Researchers study program to help older adults transition from hospital to home

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In light of health care reform measures, Rush University Medical Center has launched a study of its program to help older adults transition from hospital to home.

The goal of the study is to determine whether the program, first implemented two years ago, succeeds in reducing readmissions within 30 days for seniors. If it does, it could serve as a model for hospitals across the country that are seeking ways to lower their rates of readmission.

On average, one in five Medicare beneficiaries who are discharged from a hospital re-enter the hospital within a month. Reducing the rate of hospital readmissions to improve quality and achieve savings are key components of President Obama's health care reform agenda. Hospital readmissions cost Medicare an estimated $12 billion dollars annually.

"Patients who have been enrolled in our enhanced discharge planning program over the last two years are extremely pleased with the service," said Robyn Golden, LCSW, director of the older adult programs at Rush. "But beyond patient satisfaction, we now need to formally evaluate the program in a randomized, controlled study to determine whether our model—using social workers rather than nurses—not only reduces readmissions, but also reduces emergency room visits, avoids nursing home placements, and improves quality of life."

The program targets seniors 65 years of age and older who are discharged to their homes and have multiple prescribed medications, plus other risk factors.

Within 48 hours of discharge from the hospital, the patient receives a call from a Rush social worker, whose responsibility is to ensure full implementation of the discharge plan, assist with coordinating community resources and followup appointments, and intervene around any issues that might arise once the patient is back in the community. Those issues may range from transportation to meals and in-home care.

Over the two years of the Rush program, the social workers involved have found several common themes in post-discharge care. Patients reported difficulty getting around after discharge, particularly if their illness affected their mobility. Patients also reported difficulty scheduling medical appointments and getting to their physicians' offices, and delays in home health care services. Caregivers were often overwhelmed.

In other programs to help patients transition from hospital to home, nurses coordinate the after-hospital care, but Golden believes that social workers are ideally trained for the role.

According to Golden, research has shown that 40 to 50 percent of hospital readmissions are linked to social problems and lack of community services - issues that social workers are trained to address.

"Social workers possess extensive knowledge of community resources, expertise in navigating complex social systems, experience using a framework of practice that focuses on the person in the environment, and training in case management and care coordination," Golden said. "Social workers are also able to use psychosocial assessment skills to explore family dynamics or resources that may affect the success of the discharge plan."

In its efforts to find new ways to help patients transition from hospital to home, Rush is also participating in Project BOOST (Better Outcomes for Older Adults through Safe Transition), a national project involving 30 hospitals to redesign the discharge process. Rush is the only hospital in Illinois included in the project. Like Rush's enhanced discharge planning program, Project

BOOST, sponsored by the Society of Hospital Medicine, is aimed at reducing readmissions.

Source: Rush University Medical Center (news : web)