

Studies evaluate programs to transition care of patients after hospital discharge

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Programs designed to help transition care for hospitalized older patients to outside healthcare clinicians and settings are associated with reduced rates of hospital readmissions, according to two reports in the July 25 issue of *Archives of Internal Medicine*.

"In the United States, 30-day all-cause readmission rates for patients 65 years or older generally range from 20 percent to 25 percent, depending on clinical condition and geographic region, indicating much room for improvement," the authors write as background information in one of the articles. "Interventions addressing patient- and systems-level factors show promise for reducing hospital readmissions."

In the first article, Rachel Voss, M.P.H., of Quality Partners of Rhode Island, Providence, and colleagues examined the effects of the Care Transitions [Intervention](#) randomized [controlled trial](#) in a real-world setting to test its effectiveness in reducing hospital readmissions. The intervention occurred over a period of 30 days and included a coach who completed a hospital visit, a home visit and two follow-up telephone calls with the patient.

Between January 2009 and June 2010, the authors recruited patients at six Rhode Island acute care hospitals for participation in the intervention. Patients were separated into three groups: [intervention group](#), internal [control group](#) (patients were approached but declined the intervention or did not complete the home visit) and external control group (patients not approached but eligible for participation based on

study criteria).

Of the 1,888 patients approached for the study, 1,042 (55.2 percent) agreed to participate and of those, 257 (24.7 percent; 13.6 percent of the eligible participation group) completed the full intervention with home visit. The odds of hospital readmission within 30 days of discharge were significantly lower for patients participating in the intervention compared with those who were never approached for participation (12.8 percent readmission rate vs. 20 percent readmission rate). Individuals in the internal control group had readmission rates similar to those of the external control group (18.6 percent).

The authors conclude that, "the Care Transitions Intervention appears to be effective in this real-world implementation. This finding underscores the opportunity to improve health outcomes beginning at the time of discharge in open [health care](#) settings."

In a second article, Brett D. Stauffer, M.D., M.H.S., of the Institute for Health Care Research and Improvement, Baylor Health Care System, Dallas, evaluated an advanced practice nurse-led transitional care program for patients 65 years and older with heart failure who were discharged from Baylor Medical Center Garland (BMCG) from August 2009 through April 2010. The program included a pre-discharge intervention by the advanced practice nurse and at least eight post-discharge house calls per patient.

The study examined the association between the transitional program and 30-day (from discharge) all-cause readmission rate, length of stay and 60-day (from admission) direct cost for BMCG with that of other hospitals within the Baylor Health Care System.

During the study period, 140 Medicare patients with heart failure were eligible for the intervention and of these, 56 (40 percent) enrolled in the study. The adjusted 30-day readmission rate was 48 percent lower at

BMCG after the intervention than before, however the intervention had little effect on hospital length of stay or total 60-day direct costs for the center compared to other hospitals in the Baylor system.

"Preliminary results suggest that transitional care programs reduce 30-day readmission rates for [patients](#) with heart failure," the authors conclude. "This underscores the potential of the intervention to be effective in a real-world setting, but payment reform may be required for the intervention to be financially sustainable by hospitals."

Editorial: Interventions to Decrease Hospital Readmission Rates

"Decreasing hospital readmissions offers the hope of improving care while simultaneously reducing health care costs," writes Mitchell H. Katz, M.D., of the Los Angeles County Department of Health Services. "It is therefore comforting to read in this issue of the Archives about two successful real-world translations of interventions shown to be effective in reducing hospitalizations in RCTs."

However, Dr. Katz also notes that, "Although it is pleasing to see the results of the prior interventions extended, other aspects of these real-world trials are sobering." He points to the low participation rate in the Voss et al study, as well as the limited financial benefit found in the Stauffer et al study. "The cost-analysis by Stauffer et al points to a widespread problem in American medicine," he writes.

"Reimbursements are generally linked to episodes of care: visits, hospitalizations, treatments and procedures. Reimbursements are rarely provided for preventing negative outcomes."

"We need to pay for quality not quantity, for preventing illness not just treating it," Dr. Katz concludes. "Global payments with quality

incentives are needed to improve America's health care system and reduce its cost."

More information: *Arch Intern Med.* 2011;171[14]:1232-1237; 171[14]:1238-1243. and *Arch Intern Med.* 2011;171[14]:1230-1231.

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