

Case Study:

Avoiding hospital readmissions

Patricia is a service coordinator in Florida at a property for low-income seniors aged 62 and older and for people with disabilities.

“Mary”

When she came to work one Monday, Patricia learned that one of her residents, “Mary,” had been admitted to the hospital over the weekend. Mary is 80 and receives Medicare and Medicaid. She lives alone and doesn’t have much support from family. Patricia checked in on Mary in her apartment and noticed that Mary was lethargic and not her normal self. Mary had not opened any of the discharge materials the hospital gave her. She shared them with Patricia, who noticed that there were prescriptions that hadn’t been filled. Mary also had instructions to follow up with her primary care physician (PCP), but she had not scheduled an appointment.

Patricia immediately faxed Mary’s prescriptions to the pharmacy. She also helped Mary contact her PCP and arranged transportation to get Mary to the appointment. Patricia made sure that Mary attended the scheduled appointment and was taking her medications.

Before her hospitalization, Mary had been receiving long-term care (LTC) services in her home. Patricia reached out to Mary’s case worker to temporarily increase her LTC hours, which helped Mary get back on her feet.

Without Patricia’s assistance, Mary would likely have been readmitted to the hospital, a costly expense to Medicare and Medicaid. **“It’s not that the residents can’t do things for themselves,” Patricia said. “But they get overwhelmed or tired or frustrated. Having someone to support them is often just what they need.”**

20%

**of Medicare patients
are readmitted to the
hospital within 30 days***

\$17 billion

**Cost of avoidable
readmissions in the U.S.
per year***

*“Rehospitalizations among Patients in the Medicare Fee-for-Service Program,” The New England Journal of Medicine, 2009

**489 Village Park Drive, Powell, Ohio 43065
614-848-5958 | www.servicecoordinator.org**

