avoiding unnecessary hospitalizations

Hospitalizations can be necessary and appropriate, but in some instances may be avoidable. Unnecessary hospitalizations are not only costly but can also slow down the recovery process. Evidence from multiple studies suggests that repeat hospital stays can be avoided through more effective transitioning of the patient from hospital to home and with health coaching, education and support to enable the patient to self-manage their condition.

Most hospital patients are anxious to return to the comfort of their home, but they may need some additional support to make that goal a reality. Home health agencies can offer services that may help patients make a smooth transition and avoid a readmission to the hospital.

Too often, patients mistakenly believe that they can promptly return to the life they were living prior to their hospital admission. Generally, patients are discharged from the hospital when they are stable and improving but long before they have regained all their strength. Home health agencies may be the right option for patients who need extra help recovering.

Many home health agencies offer care for patients following a hospital stay for surgery, illness, injury or exacerbation of a disease. These programs help patients recover, to the greatest extent possible, in the comfort and familiarity of home. Some agencies even offer specialized programs targeted to manage certain diseases.

For instance, THE MEDICAL TEAM, a Medicare-certified home health agency serving Northern Virginia that offers home care programs for a wide variety of patients, has a specialty program for Congestive Heart Failure patients and others with chronic heart conditions. This signature program, called Heart Smart, exemplifies how patients can be successfully supported in their recovery. The program integrates key components to reduce the likelihood of a hospital readmission, including an effective transition process from hospital to home, medication management, facilitating doctor follow-up and educational tools.

"A primary goal of our programs is to teach patients to self-manage their condition, thus giving them confidence, peace of mind, a feeling of greater control and ultimately reducing the likelihood of an unnecessary hospitalization," said THE MEDICAL TEAM's Administrator Jennifer Martin, RN BSN HCS-D, COS-C.

A vital component of the Heart Smart program is telehealth monitoring. A cardiac nurse equips the patient with an easy-to-use, wireless telemonitoring device to track vital signs. The information is promptly transmitted and reviewed allowing for early intervention before a medical condition might worsen and warrant readmission to the hospital.

The proof of the program's success is best found in patients like Martha, a 91-year-old with Congestive Heart Failure who is now recovering at home following her most recent hospitalization. An in-home nurse helped her learn to check her vital signs and set weekly diet and exercise goals. The nurse also facilitated follow-up with her doctor. With the nurse's help, Martha is resuming her normal activities and is looking forward to traveling again.

Whether it's a specialty program like the one Martha benefited from or general assistance with the tasks of daily living, home care may help patients make the transition from hospital to home. With the dedicated assistance of home care providers, many patients find the road to recovery much easier – and much less likely to involve an additional stop at the hospital. GRL

Sources:

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