HOSPITAL READMISSION PROBLEM

IS HOME CARE THE ANSWER?

The Significance of Readmissions

In the United States, there is a significant chance that a patient who is discharged from the hospital will be readmitted within 30 days of discharge. These readmission rates are even higher for patients with certain chronic diseases or patients who are elderly. In fact, some statistics estimate that up to 1 in 5 patients who are senior citizens are readmitted within 30 days of discharge.

These readmission rates cause numerous challenges for individuals, resulting in uncertainty and fear on the part of patients and family members. It also results in significant costs to the healthcare system. Readmissions can be very expensive, and hospitals bear the costs either directly or via fines that they may face. A recent estimate suggests that these readmission costs exceed $17 billion/year (and this is likely a conservative estimate).

To prevent penalties and improve patient quality of care outcomes, healthcare institutions are forced to ask the question, “what could we have done to prevent this?”

Some Readmissions Are Avoidable

It is important to note that many readmissions are highly avoidable. Some research suggests that more than 75 percent of readmissions would be avoidable if the right care coordination and patient education were put into place.

We all know that hospitals are a very complex system. They require the involvement of doctors, nurses, physical therapists, social workers, and more to improve the care of the patient. However, what happens after the patient leaves the many caring hands at the hospital? What happens when they are no longer receiving medication reminders? What if they get discharged too soon?

Some patients are simply not ready to be discharged home alone. However, it is also frowned upon for hospitals to keep patients too long; it's not cost effective and it could lead to additional health issues. As a result, hospitals have started collaborating with organizations that patients are commonly discharged to: skilled nursing facilities, rehabilitation centers, assisted living, and non-medical home health care services. The latter has shown significant promise in reducing readmission rates and improving patient outcomes.

Combating Avoidable Readmissions

Quality measures, like the ones we'll mention later, have been developed by regulatory organizations to assess and compare hospital readmission rates. As a result, many hospitals have improved on staff and patient education, the use of the electronic health record, and established task forces dedicated to lowering readmission rates.

Education

One of the most recommended and effective approaches to reducing readmission rates is education. This may be Discharge Planners ensuring that patients have full information about their condition and instructing them on the proper use of equipment they may be sent home with (e.g. nebulizers, canes, walkers, etc.). It may also involve teaching them when and how to take their medications, and scheduling a follow-up appointment.

Many healthcare providers are also being subject to additional education. By learning best practices for common healthcare conditions that often result in readmissions, they can practice prevention versus treatment.

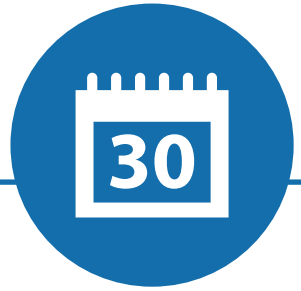
Combating Avoidable Readmissions

The Electronic Health Record

As electronic health records become more widely accepted and utilized, hospitals are increasingly booking follow-up appointments before patients even leave the hospital. It also allows other physicians and health care professionals to keep information about the patient all in one place. This collaboration of care reduces gaps and helps ensure that patients do not fall through the cracks.

Task Forces

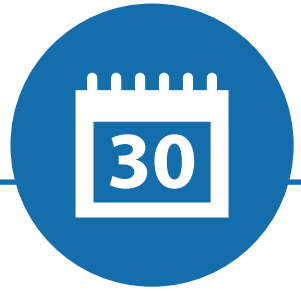
Many hospitals have developed task forces that involve both internal and external stakeholders. For example, some hospitals meet weekly with skilled nursing facilities to discuss each patient that has been readmitted to the hospital within 30 days. This allows all parties to determine why the patient was sent back to the hospital and if it was necessary. By identifying the reasons behind why patients are sent back, they can create a plan of action of what to do next time.



30-day Readmission Quality Measures

Recognizing the significant costs associated with readmissions and that many of these costs are borne by Medicare (since older patients have a higher risk of readmission), the Centers for Medicare and Medicaid Services (CMS) has launched a comprehensive program to reduce the likelihood of a patient being readmitted. Under this program, the CMS compares readmission rates at a hospital with average readmission rates for all hospitals across a range of conditions. If the hospital in question has above anticipated readmission levels it may be subject to various fines and penalties.

