Reducing Hospital Readmissions Through Appropriate Discharge Planning

Hospital readmissions are defined as readmission of the patient to the hospital for a condition associated with his/her primary complaint within a specific period after their discharge. Such readmissions are associated, not only with unfavourable patient health outcomes, but also with high expenditure of the hospital's financial, material, and human resources. Causes of hospital readmissions are often multi-factorial, and the rates vary with country and healthcare facility (McIlvennan et al., 2015). Early studies have suggested that the hospital readmission rates are as high as 20%, 12% of which are avoidable (Jencks et al., 2009). Bringing down this rate from 12% to 2% has the potential to save $1 billion of healthcare costs annually (Medicare Payment Advisory Commission, 2014).

In order to improve the quality of healthcare services and to avoid unnecessary expenses, careful evaluation during the time of discharge planning has been proposed by Henke et al. (2016). Discharge planning is the process wherein healthcare providers, patients, and their families plan healthcare for the patient following discharge from the hospital. It should ideally start several days before the patient's discharge during which time the patient should be under strict observation and sufficient information should be provided to the patient regarding medications and lifestyle changes to avoid hospital readmission (Goodman et al., 2013).

A study conducted by Shepperd et al. (2013) proved that individualized discharge planning has the potential to reduce the rates of hospital readmission. Phillips et al. (2004) showed that comprehensive discharge planning along with post-discharge support reduced the hospital readmission rates in congestive heart failure patients. Another study by Jack et al. (2009) showed that follow-up calls from healthcare providers after discharge helped patients manage their medical requirements better and reduce the need for readmission. Similarly, several other studies have also drawn associations between the quality of discharge planning and the

rates of hospital readmissions in patients suffering from different health conditions (Jha et al., 2009).

Given the strong association between discharge planning and reduction in the rate of hospital readmission, this project aims to evaluate and enhance discharge planning in the healthcare facility in order to reduce the chance of hospital readmission in patients that have availed emergency care services at the facility. The objectives of this project are three-fold: careful observation and monitoring of the patient's health status, assessment of patient's readiness for discharge, and providing materials to patient regarding his/her condition and how to take care of medical needs at home.

As part of this project, nurses will be trained to recognize post-acute care issues for patients in the emergency department as soon as patients are admitted to the hospital. For instance, if a nurse finds out that the patient cannot afford medication, s/he can start arranging for financial assistance when the patient is discharged. Similarly, the nurse can arrange for medical follow-up appointments with specialists depending on the patients' requirements. In case of elderly patients, the nurse would need to reach out to family members and caregivers to discuss post-discharge care and ensure that all information and assistance is provided to them. If a high-risk patient is being prepared for discharge, the nurse can schedule a 1-week appointment between the patient and his/her healthcare provider to prevent the chance of hospital readmission in the future. In case on low-risk patients, the nurse can schedule a call to the patient about a week after discharge to enquire about the patient's condition and assess his/her ability to manage his/her health condition.

Following the initiation of this project, the number of hospital readmission rates should be noted every week for a minimum period of 6 months, and the graph should be evaluated to see if this rate has increased, decreased, or remained constant. Additionally, following 6 months of implementing new techniques for discharge planning, patients discharged from the emergency care department should be contacted for a survey. This survey will assess if the patient faced any health issues post

discharge and/or required extra medical help due to complications during hospital stay. Specific feedback can also be obtained regarding the support and resources provided to the patient at the time of discharge. Both these outcome measures will help evaluate the extent to which effective discharge planning has affected hospital readmission rates for the emergency department.

In conclusion, hospital readmissions have several adverse effects on the hospital's quality of care, reputation, and expenditure. If this rate is high, it is essential to take the necessary steps to ensure high quality care provided in the facility. Discharge planning is a critical process where the readiness of the patient for discharge is assessed. Therefore, improving the steps taken during this process can effectively control hospital readmission rates for patients in the future.

References

Goodman, D. M., Burke, A. E., & Livingston, E. H. (2013). Discharge planning. *JAMA*, *309*(4), 406. https://doi.org/10.1001/jama.2012.145192

Henke, R. M., Karaca, Z., Jackson, P., Marder, W. D., & Wong, H. S. (2016). Discharge Planning and Hospital readmissions. *Medical Care Research and Review*, *74*(3), 345–368. https://doi.org/10.1177/1077558716647652

Jack, B. W. (2009). A reengineered hospital discharge program to decrease rehospitalization. *Annals of Internal Medicine*, *150*(3), 178. https://doi.org/10.7326/0003-4819-150-3-200902030-00007

Jha, A. K., Orav, E. J., & Epstein, A. M. (2009). Public reporting of discharge planning and rates of Readmissions. *New England Journal of Medicine*, *361*(27), 2637–2645. https://doi.org/10.1056/nejmsa0904859

McIlvennan, C. K., Eapen, Z. J., & Allen, L. A. (2015). Hospital readmissions reduction program. *Circulation*, *131*(20), 1796–1803. https://doi.org/10.1161/circulationaha.114.010270

Jencks, G. L. (2009). Rehospitalizations among patients in the medicare fee-for-service program. *Yearbook of Vascular Surgery*, *2009*, 90–91. https://doi.org/10.1016/s0749-4041(09)79176-6

Medicare Payment Advisory Commission. *Report to the Congress: promoting greater efficiency in Medicare*.

Phillips, C. O., Wright, S. M., Kern, D. E., Singa, R. M., Shepperd, S., & Rubin, H. R. (2004). Comprehensive discharge planning with postdischarge support for older patients with congestive heart failure. *JAMA*, *291*(11), 1358. https://doi.org/10.1001/jama.291.11.1358

Shepperd, S., Lannin, N. A., Clemson, L. M., McCluskey, A., Cameron, I. D., & Barras, S. L. (2013). Discharge Planning from hospital to home. *Cochrane Database of Systematic Reviews*. https://doi.org/10.1002/14651858.cd000313.pub4