



Your solution for reducing readmissions.

The cycle of avoidable hospital readmissions is frustrating and costly, for you as well as for your patients with chronic illnesses. eQHealth Solutions' Care Transitions is a proven program that is helping hospitals solve this problem.

Our solution produces dramatic results that can be achieved quickly. This enables you to reduce the rate of avoidable rehospitalizations while helping to improve care for your patients.

Contact us to set up a cost-free assessment of your discharge planning processes, and find out if our solution for reducing avoidable readmissions will work for your organization.



The need to prevent avoidable readmissions.

Cost Increases – As patients are released from hospitals more quickly today than ever before, and with many still having medical concerns at discharge, hospital readmissions and costs increase.

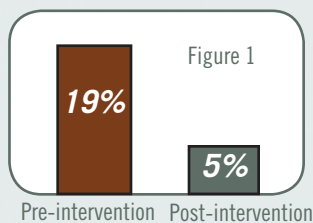
Medication Errors – Studies have shown that as many as 40 percent of patients over 65 had medication errors after leaving the hospital.

A National Problem – Avoidable hospital readmissions affect 17.6 percent of all Medicare patients.

The eQHealth solution to avoidable rehospitalization addresses all these challenges to maintaining health after hospital discharge.

Proven results.

Our Care Transitions program is modeled on a program developed by Eric Coleman, MD, a national expert on hospital readmissions. In its first year, we have succeeded in dropping the rate of unnecessary hospitalizations from almost 19 percent to less than five percent. See Figure 1.



- For the targeted population, a 74% improvement in the re-admission rate was achieved after Care Transitions was adopted.
- Avoidable rehospitalizations of these targeted patients with a chronic disease were reduced from 19% to less than 5%.

Your patients and staff will receive the support they need to ensure a smooth transition to home. From patient coaching to care planning, the eQHealth Care Transitions solution produces a full discharge process for your facility that helps your patients take control of their at-home recovery.



eQHealth Solutions Transitions Services

Discharge Planning Reengineering – Studies have shown that improvements in hospital discharge planning can dramatically improve the outcome for patients as they move to the next level of care. With several decades of combined experience as hospital team managers, our consultants understand the importance of properly discharging a patient from a hospital to home, to a rehabilitation facility or to a nursing home.

To ensure that your hospital is utilizing the latest and best discharge practices, and that your staff is properly trained, eQHealth can provide expert assistance. We have developed training modules, planning checklists, follow-up procedures and other tools that result in your patients having a successful transition from the hospital. We help with:

- Early identification of patients likely to need complex follow-up care.
- Patient and family education.
- Assessment and counseling.
- Plan development, coordination and implementation.

Patient Coaching – A Patient Coach is essential to reducing avoidable readmissions. Working on the patient's behalf, our coach is introduced to the patient upon admission. The coach works with and advises the patient about what to expect while in the hospital and after discharge. By the time they leave the hospital, the patient has been provided education about their illness and how to manage their own care.

This includes information about rest, diet and exercise, managing medicines and their potential complications, using a personal health record, when to schedule an appointment with their primary care doctor, what to do if something goes wrong and how to take a more active role in their care and guidance about continuity of care.

Community Collaboration – Our goal is to keep the patient from becoming socially isolated and with a lack of access to community support services that are essential to recovery. When a patient does not have a family caregiver, these connections are vital to ensuring they receive all the assistance necessary and not require a return to the hospital.

Our team has more than a century of combined experience developing community partnerships that benefit patients and health care providers. We will bring together home health agencies, long-term care providers and advocates, social services and any other community resources.

Our Return on Investment

Some health economists have calculated the cost savings of an avoidable hospitalization.

- The Medicare Payment Advisory Committee estimates potential savings to Medicare of over \$12 billion if readmission reductions can be replicated nationwide.
- A study presented in 2007 by the International Health Economics Association calculated savings in one primary care clinic to be \$947,433 for one year. The intervention cost to the clinic was \$7,400.
- For the reduced readmissions in Baton Rouge, calculations by eQHealth show an estimated savings of more than \$365,000.*

* Based on 300 coached patients (42 avoidable readmissions) at an average of \$8,624 for each readmission and at home health cost of \$22.50/hour.

In this time of unsustainable cost increases in Medicare, Medicaid, private insurance policies and almost medical services, our care transitions intervention not only improves patient care outcomes, it addresses a major contributor to rising health care spending; avoidable rehospitalizations.

eQHealth Solutions is your care transition expert. Call us today for a free consultation.



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