Solving The High Rates Of Hospital Readmissions

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Statistics show that about 1 in 5, or 20 percent of all Medicare patients are readmitted to hospital within 30 days of discharge. That’s a staggering number, not to mention all those patients that are readmitted frequently during the course of a year, but not necessarily within 30 days.

The problem of frequent hospital readmissions is actually one that exists all over the world and not just in the United States. Healthcare systems everywhere are seeking solutions to keep their patients healthier and away from hospital. Any doctor practicing at the frontlines will be able to tell you what a big issue this is right now. We regularly see the same patients on something of a merry-go-round of frequent hospital admissions, often with the same illness.

Why does this happen? This issue is complex. In my experience as a hospital medicine doctor, there are number of factors in play, falling into different categories according to the type of illness, availability of definitive treatment, and the social circumstances of the patient.

Severity of illness. Certain chronic conditions, such as congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD), when in their advanced stages, are very labile and prone to exacerbations. As much as doctors try to control these with medications, it’s a very difficult task, as it only takes a slight precipitant such as a minor infection or dietary indiscretion to push somebody over

the edge. By their very nature chronic diseases tend to get worse over time. And with an aging population, these conditions are increasing in prevalence. Unless we find definitive cures, hospitalizations are always unfortunately a possibility.

Social situation. Patients who have inadequate family support tend to be admitted to hospital more frequently for a couple of reasons. Firstly, their threshold for being able to cope at home with their illness is much lower. Secondly, they will not be able to co-ordinate their regular follow up care so easily. We see the effects of this all the time at the frontlines — two patients with the same level of illness severity; one will be managed at home, the other will require hospital admission for several days.

Lack of follow-up. Many studies have shown that lack of follow-up with a primary care physician in the weeks after discharge can lead to a higher likelihood of re-hospitalization. Seeing a doctor quickly post discharge allows for any potential problems to be “nipped in the bud”. It also allows for care co-ordination and medication reconciliation. Sadly, a large number of patients do not have a regular primary care doctor (mostly for insurance reasons). They therefore tend to use the emergency room as their first point of contact when they feel unwell again.

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