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Crouse nurse helps elderly patients stay well enough to not come back

By James T. Mulder
Staff writer

Shortly after Jane LaBarre returned home from the hospital, she had a visitor.

A Crouse Hospital nurse stopped by to tell the 80-year-old how to avoid another trip to the emergency room. The two sat on a couch in LaBarre's North Syracuse home, discussing the proper way to take medications and what to do if she suddenly gains weight, her ankles swell or she develops other symptoms of a recurrence of congestive heart failure.

"At the first sign of any of that, call your doctor, say you are a heart failure patient and you need an appointment today or tomorrow at the latest," said Diane Nanno, a registered nurse recently hired by Crouse to serve as its patient transition coach. "If you have any trouble getting an appointment, remind them your goal is to stay out of the hospital."

Hospitals typically forget elderly patients once they are discharged, leaving them to fend for themselves at home – maybe with assistance from family or home care services – or handing them off to a nursing home. Research shows that during this transition, chronically ill or frail patients are vulnerable to potentially life-threatening medical errors and other problems because there is little continuity in the U.S. health care system.

Crouse wants to change that. It hired Nanno to help smooth the transition for elderly patients as they move from the hospital to home or another setting.

"The hospital does its thing, makes sure you are discharged safely, then we leave you and don't stay involved," said Christy Bond, Crouse's director of senior centered care. "Then maybe a home care agency picks up your care and they are not quite sure what happened in the hospital."

The effort at Crouse is part of a program sponsored by the Community Health Foundation of Western & Central New York. Crouse is one of 13 Upstate health care organizations – and the only hospital in Central New York – participating in the program.

It received a \$30,000 grant from the foundation to help pay for the program.

The idea of using transition coaches is the brainchild of Dr. Eric Coleman, a geriatrician at the University of Colorado at Denver. About 77 hospitals and other health care organizations nationwide are using transition coaches. Coleman is serving as a consultant to Crouse.

"Health care professionals align themselves with institutions or settings," Coleman said. "It's rare for any health care professional to cross the boundaries with the patient."

Confusion about medication is one of the biggest problems elderly patients encounter when they go home from the hospital, he said. That's because they get a list of medicines from the hospital, in addition to all the old prescription drugs they already had at home. "Confusion leads to possible errors and errors lead to harm and going back to the hospital again," Coleman said. He did a study showing more than 14 percent of elderly patients experienced medication discrepancies after being discharged from hospitals.

"Confusion leads to possible errors and errors lead to harm and going back to the hospital again."

Transition coaches help patients reconcile all their drugs.

Another problem area for recently discharged patients is scheduling appointments for follow-up care. Most elderly patients discharged after a hospital stay should be seen by their doctor within a week, Coleman said. When they call, however, receptionists often tell them they must wait five or six weeks for appointments.

"Most older people, bless their hearts, are sometimes a little too respectful," Coleman said.



Frank Ordoñez / Staff photographer

DIANE NANNO (right); a registered nurse from Crouse Hospital, visits with Jane LaBarre, a heart failure patient, at her home in North Syracuse. As a transition coach, Nanno works with elderly patients after they leave Crouse to help them take care of their health so they don't end up back in the hospital.

Transition coaches teach patients how to be more insistent about getting in to see a doctor sooner. They also help patients create personal health records.

For now, Crouse's coach is focusing exclusively on elderly congestive heart failure patients. Eventually, Nanno also will work with patients with diabetes and

hospitalized for the same problem within the previous 30 days.

Coleman's studies show patients who get coached are significantly less likely to be readmitted up to five months after they receive coaching. His research also estimates that for every 350 patients who get coached, hospital costs are reduced by about \$300,000.

Nanno came to Crouse after working in home care for 25 years with the Visiting Nurse Association.

Transition coaching is different from home care because it focuses on teaching patients how to manage their care during vulnerable transitions, according to Nanno.

"It recognizes that the patient is ultimately in control of their own health," she said. "Once they leave the hospital, they are the ones putting the pills in their mouth and weighing themselves on a regular basis."

Nanno sees the patients in the hospital, visits them at home and talks to them by phone at least four times in the month after discharge.

LaBarre was pleased a familiar face from the hospital came to her home to follow up.

"It's very reassuring," LaBarre said. "I knew she was looking out for my well-being."

chronic obstructive pulmonary disease.

Congestive heart failure is a condition that occurs when the heart is unable to pump enough blood to meet the needs of the body's tissues. In most heart failure cases, fluid backs up and accumulates in the lungs. It is the No. 1 cause of hospital readmissions.

Hospitals have a financial incentive to avoid these readmissions because Medicare and most private insurers usually won't pay to treat congestive heart failure if the patient was