Introduction and Objective

Hospital readmission rates are a current topic of interest for efforts looking to lower healthcare costs and improve patient care. Rates of readmissions are often used as an indicator of health care quality, thus their overall decrease in the United States seems to reveal that healthcare is improving. However, if one begins to compare readmission rates of different conditions, less promising trends are exposed. Medicare’s readmissions reduction program tracks three major conditions - acute myocardial infarction, heart failure, and pneumonia - and found that the readmissions rates for these patients dropped from 21.5% to 17.8% from 2007 to 2015. Cancer patients, on the other hand, are typically not tracked by readmissions reduction programs. A study using data from the National Readmissions Database from 2013 found that the overall 30 day readmission rate for cancer patients was 20.2%. Lastly, Patients with multiple comorbidities are known to have higher rates of readmissions, with cancer being a chronic condition of note. An article published in 2013 stated that 16.8% of readmitted patients on Medicare and over the age of 65 had a primary diagnosis of cancer. This was approximately double the readmission percentage of patients with other comorbidities.

Addressing the readmissions rate gap for cancer patients is an important step in identifying limitations and areas for improvement in patient care. Currently, most literature studying readmissions has focused on retrospective chart reviews. Therefore we would like to incorporate the patients’ voices for a more robust study on this topic. This study hopes to identify specific, and potentially personal, reasons that bring cancer patients back to the hospital. Patient perspective may reveal trends that are not apparent in medical record chart reviews. This information can present an opportunity to improve the quality of oncology care, and reduce the number of preventable readmissions.

Methods

Prior to the start of the study, investigators were trained by the PI to conduct semi-structured interviews and to recognize distress in subjects during the interviews.

Subjects for the study are being identified by using reports generated by Jefferson’s Electronic Health Records. Researchers will approach any oncology patient with an unplanned readmission to the Medical Oncology Service at TJUH, and conduct an interview if patients consent. Each interview has taken around 20-30 minutes.

Interviews are audio recorded and later transcribed into word documents by the interviewers, without using any patient identifiers. PHI collected from each subject includes admission date, readmission date, diagnosis, sex, medical record number, cancer diagnosis, and admission diagnosis. Each subject is assigned a unique code, stored in a secure database that is only accessible to the PI.

The transcribed interviews will be thematically analyzed using NVivo 12, which is a qualitative software program. Across all the interviews, themes and trends will be compared for interrelationships using data displays (table, graphic, text, etc) after data reduction is completed. Data reduction will be conducted using inductive and deductive reasoning and will concluded with consensus of the research team. These generated data displays will be used to draw conclusions about the data collected. The data will continually be revisited to check the validity of these conclusions as credible, defensible and warranted.

Results

The interviews are still yielding new themes, and thus are ongoing. So far, major themes that have emerged center around caretaker-patient communication, expectation management, and home-care assistance.

Some of the current themes seen among preliminary data include:

Patients' desire to be home: “I felt good to be home, but not necessarily that I should have been home. And after a couple of days, it was pretty apparent that nah, this isn’t going to workout.”

Lack of communication: “Nobody was saying much about what I should have been doing. I just think that everything could maybe be discussed in more depth from that start.”

Expectation Management: “Maybe if I had a little more understanding of everything, I would not be spooked. Like what could happen, what I could do at home to make things better.”

Conclusions

Through the surveys and chart reviews we expect to find similar reasons for readmissions – pain management, nausea, vomiting – as other studies. Our results could point toward more nuanced reasons, beyond a one line medical condition, behind readmissions. Patients believe more communication and realistic descriptions of the pain, nausea, and other expected symptoms can assuage fears and prevent hasty returns to the hospital.

Improved communication – phone calls, home-nursing visits, explicit discharge instructions – can be a step in helping patients navigate their discharges and prevent avoidable readmissions. It is the hope of our research team that patient voices will add to the understanding of these important questions. By addressing the problems illuminated by this study, there may be potential for lower health care costs, earlier intervention to prevent readmission, and improved patient care.

Future Directions

Multiple questions have been raised during this study. A few directions for future studies that have been discussed include looking at readmitted cancer patient's awareness of who is on their care team. Along with this, making sure patients medical records truly reflect their care plan as well as documentation of planned readmissions.

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References