

For Immediate Release

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Direct Patient Coaching Works to Reduce Hospital Readmissions **Coaching Helps Patients Stay Out of the Hospital**

(Lansing, MI, February 8, 2010) — Patient coaching conducted with a select group of 40 patients at Ingham Regional Medical Center in Lansing, Michigan, showed a significant reduction in readmissions among that group, from September 2009 through January 2010. The data demonstrates the positive outcomes associated with patient coaching at discharge. The hospital's all-cause readmissions rate, based on Medicare claims data from January 2009 through June 2009, stood at 22.5%. Following patient coaching, the readmissions rate among the 40 patients improved to 12.5% according to hospital case management data.

The Greater Lansing Community has a 22.1% rate of hospital readmissions within 30 days of discharge based on Medicare claims data January – June 2009. The national rate is 17.6%. The process by which patients move from hospitals to other care settings is increasingly problematic as hospitals shorten lengths of stay and as care becomes more fragmented. Medicare patients report greater dissatisfaction related to discharges than to any other aspect of care that the Centers for Medicare & Medicaid (CMS) measures. The Medicare Payment Advisory Commission estimates that up to 76% of readmissions within 30 days of discharge may be preventable.

Ingham Regional Medical Center is an active participant in MPRO's Care Transitions Project, part of a national initiative to reduce readmissions within 30 days of discharge. Ingham County Regional Medical Center's data is the Lansing project's first glimpse to support the importance of patient coaching as an intervention to reduce unnecessary hospital readmissions.

"This is just a small sampling of patients, but the results are very encouraging, as they support the argument that patient coaching works to empower patients to take a more active role in their own care. This, in turn, helps to reduce potentially unnecessary hospital readmissions," said Lisa Cutcher, LMSW, CASWCM, Social Worker/Patient Coach, Ingham Regional Medical Center. Direct patient coaching involves working with the the patient and his/her caregiver at discharge to understand the following:

- Medication self-management
- How to incorporate a Personal Health Record into health care management
- The importance of timely follow up appointments with primary care/specialty care doctors
- Understanding any red flags that indicate a worsening of the patient's condition and knowing how to respond

"These interventions focus on the four conceptual domains referred to as pillars, which are part

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of the Care Transitions coaching model developed by nationally renowned expert Dr. Eric Coleman,” said Donna Beebe, RN, C, BSN, FACDONA, Care Transitions Senior Project Manager, MPRO.

The Care Transitions project is a national pilot program supported by CMS. Lansing is one of 14 communities selected by CMS to conduct this quality improvement work. The Lansing area program began in August 2008 and will run through July 2011. Ingham Regional Medical Center is working with numerous providers throughout the region and across health care settings to promote seamless transitions from the hospital to home, skilled nursing care, or home health care. The goal is not only to reduce hospital readmissions within 30 days of discharge but also to create a model for improving care transitions.

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The Greater Lansing Care Transitions project convened a Heart Failure Workgroup composed of representatives from all care settings and the community in fall, 2009. The Workgroup meets twice a month to discuss barriers and processes that can lead to systems improvements. In addition, MPRO is hosting one-day conference to discuss reducing heart failure readmissions. The conference is taking place on Wednesday, February 10, 2010, at Lansing Community College-West Campus. Lansing area providers and community members will gather to learn about national initiatives that are designed to reduce heart failure readmissions.

For further information about the Conference, go to: <http://www.mpro.org/pathways.htm>. Outcomes associated with the Care Transitions Project will be available by fall 2011.

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Editor’s Note: Provider partners in the Care Transitions Project include:

Hospitals

Clinton Memorial
Eaton Rapids Medical Center
Ingham Regional Medical Center
Sparrow Hospital
Sparrow Specialty Hospital

Nursing Homes

Burcham Hills Retirement Community
Holt Senior Care and Rehab Center
Dimondale Nursing Home
Eaton County Medical Care Facility
Ingham County Medical Care Facility
Okemos Health and Rehabilitation Center

Home Health/Hospice

Great Lakes Home Health and Hospice
Hospice of Lansing
In-House Hospice Solutions
McLaren Visiting Nurse and Hospice
Sparrow Home Health
Sparrow Hospice