based on the score, each patient is assigned to one of three clinical pathways corresponding to the level of risk. Those at the highest risk receive face to face visits while still in the hospital and home visits beginning within 24 hours of discharge.

CCN visits the home to assess the patient’s current status and caretaker/family involvement, including:
- Medical stability
- Capacity for self-management of illness
- Need for community resources
- Appropriate safety precautions in the home
- Establishment of safe, accurate system for administration of medications
- Understanding of urgent/emergent care plan
- Education about advanced care planning

CCN makes home visits and contacts at the frequency needed to:
- Accompany patient to follow-up appointments with PCP and specialists
- Provide patient/family education to strengthen self-management skills
- Monitor medical conditions and alert providers to issues
- Maintain and strengthen medication administration system
- Maintain plan for patient to contact CCN and on-call clinician regarding health concerns

Based on ongoing progress or barriers, CCN can increase or decrease frequency of supporting visits and contacts. The period of monitoring can be for 30 days, 60 days, or 90 days based on need.

Established Ties with UPENN and Its Evidenced-Based Transitional Care Model Using:
- UPenn’s established and successful program resources
- 1-3 month period of interventions with high-risk older adults to prevent hospital readmission
- Evidence-based risk assessment and intervention tools
- Fully developed clinical and program pathways performed by a transitional care nurse
- Fully developed implementation plans

Partnering with Liberty Delivers Results by Optimally Managing Care Transitions

Liberty Healthcare has three decades of experience with both private and public entities to provide health programs and services to specialized and vulnerable populations. Our collaborative and innovative transitional model leverages:
- Liberty’s QualityCare® framework that governs and standardizes the program’s performance management, risk management, and quality improvement requirements
- Established standard operating procedures
- Systems for recruiting, credentialing, and educating high-quality clinicians and administrators
- Skills for developing community and system networking and integration strategies

About Liberty Healthcare

Established in 1986, Liberty Healthcare has a proven record of successfully embracing healthcare challenges that seem to defy solutions. Our ability to improve quality and performance measures redefines what health care organizations can achieve.

Our commitment and results are unmatched. No other organization offers the diversity of experience or solutions that Liberty routinely delivers. Our goal is to liberate our customers from the operational burdens of program management so they can focus on their priorities and thrive.

We’re Liberty... and we give you the freedom to succeed™.