Better Care Transitions Key to Lower Rates of Rehospitalization among Home Health Care Patients

Hospital readmissions remain a large financial burden on the Medicare system, accounting for $17.4 billion of the annual budget of $102.6 billion. To combat these rising costs, researchers have attempted to identify the predicting factors of rehospitalization. A team of researchers from the University of Wisconsin Milwaukee and the University of Massachusetts Boston specifically looked at data compiled in the Outcome and Assessment Information Set (OASIS) for their study published in a recent issue of *Home Health Care Management & Practice*.

“OASIS data are used by [Medicare] to determine payment and to measure home health care patient outcomes,” explain the researchers. Because each patient admitted to home health care is required to undergo an OASIS assessment every 60 days, the team used the recorded data from a large home health agency to determine if OASIS could be used more constructively to identify rehospitalization factors.

**RATE OF REHOSPITALIZATION**

“Of 1,268 home health care patients 65 to 99 years of age, 212 (16.7%) were readmitted to the hospital within 30 days after discharge,” report the authors. Among these patients:

- 83% were receiving help with ADLs and IADLs after hospital discharge
- 97 (45.8%) were rehospitalized within 0 to 9 days
- 67 (31.6%) were rehospitalized within 10 to 19 days
- 44.7% had median to severe levels of cognitive impairment

**CARE TRANSITIONS**

According to the authors, the high rates of rehospitalization within the first 10 days after discharge suggest that patients may not be properly transitioned from the hospital.

“More emphasis needs to be placed on transitioning hospitalized patients to home care,” they suggest. “The cost savings from early hospital discharges could be used to reimburse agencies...for providing mechanisms to safely transition and maintain patients in their homes.”

**PREVENTATIVE FACTORS**

The study notes that informal care outside of ADLs and IADLs, such as assistance with functional ability and cognitive functioning, contributes to a low rate of rehospitalization.

Additionally, “it may be that persons with adequate social environmental support are more likely to engage in health-promotion behaviors, and are more likely to seek medical care before health problems become serious,” note the authors.

Ultimately, the researchers found that OASIS data can be used by home health care providers to identify high-risk patients. “The two predictors of rehospitalization found in this study, functional ability and cognitive functioning, call for policy changes and a shifting of resources from hospitals to communities, especially to the home health care delivery system designed to reduce rehospitalizations.”

Patients with Heart Failure Benefit from Improvements in Care Transitions

According to an article recently published in *Home Health Care Management & Practice*, 3.6 million hospitalizations each year are related to heart failure. During the 90-day period following hospital discharge for these heart failure patients, “there is an 8.3% and 29.6% [risk of] death and hospital readmission, respectively,” note the article authors, a team of researchers from East Tennessee State University.

The authors point to a lack of scrutiny toward transitional care (TC) as a possible reason for this high rate of rehospitalization. Because clear standards have been established for inpatient and outpatient care of heart failure patients, but not for health care transitions, “the possibility exists that hospital readmission rates may be more related to TC issues than improper inpatient treatment,” the researchers state.

**TRANSITION CARE FROM HOME TO HOSPITAL**

For patients with acute decompensated heart failure (ADHF), admission to the hospital often means a shift in care focus from outcome prevention to relief of acute symptoms, resulting in significant alterations to chronic medication regimens. The authors suggest that a detailed care history be provided to the hospital care team upon admission, including the following:

- Assessment of changes in the symptoms of ADHF (including onset and duration)
- Changes in diet and fluid consumption
- Accurate medication list, including over-the-counter medications, and dosages of each

These details will provide the hospital care team with information necessary to “reconcile medications with the patient’s chronic outpatient regimen at the time of discharge,” explain the authors.

**TRANSITION CARE FROM HOSPITAL TO HOME**

For transition from inpatient to outpatient care, the research team recommends:

- Extensive discharge plans, including instructions to outpatient caregivers for appropriate diet (sodium/fluid restriction, etc.)
- Scheduled follow-up with primary care providers/specialists
- Inclusion of the home health care team in discharge planning and collaboration

*Involvement of the home health care team is crucial to proper transitional care, as “up to 25% of early readmissions may be avoided with inclusive discharge planning...among inpatient and outpatient health care providers.”* The authors point out that home health providers are uniquely positioned to recognize the individual needs of each patient and advocate for them to ensure that these needs are met. “Home health care providers who are aware of the changes that can occur and the potential complications that may result in the transition of care for HF patients will be able to take better care of the patient,” they conclude.