

Leaving hospital? Heed care tips or you may return

LAURAN NEERGAARD - AP Medical Writer - Associated Press

Michael Lee knew he was still in bad shape when he left the hospital five days after emergency heart surgery. But he was so eager to escape the constant prodding and the roommate's loud TV that he tuned out the nurses' care instructions.

"I was really tired of Jerry Springer," the New York man says ruefully. "I was so anxious to get out that it sort of overrode everything else that was going on around me."

He's far from alone: Missing out on critical information about what to do at home to get better is one of the main risks for preventable rehospitalizations.

"There couldn't be a worse time, a less receptive time, to offer people information than the 11 minutes before they leave the building," said readmissions expert Dr. Eric Coleman of the University of Colorado in Denver.

Hospital readmissions are miserable for patients, and a huge cost — more than \$17 billion a year in avoidable Medicare bills alone — for a nation struggling with the price of health care.

Now, with Medicare fining facilities that don't reduce readmissions enough, the nation is at a crossroads as hospitals begin to take action.

"Patients leave the hospital not necessarily when they're well but when they're on the road to recovery," said Dr. David Goodman, who led a new study from the Dartmouth Atlas of Health Care that shows different parts of the country do a better job at keeping those people at home.

And The Associated Press, teamed with the Robert Wood Johnson Foundation, found hospitals are hunting innovative ways to fix a key hole in this health care: Those missed instructions.

In Portland, Ore., nurses at Oregon Health & Science University start teaching heart failure patients what they'll need to do at home on their first day in the hospital, instead of just on their last day.

In Salt Lake City, a nurse acts as a navigator, connecting high-risk University of Utah patients with community doctors for follow-up treatment and ensuring both sides know exactly what's supposed to happen when they leave the hospital.

Some techniques are emerging as key, Coleman said: Having patients prove they understand by teaching back to the nurse. Role-playing how they'd handle

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Published on Bioscience Technology (<http://www.biosciencetechnology.com>)

problems. Finding a patient goal to target, like the grandmother who wants her heart failure controlled enough that her feet don't swell out of her Sunday shoes.

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You'd be mad at having to return your car to the mechanic within a month, yet rehospitalization after people get their hearts repaired too often is treated as business as usual, laments Dr. Ricardo Bello, a cardiac surgeon at New York's Montefiore Medical Center.

Heart surgeons try to prevent that by re-examining patients two to three weeks after they go home. But Montefiore patients tend to be readmitted sooner than that.

So last fall, Bello's team began a special clinic where nurses check heart surgery patients about a week after they go home, at no extra charge — and have a chance to re-teach those discharge instructions when people are more ready to listen.

Plus, for that first month at home, patients are supposed to wear a bracelet with a phone number to reach Montefiore's cardiac unit 24 hours a day with any worries.

"It changed my conception of dealing with a doctor," said Michael Lee, 60.

Montefiore surgeons repaired a life-threatening crack in Lee's aorta, the body's main blood vessel, but his recovery derailed days after getting home. He quit some medications. He was scared to wash the wound that ran from chest to navel, an infection risk. He developed a scary cough and called that special clinic in a panic.

It turned out the cough was a temporary nuisance — but nurses discovered a real threat: Lee's blood pressure was creeping up, a risk to his healing aorta. Those pills Lee quit were supposed to keep it extra low, a message he'd missed. And some hands-on instruction reassured Lee that he could handle his wound without tearing it.

Without the clinic, "he's definitely somebody we would have been called to see in the emergency room," said physician assistant Jason Lightbody.

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In heart failure, a weakly pumping heart allows fluid to build up until patients gasp for breath. Spotting subtle early signs like swelling ankles or creeping weight gain is crucial. But at the Oregon Health & Science University, nurse practitioner Jayne Mitchell spied as patients were told what to watch for as they were discharged — and they barely paid attention.

The new plan: Learn by doing.

Every morning, hospitalized patients weigh themselves in front of a nurse, record the result and get quizzed on what they'd do at home. Gained 2 pounds or more? Call the doctor for fast help. Lots of day-to-day fluctuation? A weekly log can help a

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doctor tell if a patient is getting worse or skipping medication or having trouble avoiding water-retaining salty food.

Step 2: These patients need a check-up a week after they go home. The hospital makes the appointment with a primary care doctor before they're discharged, to ensure they can get one.

And for some high-risk patients who live too far away to easily track, Mitchell is pilot-testing whether a high-tech option helps them stick with care instructions.

During that first vulnerable month at home, those patients record their morning weight, blood pressure and heart rate on a monitor called the Health Buddy. It automatically sends the information back to Mitchell's team at OHSU and also will flash instructions to the patient if it detects certain risks.

In Sun River, Ore., Richard W. Pasmore's phone rang one morning. Nurses three hours away in Portland saw that his weigh-in was high and adjusted his medications over the phone.

The 67-year-old Pasmore thinks it prevented a return to the hospital: "It kept them totally abreast of everything that was happening with me." And by the end of the month, he says he'd gotten in the habit of his morning heart failure checks.

At the University of Utah, nurse Stephanie Wallace links high-risk patients to the outside care that could keep them from returning. And she's the one whose phone rings when that care falls through.

Consider the single mother who couldn't afford post-hospital blood tests to make sure her blood-thinning medication was working properly, or time off work to get them and didn't speak enough English to seek help. When the woman missed her lab appointment, Wallace pieced together the trouble, helped her enroll in a program for low-income patients — and stressed the importance of sticking with this care.

"It's not that they don't understand why they're sick. They don't grasp the importance of why they need follow-up," Wallace said.

The customized programs reflect the Dartmouth study's findings that there's great geographic variability in hospital readmissions.

In Miami, for example, more than a quarter of Medicare patients with heart failure returned to the hospital within a month in 2010, the latest data available. That's double the readmission rate for those patients in Provo, Utah.

In Dearborn, Mich., the readmission rate for pneumonia was 20 percent, twice that

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of hospitals in Salt Lake City.

"Every place is different and faces different challenges in terms of improving care after patients are discharged from the hospital," Goodman said.

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