Western Physicians' Alliance

NEWSLETTER

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Prevention of Potentially Avoidable Hospitalizations Throughout the Continuum of Care

An unplanned return to an acute care hospital shortly after discharge has become a major health care policy issue. Unplanned, often avoidable, readmissions add significantly to the nations' annual health care bill. The causes of these readmissions are a mix of identifiable and correctable system failures and the natural uncertainty associated with the art of medical care. Policy makers and clinicians alike are motivated to address the systemic problems associated with the "avoidable" returns to acute care.

A surprisingly large fraction of Medicare patients discharged from acute care hospitals are readmitted within the subsequent 30 to 90 days. Analyses of Medicare data from 2005 showed that 17.6% of discharge resulted in a readmission within 30 days and accounted for $15 billion in spending. Of these Medicare readmissions, 64% were patients initially discharged home with home health care. Another 20% were patients discharged to Skilled Nursing Facilities (SNFs) and the remaining 5% were patients initially discharged to rehabilitation hospitals, long-term care hospitals or psychiatric hospitals.

Moreover, the magnitude of the rehospitalization problem appears to be growing. The fraction of Medicare hospital to SNF discharges that returned to acute care within 30 days increased from 18.2% in 2000 to 23.5% in 2006 with a price tag in the latter year of $4.3 billion.

Causes of Avoidable Rehospitalization

To some degree, the cause of unplanned rehospitalization can only be established by a detailed case review. However, researchers have noted that a significant portion of SNF rehospitalization is for conditions that are possible markers of suboptimal care. In particular, five such conditions – congestive heart failure, respiratory infection, urinary tract infection, sepsis and electrolyte imbalance – represented 78% of Medicare SNF returns to acute care. As the cost per day in hospital tends to exceed that in SNFs, any reduction in the rate of "avoidable" hospitalizations could mean significant financial savings and improvement in the quality of care.

Miscommunication between providers is another cause of unplanned readmission. This can occur in transition situations when the patient or resident is moving from one site of care or one provider to another along the health care continuum. A commonly cited example is problems with communicating information on medication regimens. Another is lack of complete and accurate description of a patient's medical condition prior to arrival at a SNF, a situation detrimental to adequate preparation so the care of the newly arriving patient.

Another cause of rehospitalization is the general lack of coordination of services amongst providers across the care continuum. Providers tend to deliver care in silos and on a day-to-day basis largely ignoring or omitting preceding orders and plans of care. The fee-for-service system with its separate payment streams to each type of provider reinforces practice silos and does not encourage care coordination.

Tools for Addressing Rehospitalization – Process Improvement

Reduction of hospital readmission is an important element of healthcare reform initiatives. While the reforms set up structures that should encourage providers to reduce readmissions, they do not specify the mechanisms for achieving this end. These are left to the affected providers to select or develop.

Fortunately, providers in general, and post acute care providers in particular, are not in the position of having to develop rehospitalization reduction programs from scratch. Various organizations offer instructional materials on rehospitalization reduction methods. Two of these are the INTERACT Tool Kit and the American Medical Directors Association's (AMDA's) recently published practice guideline on Transitions of Care in the Long-Term Care Continuum.

INTERACT is a set of tools – pocket cards, forms, checklists and diagrams – designed for the purpose of reducing

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Current Resident or

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unnecessary transfers of nursing home residents to higher levels of care. INTERACT's developers assert that the tools achieve this end by: aiding in the early identification of a resident's change in status; guiding staff through a comprehensive resident assessment when a change has been identified, improving documentation around the change in condition and enhancing communication with other providers around the resident's change in status.

The AMDA Transitions of Care practice guidelines appear to be broader in its scope than the INTERACT system. The guideline is a comprehensive document that "focuses on transitions of care between settings within the LTCC (Long Term Care Continuum), between LTCC and acute-care settings (e.g., ED, Hospital) and between an LTCC setting (e.g., SNF) and the patient's community home." The heart of the guideline is a seven step approach with accompanying forms and check lists for implementing a care transition program in a long term facility.

Within Washoe County the INTERACT Tool Kit and AMDA Transitions of Care Practice Guidelines are routinely used in the post acute continuum of care by Geriatric Specialty Care (GSC). GSC providers are members of WPA and committed to assisting in the management of all patients being served through the WPA member network of providers. By utilizing a coordinated delivery model direct care of the patient population within the WPA network of providers can be improved. This model of care has been endorsed by the WPA Board of Directors as an alternative approach for managing the post acute continuum of care.

The WPA Primary Care Pilot project will incorporate these elements of post acute care into the delivery model.

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