34 Preventing Readmission to Hospitals

Teaching Plan

To use this lesson for self-study, the learner should read the material, do the activity, and take the test. For group study, the leader may give each learner a copy of the learning guide and follow this teaching plan to conduct the lesson. Certificates may be copied for everyone who completes the lesson.

Learning objectives

A participant in this lesson will be able to:

- Understand the importance of avoiding readmissions
- Identify strategies to avoid readmissions
- Recognize how proper medication compliance can affect readmission rates
- Recognize the role of patient and family education in reducing readmissions
- Identify red flags of care that indicate action is needed
- Understand the team approach to patient care to avoid patient complications

Activity

1. Brainstorm reasons a patient might need to go back to the hospital. Come up with a few scenarios where proper identification of a change in condition earlier on may possibly have prevented the patient from going back to the hospital.
2. Read "Overcoming Obstacles: Case Study" and discuss the questions that follow it.

Overcoming Obstacles: Case Study

Kate's patient, Marla, was not taking her blood pressure medications regularly. Marla told Kate she always took her medications, but Kate could tell this was not the case based on how many pills were yet to be ingested. Eventually, Kate realized that she had never seen Marla read. It dawned on her that Marla might be illiterate and was likely too embarrassed about her illiteracy to bring it up. When Kate asked Marla to read a bottle for her and Marla responded that she could not because she didn't have her glasses, Kate's suspicion was confirmed, as she had never once seen Marla wearing glasses. To overcome Marla's illiteracy without pressuring her to admit something that she was not comfortable talking about, Kate needed to devise a system that would allow Marla to take her proper medications without having to read anything. First, Kate made certain that Marla could read numbers. Then, she took paper plates, wrote the amount of medication and the time each needed to be taken daily, and placed the pills on their designated plates. After a few weeks, Marla was able to recognize which pills needed to be taken when, and she no longer had to use the paper plates. Sometimes, a little creativity when it comes to providing care can go a long way.

Consider the following questions:

1. Can you think of another method that Kate could have used to overcome Marla's illiteracy?
2. Why was Kate careful not to question Marla about her reading ability?
3. Should Marla's illiteracy be shared with the other members of the care team?

The lesson

Review the material in the lesson with participants. Allow for discussion.

Conclusion

Have participants take the test. Review the answers together. Award certificates to those who answer at least seven (70%) of the test questions correctly.

Test answers

1. b
2. d
3. a
4. d
5. d
6. c
7. d
8. d
9. c
10. b

Preventing Readmission to Hospitals

Contents:

- Understand readmissions
- Strategies for preventing readmissions

The need for containing and reducing healthcare costs has been in the news for quite some time. A significant cause of high healthcare costs is hospital readmissions. **Readmissions**, also called rehospitalizations, refers to patients who are discharged from an acute care hospital and are hospitalized again within 30 days of discharge.

Readmissions may have a financial impact on facilities; it may also have a significant impact on how partnering hospitals and—most importantly—beneficiaries view the safety and quality of care provided both in the hospital and at home.

Home health staff play a key role in preventing readmissions. Proper observation, monitoring, and documentation of patients' conditions will help limit the risk of complications.

Understanding Readmissions

Readmissions are classified as unanticipated, unscheduled readmissions to the hospital that are clinically related to the initial admission. Although the person is typically returned to the original admitting hospital, a readmission occurs when the person is being admitted to any hospital for treatment of the original condition. This phenomenon is sometimes called bounce back. A newer term is **complicated (or complex) transition.**

Very few people want to return to the hospital. Likewise, hospitals do not want their discharged patients to return. It is usually a lose-lose situation for both parties. In 2012, nearly 2 million Medicare beneficiaries were readmitted within 30 days of release, costing Medicare $17.5 billion in additional hospital bills. According to a 2013 Robert Wood Johnson Foundation study, patients admitted from larger, urban academic

teaching hospitals are readmitted more than their counterparts. However, the vast majority of hospitals struggle with readmission rates.

In 2010, the surgical 30-day readmission rate was about 12%; the medical 30-day readmission rate was about 16%. Readmission rates for congestive heart failure were about 21%, acute myocardial infarctions 18%, and pneumonia 15%.The report also found that many patients feel they are discharged too soon and often do not understand discharge instructions they often found too general.

