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The implementation of a continuous review process for Hospitalist 7-day readmissions

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Abstract

Introduction: Research on the root causes of inpatient hospital readmissions has focused on the 30-day benchmark. This arguably arbitrary time period is linked to the CMS financial penalty to hospitals with high 30-day readmissions. Critics speculate that a 30-day readmission is an outcome not reflective of the quality of the hospital care, and might be due to patients' natural history of disease process or a new condition altogether. Little research looked into whether causes of 7-day readmission (7DR) can be attributed to the index hospitalization.

Hypothesis: In order to eventually reduce readmissions to hospitalist services at an academic tertiary care hospital, our project sought to implement a process to continually evaluate root-causes of all 7-day readmissions hospitalists. Our hypothesis was that 7DR would be due to:

1. Errors in the discharge process during index hospitalization.
2. Misdiagnoses during the index hospitalization.
3. Patients returning after previously leaving AMA on index hospitalization.
4. "Superutilizers" aka "High Cost/High Need" patients.
5. Chronically ill patients, some at the end-of-life.

Methods: We developed a 7DR Tool allowing the Provider (Attending or APP) of the subsequent hospitalization to quickly determine the

most likely reason for readmission. An Epic report identified all Hospitalist patients readmitted within a 7-day period. Our administrative assistant emailed the 7DR Tool to the appropriate provider with the inputted demographic patient information. To complete the tool, the provider had to check the box next to the most likely reason for readmission, determine if the readmission was avoidable, and free text the cause(s) of readmissions with suggestions to prevent future readmissions. The finalized 7DR tool was then sent to the discharging provider as a learning opportunity. Pilot data was collected over a 2 -month period in 2020, and further refinements to the tool were made. Responses were again gathered over a 4-month period in 2021, from January- April.

Results: From October 2020 through April 2021, a total of 375 7DR were identified. Of these patients, 192 (51.2%) emails were sent to the subsequent Hospitalist containing the 7DR tool. We purposely avoided sending the tool to Attendings where the index admission had an AMA discharge. The average tool completion rate was 48.1%. The discharge disposition from the Index hospitalization was 49.7% Home, 26.2% AMA, 13.3% from a facility, and 10.8% home with homecare. Of the cases reviewed, only 18 (4.97%) were deemed avoidable by the subsequent Attending physician. Of the major reasons for readmission, 57% were related to the index diagnosis, while 21% were related to a new diagnosis. Of the reported causes for readmission, Substance abuse (20.8%) and Lack of Support (18%) were cited most commonly.

Conclusions: The fact that 57% of readmissions were related to the index diagnosis is supported by other studies. Almost half of the readmitted patients came from home. This perhaps represents an opportunity to support post-discharge care interventions aimed at helping patients understand their hospitalizations, new medications, and the transition to outpatient providers. Substance abuse and homelessness were common and this may be particular to our urban underserved environment. With less than 5% of readmissions deemed avoidable, one can argue that 7DR review is also not reflective of the index hospitalization care. We understand that our process is subjective and might underestimate the avoidable readmissions when asking a provider if they colleague could have done anything better. In summary, having Hospitalist review 7DR

provides a valuable tool to gain insight on local factors contributing to readmissions, and provide guidance for targeting quality improvement interventions.