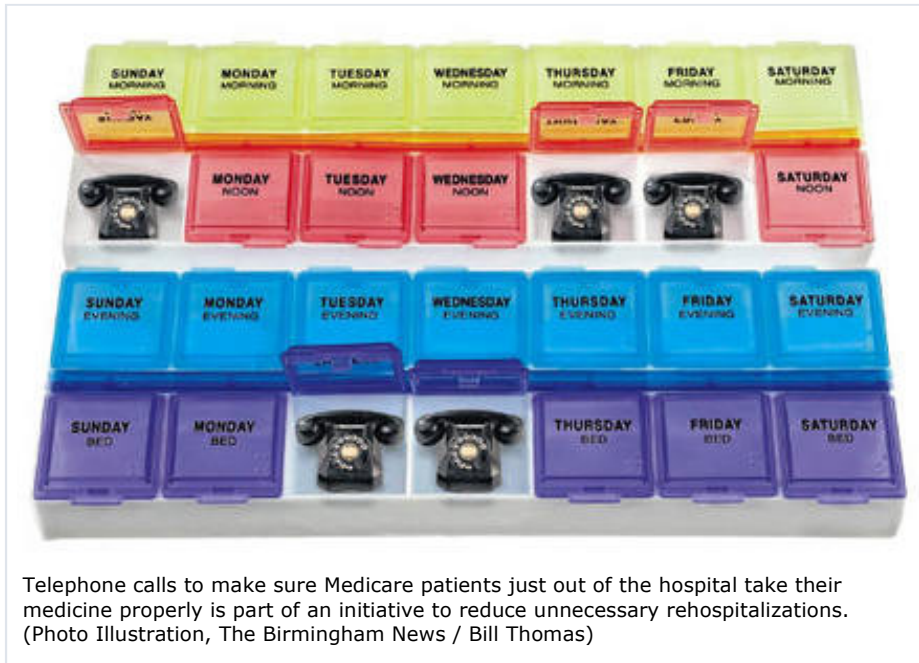




Project aims to reduce hospital readmissions through better communication and organization

By Anna Velasco -- The Birmingham News

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One in five Medicare patients discharged from the hospital lands back in the hospital within 30 days.

More than 75 percent of those readmissions are preventable, according to the **U.S. Centers for Medicare & Medicaid services**. Some of the avoidable reasons patients return so quickly to the hospital are because they didn't understand how to care for themselves, didn't get to the doctor soon enough, couldn't afford their prescriptions or didn't understand how to take their medicine.

The problem is both bad for patients and costly to the federal government, provider of health coverage to those 65 and older and the disabled.

AQAF, the Alabama nonprofit group contracted by the federal government to improve Medicare quality in the state, is one of 14 groups nationwide piloting a "care transitions" project aimed at curbing avoidable hospital readmissions. The group, through a \$2.6 million grant, is testing strategies in hospitals, nursing homes and home care agencies in Tuscaloosa and the seven surrounding counties.

That area provides both rural and urban patients and a high concentration of people with chronic diseases, AQAF officials said. Also, **DCH Health System**, which runs both DCH Regional Medical Center and Northport Medical Center, already was on board with trying to reduce readmissions.

The three-year project runs through July 2011. The first phase was assessment, but health providers have now started to implement suggested interventions. Ideas implemented so far for Medicare patients include:

>> Providing patients, before they're discharged, detailed education on their medicine, diagnosis and the need to follow up with doctors.

>> Giving patients pill planners to help them organize two weeks' worth of medicine.

>> Having a nurse from the discharging hospital call to check up on heart failure and pneumonia patients. The nurse calling asks whether the patient understood discharge instructions, has made an appointment with the doctor and can afford the prescribed medicine.

>> Having home health agencies call high-risk patients shortly after hospital discharge to ensure their needs are met even before the nurse comes for a visit.

"With this project, we have the ability to impact individual patients' lives," said Sherrie Smith, an AQAF quality resource specialist.

While AQAF is focusing its work on Medicare patients, DCH Health System is expanding interventions to all patients, no matter who pays the hospital tab. For example, DCH has hired a nurse full time to call all heart failure, pneumonia and surgical patients after discharge from DCH Regional and Northport Medical, and plans to do it for all patients regardless of why they were in the hospital. They are also calling patients at risk for congestive heart failure, even if they have not been diagnosed with the chronic disease.

"It's just the right thing to do," said Brian Pisarsky, director of case management for DCH.

DCH Regional also has started staffing the emergency department with case workers who can help frequent ER patients connect with other health resources in the community, so that for future health needs they can seek a more appropriate level of care.

AQAF also plans to start "coaching" patients at high risk for readmissions through two to three home visits to educate the patients on what questions to ask their doctors and how to use the pill planner.

Through the pilot project, nursing homes and home health agencies have met as groups regularly with hospitals to clarify what type of information they need the hospitals to send to provide a smoother transition for the patients.

Marcia Bailey, director of home care for DCH Home Health Care Agency, said her agency started calling high-risk patients within a day of their discharge from the hospital as of July 1 to offer additional help.

"The patients seem to appreciate the contact," she said. "We've been able to get patients in to see their doctors sooner, depending on their symptoms. .. You can be overwhelmed after an illness very easily, especially the elderly population."

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