Some hospitals have objected to this incentive scheme--arguing that it fails to consider the patient demographics that a hospital serves. For example, patients at a hospital in a poor or urban area may lack necessary resources after discharge. And this resource shortage/mismatch may mean that they are more likely to be readmitted. The CMS standards are absolute, not relative. Yet, despite this concern, most people believe that the CMS standards are a good first step toward addressing readmissions, and addressing the myriad associated costs.



30-day Readmission Quality Measures

The fines and penalties described above can be significant, although the formula for calculating the actual fees is complex. For this reason, hospitals and organizations have implemented strategies like the ones mentioned above to address and minimize the likelihood of readmissions.

It is important to remember that the CMS is not simply looking at overall readmission rates. Instead, the CMS is looking at readmission rates broken down for different illnesses and conditions (many of which predominantly impact older Americans). Some of these key indicators are listed below:

- READM-30-COPD: Chronic obstructive pulmonary disease (COPD) 30-day readmission rate.
- READM-30-AMI: Acute myocardial infarction (AMI) 30-day readmission rate
- READM-30-HF: Heart failure (HF) 30-day readmission rate
- READM-30-PN: Pneumonia (PN) 30-day readmission rate
- READM-30-STK: Stroke 30-day readmission rate

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- READM-30-CABG: Coronary artery bypass graft (CABG) surgery 30-day readmission rate
- READM-30-HIP-KNEE: 30-day readmission rate following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA)
- READM-30-HOSP-Wide: 30-day hospital-wide all-cause unplanned readmission (HWR)

These quality measures have been selected because research has identified them as the top conditions that lead to hospital readmission within 30 days. Other illnesses with a high degree of readmissions, but that did not make the list, include asthma and Type 2 diabetes.

Additional proactive education and patient management initiatives should be taken with these high-risk patients.

Common Reasons for Readmission

To better understand the phenomenon of hospital readmissions, research has been conducted into the topic. New research has focused on surveying patients who have been readmitted. These survey results show that certain demographic characteristics make a patient more likely to be readmitted. For example, women, older people, and people with a lower socioeconomic status are more likely to be readmitted, all else equal. Patients who do not speak English as their primary language are also more likely to be readmitted.

Many of these surveyed patients reported that they had not received appropriate education at discharge (although some were satisfied with their discharge education). And, other patients noted that there was a significant gap between when they were discharged and when they received follow up care. This meant that many patients fell through the gap, and problems had a chance to spiral to the point that they required in-patient treatment.

Challenges Due To Readmission

As indicated above, readmissions can be extremely costly ~ with estimates exceeding $17 billion per year (and some people suggesting that costs are even higher). But, these financial costs are not the only risks and challenges associated with readmissions. Readmissions can place a significant strain on the medical system, leaving doctors and nurses scrambling to serve all patients who are in need. Some areas of the country have hospital bed shortages; and readmissions make these shortages even more critical. And, these readmissions can cause stress, anxiety, and uncertainty in people's (both patients and family members) lives. This makes it difficult to move past a hospital admission and re-establish one's ordinary life.

An additional problem that is sometimes overlooked is the fact that longer hospital stays resulting from readmissions may lead to a greater risk of developing hospital-related infections which can have serious consequences for patient outcomes. Patients who become part of a readmission cycle may also experience deconditioning. For older patients, deconditioning can be hard to reverse or overcome. Thus, recurring hospital stays may mark the beginning of an irreversible decline in patients' health.

What Additional Steps Could Be Taken

Given the inability of traditional measures to reduce hospital readmission rates in a meaningful manner, what additional steps should hospitals and medical providers be taking?

One could argue that hospitals need to start thinking outside-of-the-box. And, thinking outside-of-the-box largely requires involving a more expanded group of stakeholders in the care team.

Evidence-based research suggests that having a non-medical home healthcare provider visit a patient in their home following discharge may be an effective tool to reduce readmission rates for a variety of reasons.

