A Targeted Discharge Planning Process for High-Risk Readmissions: Improving Health Equity

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WHAT WE LEARNED

A discharge planning process tailored for the targeted high-risk readmission patients increased patients' health knowledge, skills, and willingness for self-care and decreased 30-day hospital readmissions.

BACKGROUND

- Racial/ethnic minorities with socioeconomic disadvantages are vulnerable to 30-day hospital readmissions, widening the health disparity gap
- Having a higher propensity to live with many chronic diseases and a lower treatment compliance rate increases readmission vulnerability
- Seventy-five percent of patients the hospital serves come from from 16 ZIP codes. Majority patients come from 5 ZIP codes include 43-89% Blacks & 30-44%of the population living below the Federal Poverty Level

PURPOSE & AIMS

- To determine if using a 25-item checklist for targeted high-risk readmissions increases patients' health knowledge, skills, and willingness for self-care and decreases their 30-day hospital readmissions

Study Aims:

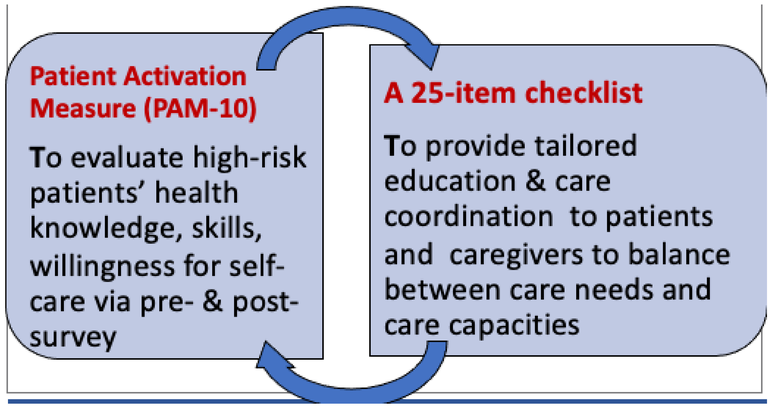
- To reduce 30-day hospital readmissions
- To improve patients' health knowledge, skills, & willingness for self-care management

METHODS

- Design: Casual comparative/ Pre-Post intervention study design
- Population & Setting: Medicare & General Medicine Unit patients discharged home from an inner-city hospital in Mid Atlantic region, USA
- Intervention: Administered pre survey, intervention, & post survey 30 days after discharge to after-intervention group
- Analysis: Fishers Exact test for readmissions; Paired t-test to compare mean of pre & post survey scores; Wilcoxon Signed Rank test to compare mean of pre & post survey levels

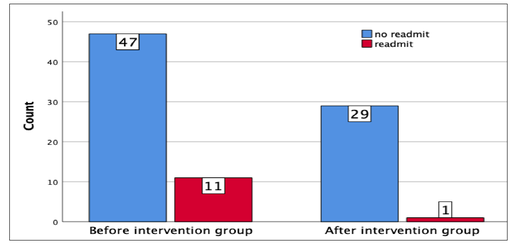
SURVEY & INTERVENTION

- Before-Intervention Group n=58 (5/1/21-8/31/21)-usual care
- After-Intervention Group n=39 (8/1/21-11/30/21)-Thirty patients & their caregivers received the intervention after completing the pre-Patient Activation Measure (PAM-10) survey questionnaires. Thirty days after home discharge, 23 patients from this group completed post-survey questionnaires.

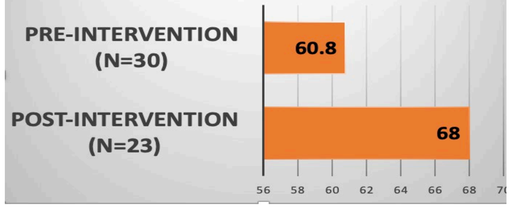


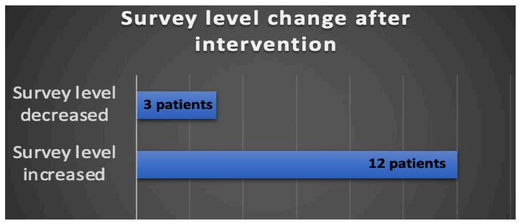
RESULTS

Aim 1- Readmission was decreased from 11 (19%) to 1 (4%) After intervention Fisher's Exact test p=.038



Aim 2- Patients' health knowledge, skills, & willingness for self-care were improved after receiving interventions (Paired t-test for survey scores t(22)=2.67, p=.014; Wilcoxon Signed Rank test for survey levels, p=.01)





CONCLUSIONS

- A targeted discharge planning process offered an intervention to patients vulnerable to readmissions
- Accurate evaluation of how patients and caregivers manage self-health was essential to tailor their discharge need
- **Tailored discharge process improved patients' health knowledge, skills, & willingness for self-care**
- **The checklist was statistically and clinically effective in decreasing 30-day hospital readmissions of vulnerable patient populations**

References: Census Reporter https://censusreporter.org/profiles; Hibbard et al., 2004; Hu et al., 2014; Khau et al., 2020; Lewsey & Breathett, 2021; Lloren et al., 2019; Rodriguez et al., 2017