Doing More To Prevent Hospital Readmissions

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Suffering from heart failure, Eddie Malleis, 73, had been at the University of Colorado hospital for 13 days. All he wanted to do was go home.

But first, Colleen McIlvennan, a clinic nurse specialist in the hospital's advanced heart failure unit, needed to review his discharge instructions. Did Mr. Malleis understand which new medications he was taking and why? Did he know which ones he should continue taking and which he should stop?

Sitting on the edge of his hospital bed, silver-haired and lean, Mr. Malleis answered yes to all of the nurse's questions. But he hinted that he might not remember everything she was telling him: "When I go to the pharmacy, they'll have all this written out on the bottles, right?"

Ms. McIlvennan assured him that they would and handed him a five-page summary of what he needed to know when he went home. Included was information about a follow-up appointment scheduled within the week and a number for that physician. Was this the number to call if he had any questions after leaving the hospital? It wasn't clear; there were several phone numbers on the sheets, but none of them were highlighted.

Of all conditions that land people in hospitals, heart failure is the one that most commonly causes older adults to bounce back within 30 days. It's one of three conditions that Medicare is concentrating on as it pushes to reduce readmissions by 20 percent and imposes financial penalties on hospitals [1] with higher-than-average readmissions rates.

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