Development of a Patient-Centered Instrument to Evaluate 30-Day Hospital Readmissions

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Background

- Early unplanned hospital readmission is a marker of the quality of care provided in the hospital and immediate post-hospital setting.
- One in five Medicare patients is readmitted to a hospital within 30 days of the original discharge date.
- Annual Medicare costs related to hospital readmission are estimated to be $17 billion.
- The hospital discharge is non-standardized and frequently marked with poor quality.
- The Re-Engineered Discharge (RED) team has developed and tested a set of 12 mutually reinforcing components that define a high-quality hospital discharge.
- The RED components form the basis of the National Forum "Safe Practice" on hospital discharge.
- The success of the RED was due to the increased attention brought to many patient-centered factors of care, but there is still much to be learned about the patient's perspective on the causes of hospital readmission.

Aims

- Explore patient-centered behavioral and social factors related to hospital readmission.
- Identify root causes of readmission from the perspectives of readmitted patients, as well as their caregivers and providers.
- Create a patient-centered instrument to examine the causes of readmission and to identify possible reversible causes of readmissions.

Methods

- Qualitative interviews of patients readmitted to a general medical hospital service, including family members, patient caregivers, and clinical providers.
- Comparative narrative analysis and chart reviews to identify roots causes of hospital readmission.
- Thematic analysis based on grounded theory.
- Modified Delphi panel review of themes.
- Development of patient-centered instrument.

Results

Patient Characteristics

Total Interviewed, n	37
Patients, n (%)	24 (65)
Caregivers, n (%)	4 (11)
Providers, n (%)	9 (24)
Female, %	45%
Mean age, years	53

Interview Themes

- Previous Discharge Process
- Hospital Communication
- Medications
- Mood
- Burdensomeness
- Transportation
- Self-Efficacy
- Housing
- Health Literacy
- Primary Care Access
- Social Network
- Isolation/Loneliness
- Substance Abuse/Pain Management
- Financial Constraints
- Access

Selected Thematic Quotes

Previous Discharge Process

- *I was not told about my appointment with my [primary care physician]. Even if they did, I don't remember.*
- *So when I left from here, I didn't know where to go.*

Hospital Communication

- *So when I started having this problem at home, I couldn't figure out anywhere to call. I had to call the social worker. I had to call the social nurse, or whatever, even I had to call the neighborhood nurse, the neighborhood health plan nurse. She is the one that figured out and started finding out and eventually get a phone number where we could call. And then I made a lot of phone calls, nobody returned- nobody returned the call. Until three or four days later before I got a return call, and then I came to the hospital again.*
- *I complained to [my primary care physician] about my stomach bothering me, bothering me, bothering me. There's something wrong. She said she couldn't find anything wrong. And I was getting very frustrated with her. I think this whole thing could have been avoided if she had taken one step further*
- *No, I think maybe if they'd told me what dialysis was actually gonna do to my body, it might have helped me*

Medications

- *They were just treating it with IV antibiotics, I think they were probably trying to get me out of here and back home as quickly as possible with some treatment that was gonna work, but that wasn't it. I wasn't on the IV antibiotics long enough.*
- *They should have weaned me off the PCA. They didn't. They just sent me home; after a few hours at home I went into withdrawal.*
- *I mean, I was told that [the medication] is supposed to help with my sickle cell, that it will reduce the number of my hospitalizations. I've been on it since I was four years old, and it hasn't done anything. As you probably know, I've been in the hospital every month. I tell them not to prescribe it anymore, that I don't take it. And two other medications. But they won't listen. They keep writing these pills for me - a bunch of pills I'm not taking, and now I have bottles and bottles at home.*

Mood/Burdensomeness

- *I believe my mood has affected my health. I exhausted myself trying to do things that cheer me up. Maybe if I had not engaged in too much social activities in the cold weather, especially knowing how I'm not good with the cold.*
- *My health is no longer important to me. I already know I'm gonna have a poor quality of life, and that I'll die in my 40s, unlike other people [who don't have sickle cell anemia]. So I just don't care anymore.*

Transportation

- *Because [patient transportation] never shows up. And they said they got me a ride, but it's never there and I'm always missing it. That's why I'm back here. Because I've missed dialysis three times in a row, and I'm not looking to die.*

Pain Management

- *I was in so much pain, and I missed the appointment, [because] I didn't know about it.*
- *I didn't know who to call, [and] even if they said it, I was in pain, I couldn't remember. It was not written in my paper.*

Example of Comparative Narrative Analysis

- [Patient] *Looking back I think I was discharged a little too early. I should have stayed longer in the hospital. I was aware that there might be some flare ups, I just didn't know that they could get to the extreme that they got to.*
- [Clinician] *He was admitted for IV therapy which worked and improved his symptoms significantly to the point where I think it was appropriate that he was discharged. He called me the next morning and told me that things were getting worse. It turns out that he didn't get his steroid prescription filled.*

Discussion

- Qualitative interviews of readmitted patients identified 15 themes related to early, unplanned hospital readmission.
- Surprising themes were issues of burdensomeness and understanding of discharge instructions.
- Using these themes, a conceptual framework was created using Andersen's Behavioral Model of Health Services Use as a foundation.
- This framework was translated into a patient-centered survey instrument, which was piloted on patients to further refine themes.

Next Step

- Recruitment of 200 readmitted patients for questionnaire testing and subsequent factor analysis.

This research was funded, in part, by a grant from the Patient-Centered Outcomes Research Institute.

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