The U.S. health care system suffers from a chronic malady—the revolving door syndrome at its hospitals. It is so bad that the federal government says one in five elderly patients is back in the hospital within 30 days of leaving.

Some return trips are predictable elements of a treatment plan. Others are unplanned but difficult to prevent: patients go home, new and unexpected problems arise, and they require an immediate trip back to the hospital.

But many of these readmissions can and should be prevented. They are the result of a fragmented system of care that too often leaves discharged patients to their own devices, unable to follow instructions they didn’t understand, and not taking medications or getting the necessary follow-up care.

The federal government has pegged the cost of readmissions for Medicare patients alone at $26 billion annually, and says more than $17 billion of it pays for return trips that need not happen if patients get the right care. This is one reason the Centers for Medicare & Medicaid Services has identified avoidable readmissions as one of the leading problems facing the U.S. health care system and now penalizes hospitals with high rates of readmissions for their heart failure, heart attack, and pneumonia patients.

This report is being released in conjunction with the Robert Wood Johnson Foundation’s Care About Your Care initiative, which is devoted to improving care transitions when people leave the hospital. It looks at the issue of readmissions in two ways: by the numbers and through the eyes of the people who live them.

In section one, “After Hospitalization: A Dartmouth Atlas Report on Readmissions in Medicare Beneficiaries,” researchers from the Dartmouth Atlas Project analyze Medicare data to demonstrate that this national problem is really a series of local problems.

“The burden of readmissions falls unevenly on Medicare beneficiaries, and is closely linked to their place of residence and the health system providing their care,” the Dartmouth researchers conclude. “Patients with similar illness have very different chances of hospital readmission depending on where they live. The variation in the quality of care between health systems is hard for patients and doctors to see, but the differences are substantial. Many patients are readmitted simply because they live in a locale where the hospital is used more frequently as a site of care for illness, leading to both higher initial admissions and higher readmissions.”

The data show that the rate of readmission for patients discharged after a medical admission in 2010 varied from a high of 18.1 percent in Bronx, N.Y., to a low of 11.4 percent in Ogden, Utah.

The spread was even wider for patients hospitalized for surgery. In 2010, 18.3 percent of Medicare beneficiaries in Bronx, N.Y., made a return trip to the hospital within 30 days, compared to a low of 7.6 percent in Bend, Ore.
This report builds on a preceding 2011 Dartmouth Atlas report finding that more than half of discharged Medicare patients do not see a primary care clinician or specialist within two weeks of leaving the hospital, an indicator of poor coordination of care between hospital and community clinicians.

Improving this and other aspects of care coordination is at the heart of efforts by hospitals, community-based clinicians, and allied health care professionals to keep people from returning to the hospital. Nurses and others inside hospitals are working to do a better job of educating patients and their caregivers about what they need to do when they go home. They are also working harder to connect them with primary care. These are all positive developments.

But policy-makers must also confront the Dartmouth research’s overarching finding—some communities use hospitals as a site of care more than others, regardless of illness levels within the community. This is vital to understand, because even though hospitals are places where life-saving heroics are routine, they can also be costly and dangerous places to receive care. People who do not need to be in the hospital should not be there. Getting people the care they need outside the hospital is imperative, and policy and payment initiatives should account for the interplay of the distribution of hospital resources and the role delivery and reimbursement systems play in hospital admissions and readmissions.

Section two, “Hospital Readmissions From the Inside Out: Stories from Patients and Health Care Providers,” reports on the results of 32 interviews conducted by PerryUndem Research & Communication with patients, caregivers, and health care providers who live and work in metropolitan Washington, D.C., New York City, and Dallas.

No two stories are alike.

One patient, Eric, said he left the hospital dog tired with a diagnosis of chronic obstructive pulmonary disease but no understanding of when to use his inhaler. He also continued to smoke. To no one’s surprise, he was back in the hospital. Thankfully, the second time around, he was flagged by his health plan and received better follow-up care. He now answers five questions daily so his care team can monitor his breathing, and he takes smoking cessation classes.