With the fragmentation of care and chaos of having multiple providers for one patient, homecare often remains the anchor in a sea of chaos for many patients transitioning home after a hospital episode of care. Home health can help patients understand their conditions, help with medications, and recognize problems before they become more severe.

It's worth noting that **front-loading** homecare series to provide 60% of planned visits in the first two weeks of the home healthcare episode has proven to lower readmission rates, along with weekly phone calls before the weekend to remind the patient/caregiver of when to call the nurse or physician to prevent an emergency room visit/hospitalization. It's obvious that home health does have a vital role in preventing readmissions.

Relocation stress syndrome

Transitioning from one setting to another has the potential for causing or increasing confusion and traumatizing an elderly or sick patient. Signs and symptoms include:

- Increased dependence
- Delirium
- Depression
- Anger
- Withdrawal
- Changes in behavior
- Changes in sleeping habits
- Feelings of insecurity, loss of trust

- Weight loss (or, less commonly, gain)
- Falls

This is the phenomena known as relocation stress syndrome. Older terms that may still be used are transfer trauma and relocation shock. Transfer trauma is a consequence of the stress and emotional shock caused by an abrupt relocation of a patient from one location or agency to another, including the home. Unless a proposed transfer is emergent, involve the patient in planning for transfer.

Evidence suggests that ensuring continuity of care of elderly or sick people during care transitions improves patient outcomes, reducing the rate of avoidable readmissions.

Strategies for Prevention

Because home health can have an effect on readmission rates, it's import to implement strategies to prevent avoidable readmissions. The following are a series of strategies to help care for patients in this way.

Recognize red flags

Obtain information from the discharging agency of key points for patients/families (and home health providers) to monitor. This should include a written list of specific symptoms to watch for and what to do if they occur. (See Figure 34.1 for an example.) This will help you know who to call and when.

Figure 34.1

Sample of Red Flag Instructions

Medical problem	Call RN (phone number) Physician (phone number)	Call 911
Heart failure	• Increased shortness of breath especially when lying flat • Increased fatigue/weakness • Weight gain of 3 pounds in a day or 5 pounds in a week • Swelling in ankles • Irregular heartbeat	• Severe shortness of breath (unable to breath) • Chest pain unrelieved with medication • Frothy sputum
Diabetes (low blood sugar)	• Dizziness, shakiness • Increased hunger • Headache • Changes in vision	• Loss of consciousness • Seizures
Respiratory (COPD)	• Increased shortness of breath • Increasing cough • Change in color, thickness, or amount of sputum • Loss of appetite • Fever greater than 101 degrees Fahrenheit	• Severe shortness of breath that does not respond to bronchodilators treatments • Changes in skin color to bluish or grayish tone • Increasing confusion

There are areas or times of increased risk to this process that the nurse should be aware of. One such instance would be when the patient is seen by a clinic or for a follow-up appointment. If there is a change in the patient health status or if the patient is transferred to an alternative level of care, there is increased risk that medication reconciliation will not occur, and red flags should be placed at these points. The goal is always to communicate to the next provider an up-to-date, complete, accurate list of prescription and non-prescription medication list. At each of these red flag areas, the homecare nurse should verify that the family and the patient understand any changes to the medications. If there are questions, they should be answered. The new medications should be reviewed and instruction provided regarding the purpose and how it pertains to and affects the patient's health.

Another red flag would be several treating providers (e.g., the patient sees a nephrologist, cardiologist, and internal medicine physician). It is important in this instance to pick the "captain of the ship," which is often the referring physician who oversees the medications and reviews and approves any changes. However, situations arise where an underlying condition is out of control; therefore, the primary physician becomes the one

who is likely to change the medications because of the effect they are having. For example, a physician treating a patient in liver failure may request notification of any new medications the patient is given and require his approval of the medication prior to administration because of the effect it might have on the liver disease.

