A Targeted Discharge Planning for High-Risk Readmissions: Focus on Patients and Caregivers

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Introduction

- 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 16 ZIP codes. Majority patients coming from 5 ZIP codes includes 43-89% Blacks & 30-44% of the population living below the Federal Poverty Level.

Purpose & AIMS

- To determine if using the 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
- 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.

Patient Activation Measure (PAM-10)

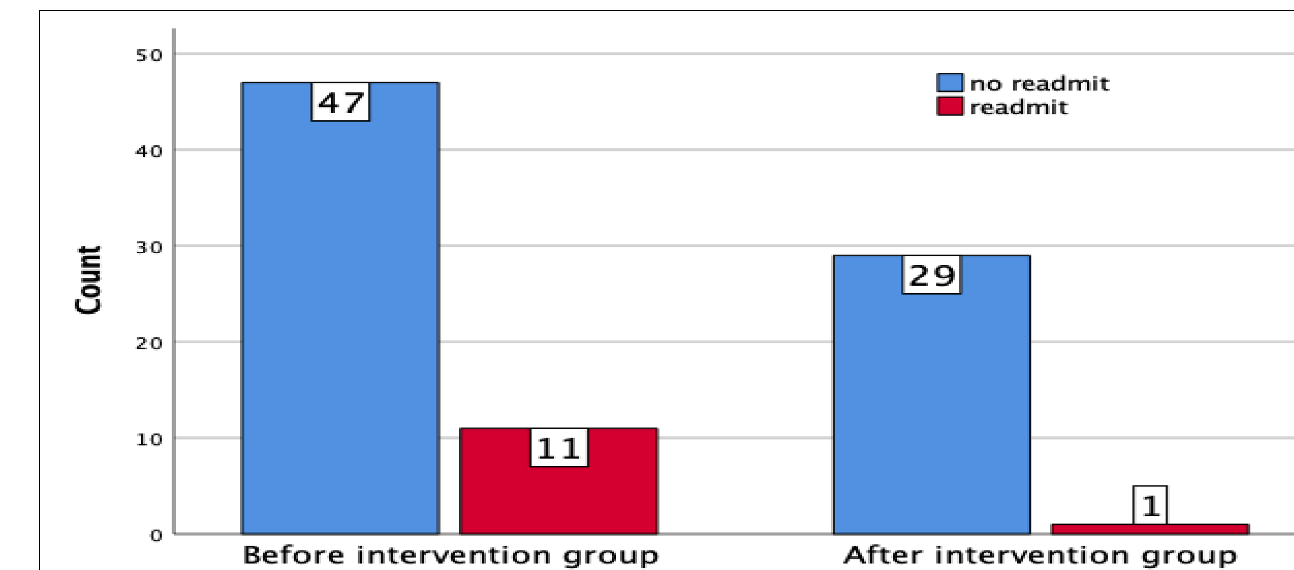
To evaluate high-risk patients' health knowledge, skills, willingness for self-care via pre- & post-survey

