CLINICAL GUIDELINE:

All Cause 30-Day Readmissions

Physician Clinical Integration Network, LLC

Scope

Increasing information suggests hospital readmissions can be reflective of quality of care received in the ambulatory and hospital care settings during the immediate period (30 days) after discharge.

Guidance

The PCIN Quality Committee and its designees reviewed the available information in the medical literature and societal guidelines, as well as information derived from their clinical practice, and results from the PCIN analytics team on readmissions, to devise the recommendations in this guideline.

Population Included

Readmissions <30 days post-discharge in the ambulatory and hospital care setting

Exclusions

Readmissions >30 days post-discharge

Recommendations

Inpatient Recommendations:

- ✓ Multidisciplinary care team approach should be provided to all patients from admission through discharge.
- ✓ Inpatient providers should follow-up on all tests and procedures for treatment and management decisions prior to patient discharge. An electronic handoff by the inpatient provider to the patients designated primary care provider will be done upon discharge to transition the care to the outpatient setting. If deemed appropriate, a verbal handoff will be completed by the inpatient provider to the patients designated primary care provider. All results and communications will be coordinated to the outpatient primary care provider.
- ✓ Medication reconciliation should be completed upon admission and updated and completed for transition to ambulatory environment prior to patient discharge.
- ✓ Providers and care team members should actively participate in the discharge planning process beginning at admission and continuing through discharge, providing patient-centered discharge instructions to patient and caregiver upon discharge.
- ✓ Providers should facilitate and actively participate in patient education encompassing but not limited to disease state, medications, medication adherence, disease warning signs, disease self-management, and proper technique and use of supportive devices.
- ✓ Providers should communicate with ambulatory care team upon admission and throughout hospital course to augment transitions of care and to establish an individualized plan of care.
- ✓ Providers involved in the inpatient care process should directly communicate the patient's transition of care with the ambulatory provider prior to or upon discharge from the acute care setting, as well as, complete a discharge summary at the time of discharge to enhance and coordinate care decisions made by the ambulatory team.

Ambulatory Recommendations:

- ✓ Ambulatory care team should contact the patient within 48 hours from discharge to support the patient and ensure a smooth transition from the hospital.
- ✓ Patients discharged from the hospital should be seen by a member of the ambulatory care team within 7 calendar days from discharge.
- ✓ A member of the ambulatory care team should conduct a thorough and comprehensive baseline health assessment prior to inpatient admissions, if possible, and updates the assessment after discharge from the acute care facility.
- ✓ The ambulatory care team should work with patients and their caregivers to establish, document, and keep up-to-date on patient goals and care decisions, promotes disease self-management, and informs the patient and all members of the patient's support team of community resources available for financial, emotional, and educational support.
- ✓ The ambulatory care team should communicate with the patient, caregiver, his/her pharmacy, and other care team members to promote safe medication use and medication adherence.
- ✓ The ambulatory care team should coordinate and synchronizes care within all disciplines of the care team to enhance patient's overall well-being.

Rationale

Inpatient Recommendations

A multidisciplinary team approach should be implemented and sustained throughout hospitalization [1]. Patients cared for by a multidisciplinary team had a 2.9% decrease in readmissions compared to those cared for by a single expert [2]. Reconciliation of medication should be completed on admission and prior to patient discharge or transfer [1, 3-4]. Comprehensive discharge planning is attributed to significantly lowering readmission rates [3, 5-7]. High-quality and individualized discharge instructions should be given to the patient and caregiver upon transfer [1]. Patient-centered discharge instructions were effective in lowering readmission rates [8-9]. Patients that had a marginal health literacy level had a readmission rate of 28% [10]. Discharge interventions that included patient and caregiver education observed lower occurrences of rehospitalizations [3-4, 11]. Communication between inpatient and ambulatory providers needs to occur upon discharge. Ineffective handovers that lead to patient readmissions are caused by poor information exchange, poor coordination of care, and poor communication between hospital and primary care providers [9]. Discharge summaries should be sent to the ambulatory care team within 48 hours of discharge. Studies indicate discharge summaries were available for only 15% of visits usually due to not being generated in time or not being sent to ambulatory care physicians entirely [12]. Ideally, discharge summaries should be completed on the day of discharge. A spokesman with Johns Hopkins University states unnecessary readmissions could be avoided if discharge summaries were completed the same day. With the adoption of the electronic medical record system, healthcare providers have earlier access to discharge summaries [21].

Ambulatory Recommendations

Three days post discharge was found to be the most critical time for a phone call [13] with 26% of unplanned readmission occurring by day 3 [14]. Interventions that included a follow up call within 48 hours along with a provider appointment within 7 or 10 days of transition decreased hospital readmission rates [5, 4]. 45% of all unplanned readmission occurred between days 0-7 post discharge [14]. Interventions that included early follow-up appointments with ambulatory care providers were associated with decreased hospital readmissions and emergency department use [4, 15-17]. Discharge from hospitals in which a greater proportion of patients received early follow-up, within 7 days, was independently associated with lower rates of all cause 30-day readmissions [18]. The ambulatory care team should conduct a thorough and comprehensive baseline health assessment prior to inpatient admissions if possible and update the assessment after discharge from the acute care facility [19]. The ambulatory care team should establish a set of care goals that attend to the patient's needs, values, strengths, risks, and available resources [19]. Supporting the patient capacity for self-care was most effective in preventing early readmissions [20].

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