

Avoiding Revolving Door Hospitalizations: How Not To Be A “Frequent Flyer”

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Martin D. is an 84-year-old retired engineer. He lives alone, drives, and is reluctant to have home health care or any alternatives in his current living situation. Mr. D. believes “he is doing the best he can, given the circumstances.” He was recently hospitalized for Congestive Heart Failure and is again having chest pains and shortness of breath, so he has once again called 9-1-1. This will be Martin’s third trip to the hospital in two months and could now be referred to as an admission “frequent flyer.”

Older adults are particularly vulnerable to needing ongoing medical attention when the discharge home from the hospital does not plan for ongoing professional care coordination and management.

A recent New England Journal of Medicine study offers some startling statistics: Five percent of Medicare recipients are readmitted to the hospital

within five days of discharge; 20 percent are re-admitted within a month; and at 90 days post-hospital discharge, the percentage of Medicare readmissions rises to 35 percent.

Many readmissions, which are so traumatic for older adults and their families, cost the health care system millions of dollars and are preventable. There are multiple approaches currently being started and designed to address this ever-growing issue. Several provisions mandated in the Affordable Care Act seek to reduce frequent hospital readmissions by encouraging hospitals to improve their post-hospitalization care coordination and follow up services.

Some key causes of hospital readmission include poor communication between doctors and other members of the patient’s care team, conflicting or misunderstood medical information and instructions, missing doctor’s appointments and medication errors. Studies have also indicated that almost half of readmissions are linked to lack of community services and follow up care.

It is well known that a large percentage of Medicare patients require assistance with daily needs in the period following hospitalization.

One recent study indicates that a patient who lives alone and does not receive support upon discharge home is **twice** as likely to be a “frequent flyer” as someone who does have support at home. However, the reality is that many family caregivers are not able to assist with the increased care needs of their loved one weakened by a hospital stay and illness.

Some critical things to consider and address upon hospital discharge include:

1. Asking for specific, clear follow up instructions in “every day” terms you can understand. A family member, trusted friend, or professional geriatric care manager should be with you to listen, as well. Your discussion should include your diagnosis and reason for hospitalization, a list of all medications you will be taking and why, including review of any medications you were previously taking. And, specifically ask what you can do to avoid returning to the hospital.
2. Ask what signs and symptoms you should be aware of and should be monitoring at home.

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| <p>3. What would indicate an infection? What should you do and whom should you call if and when you notice these symptoms?</p> | <p>been ordered and delivered prior to your discharge.</p> | <p>appointments for Martin's care after his discharge.</p> |
| <p>4. Discuss follow up appointments and therapies, who will be providing them, when they will occur and how can you reach that particular provider. Typically, a nurse will review your discharge and provide you with a written summary.</p> | <p>7. How will you get home safely the day of discharge?</p> | <p>Post-hospital care coordination includes maintaining open lines of communication with the client's family pre- and post-hospitalization. In Martin's case, this would be Martin's son, Ben, who lives out of state. On a regular basis, contact with a care manager would allow Ben to stay at his home yet continue to still be aware and involved in his father's care.</p> |
| <p>5. Will you receive home health services and rehabilitation? Will your at-home services be covered by Medicare? When will the services begin and how long can you expect them to continue?</p> | <p>8. What awaits you at home? Is there food in the pantry? Do you need to go to the bank? Who is available to assist you with these tasks?</p> <p>Had Martin been a client of Elder Life Management, his care manager would have been at the hospital the day of discharge and would have consulted with him to follow up on all these questions and issues. Care Managers are post Masters trained social workers or nurses that work closely with the hospital social worker, case manager, the doctors and other professionals that provide care while a client is hospitalized</p> | <p>The Care Manager can bridge the gap between you, the doctor and the hospital. Their expertise covers finance, legal issues, organization, government programs, behavioral health, and more. A Care Manager is skillful in recognizing when a discharge is premature or overdue, and can be the extra support needed during a stressful and emotionally challenging time. This would enable you to keep your focus where it needs to be: getting home safely and staying there.</p> |
| <p>6. Obtain confirmation that any needed medical equipment has</p> | <p>The Care Manager would also schedule and attend follow up</p> | |

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