House Call *Conversations*

Avoiding Hospital Readmissions

When chronic, multi-comorbid patients are discharged from the hospital there is a 26% chance they will be readmitted within 30 days, according to a Medicare Payment Advisory Commission report to Congress. The report also shows that 75% of those instances are preventable. Multiple studies support that a patient's best shot at avoiding a readmission is to receive closely-monitored post-discharge care.

Patients often fail to comply with a recommended post-discharge visit to their primary care provider. This can be due to inadequate transportation, a false sense of wellness, scheduling availability with the PCP office, and so forth. Regardless of the cause, one thing is certain; if a patient doesn't have medications reconciled after a hospitalization, or a medical professional tracking their post-hospital stability, the risk of readmission and increased health care spend rises significantly.

The value of a Landmark post-discharge visit:

- Nearly 80% of engaged Landmark patients have one or more post-discharge visits within 30 days compared to 55% of non-engaged patients.
- Engaged Landmark patients with a post-discharge visit following completion of an inpatient stay had an almost 60% lower risk of readmissions than those without a post-discharge visit.

MINIMIZING READMISSION RISK

Landmark-shared patients have minimized readmission risk attributable to several strategies:

1. While a patient is hospitalized or placed in a skilled nursing facility, a Landmark nurse care manager communicates with the patient's acute care team. Landmark shares baseline information on the patient's comorbidities and ensures the hospitalist, specialist, and PCP care plans are aligned.
2. Following a hospital or facility stay, Landmark relays detailed notes back to the PCP, highlighting critical information that the PCP may use in follow-up care.
3. Landmark may assist the patient in scheduling a post-discharge office visit with their PCP and help arrange transportation to their visit.

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4. Landmark strives to provide a thorough in-home visit within 72 hours of discharge. In a Landmark post-discharge visit, the provider (i.e. medical doctor, nurse practitioner or physician's assistant) evaluates the patient and:

- Adjusts medications
- Educates patient on his/her individual readmission risks and symptoms
- Follows up on labs
- Oversees home health vendors ordered by the hospital
- Evaluates for and manages hospital acquired infections
- Communicates with PCP and specialists involved in care

BRIDGE FOR PATIENT CARE FROM THE HOSPITAL TO HOME

Patient condition after an acute hospitalization often changes quickly from day to day. Having a Landmark provider in the home immediately following discharge — with regular follow-up visits over the subsequent weeks/months as the patient returns to baseline — allows us to thoughtfully adjust medications and provide care in concert with the patient's evolving condition. All home visit notes are shared with the PCP.

When needed, Landmark becomes a bridge for patient care from the hospital to home. With 24/7 patient access and through strong community relationships, Landmark provides an additional layer of of support to chronically ill patients and their PCPs, to ensure safer transitions home after hospitalizations and rehabilitation stays.

A PCP sharing patients with Landmark can call on a Landmark provider to perform in-home evaluations of their program-eligible patients whenever they are unavailable. Landmark answers calls 24 hours per day, 365 days per year, helping catch problems early to reduce hospitalizations. Landmark's care team consists of providers, behavioral health specialists, pharmacists, social workers, dietitians, nurse care managers, care coordinators and ambassadors.

Landmark partners with clients, such as health plans and other care delivery systems, to bring house calls and care coordination to patients living with multiple chronic conditions. We're working to help patients stay well at home and receive in-place urgent care when needed.

For more information about Landmark please visit: **www.landmarkhealth.org**

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