A 25-item checklist

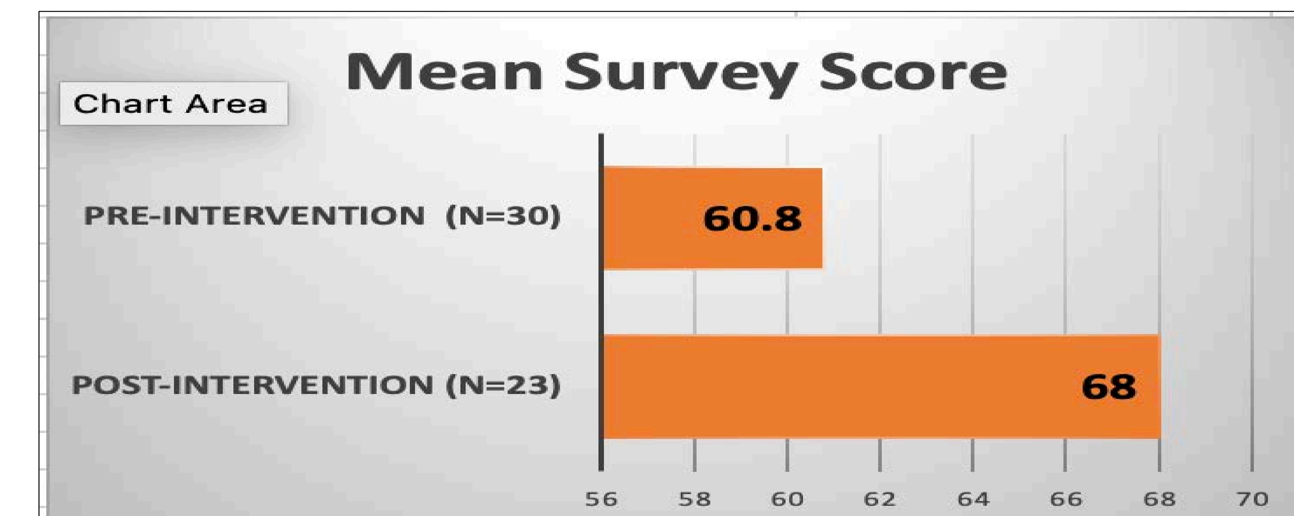
To provide tailored education & care coordination to patients and caregivers to balance between care needs and care capacities

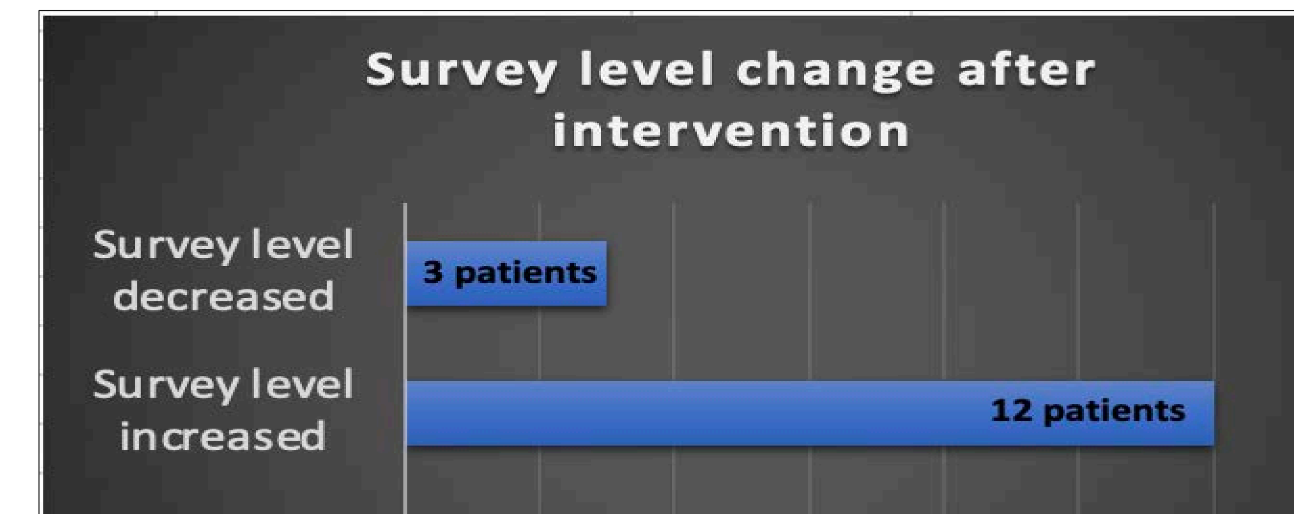
Results

- **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)**





Conclusion

- 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' self-activation functions**
- **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; Public Health Management Corporation (2016). *University of Pennsylvania Health System Community Health Needs Assessment.* https://www.pennmedicine.org/~/media/documents%20and%20audio/annual%20reports/community/community_health_needs_assessment_uphs_chna_2016_1.ashx; Rodriguez et al., 2017