

## Guest Column

### We need to break the cycle of re-hospitalizations; how you can help

By Gary Oppedahl

As we discuss, as a nation, the costs and approach to healthcare in the United States, here is an issue: One out of every five Medicare patients discharged from a hospital will be back in the hospital within 30 days.

What can you do about this alarming trend? Familiarize yourself with the main causes of re-hospitalizations and help others get help when dealing with the healthcare system.

Here's the problem: We all used to have a "family doctor" who knew everything about us and would follow us into the hospital, through our hospital stay, and be there when we left the hospital. This is no longer the case. Now, your PCP (primary care physician) may not even know you have been in the hospital. You will be assigned a "hospitalist" while in the hospital. A hospitalist is (another) specialist who only works in the hospital. All the "ists" in your life (cardiologist, orthopedist, there are even "Nocturnalists", doctors who only work at night!) lead to a care model that can be disjointed and confusing.

The three major causes of re-hospitalizations and emergency room visits:

- Medications
- Falls
- Ignorance of Signs and Symptoms

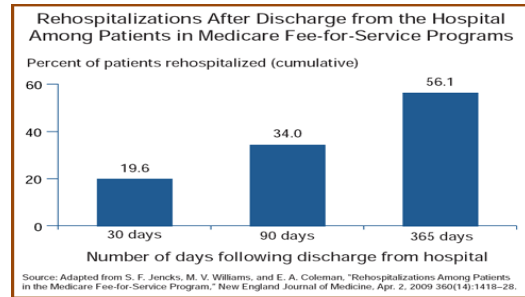
#### Protect Against Hospital Returns and ER Visits

In order to help, become an expert in the three major causes (above) of hospital readmissions and emergency room visits following a hospital stay. If you feel that you need help in this, there are "private duty" care management companies that can be extremely helpful. The private duty home care industry is built around a need for professionals to follow and assist individuals through the medical maze and every transition, especially from hospital to home. The guidance provided is based on a comprehensive care plan and availability of experienced practitioners that have current information about a clients and their family's goals, preferences, and clinical status.

It includes logistical arrangements, and client / family education, as well as coordination among the health professionals involved in the transition.

As a professional in the home care assistance industry I first became concerned with these transitions when I would see my clients coming home from the hospital with a plastic bag full of medications in addition to the shoebox full of medications already in their home.

These individuals often times had no idea if the medications in the box were the same as the ones in the plastic bag, and which ones they should take – the ones in the bag, the shoe box, or both.



This is how it works: When clients come home, we develop a baseline nursing assessment that includes medication reconciliation, fall risk assessment and client education on signs/symptoms of recurring or new issues.

**Medication issues:** Our nursing staff works with the client, the clients' doctors and the health plan pharmacist to ensure clients are taking only the appropriate medications. Help with medication adherence to reduce the chances for hospital readmission. Also, we provide each client with a compact medication booklet, that allows them to keep track of all their medications and they can take it with them to their doctor's office, pharmacist and/or hospital so that all health care providers will know which medications the client is on. (Call FootPrints Home Care at 828-3918 for your free copy of this booklet named "My Passport to Good Health")

**Falls:** Within the first few days home from the hospital we conduct a fall risk assessment in the home and/or living quarters. This should include educating the client on the top three causes of falls – proper medication use, ear and urinary tract infections, and proper foot care.

**Education on signs/symptoms of recurring or new issues:** Depending on the client's disease process, we educate the client and the family on what types of signs and symptoms they should monitor to ensure a full recovery. For example, if the client recently had a urinary tract infection, educate them to the signs/symptoms that would indicate the infection has returned.

### **Back at Home**

When clients are transitioning from the hospital back to their home, there are a couple of private duty components that need to be in place to ensure a successful transition and reduce the likelihood of the clients returning to the hospital.

For example, caregivers, whether family or professionals, should offer transportation to and from medical appointments, the lab, pharmacy and grocery store. They will prepare meals, do laundry and assist with activities of daily living. This is where caregivers can really come to the rescue and add value to their clients' overall recovery.

The challenge is that discharge planners often neglect the non-medical and paramedical parts of the client's care plan. Elizabeth Hogue (a prominent home healthcare attorney) recently published an article on the role of Private Duty professionals in discharge planning. Clearly stated in the position paper is that discharge planners have the responsibility to ensure that clients who are being discharged know that private duty care is available to help them with the nonmedical and paramedical support necessary for a full recovery.

We can all help in reducing health care costs in America while at the same time helping with better outcomes for our friends and loved ones by educating ourselves on the processes of care transitions, and the appropriateness and efficacy of various activities within the transitions.

***Gary Oppedahl is President and CEO of FootPrints Health Care Services. He has built a successful business helping people navigate the medical model. He was inspired by his mother's battle with a non-Hodgkin's lymphoma to create FootPrint's parent company; To Be A Blessing (TBAB) Health Care. He encourages calls on this subject can be reached at gary@tbabhcs.com or at 828-3918.***