



VDA WEEKLY E-MAILING

September 4, 2013

Table of Contents

[NASUAD Friday Update and ACL Weekly Update](#)

[Celebrate Grandparent's Day Sunday September 8, 2013](#)

[Hospital to Home Focus May Reduce Readmissions, Study Finds](#)

NASUAD Friday Update and ACL Weekly Newsletter

Cecily Slasor, Administrative Assistant

NASUAD Friday Update

<http://archive.constantcontact.com/fs163/1109249143446/archive/1114611100170.html>

Administration for Community Living Newsletter

<http://www.acl.gov/NewsRoom/eNewsletter/CurrentNewsLetter.pdf>

Celebrate Grandparents Day on Sunday, September 8, 2013!

Ellen M. Nau, MA, Program Coordinator

In 1978, the United States Congress passed legislation proclaiming the first Sunday after Labor Day as National Grandparents Day. A presidential proclamation was signed by President Jimmy Carter and thus began the observation of this special holiday.

Generations United can help you celebrate this special day. One suggestion is to change your profile picture on FACEBOOK. Load up those pictures of your grandchildren as your profile! More suggestions for celebrating on September 8 can be found in *The Grandparents Day Take*

Note: The web links in this document may change over time. DARS-VDA does not attempt to refresh the links once the week has passed. However, this document is maintained on the web for a period of time as a reference. Some links may require registration.



Action Guide. Access the guide at:

<http://www.gu.org/LinkClick.aspx?fileticket=5RwWJfPerUk%3d&tabid=157&mid=606>

September is now Intergeneration Month! To find out more information about Intergeneration Month, and ways to celebrate the important interaction between generations, go to: <http://www.intergenerationmonth.org/>. This website contains media kits for acknowledging Intergeneration Day and Month, State Proclamations, and tips for genealogy searches.

Hospital to Home Focus May Reduce Readmissions, Study Finds

James A. Rothrock, Commissioner, for Kristy White, Appalachian Agency for Senior Citizens

Andrew Seaman Reuters

Helping people who were recently released from a hospital understand how to care for themselves and informing their primary care doctors about their stay may reduce their risk of being admitted back into the hospital, says a new study.

Researchers found that implementing a statewide transitional care program for North Carolinians on Medicaid - the state and federal insurance for the poor - was linked to a 20 percent reduction in patients' risk of going back to the hospital during the next year.

"That finding is fairly consistent with what had been shown in other studies... We were hoping to achieve that big of a difference. The novelty was being able to achieve it on this scale," Dr. Annette DuBard, the study's lead author from Community Care of North Carolina in Raleigh, told Reuters Health.

Researchers have known that the time immediately following patients' release from a hospital is critical to their chance of being readmitted later on.

"The time of discharge from the hospital was a very vulnerable time for patients with complex care needs and we need to get resources in place to make sure they go more smoothly," DuBard said. Much emphasis has been put on programs to reduce readmissions and ultimately save money, but there have been some questions about how to address issues at home that may increase a patient's risk for another hospitalization.



In 2012, a study found issues such as not being able to take medication or get to doctors' offices were linked to an increased risk of being readmitted.

Studies conducted at individual hospitals have found promising results with programs that coordinated patients' care when they left the hospital, taught patients and their families how to manage their medical conditions at home and then followed up with the patients after they were back home.

For the new study, DuBard and her colleagues calculated the rate of readmissions among more than 13,000 patients on Medicaid with multiple chronic health conditions who enrolled in the statewide transitional care program between 2010 and 2011. They compared that to the rate of readmissions among about 8,000 patients who received standard care with no extra help at discharge.

Overall, the researchers found those who went through the transitional care program were less likely to be readmitted to the hospital during the next 12 months.

The biggest difference was for patients who were the sickest and thus at the greatest risk for having to go back to the hospital. Among those people, the researchers found 20 percent in the transitional care program were readmission-free after a year, compared to 12 percent of the usual care group.

The researchers write in *Health Affairs* that one readmission was averted for every six patients who went through the program. For the sickest patients, one admission was averted for every three patients in the program.

"It's an important point to recognize that we have to be smart about targeting care management resources," DuBard said.

She added that targeting the highest-risk patients would increase the return on the investment hospitals and systems put into their programs, although the study did not include a formal cost-benefit analysis.

Copyright 2013 Thomson Reuters.