Other red flag issues to consider include:

- More than five medications, which can place a patient at high risk
- Patients who ask, "When was I supposed to take that medication?"
- Pill bubble packs that are punched out irregularly
- Pills left all over the home, such as in the kitchen, bathroom, and bedroom, are a signal that medications are likely being taken at random times
- Nonprescription medications that the patient takes, which they may neglect to start taking again after discharge from the hospital
- The patient does not know where his or her medications are and how often they are to be taken
- Hospital visits that could be avoided had medications been taken at the correct time or through the proper administration method
- The patient accidentally overdosed in the past
- The patient takes high-risk medications (i.e., medications that sound the same as other drugs or the dosage is particularly confusing)

These are several of the more common or obvious red flags. There are probably many more with which you are familiar. What is important is that the homecare nurse identifies those that are specific to the patient in order to be alert to potential problems so he or she will be aware of when to contact the physician if problems arise. Elevated blood pressure, elevated pulse, difficulty breathing, symptoms of wound infection or digoxin toxicity, and a bladder infection that affects patients with a Foley catheter are some examples.

Engage the patient in self-care

Engaging the patient in his or her care can be achieved in a number of ways. For example:

- Provide the list of medications you develop and give it to the patient to review for accuracy or completeness.
- Ask open-ended questions during the interview process, which will help collect the patient's information.
- Have the patient show you all of the bottles of medications he or she takes, including any daily vitamins.
- Ask the patient for the telephone number of his or her pharmacy and then place it in an easy access area, perhaps on the refrigerator or at the bedside.
- Provide the patient with little-known information about his or her medications; this always seems to stimulate attention. In addition, stories about the medication help too and may also serve as a memory aid.
- Encourage the patient to ask questions, especially if new medications are ordered or if the dosage is changed on a medication.

Patients with **diabetes, heart disease, and respiratory problems are at a high risk for readmissions** and remain a target population for intense monitoring of health status, self-care skill, and self-care knowledge. **Any discharged patient with four or five comorbid conditions requires a focused approach** with specified care guidelines, triggers for readmission, and patient-centered goals.

- Have the patient keep a daily log of when medications were taken. This provides the additional benefit of maintaining an accurate medication list.
- Provide the patient with handouts discussing his or her disease and the medications used to combat it.
- Use plain and simple terms to help the patient understand and feel more in control of his or her care. Use words that the patient can pronounce.
- Create a supportive atmosphere for the patient so he or she feels at ease in stating what is not understood or what is confusing.
- A patient may feel more engaged during treatment if there is an easy and comfortable way for him or her to report discrepancies or errors.

- Be sure to include potential risk to patients in your care plan and then list evaluation methods that are quick and easy for the other healthcare team members to follow.

Ensure timely physician follow-ups

Schedule a physician follow-up visit after a hospitalization, as the physician directs in the discharge orders. If there is no mention of when to schedule a follow-up appointment in the discharge note, make certain to ask the physician about a follow-up visit when the initial interview with the patient is completed. This can occur when you contact the physician to resolve medication questions or clarify other issues. The initial follow-up visit should never be more than two weeks postdischarge.

There are many things the home health nurse can do to facilitate the physician follow-up and make the visit more beneficial to the patient and doctor. A few suggestions include:

- Keep a medical appointment log up to date.
- Use a large calendar for appointment dates. Place it in an area where all can see.
- Stay organized. Help the patient form questions and write them down. Have the patient write brief questions regarding his or her disease or the disease process. This increases communication between the patient and the physician.
- Place the insurance card in the patient's folder to bring to the physician.
- Be certain the current list of medications is with the patient but also have the patient bring all medication bottles, as well as the box with the scheduled pills in it. Include both prescription and nonprescription medications, so if there are questions about medications, the physician has them readily available to look at.
- Identify adverse signs and symptoms that should be looked for and under what circumstances the physician should be called.
- Find out from the physician what to do in an emergency and when office hours are.
- Make certain the patient has transportation to the follow-up visit.

When patients have this information, it is easier for them to feel relaxed, decreases their anxiety, and enables them to become a more effective contributor to their ongoing medical treatment. This also ensures that the physician has as much information as possible to thoroughly evaluate the health status of the patient during the office visit.

Medication compliance, safety, education, and effects

Older adults frequently fall victim to medication nonadherence. There are many reasons for this, ranging from simple to complex. From consciously skipping medications due to financial concerns or simply forgetting to properly take multiple medications, education is key.

A system of checks and balances should be in place, as the older adult can be especially vulnerable to the unintentional consequences of polypharmacy, missed doses, and accidental "adjustments" that may occur. The therapeutic range of many lifesaving medications may be very narrow, and monitoring by the home health staff should be frequent and thorough.

