

Readmissions and Adverse Events After Discharge

June 15, 2024

Readmissions and Adverse Events After Discharge. PSNet [internet]. 2019.

<https://psnet.ahrq.gov/primer/readmissions-and-adverse-events-after-discharge>

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Background

Being discharged from the hospital can be dangerous. A classic [study](#) found that nearly 20% of patients experience adverse events within 3 weeks of discharge, nearly three-quarters of which could have been prevented or ameliorated. Adverse drug events are the most common postdischarge complication, with [hospital-acquired infections](#) and procedural complications also causing considerable morbidity. More subtle discharge hazards arise from the fact that nearly 40% of patients are discharged with [test results pending](#), and a comparable proportion are discharged with a plan to complete the [diagnostic workup](#) as an outpatient, placing patients at risk unless timely and complete follow-up is ensured. In addition, there is increasing concern that the stressful hospital environment may lead to [post-hospitalization syndrome](#)— a pathophysiologic syndrome of weakness and increased stress that may leave patients vulnerable to clinical adverse events such as falls and infections. As nearly 20% of Medicare patients are [rehospitalized](#) within 30 days of discharge, minimizing post-discharge adverse events has become a priority for the US health care system.

Systematic problems in care transitions are at the root of most adverse events that arise after discharge. Discontinuity between inpatient and outpatient providers is common, and [studies](#) have shown that traditional communication systems (such as the dictated discharge summary) generally fail to reach outpatient providers in a timely fashion and often lack essential information. Patients frequently receive new medications or have medications changed during hospitalizations. Lack of medication reconciliation results in the potential for inadvertent [medication discrepancies](#) and adverse drug events—particularly for patients with low health literacy, or those prescribed high-risk medications or complex medication regimens.

Even if communication between providers *is* timely and accurate, and appropriate steps are taken to ensure medication safety, patients and their families still assume a large [burden](#) of care after discharge. Accurately assessing patients' abilities to care for themselves after discharge can be difficult and requires a

coordinated multidisciplinary effort. Failure to enlist appropriate resources to help with the transition from hospital to home (or another health care setting) may leave patients vulnerable. Finally, the fragmented nature of the health care system may limit individual hospitals' incentive to improve their discharge process, despite the benefits to patients that may result.

Preventing Adverse Events After Discharge

Ensuring safe care transitions requires a systematic approach. Three key areas must be addressed prior to discharge:

- [Medication reconciliation](#): The patient's medications must be cross-checked to ensure that no chronic medications were stopped and to ensure the safety of new prescriptions.
- [Structured discharge communication](#): Information on medication changes, pending tests and studies, and follow-up needs must be accurately and promptly communicated to outpatient physicians.
- Patient education: Patients (and their families) must understand their diagnosis, their follow-up needs, and whom to contact with questions or problems after discharge.

No consensus exists on how to ensure patient safety after hospital discharge, but some evidence indicates that comprehensive, multi-modal interventions may be more effective at preventing rehospitalization than targeting individual components of the discharge process. Two notable interventions used specially trained staff to meet with patients before (and sometimes after) discharge to reconcile medications, instruct patients and caregivers in self-care methods, prepare [patient-centered](#) discharge instructions, and facilitate communication with outpatient physicians. These studies, the [Care Transitions trial](#) and the [Project RED study](#), both successfully reduced readmissions and emergency department visits after discharge. Multifaceted interventions to improve medication safety can also be an effective approach at improving safety around care transitions. While medication reconciliation alone does not appear to reduce rehospitalization risk, [pharmacist-directed interventions](#) that combine medication reconciliation with education and postdischarge follow-up have been shown to prevent adverse drug events and reduce readmissions in [some studies](#). There is considerable interest in harnessing the power of [checklists](#) to standardize the discharge process, and [electronic health records](#) offer great potential for improving information transfer between inpatient and outpatient physicians and developing standardized discharge instructions for patients.

Evaluating the effectiveness of care transitions interventions is hindered by the fact that the standard outcome measure—30-day readmission rates—has significant limitations. Several [studies](#) have shown that only a minority of 30-day readmissions in medical patients are truly preventable, and clinicians lack [tools](#) to predict which patients are at risk of being readmitted. The reasons why patients are readmitted likely vary between hospitals and patient populations, indicating that care transitions interventions must be tailored carefully to individual patient circumstances. For example, a recent controlled [study](#) reduced readmissions through a program that included linkage to community resources and care coordination with long-term care facilities when appropriate, as well as medication reconciliation and follow-up phone calls.

Current Context

A variety of policy initiatives have been implemented in order to encourage hospitals to address adverse events and readmissions after discharge. The Patient Protection and Affordable Care Act of 2010 contains multiple payment reforms intended to promote hospital efforts to address and prevent adverse events after discharge. Chief among these is the [Hospital Readmissions Reduction Program](#) (HRRP), which financially penalizes hospitals with above-average readmission rates for target illnesses. Since those penalties were implemented in 2012, more than 2600 hospitals had a proportion of their annual Medicare reimbursements withheld due to excess readmissions. This program appears to be effective, as readmission rates for Medicare patients have decreased since the HRRP was implemented. However, the program has drawn [criticism](#) for disproportionately penalizing hospitals that care for vulnerable patient populations. Hospitals now also receive bundled payments for target illnesses that cover all costs associated with patient care for a 30-day period, providing a financial incentive to ensure continuity of care.