SCP HEALTH

Strategies for Care in the "Gap"

Avoidable readmissions cost everyone.

Hospitals and health systems pay in penalties.

Patients pay in outcomes.

Effective care coordination strategies reduce hospital readmissions and repeat ED visits.

In order to impact patient outcomes, increase cost-effectiveness, and address patient satisfaction, hospitals must address very common problems.

Most patients don't understand their discharge instructions.

Only 7% of U.S. health care organizations fully coordinate care between hospital, post-acute, and home settings.

$25-$45 billion in health care spending is wasted due to care coordination failure.

Effective, patient-facing coordination strategies are associated with **higher hospital ratings, higher patient satisfaction**, reduced readmissions, and cost efficiencies.

Change must start somewhere.

There are many options for care coordination strategies such as:

Utilizing patient navigators to:

- Prompt patients to follow their discharge instructions
- Encourage filling and taking prescriptions as ordered
- Coordinate timely access to primary care (or specialist)
- Find primary care physicians for patients
- Obtain timely appointments
- Escalate to nurse or physician as needed

Implement nurse outreach to:

- Answer additional questions about their care
- Escalate to NP/PA or physician as required

Provide supportive care via:

- Telemedicine
- Home visits
- Nurse practitioner or PA visits
- SNF encounters
- Return ED visit if needed

Addressing Care in the Gap is critical.

Be a part of the solution!

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