Reducing revolving door hospital re-admissions

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Currently, one in five elderly patients discharged from a hospital is readmitted within a month. Seeking to address the human and substantial financial burden of revolving door hospital readmissions, the Affordable Care Act proposes a number of initiatives to improve care and health outcomes and reduce costs for the growing population of chronically ill people in the U.S. While transitional care is a central theme in these provisions, there is little information available to guide those responsible for implementing these important opportunities.

To bridge the gap, researchers at the University of Pennsylvania School of Nursing reviewed existing programs in order to determine what works, for whom and for how long. They discovered "a robust body of evidence" that transitional care can improve health outcomes and reduce hospital readmissions. Their paper published in the current edition of Health Affairs, the major public policy journal, highlights a range of solutions to reduce avoidable hospitalizations and health care costs.

Specifically, their review shows that, among the common elements of successful transitional care programs, is the use of nurses, often master's prepared, who work with patients, family caregivers and health teams to prevent medical errors and assure continuity of care as patients navigate a very fragmented care system. "All nine interventions that showed any positive impact on readmissions relied on nurses as the clinical leader of manager care," wrote lead author Mary Naylor, Ph.D, R.N., a professor at the University of Pennsylvania School of Nursing.

Transitional care, short-term services that bridge gaps between hospital and home, focuses on identifying and addressing patients' and family caregivers' goals as well as needs for education and support, such as access to community services, to prevent poor outcomes. "We have identified a number of strategies that result in short term benefits and a few that effectively reduce all-cause hospital readmissions through six or 12 months," Naylor said.

"The good news is that available evidence provides those responsible for implementing community-based care transitions programs, accountable care organizations and other innovative delivery and payment models with a strong foundation upon which to build these programs and achieve better care and better outcomes while reducing costs" Naylor said. "If we capitalize on what we know, the real beneficiaries will be those living with complex chronic conditions and their family caregivers."

Mary Naylor and colleagues Linda Aiken, Ellen Kurtzman, Danielle Olds and Karen Hirschman published their findings in the April issue of Health Affairs. Their paper is based on Penn Nursing research sponsored by The Robert Wood Johnson Foundation's Initiative on the Future of Nursing at the Institute of Medicine.

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