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THE INFORMED PATIENT

By LAURA LANDRO



Keeping Patients From Landing Back in Hospital

December 12, 2007; Page D1

Hospitals are taking steps to prevent the most common risk to patients after discharge: landing back in the hospital due to complications that could have been prevented with better follow-up care.

Signs of Heart Failure

**If you have one or more
of these symptoms:**

- Weight gain of 3 pounds in 1 day or more in 1 week
- Weight gain of 5 pounds or more in 1 week
- More shortness of breath
- More swelling of your feet, ankles, legs or stomach
- Feeling more tired – no energy
- Dry, hacking cough
- Harder to breathe when lying down
- Chest pain

 Call doctor _____
 at _____

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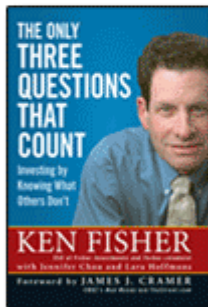
One hospital sends a refrigerator magnet home with heart-failure patients

readmission rates are coming under increasing scrutiny from regulators, insurers, employers and quality-measurement groups, who are considering methods to tie payment to lower

A revolving door of readmissions is driving up costs for hospitals and causing needless harm to patients, especially elderly people with multiple chronic diseases. Nearly 18% of Medicare patients admitted to a hospital are readmitted within 30 days of discharge, accounting for \$15 billion in spending, according to the Medicare Payment Advisory Commission, the independent federal body that advises Congress on Medicare. As a result,

**According to
Jim Cramer,**

**“It could be
the kind of
book that
changes
the face of
investing
from here
on out...”**



readmissions.

"We have to start paying attention to people's needs beyond the hospital door," says Mary Naylor, a professor at the University of Pennsylvania's School of Nursing. She has conducted a number of clinical trials on a model to help older adults with complex care needs after they are discharged.

"The experience of multiple hospitalizations can take a devastating toll on the human psyche and the quality of life for patients and their caregivers," she says.

There are about five million readmissions a year in U.S. hospitals, with approximately a third occurring within 90 days of discharge, according to the Institute for Healthcare Improvement, a Boston-based nonprofit. But with so-called transitional-care programs, which follow patients for varying periods of time at home, as many as 46% of readmissions could be prevented, says Pat Rutherford, an IHI vice president.

The institute is working with hospitals to reduce readmissions. Its programs include: identifying patients at risk for return, scheduling follow-up doctor's appointments before patients are discharged, sending nurses to patients' homes within a few days of discharge, monitoring patients at home, and educating patients and families on how to adhere to medication schedules and self-care regimens.

Still, hospitals often don't provide such services. Even patients who qualify for home care frequently don't get referrals that would help, and in one survey, 64% of patients said no one at the hospital talked to them about managing their care at home.

Part of the problem is that hospitals aren't paid to coordinate care change: Large managed-care groups and insurers are now experimenting with such services. Both [Aetna](#) and Kaiser Permanente, the California-based pilot programs based on Dr. Naylor's model. Her studies show that such services for at-risk hospitalized elderly patients can reduce readmission and discharge, and cut the cost of providing care.

Broad Rollout Is Possible

If pilot programs in Chicago and Philadelphia do succeed in reducing readmissions, such programs could be rolled out more broadly, says the director. "We believe this can improve the quality of care for many patients while reducing the costs of care by a larger amount than the cost of the

IHI and other groups are focusing in particular on follow-up care for patients with congestive heart failure, the leading cause of hospitalization among older patients. According to Ms. Rutherford, almost a third of heart-failure patients are readmitted within 30 days of discharge with complications from the condition, in which the heart can't pump enough blood to the body's other organs. Changes such as sudden weight gain can signal a crisis, so diet and exercise must be closely monitored, along with adherence to treatments such as blood-pressure medications after a patient leaves the hospital.

Stayir

A checklist

- Get in touch with your doctor about your care plan.
- Make sure you have an appointment for transportation.
- Ask for a name/number for your doctor.
- Under-stand your condition and take it seriously.

Source: IHI,

St. Luke's Hospital, a Cedar Rapids, Iowa, institution that's affiliated with IHI, collaborated with IHI on a program called Ideal Transition Home. The program works with local doctors and an affiliated home-care group to coordinate care.

Among other things, it uses a method called Teach Back, asking patients to repeat in their own words what they've been told about how to follow care instructions. The program also uses a refrigerator magnet that includes a list of symptoms to watch for. Gail Nielsen, Clinical Performance Improvement Education Administrator at St. Luke's, says the program helped the hospital cut unplanned-readmission rates by 10 percent.

David Dunn, a 69-year-old retired golf-course manager suffering from congestive heart failure and kidney disease, was admitted to St. Luke's earlier this year to treat his arteries; with a history of repeated hospitalizations, he was signed up for the program, which included follow-up visits by home-care nurses and special monitoring for his condition.

"The care was so much better than anything we'd experienced," says Dunn. "I recall other hospital stays marked by poor communication with the staff. It was really crucial, because there were so many things going on with my condition."

Cutting Through Red Tape

After patients who may be at high risk for readmission are discharged from St. Luke's Medical Center, nurses visit them -- cutting through red tape, if necessary -- to make sure they understand their care plan.

appointments. "We form trusting relationships with the patient, a could get them back in the hospital," says Jill Murray, a nurse in

One grateful patient is 78-year-old Irwin Goldner, a retired cloth this year with pneumonia and complications from heart failure ar nurses in the program accompanied him to doctor's appointments make sure he was taking his medication correctly and watching h their instructions to the letter in order to avoid going back in the says. "I like living."

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