One significant study on this topic noted that if a home care aide visited at least once in the first week that the readmission rate declined. This rate was further dramatically reduced to just over 10 percent if a patient was visited at least three times per week by home healthcare aides. This result should be reassuring for patients and families who may be concerned about their ability to afford regular home healthcare or round-the-clock care. Home healthcare has a demonstrable and quantifiable positive impact on patients.

What Can A Non-Medical Home Care Service Do?

Depending on the experience that a caregiver has and the unique medical needs that his/her patients may have, a homecare worker may be able to carry out many activities that reduce the risk of hospitalization. For instance, bilingual caregivers can bridge language gaps between patients and their physicians. Language barriers are one potential reason for high readmission rates. Language barriers can also make it complicated for patients to understand their discharge instructions.

Based on the results of a Robert Wood Johnson Foundation physician survey, 85 percent of primary care physicians agreed that "unmet social needs—things like access to nutritious food, reliable transportation, and adequate housing—are leading directly to worse health for all Americans." These same unmet needs can lead to readmissions.

A home health care provider can assist in meeting those unmet social needs. Agencies like Caring Senior Service can send a trained caregiver over to help with meal preparation and personal care needs. They can also assist patients in getting to and from their doctors appointments, which are often cancelled/missed. Older adults are disproportionately disadvantaged by transportation barriers since

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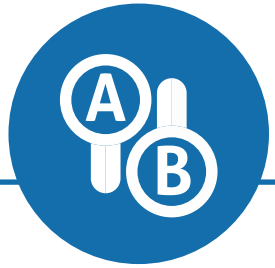
driving frequency declines with age. When seniors miss their doctors appointment, it causes disease progression and mismanagement, which limits communication with physicians, and therefore hinders a patient's' ability to manage their conditions.

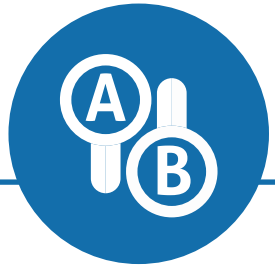
Nutrition needs are often overlooked in the recovery process, but are very important. Many discharge instructions include foods and beverages that should be avoided when taking certain medications. The instructions may also include restrictions and limitations. Some conditions may require patients to change to a low fat or low salt diet. Others may suggest a high caloric diet to promote weight gain. Regardless, a patient returning home after discharge could potentially struggle with these dietary changes. Having a caregiver would not only encourage a senior to follow a proper diet, but also prevent the spread of bacteria by cleaning up afterwards.



Consider the Following Two Examples:

In example one, an elderly patient with Type 2 diabetes was discharged from the hospital after receiving IV antibiotics for a leg ulcer. The patient is instructed to change their dressing daily and continue to take oral antibiotics after discharge. Because of mobility issues, the patient struggles with these dressing changes and because of vision challenges does not notice increasing swelling and redness around the site, which indicates that the infection may be worsening. These concerns go unnoticed until the patient's seven-day wound check at their primary physicians. During this wound check, the doctor notices the significant infection and the patient is readmitted for more IV antibiotics and a potential concern arises about the need to amputate the affected limb.

Now imagine a very different scenario if the patient has a home healthcare provider who visits daily to assist with personal care. In this scenario, the home healthcare worker would likely notice potential signs of a wound infection at an early stage. He/she would then be able to alert a physician or family member. As a result, a change in the treatment regimen could be prescribed far ahead of the one-week appointment. In this case, a costly hospitalization would likely be avoided and patient outcomes would likely be improved as well.



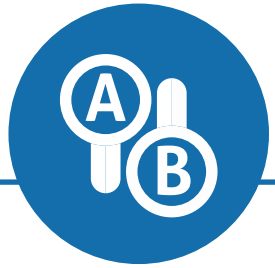
Consider the Following Two Examples:

Now, consider a second example. A patient is discharged from the hospital with a congestive heart failure diagnosis. During discharge education, the nurse explains that it is essential to weigh oneself daily to ensure that fluid retention is not a concern. However, the patient is in a hurry to leave and does not fully listen to what the nurse is saying. The patient also is an English as a second language speaker and does not fully understand all the directions.

Therefore, the patient does not weigh himself until the next doctor's appointment when it is discovered that he has gained 15 pounds due to fluid retention. He is then hospitalized for necessary treatment to reduce this fluid which is impacting his cardiopulmonary functioning.

