Ohio Association of Area Agencies on Aging
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Region lands federal contract to reduce hospital readmissions

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Published: November 29, 2011 - 12:00 AM

Long term care nurse supervisor with the Area Agency on Aging Melissa Pessefall, RN, (left) talks with patient Barbara Boettin of New Franklin, about her follow-up care upon leaving Barberton Hospital on Wednesday. Long term care nurse consultant Barb Wheeler, RN, (right) will be visiting Barbara at her home. (Paul Tople/Akron Beacon Journal)

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Thousands of area seniors can soon get help staying healthy at home after they leave the hospital.

The Greater Akron-Canton Area Agency on Aging and 10 hospitals throughout the region recently landed a federal contract for a pilot project to help prevent hospital readmissions.

Through the program, Medicare patients who are hospitalized for heart failure, heart attack or pneumonia can work with a health coach from the Area Agency on Aging.

The specially trained nurses and social workers will begin assisting patients before they leave the hospital, said Gary Cook, the Area Agency on Aging’s chief operating officer. The coaches will continue to provide help through follow-up visits and calls to the patients’ homes, whether they live independently or in a nursing home.

The goal is to empower patients “to take care of themselves” by understanding and following discharge instructions, taking their medications properly and going to doctor appointments, Cook said.

“They can very efficiently prevent a lot of these readmissions by simply meeting with the person in their home and providing them with coaching so they can manage their own diagnoses,” Cook said. “The basic reason for most avoidable readmissions are patient self-management issues.”

The Akron-area partnership is one of seven projects nationwide selected to participate in the federal Community-Based Care Transitions Program. Others include collaborative efforts in Cincinnati, Atlanta, Chicago, Maine, Arizona and Massachusetts.

The program was created through the federal health reform law passed last year as a way to help hospitals develop partnerships that prevent patients from having problems after discharge. A total of $500 million is available over a five-year span.

The federal initiative aims to reduce preventable readmissions among patients covered by Medicare.

The 30-day readmission rate among Ohio hospitals is 19.8 percent, according to the Commonweath Fund, a nonprofit group that promotes medical system improvements. Nationwide, the readmission rate is 17.5 percent.

Estimated savings

Each hospital readmission costs the Medicare program an average of $9,600, the Area Agency on Aging’s Cook said. He estimates the pilot program can save Medicare $2.7 million annually by cutting local readmissions in half.

Medicare is the federal health insurance program for millions of people ages 65 and older and some younger disabled Americans.

“Lack of coordinated care between hospitals and caretakers such as nursing homes or home health providers can sometimes result in medical complications and costly, potentially avoidable return trips to the hospital,” Dr. Donald M. Berwick, administrator of the U.S. Centers for Medicare and Medicaid Services (CMS), said in a news release. “These programs will be looking at methods to improve collaboration among caregivers to promote better health and better use of health-care dollars.”

Hospitals are under increasing pressure to reduce the number of patients who come back within 30 days after discharge. Beginning in October 2012, Medicare can withhold a portion of inpatient Medicare payments to hospitals that have a “higher-than-expected” readmission rate for heart failure, heart attack and pneumonia patients.

"It is confusing when you don't feel well and you're being discharged to keep everything straight," said Marianne Lorini, president and chief executive of the Akron Regional Hospital Association. "I think it's great to have somebody who can help be that support, that connector from hospital to home. I think we're going to get some great results and positive outcomes from this."

Participating hospitals

Participating Akron-area hospitals include Affinity Medical Center in Massillon; Aultman Hospital and Mercy Medical Center in Canton; Akron General Medical Center and Summa Akron City and St. Thomas hospitals in Akron; Summa Barberton Hospital; Summa Western Reserve Hospital in Cuyahoga Falls; Robinson Memorial Hospital in Ravenna, and Summa Wadsworth-Rittman Hospital in Wadsworth.

The project is the latest effort by the Area Agency on Aging to ease the transition from hospital to home for elderly patients. The agency already has been working within area hospitals on initiatives to help patients make a smoother transition. Under the new two-year contract with CMS, the Area Agency on Aging will be paid for each patient who receives care from a transition coach, Cook said. If successful, the contract can be renewed for another three years.

The total contract could end up being a multi-million dollar deal, depending on how many patients are seen. But CMS declined to release the per-patient payment amounts because proposals still are being submitted from other potential participants.

Cook estimates as many as 4,000 patients could receive services through the program annually. About 14 additional people likely will be hired to provide coaching for patients.

http://www.ohio.com/news/top-stories/region-lands-federal-contract-to-reduce-hospital-readmissions-1.247822

Local agencies to help test Medicare improvements

The Akron/Canton Area Agency on Aging and the Southwest Ohio Care Transitions Collaborative are two of seven organizations across the country selected to test new ways to improve care for people with Medicare, the Centers for Medicare & Medicaid Services (CMS) has announced.

The new Community-Based Care Transitions Program was created by the Affordable Care Act, the new health care law of 2010. The program will help the selected community-based organizations form partnerships with hospitals to prevent problems after patients leave the hospital. The organizations will support 38 local hospitals and help more than 34,000 Medicare beneficiaries across the country.

The Community-Based Care Transitions Program is an initiative of the Partnership for Patients, a new public-private partnership created by the new health care law. Partnership for Patients is designed to help improve the quality, safety, and affordability of health care for beneficiaries of Medicare, Medicaid and the Children's Health Insurance Program. The partnership's two goals are to reduce harm in hospital settings by 40 percent and to reduce hospital readmissions by 20 percent over a three-year period.

The local organizations join five other community-based organizations entering into a two-year agreement with the CMS Center for Medicare and Medicaid Innovation, which will run the program. Each group will be paid a flat fee per beneficiary for those services. This is the first round of awards for the Community-Based Care Transitions Program, which is continuing to accept applications. For more information, visit www.healthcare.gov/partnershipforpatients.

http://www.cantonrep.com/news/x1471939753/Local-agencies-to-help-test-Medicare-improvements

About the Ohio Association of Area Agencies on Aging | o4a
The Ohio Association of Area Agencies on Aging (o4a), a nonprofit organization, is a statewide network of agencies that provide services for older adults, their families and caregivers, as well as advocate on their behalf. The Association addresses issues that have an impact on the aging network, provides services to members, and serves as a collective voice for Ohio's Area Agencies on Aging (AAAs). Equal Opportunity Employer/Provider. For more information visit, www.ohioaging.org.

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