30 Day Readmission Project: Identifying Barriers to Patient Recovery Within 30 Days of Discharge from Samaritan Hospital Lebanon

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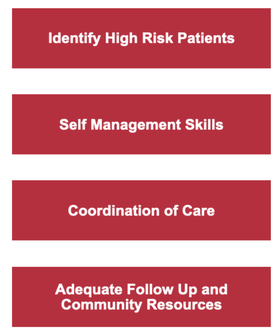
OBJECTIVE

To identify barriers to health and recovery of patients discharged from Samaritan Hospital Lebanon

INTRODUCTION

- The HRRP (Hospital Readmissions Reduction Program) aims to improve care coordination, patient communication and reduce hospital readmissions through financial penalization of hospitals with higher than expected readmission rate (1).
- When readmission rates are higher than expected, the Center for Medicaid and Medicare Services can withhold funding from hospitals.
- Patients on medicare often have conditions that account for expensive, high volume admissions as well as frequent readmissions.

Health Resource and Educational Trust (HRET) identified the drivers of lower readmission rates on the diagram to the right (1). Follow up is a key factor, and the 30 Day Readmission Survey is one way to increase follow up while also giving medical students a chance to interact with patients.



STUDY DESIGN

- Medical students are assigned a recently discharged patient from Samaritan Hospital Lebanon who would like to participate in the survey
- Students follow up via phone call 1x week for 30 days
- Students unable to perform home visits once COVID-19 started
- Students collect information from the patients regarding their post-hospitalization status, including economic, social and emotional barriers to recovery.
- After 30 days, students will submit survey information from the patient via Survey Monkey, noting if the patient was readmitted or not.

CASES

PATIENT 1

73 year old male with a history of diabetes admitted for urosepsis

- Discharge Instructions: antibiotic prescription, urology follow up, home health
- Home Life: Patient's daughter is primary care taker in administering medications and changing catheter
- Barriers to Recovery:
  - Patient-Caretaker Relationship: Both the patient and his daughter expressed discomfort with catheter changes due to the nature of their relationship. Patient reportedly concealed his symptoms for some time before initial hospital admission.
  - COVID-19: Hospital visitation limited, limiting patient's ability to see his only source of support (daughter)
- Patient was readmitted with UTI

CASES

PATIENT 2

89 year old female with a history of hypertension and COPD admitted for COPD exacerbation

- Discharge Instructions: pulmonary rehabilitation, continue medications and home oxygen, outpatient follow up
- Home Life: Primary caregiver is son. Patient states she feels very well supported by family.
- Barriers to Recovery:
  - Equipment Malfunction: patient's O2 machine malfunctioned one night due to power outage, however her son was able to fix the machine the very next morning
- Patient had excellent family support and few barriers to recovery were noted

PATIENT 3

79 year old female who is wheelchair bound admitted for pneumonia

- Discharge Instructions: Patient unclear on instructions
- Home Life: Patient lives alone. Visited by caretaker 3x week who is patient's primary social interaction.
- Barriers to Recovery:
  - Patient Understanding: Patient appeared unclear about discharge instructions, and was unsure why her physical therapy was discontinued, even though she states she was "almost walking again"
  - Living Situation: Patient is wheelchair bound, but lives in a building with no wheelchair ramp and narrow hallways
  - Emotional Barriers: Patient told the students she "cries a lot" and feels very lonely. She asked the students to visit her again.
- Patient was able to pursue outpatient follow up, no readmission within 30 days

PATIENT 4

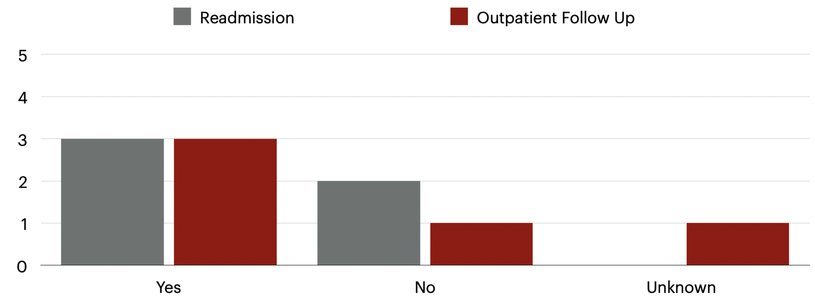
74 year old male admitted for bowel obstruction, non surgical candidate (2)

- Discharge Instructions: medication changes, all liquid diet 4 weeks, outpatient follow up
- Home Life: Students were able to visit patient's home which was noted to be dark and unkempt
- Barriers to Recovery:
  - Economical: Patient stated he would stick to soup broth for 4 weeks as he could not afford Ensure (nutritional shakes)
  - Patient Understanding: Patient unclear on medication changes and unclear on how to schedule PCP appointment
  - Living Situation: Noted to be dark and unkempt by students
  - Support: Patient lives with spouse who is memory impaired.
- Patient sustained a fall after 2 weeks due to weakness from only eating soup broth, resulting in readmission

PATIENT 5

83 year old male with a history of atrial fibrillation and gait instability admitted for bacterial pneumonia (2)

- Discharge Instructions: antibiotic prescription, recommended caloric intake, outpatient follow up
- Home Life: Patient lives with wife who is a great source of support. Lives in home with split level staircase
- Barriers to Recovery:
  - Living Situation: Patient used walker to ambulate but could not get walker past the split level staircase. He only used walker ambulating around half of the home, otherwise he was ambulating freely.
- Patient was recovering well from pneumonia, but suffered a mechanical fall secondary to weakness, resulting in readmission



CONCLUSION

Through the 30 Day Readmission Project, students have gained insight on patient barriers to recovery including:

COVID-19 limited our insights into patient recovery due to lack of home visits. We had some difficulty reaching patients via phone calls only.

- 12/30 referrals reached from Feb 2020 - Feb 2022

LITERATURE REVIEW

- **Utilization of Transitional Care plan reduced readmission rates by 19.3%**
  - Schultz BE, Corbett CF, Hughes RG, Bell N. Scoping review: Social support impacts hospital readmission rates. *JOURNAL OF CLINICAL NURSING*. December 2021.
- **Association of lower nursing staff/patient ratio and decreased risk of being penalized for readmission rates (decrease by 25%)**
  - McHugh MD, Berez J, Small DS. Hospitals with higher nurse staffing had lower odds of readmissions penalties than hospitals with lower staffing. *Health Aff (Millwood)*. 2013;32(10):1740-1747.
- **Implemenation of home visits after discharge in patients with chronic conditions decreased risk of readmission(odds ratio 0.52)**
  - Jackson C, Kasper EW, Williams C, DuBard CA. Incremental Benefit of a Home Visit Following Discharge for Patients with Multiple Chronic Conditions Receiving Transitional Care. *Popul Health Manag*. 2016;19(3):163-170.
- **Home health visits in patients with CHF reduced readmission by 8%**
  - Murtaugh CM, Deb P, Zhu C, et al. Reducing Readmissions among Heart Failure Patients Discharged to Home Health Care: Effectiveness of Early and Intensive Nursing Services and Early Physician Follow-Up. *Health Serv Res*. 2017;52(4):1445-1472

ACKNOWLEDGEMENTS

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1. 30 Day Readmission Survey Powerpoint Presentation. Monica Thurston and Mary Herberger. Accessed on 2/2/2022.