Again, this outcome would likely have been different if a home healthcare provider was involved. In this case, the caregiver would have weighed the patient daily and noticed any troubling uptick in weight.

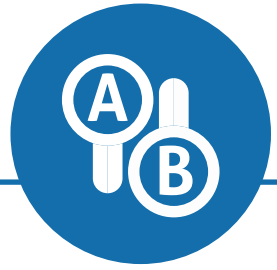
At this point, early intervention would have been implemented and the likelihood of hospitalization would have declined. Treatment costs would also have been lower.



Consider the Following Two Examples:

Again, these examples underscore how homecare providers can identify problems more quickly than patients and family members may be able to, particularly if the caregiver has been given specific instructions by the patient's nurse or doctor on what to monitor and when and how to report. This early identification allows for the launch of effective treatment -- mitigating the need for hospitalization and lowering treatment costs.

Even though the above-mentioned examples are clear cut, they are not the only ways that non-medical homecare services can reduce the risk of readmissions. Homecare services can also help ensure that patients take their medications on time with friendly medication reminders. Seniors are often discharged from the hospital with several new medications that require a specific regimen. The dosage, frequency, and even the reason the prescription was given may have changed. Receiving this information upon hospital discharge can be very confusing and challenging to keep up with alone. Ultimately, poor drug management can lead to rehospitalization.



Consider the Following Two Examples:

Homecare services can also lessen the risk that a patient will fall in their home. Falls, especially when a patient is relatively frail post-hospitalization, may lead to broken bones and necessitate re-hospitalization. Confusion, issues with balance, and muscle weakness are common post-discharge symptoms. One study found that older patients have relatively low levels of knowledge about appropriate falls prevention strategies that could be used after discharge in spite of their increased falls risk during this period. Caregivers can assist patients during this timeframe by handling or assisting with tasks that commonly lead to falls. Tasks like bathing, toileting, and dressing may be particularly difficult for a senior to do alone when just returning home.

Lastly, a caregiver can also be a source of companionship; an important, but often overlooked factor.

Where Do I Find an In-Home Care Provider?

If you have never used a Non-medical homecare service, the process of finding the right person or agency can be stressful and challenging. It likely feels like just another hurdle you have to tackle on your healthcare odyssey, when you are likely already tired, stressed, and overwhelmed.

A quick Google search in your area will likely yield results for numerous home healthcare agencies. However, even though there may be reviews on Google or Yelp, it may be difficult to differentiate between the agencies that are great and not so great. Word-of-mouth recommendations may be another source of information. However, not everyone knows people who have used homecare services. Therefore, this approach may be a dead end.

One way to get around the potential stumbling block of selecting an agency is to ask the social worker or case manager at the hospital if she or he has any recommendations. These healthcare professionals are often able to make a referral to one or more agencies they have worked with in the past. The case manager may even be able to suggest the types of services needed to transition a patient from hospital to home safely.

Where Do I Find an In-Home Care Provider?

In addition to looking for recommendations, you should also be an informed consumer who is prepared to ask questions. Below are three important questions that should be asked:

1. What are the qualifications and experience of the person who will be interacting with/caring for your loved one?

2. Does the agency/healthcare worker have experience treating and assisting people with similar diagnoses?

3. What happens if for some reason I would like to replace a caregiver the agency has sent?

These questions should be geared at understanding and having confidence that the selected home care provider will be able to provide you or a loved one with outstanding care. It should also reduce the risk that you or your loved one will need to be readmitted to the hospital. No one wants to spend more time than they must in the hospital!

Non-Medical Home Care Can Decrease Readmissions

In the end, the goal of the healthcare system is to reduce the troublingly high readmission rates that are seen in the United States. These rates are significantly higher than what is seen in most of the advanced industrialized world. Hospital readmissions are costly and they can have a distinctly negative impact on patients' outcomes and their emotional and physical well-being (resulting in everything from depression to hospital-borne infections). Homecare agencies may play a critical role in reducing preventable hospital readmissions, for the many reasons discussed above, and in many circumstances, should be explored as a care option to countless patients that are discharged and are identified as high risk.

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