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Enhancing healthcare efficiency through IT

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Healthcare organizations today are pursuing a wide range of health IT initiatives in the hopes of reducing costs, improving efficiencies and, most importantly, enhancing patient care. While a great deal of attention is being paid to high profile health IT topics, such as electronic health records (EHRs) and health information exchange (HIE), there are basic aspects of the workflow at healthcare organizations that can also play a key role in driving healthcare efficiencies. One of these is the patient discharge experience.

How well patients are communicated with upon discharge is a leading threat to a healthcare organization's top-line revenue, as well as an endangerment to the patient experience. With Medicare/Medicaid regulations now making it difficult to collect revenue for a patient's second visit for the same problem within 30 days, special attention needs to be paid to how well healthcare organizations are preparing the patient when they walk out the hospital door-and at home following their release. Patients need to be able to understand their at-home instructions for post-visit care so they don't have to return to the healthcare facility for more treatment or instructions, which will negatively impact the hospital's revenue and the patient experience.

Creating a more effective discharge experience for patients requires providing clear, easy to read discharge instructions. Accomplishing this is not always a simple task given that the instructions typically are compiled from a large set of data feeds, gathered from multiple treating physicians and need to be provided in a language that the patient can understand. Health IT

can play a critical role in overcoming these hurdles.

Similarly, healthcare organizations will benefit from considering the archival system in place. It is important to have an archival process that will enable the organization to prove that discharge instructions were complete and comprehensive. This will avoid the potential for losing Medicare/Medicaid reimbursements in the event of an audit. Not having the ability to easily retrieve all relevant records exposes the healthcare organization to avoidable revenue loss.

What steps should healthcare organizations take to assess if they are being thorough in their patient discharge workflow?

1. Conduct a review of the documents that patients receive upon discharge

A careful review of discharge paperwork will help ensure that patients are receiving all of the pertinent information they need, including contact information for treating physicians, home care instructions, a list of medications and doses, instructions for obtaining any needed medical equipment, follow-up appointment dates and social services information, if applicable.

2. Examine the information flow from all of the service providers in the healthcare organization

Patients may be treated by multiple physicians, therapists and other clinical personnel. Moreover, each clinical department may have a different document workflow. Mapping these workflows is essential in order to ensure that all of the necessary information is available to the discharge planner or other personnel providing discharge instructions to the patient.

3. Establish safeguards to avoid confusing instructions and misinformation

Precautions should be in place to flag potentially conflicting instructions resulting from a lack of coordination between clinical departments and/or treating physicians. For example, a patient may receive multiple recommendations to use a medication, such as acetaminophen, that when combined would cause an unsafe dose.

A failure to coordinate the information provided to a patient from disparate departments within the healthcare organization could lead to a poor understanding of the discharge instructions. This, in turn, can result in otherwise avoidable follow-up visits due to a misunderstanding of the treatment plan or a worsening of the patient's condition.

Healthcare IT can play an important role when it comes to ensuring patients receive clear, easy to understand and accurate information upon discharge. Here are five key considerations when evaluating technology to help consolidate the data and make discharge instructions more accurate and automated:

1. Envision the perfect communication and determine what data and content is needed.
2. Ensure that your communication IT infrastructure can access and use all essential information.
3. Do you have the ability to incorporate graphics in discharge communications and provide them in multiple languages that will make the information easier to understand?
4. Can you deliver the discharge document in a variety of formats?
a. Patients may keep paper-based discharge instructions at home.
b. They may want prescription information on their smartphone when they are at the pharmacist.
c. They may want to browse discharge information on a tablet, for example, to research medication side effects or view educational websites.
5. Do you have the ability to share discharge documents securely with relevant archival systems?

For many healthcare organizations, patient communications involve a number of complex, unorganized data points. In those cases, the patient has to make the information useful on their own to facilitate a successful recovery-and without a detailed understanding of medical, legal or insurance-related jargon. To improve the outcome, a discharge statement must turn data into organized information, and then strive to turn that information into insight that can support a better outcome for the patient and the healthcare provider.