Barbara, who has type 2 diabetes, went to the hospital because her blood sugar was out of control. She went home nowiser about how to properly administer her insulin or eat right. On her second trip to the hospital, she met repeatedly with a dietician and went home with instructions on how to adjust her insulin. She’d had diabetes for 14 years without her primary care doctor ever offering that kind of help.

David was hospitalized for 14 days with chronic obstructive pulmonary disease, and although doctors suspected a mucus plug, they did not remove it. When he got home, his breathing was just as bad as before. A few days later,
he checked himself into a prestigious academic medical center that his insurance would not have authorized by entering through its emergency room. The second time was the charm; they removed the plug and he went home breathing better.

Tracey, a hospital discharge planner, said “sometimes the plan doesn’t work because families, just to be quite frank, don’t want the plan to work. They can’t manage the patient at home, and sometimes it’s they can’t do it, and sometimes they don’t want to do it.” She also noted that patients discharged on weekends get worse care because of short staffing. “There’s not a lot of face time.”

Tom, an emergency room doctor, said, “A lot of times you get the feeling that, I know that this person doesn’t need to be in the hospital, but I’ve got distraught family members who are practically wringing their hands and crying at the patient’s bedside begging me to admit the patient into the hospital.”

Glenn, an internist, finds that doctors and patients are caught in a squeeze play. Hospitals administrators carefully monitor length of stay—they are eager to send people home because the longer a patient stays, the less money they make under many payment systems. So, sometimes patients are sent home before they’re ready. On the other hand, he noted, the longer you are in a hospital, the more likely you are to get an infection.

As the report concludes, “Every patient’s story about his or her hospital readmission is complicated, unique, and hard to characterize. Yet there are common traits across the stories.”

Over and over, patients with a new diagnosis said they did not receive or understand information about everything from taking their medications to potential complicating factors. They talked about rushed discharge processes and lack of follow-up care. Providers told us about family members desperate for a break from caring for a sick loved one and begging to have them readmitted. And they complained of reimbursement methods that send some people home before they are ready and others that encourage bringing them back.

But there were also signs of encouragement. One hospital now has a 24-hour pharmacy on-site so patients can fill their prescriptions before they go home. Another created a special clinic for heart failure patients who are particularly prone to repeated admissions. Efforts are underway to better connect people to community resources. And all of the providers said the issue is firmly on their hospital’s radar screen, and as a result, discharge planning and follow-up care are improving.

This report is the latest effort by the Foundation to grapple with the vexing issues of care transitions and avoidable readmissions. Our efforts go back to 1979, when we first funded a program at Cedars-Sinai Medical Center to improve discharge plans. Since then, we have continued working with hospitals to target patient populations at risk for high readmissions. These programs have developed disease-specific discharge instruction forms, launched off-site heart failure clinics, streamlined referrals to rehabilitation programs for heart
attack patients, and provided discharge instructions in languages for non-English-speaking patients.

The Foundation also works with communities to create long-term support systems outside of the hospital for patients who are often readmitted, such as older adults and “super-utilizers,” patients who frequent hospitals and emergency rooms. We have supported research that has explored this issue from some less obvious angles as well, such as how nurses’ working conditions affect readmissions, and if socioeconomic and environmental factors, like living alone, cause Medicare patients to be at risk for returning to the hospital.

This report is part of broader effort by the Foundation to help keep avoidable readmissions on everyone’s radar. It is important to note that while hospitals are getting hit with Medicare penalties because they are the key venue of care, they do not own this issue alone. Everyone in the health care system does. As this report demonstrates, no two communities are alike, and the reasons people end up back in the hospital vary from ignorance about what to do, to lack of transportation. Ignorance is avoidable. And getting people a ride to a clinic is cheaper than putting them back in the hospital. The sooner we all own up to our role, the sooner we can tackle this problem together.