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Patient Coaches Improve Quality, Cut Costs

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The early returns of a pilot project designed to reduce unnecessary hospitalizations among seniors have been no less than remarkable, according to Louisiana Health Care Review officials, the leaders of the project.

So far, participants in the Care Transitions Collaborative have slashed their readmission rates among the elderly from 18 percent to 4 percent, said Laurie Robinson, LHCR quality improvement director and a registered nurse. The five hospitals participating in the three-year, \$2.1 million pilot project are Baton Rouge General Medical Center, Lane Regional Medical Center, Ochsner Medical Center – Baton Rouge, Our Lady of the Lake Regional Medical Center and St. Elizabeth Hospital in Gonzales. More than 10 Baton Rouge-area home health agencies are also participating, including Amedisys Home Health, Health Care Options, Feliciano Home Health, Pinnacle Home Health, Lane RMC Home Health, Delta Home Health, Pointe Coupee Homebound Health Services, and Audubon Home Health.

The federal Centers for Medicare & Medicaid Services awarded the grant last year, Robinson said. The agency's goal was to reduce the readmission rates by a minimal amount, 2 percent or so.

"We knew we could do way better than that," Robinson said.

During the first six months, the Care Transitions Collaborative worked with 93 patients, and only four were readmitted to hospitals. Under normal circumstances, 17 of those patients would have returned to the hospital unnecessarily.

The project is targeting patients 65 and older who have been admitted to the hospital after a heart attack and patients with congestive heart failure or pneumonia.

The program works, Robinson said, by pairing older patients with a health coach. The coach begins working with patients while they are still in the hospital, but Robinson said the real action takes place after the patient leaves a facility.

Often times, patients and their caregivers are too overwhelmed at the time of discharge to pay close attention to the instructions from their doctor or nurse. The patients are tired and ready to be home. They may not remember the directions on what medicines to take and when, how much rest they should be getting, what and when to eat and when to make a follow-up doctor's appointment.

In Care Transitions, the health coach meets the patient when he or she is admitted to the hospital, Robinson said. The coach helps the patient know what to expect during the hospital stay and after discharge.

By the time the patient is ready to leave the hospital, he or she has been given advice and information about managing his other care. The health coach provides information on everything from diet and exercise and medications and their potential side effects to scheduling an appointment with the primary care physician and what to do if something goes wrong.

Just as important, the health coaches also follow up with patients, which helps ensure a smooth transition, Robinson said. The health coach meets with the patient before leaving the hospital and within two days of checking out of the facility. The health coach also calls the patient one week after discharge, at the two-week mark and one month after discharge, she said. The follow-up work smoothes the transition for patients and helps ensure continuity of care.

Coaching activities include helping patients make a list of questions for their primary care physician and teaching patients the correct medical terms so they can better communicate with their healthcare providers.

Baton Rouge is one of 14 communities chosen for the CMS pilot project. Louisiana Health Care Review officials hope their project can become the national model. The LHCR and many other industry experts consider preventable hospitalizations an indicator of poor quality care and higher costs. In Louisiana, two out of 10 chronically ill patients discharged from the hospital end up being readmitted within 30 days. In 2007, the Commonwealth Fund reported that Louisiana had the highest Medicare 30-day readmission rate in the country.

The high rate of preventable hospitalizations was a major reason Louisiana ranked last in United Health Foundation's 2008 America's Health Rankings.

The problem isn't limited to Louisiana.

The Medicare Payment Advisory Committee estimates that 76 percent of Medicare readmissions may be preventable. Reducing those readmits would cut Medicare costs by an estimated \$12 billion a year.

Robinson said it's unclear exactly how much hospitals save by using the health coaches, but a day in the hospital amounts to hundreds if not thousands of dollars. And the price may become even steeper. The Obama administration has proposed penalizing hospitals with high rates of readmission starting in 2012. The administration wants to bundle payments to hospitals to cover hospitalization and some post-acute care for the 30 days after hospitalization.

Peter R. Orszag, director of the White House's Office of Management and Budget, said the combination of incentives and penalties should lead to better post-hospital care and save \$26 billion over the next 10 years.