Measures to avoid hospital readmission often don't work

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(Medical Xpress)—Health care interventions designed to keep patients from having to be readmitted to the hospital are proving unsuccessful, a researcher from the University of Michigan School of Public Health and a colleague have found.

Further, Ariel Linden, adjunct associate professor in the School of Public Health's Department of Health Management and Policy, noted that another study just released reached a similar conclusion, suggesting that those who administer Medicare may want to take a look at policies, a recent one in particular.

At issue is a change in Medicare reimbursement policies that went into effect in 2013, which penalizes hospitals when patients are readmitted within 30 days for certain conditions by not paying hospitals for those readmissions.

"After this change, hospitals began implementing interventions to fix this," Linden said.

These included pre-discharge measures such as patient education, discharge planning, medication reconciliation and the scheduling of follow-up appointments in advance.

Post-discharge interventions included follow-up phone calls by health professionals, the availability of a patient hotline, assistance to bridge the transition from hospital to home or a care setting, and help with

behavioral changes (i.e., smoking cessation). For the study, additional interventions were put in place, including health coaching and symptom monitoring, the latter using an interactive voice response system.

Linden and colleague Susan Butterworth of Oregon Health & Science University followed 512 patients diagnosed with congestive heart failure or chronic obstructive pulmonary disease, who were hospitalized at two community facilities in Oregon. In general, participants were predominantly female, married (or living with a caregiver), over age 65, insured by Medicare and sick with several chronic conditions. Participants also had used substantial acute hospital services in the prior year.

The researchers documented readmissions, emergency room visits and mortality rates up to 90 days for two groups: those who received the interventions and those who were given the usual care. They found no statistical difference in ER visits, readmissions and mortality rates between the two groups.

Part of the reason for failure of the interventions could be the serious nature of the illnesses, the researchers said.

"We are talking about conditions with a 5-year survival rate of about 20 percent. You're almost guaranteed to be readmitted multiple times," Linden said.

But what Linden and Butterworth offered as a more likely explanation for the readmissions is that interventions can only be successful when everyone on a patient's medical team is invested in making them work. At small community hospitals, physicians organizationally are rarely part of the hospital team.

"If the hospitals don't have a close relationship with the patients' doctors,

the system can break down—unlike at U-M where everyone is working together," said Linden, noting that previous studies on such interventions had taken place in large systems.

What the researchers heard from nurses who were following up on behalf of patients is that physicians in these smaller communities frequently didn't have time to see the patients and often automatically referred them to the ER, which contributed to the readmissions.

The study, "A Comprehensive Hospital-Based Intervention to Reduce Readmissions for Chronically Ill Patients: A Randomized Controlled Trial," is published in the *American Journal of Managed Care*.

More information: "A Comprehensive Hospital-Based Intervention to Reduce Readmissions for Chronically Ill Patients: A Randomized Controlled Trial": www.ajmc.com/publications/issu … d-controlled-trial/1

"Support From Hospital to Home for Elders: A Randomized Trial" *Ann Intern Med*. 2014;161(7):472-481. DOI: 10.7326/M14-0094

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