Keep tabs on medication habit and compliance. Be sure to:

- Ask the patient whether he or she is taking their medications, and if not, ask open-ended questions regarding why this is happening (e.g., do you feel the medication simply is not working?).
- Document the patient's cognitive level, response to teaching, support system, and changes in conditions (this should be ongoing).
- Take action if you notice subtle changes in health, such as:
  - Increased bruising
  - Bleeding gums (indicating increased coagulation)
  - Slight shortness of breath or pedal edema (indicating missed diuretics)
- Ask the patient to identify specific pills and reasons for taking them.
- Check to make sure the medications in the pill bottle are going down.
- Perform a simple physical assessment—is there weight gain or elevated blood sugars? Elevated blood pressures, headache, pain—these symptoms may dissipate if the patient is taking his or her medications.
- Help the patient remember medication by organizing a pill box.
- If there are problems with the purchase of medications, refer the patient to a social worker in order to obtain Medicare Part D coverage or other insurance coverage. Consult with the pharmacist on lower-cost medications that provide the same result. Ask the physician if he or she has samples.
- Continue to monitor for adherence and medication side effects that could be present and may be keeping the patient from compliance.

- Monitor laboratory work for the prescribed medications.

Assemble an accurate list of all medications

Request that the patient write down all medications he or she is taking, including over-the-counter drugs and nonprescribed medications. Include the name of the doctor who prescribed the medications and what the medication is taken for (this can be done in laymen's terms [i.e., water pill, high blood pressure]). Even writing "I don't know" is acceptable so that the physician or pharmacist can then explain why the medication is prescribed. If the patient knows that they have a side effect to the medication, it is a good time to write that down so it is available at the next follow-up visit with the physician or the pharmacist.

Tell patients to keep the medication list with them at all times. Take it to physician visits and always on visits to the hospital.

Explain to the patient the importance of updating the list when medications change or when the physician changes the dose, stops a medication, or tells the patient to discontinue taking it.

Help the patient manage medications themselves

In determining the patient's ability to manage his or her medications, adhere to the following steps:

- Encourage the patient to learn about their medications. What is the name of the drug? What does it do? How do you take this medication? How does it make you feel? Are there special instructions? Do you have to take it with food?
- Screen for adverse or drug interactions. If adverse drug interactions are identified, report them to the prescribing provider and the pharmacist.
- If the medical diagnosis is present, provide the primary and the secondary diagnosis from the prescribing provider.
- If the patient is older than 65, use BEERS criteria or high-risk criteria for evaluation.
- Instruct the patient to never take someone else's medication, especially prescription medication.
- Explain that the medication is like a dangerous chemical that should only be taken with a doctor's instruction.
- Use only the cup or syringe supplied with the medication. Never put insulin in a noninsulin syringe.

- Choose a primary pharmacy where a medication review can be done and where medications can be delivered to the patient's home, if possible. Fill the medications at the same pharmacy and choose to visit only that pharmacy for the patient's needs.
- Instruct patients to always tell the physician or pharmacist when they are taking an herbal medication, even if it says "all natural" on the bottle or box.
- Be certain to verify everything with a prescription, if necessary.
- Tell the patient to call the physician's office or pharmacy with any questions about medications being taken or that may be needed.
- If the patient requires surgery, he or she should ask about medication consumption prior to the surgery.
- Prior to leaving the hospital, patients should ask for a list of the medications that should be taken at home, especially blood thinners or medications that affect bleeding.

Finally, if the medication is supposed to be treating headaches but the headaches continue, notify the physician or pharmacist and discuss with the healthcare team regarding a change in medication or perhaps a change in dose. There are several tools, such as the home health tracking sheet, that will assist in monitoring medication adherence and side effects; however, it is important to use the one that works best in your system. This is paramount to its effectiveness.

Enroll the family caregiver or advocate

Effective disease control requires that the patient and the caregiver are active participants in the patient's care. The role of the family caregiver varies according to the individual's ability to provide certain types of services.

Taking time for respite care for the caregiver and assisting the caregiver in learning when to contact the physician are paramount measures to preserve the integrity of the caregiver's ability. Education and communication provide the caregiver with a better understanding of the disease and the disease process. The knowledge empowers the caregiver to feel supported in decisions.

