

Better medication data and home care cut hospital readmissions  
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Older patients who return home after a hospital stay sometimes barely get their bags unpacked before they wind up back in a hospital bed.

Doctors might discharge them without good instruction on what pills to take and when. Primary care doctors don't always receive adequate information from hospitals on new drugs their patients were prescribed.

And some patients lack help with care at home, leading to infections from wounds not properly cleaned or undetected changes in vital signs.

The problem has drawn attention from Medicare, which is looking for solutions to what has become for too many patients nationwide a revolving hospital door.

Of the roughly 19,000 people on Medicare admitted to hospitals in Douglas and Sarpy Counties annually, nearly one in six returned to the hospital within 30 days, slightly less than the national average.

"We weren't as thorough with communications as we should be," said Dr. Stephen Smith, chief medical officer at the Nebraska Medical Center.

Local hospitals say they have taken steps to alleviate the problem, which could benefit all patients. Changes include better planning for in-home nursing and more consistently informing patients' doctors about new medications. They also are working with Medicare to reduce the number of readmissions as part of a project involving 14 communities nationwide.

Not only is a return to the hospital not ideal for patients, but it also results in additional Medicare spending.

Readmissions within 30 days of discharge accounted for \$15 billion in spending nationally in 2005, according to the most recent figures from the Medicare Payment Advisory Commission. In Nebraska, yearly spending per Medicare patient rose at a faster rate than in any other state from 1992 through 2006, according to a recent national report.

Mary Holbrook of Omaha was in and out of Methodist Hospital four times last year. The 85-year-old suffers from severe lung disease.

Two returns to the hospital occurred seven weeks or less after she had been released. She hated returning.

"I never knew if I was going to come (back) out or not," said Holbrook, who takes more than a dozen pills daily. "It was a nerve-wracking fear."

Holbrook and her family said she received good care at Methodist, was not discharged too early and received proper information from the hospital on medications.

But once home, Holbrook couldn't monitor her vital signs.

Her oxygen level would dip, aggravating her lung disease and leaving her gasping for breath. She would wind

up back in the hospital to have fluid removed from her lungs.

Last year she started receiving help from the Visiting Nurse Association, which set up equipment in her home to remotely monitor Holbrook's oxygen level and other vital signs.

If her oxygen level drops too low, Holbrook gives herself breathing treatments and with her doctor's approval can take an increased dose of a steroid to help her breathe. She is on a Medicare plan that covers home health care.

Kevin Rochford, an administrator at Methodist, said the hospital encourages patients who will need home health care to seek it. Discussions with patients start in advance of discharge.

Not all patients, he said, line up home health care as soon as they should.

The hospital is tracking 20 pneumonia patients who receive home health care after discharge and a group that doesn't. Methodist expects that patients who receive the care will have lower chances of readmission. The results will be presented to other patients to encourage them to seek assistance.

Other hospitals are taking steps to reduce readmissions.

Creighton University Medical Center has expanded its meetings of nurses, therapists and social workers who discuss patients' care at the hospital and services needed once discharged.

The hospital used to hold meetings twice per week and only for long-term patients with complex medical conditions. Since January the hospital has held the meetings at least five days a week using multiple teams of nurses and other staff. They talk about all patients.

About two years ago the Nebraska Medical Center began to more consistently provide primary care doctors reports within 48 hours explaining the treatment and medications patients received.

The hospital estimates that 85 to 90 percent of patients' doctors now receive the reports by fax and mail within 48 hours after discharge. The reports also are available immediately on a secure Web site.

Alegent Health hospitals used to hand patients a list of new medication and doses when they were discharged, but that process was "probably fraught with problems," said Dr. Mark Kestner, chief medical officer for Alegent.

Alegent in the last year has made changes such as e-mailing and faxing such lists to all patients' doctors, as well as giving copies to patients. Alegent hospitals also more routinely make follow-up calls to patients to make sure they understand what medications to take or how to change bandages. ,

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