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Readmissions NEWS

The Hidden Actors in Hospital Readmissions

by Ben Rosner, MD, PhD

When a patient is discharged from the hospital, being readmitted is just about the last thing he or she wants. Not only does a readmission carry with it implicit medical stressors, but there are a multitude of family, community, social, economic, and quality of life implications. While some readmissions can neither be anticipated nor prevented, readmissions that are "potentially avoidable," are those which could be mitigated with good care transitions.

By some estimates, nearly 20 percent of Medicare beneficiaries who were hospitalized in the early 2000's were readmitted within 30 days.[1] And nearly 34 percent were readmitted within 90 days. These readmissions were associated with over $17 billion in potentially avoidable costs.

Many indicators since the advent of the Hospital Readmission Reduction Program (HRRP) and its associated hospital readmission penalties suggest that readmission rates have had a modest downward trend.[2] But arguably, we have a long way to go.

While hospitals have responded to initiatives like the mandated Comprehensive Care for Joint Replacement (CJR) program, implementing various methods to track their patients through a 90-day post-discharge period, there remain hidden actors in the readmission problem that limit the control and influence that providers and hospitals have over the very matter for which they are being held accountable.

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In This Issue

In-Hospital Discharge Program Improves Patient Experience Leaving the Hospital

by Ramon S. Cancino

Project ReEngineered Discharge (RED), a standardized, in-hospital discharge planning program which has been demonstrated in a randomized trial to decrease hospital readmission[1], has now been shown to increase scores on an important patient experience question.[2]

We analyzed patient experience surveys of adults discharged from inpatient units at an urban safety net hospital. Compared to discharged patients who did not receive the Project RED intervention, patients who received the intervention were more likely to respond "Very Good" to an item addressing if they were given instructions on how to care for themselves at home. This finding was consistent when comparing intervention patients with adult patients on the same geographical hospital unit (61% vs 35%, P <0.0001) and with adult patients on similar units in the same hospital (61% vs 41%, P <0.001) (Figure 1).

The hospital discharge process can be very confusing for patients and caregivers. They are expected to juggle competing demands, medical information, knowledge of new or altered medication regiments, and understanding of follow-up plans, future appointments, and pending tests.

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