Teaching the signs and symptoms of the disease and the disease process and the measures to take should there be a complication will help and decrease the frivolous rehospitalizations in chronic care patients.

Determine a primary care coordinator

Fewer than half of the patients with chronic illness and the targeted high-risk illnesses of HIV/AIDS, mental health, substance abuse, chronic heart failure, chronic obstructive pulmonary disease, and diabetes have primary care physicians who are dedicated to their care. Which physician or pharmacist will provide medical decisions and steer the ship through rough waters? Deciding who the primary care provider is, providing the patient with a contact number, and scheduling the follow-up visit after hospitalization is critical to keeping the patient out of the hospital with an unnecessary visit.

Connect the physician dots

When there are two or more physicians treating a patient, each should be made aware of what the other is doing. This is a daunting task; however, there are ways to make this step less complicated. A physician list with the phone numbers and contact information should be available. The name of the referring physician should also be readily available to answer any questions relating to the patient or the patient's medication regime. Typically, contacting the physician who prescribed the medication is ideal, but the pharmacist can be of best service when there are three or more medications involved.

We know the average chronic care patient ingests 10 to 12 medications daily. Making sure that the pharmacist and physicians possess a current medication sheet helps bridge the communication gap and thus eases stress on the treating provider and the patient. Requesting the pharmacist provide a medication therapeutic review will assist the physicians and reassure them that these medications can be administered together without harm.

Patient education

Educate the patient and the family to make them aware of a high-risk situation if that is what is present. Provide them with the signs and symptoms of complications and provide them with physician's orders that clearly state when to call and the parameters to follow for complications in the patient's disease or illness. For example, in cases of chronic heart failure, a daily weight gain of five pounds may cause a physician or pharmacist to order to take an extra furosemide dose or draw digoxin levels. Create an environment for the patient with chronic illness that is supportive and reassuring so anxiety is decreased (knowing what to do in an emergency is empowering to the patient).

TEST Preventing Readmission to Hospitals

Name _____ **Date** _____ **Score** _____

Directions: Fill in the correct answer or circle the correct answer.

1. **Delirium, depression, and changes in sleeping habits may be signs of _____.**
   a. rehospitalization
   b. relocation stress syndrome
   c. proper discharge planning
   d. irregular respirations

2. **Which of the following is a high-risk condition for readmission?**
   a. Diabetes
   b. Heart disease
   c. Respiratory problems
   d. All of the above

3. **A rehospitalization occurs when the person is being admitted to any hospital for treatment of the original condition.**
   a. True b. False

4. **About _____ Medicare beneficiaries are readmitted within 30 days every year.**
   a. 5 million
   b. 100
   c. 10 million
   d. 20 million

5. **The specific role and responsibility that home health staff play in preventing rehospitalizations is:**
   a. ensuring they are ready to go back to the hospital
   b. keeping the patient home at all costs
   c. they don't have a role in preventing readmissions
   d. recognizing and reporting condition changes

TEST Preventing Readmission to Hospitals (cont.)

6. **A readmission or rehospitalization occurs when _____.**
   a. a patient is transferred from one hospital to another
   b. a patient is admitted back to the hospital within the following year
   c. a patient who was discharged from a hospital is hospitalized again within 30 days of discharge
   d. a patient is admitted to a hospital after an outpatient procedure

7. **Which of the following could be indications of medication noncompliance?**
   a. Increased bruising
   b. Bleeding gums
   c. Pedal edema
   d. All of the above

8. **What are some indications that a patient is not taking her medication as directed?**
   a. Pill bubble packs that are punched out irregularly
   b. Pills all over the house
   c. The patient doesn't know where her medications are
   d. All of the above

9. **Which of the following is a strategy to help a patient comply with medication instructions?**
   a. Write the instructions down and keep it with you, the home health staff, at all times
   b. Tell the patient to take the medications at the time it says to on the bottle
   c. Organize a pill box and review it with your patient
   d. Call the pharmacy to cancel the prescriptions

10. **Which of the following strategies helps ensure timely physician follow-up?**
    a. Ensure the appointment is scheduled within two months of discharge.
    b. Use a large calendar for appointment dates. Place it in an area where all can see.
    c. Wait to determine whether the appointment happens, and then call and yell at the doctor if it doesn't.
    d. Both a and c.