Letter to the Editor

Enhancing Patient Education and Medication Reconciliation Strategies to Reduce Readmission Rates

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To the Editor:

With the rollout of the Hospital Readmissions Reduction Program (HRRP) in 2012, hospitals are facing steep financial fallout if they are unable to align readmission rates with heightened quality standards. It is part of a concerted effort by the Centers for Medicare & Medicaid Services (CMS) to improve the unacceptable rate of patients readmitted to hospitals; this currently equates to 1 in 5 Medicare patients within 1 month of discharge.

In the program's first year, 65.5% of the 3,400 hospitals falling under HRRP were hit with penalties, totaling \$280 million in losses. The financial risks associated with the program are expected to escalate, as the percentage of affected reimbursement moves from 1% in the first year to 2% in the second and 3% in the third.

Enhanced medication reconciliation and patient education strategies are critical ways for hospitals to reduce readmission rates. A growing body of research suggests that lack of attention to these two areas is a contributing factor to the revolving door effect of patients discharging from and re-entering hospitals.^{1,2}

A recent report from the Institute of Medicine (IOM) points to an alarming rate of limited health literacy among American adults – nearly half (90 million people) – when it comes using and understanding written health information.³ The report also points to a higher rate of hospitalization and use of emergency services among these patients due to complications with medication use or adverse drug events (ADEs).

An article by the American College of Clinical Pharmacy⁴ points to the critical role that ADEs play in readmission rates and how ineffective care transitions, especially as they relate to medication management, exacerbate the situation. The paper outlines the key role that pharmacists play in performing medication reconciliation and obtaining admission drug histories to avoid potential prob-

lems. Going forward, hospital pharmacy departments will need to take a greater role in developing programs that foster collaboration between clinicians providing care to an individual patient so that patient education and medication reconciliation are at the forefront of quality and safety strategies. If pharmacists are providing these services prior to discharge and engaging with patients after discharge to ensure a clear understanding of medication use and care, the potential for readmission should be greatly reduced.

OVERCOMING BARRIERS TO HEALTH LITERACY

Lean budgets and limited staff resources often mean that pharmacists are pulled in many directions to cover everything from medication adjustments and preventing adverse events to helping indigent patients obtain the medications they need. Patient education can get lost in the fray by a clinician with a long to-do list.

In addition, many patients may find it difficult to speak up or ask questions when they don't understand something. In the present environment, it is easy to see how patient education opportunities can be missed or not given the emphasis necessary to optimize patient results. Current research shows that a wide communication gap exists between providers and patients in regard to basic medical terminology and the practical importance of the information presented.⁵

A number of things should be considered by hospitals that are attempting to better integrate effective patient education programs into clinician workflows to overcome barriers to health literacy. Ownership of initiatives designed to improve patient education should not be limited to pharmacy personnel. First and foremost, health care organizations need to ensure that all staff are trained and skilled at providing relevant and useful patient education.

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Basic teaching skills are one component of a successful education program that may be overlooked, if clinicians believe that they can serve their patients simply by offering a printed handout or video link and asking patients if they have any questions. To provide patients with the knowledge they need, clinicians should include teach-back and return demonstration techniques to evaluate the patients' level of understanding. When patients are able to verbally provide a detailed explanation of what they have been taught, clinicians can be confident that comprehension has been achieved. All clinicians need to be trained in these and other education methods as a foundational component to an effective patient education program.

It is also important that clinicians view patient education as a two-way conversation. By assessing the learner's understanding through question-and-answer sessions, educators are able to individualize what needs to be taught. This assessment conversation can maximize the clinician's most precious commodity – time. Knowledge about what the learner already understands and has been taught provides a foundation of existing concepts upon which crucial, need-to-know, information is added.

Continuity and consistency are other concepts that should be part of any education strategy. Patient education must begin at admission and continue throughout the hospital stay, and the message needs to be consistent across what is being verbally taught and what is written or viewed. When teaching is not viewed as an additional step, but instead as part of every interaction, patient education becomes part of the organizational culture.

The critical next step is to arm clinicians with the most effective tools for providing patient education. Electronic education materials must cover a broad scope of potential issues in a readily understandable and straightforward way that is flexible enough to be used with patients of all ages, races, income levels, and education levels. Patient education content developers generally recommend that materials be written to accommodate readers between the 5th- and 7th-grade levels. Further confirming the need for information to be written as simply as possible, the National Assessment of Adult Literacy has determined that 87% of the US population has below basic, basic, or intermediate literacy skills.⁶ Educational materials should include bulleted, short statements of relevant

information. Materials should be printed in larger fonts for the vision impaired. Language support is critical to addressing further health literacy complications when dealing with non-English-speaking patients. As a result, the most effective applications support the need for patients to read materials in their native language. The National Standards on Culturally and Linguistically Appropriate Services intends that health care organizations must “provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.”⁷

An organizational commitment to a strong patient and family education culture where strategies are integrated and reflected in organizational goals, strategic plans, job descriptions, and quality metrics is a crucial foundational requirement. Policies and procedures must be in place to guide, support, and emphasize the patient education process, and resources must be dedicated and available.

STRATEGIES FOR EFFECTIVE MEDICATION RECONCILIATION

Like patient education, effective approaches to medication reconciliation can get lost among the myriad of duties performed by pharmacists and clinicians. The unfortunate reality is that transitions from one health care setting to another substantially increase the risk of ADEs due to unintentional changes in patient medication regimens.

Research reveals that unintended medication discrepancies occur in nearly one-third of patients, both at the time of admission and during transfer from one unit of a hospital to another.⁸ Another 14% of these discrepancies occur at discharge.⁹ When a patient's complete medication regimen is reviewed at the time of admission, transfer, and discharge and then compared with the medications being considered for a new setting, the potential for ADEs – and subsequently readmissions – can be minimized. Thus, the ability to gather a complete preadmission medication list at the time of admission and provide a patient with a medication list at the time of discharge is imperative to medication reconciliation. Drug reference tools can play a key role in the process of checking or revising medication information to ensure proper dosing and confirm that the correct medication information is provided.

A number of foundational concepts to medication reconciliation programs have been outlined by the American Pharmacists Association and the American Society of Health System Pharmacists.¹⁰ These include:

- Implementation of standardized processes and procedures that guide health care teams in providing medication reconciliation during each step of patient care continuum to maintain continuity and improve safety;
- Inclusion of patient engagement strategies as a central component to address individual concerns and empower patients to take a more active role in medication management;
- An interdisciplinary, collaborative approach with clearly defined roles that include the patient;
- A culture of accountability among clinicians where roles and responsibilities are clearly understood;
- Coordinated communication that includes standardized medication lists, medication administration programs (MAP), interventions, and referrals;
- Adoption of the service model for medication therapy management to support a standardized approach for uniformity;
- A foundation of automation and technology to close the communication gap between health care professionals.

Successful strategies for addressing effective patient education and medication reconciliation will play an important role in a health care organization's efforts to reduce the potential for significant monetary penalties that may be associated with readmission rates. Enhancing focus on these 2 areas will result in higher quality and improved patient safety. These efforts are a necessary step toward enhanced care delivery, empowerment of patients in their care, and a reduction in the costs associated with revolving door readmissions.

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