Reducing Readmissions: Steps You Can Take to Close the Community Gaps

According to an article by *Senior Housing News* titled *Senior Rehospitalizations Hinge Directly on Location,* the *Robert Wood Johnson Foun*dation's new report on hospital readmissions found that 'the burden of readmissions falls unevenly on Medicare beneficiaries and is closely linked to their place of residence and the health care system providing care.'

In fact, the study goes on to say, 'getting people the care they need outside the hospital is imperative.' So you've assessed a client's need for community-based services, given the client some agencies to call, and set the client up with your care transitions services. All set, right?

The Robert Wood Johnson Foundation (RWJF) report suggests you go further.

Ask yourself these questions:

- Is this client really going to call his or her doctor? How can we better ensure they call and/or keep the appointment that has been set up?
- Who will transport the client to the physician appointment? What other barriers may interfere with the client's ability to visit the doctor's office?
- How can we ensure that the patient understands and implements the physician's recommendations, especially when the patient is involved with more than one physician?
- Who will assist the client with his/her medications, and ensure s/he understands the purpose and schedule for each pill, especially any new prescriptions?
- Who will assist the family in understanding and maintaining the medication regimen?
- Who will coach family members on how to care for their loved one at home?
- Who is going to stay connected to this client over the next 6 months to a year to proactively identify and address issues between physician appointments? How likely is it that this client will experience an exacerbation of his/her condition?
- If I know from research that my client is unlikely to call his/her doctor, what makes me think s/he will call a community-care provider? What can I do to help ensure s/he gets the community support needed?
- Am I connecting this client with the best options for him/her based on what is needed, or am I trying to make-do with what services are covered?
- How can I help people be creative in determining and meeting their needs and goals, and that includes thinking creatively about finances and social support?

These questions should play a role in your decision-making on the best resources for your clients. According to one care transitions nurse in the Twin Cities, Minnesota, 'people need an ongoing care coordinator in the community.'

'Although hospitals are a key venue of care,' explained Risa Lavizzo-Mourey, MD, President & CEO of the Robert Wood Johnson Foundation, 'the one thing that's clear is that this is not just a hospital problem. Patients, families, friends, and the entire community have a role to play in reducing avoidable readmissions, and to succeed we need to face this problem together.'