Postdischarge Environment Following Heart Failure Hospitalization: Expanding the View of Hospital Readmission

Andrew M. Hersh, MD; Frederick A. Masoudi, MD, MSPH; Larry A. Allen, MD, MHS

Readmission after hospitalization for heart failure (HF) has received increasing attention due to the significant burden it places on patients and payers. Among Medicare beneficiaries, readmission within 30 days following heart failure hospitalization approaches 25%. Even after adjusting for case mix, significant variation in hospital readmission rates exists. This hospital-level variation suggests that many of these readmissions may be preventable. HF readmission rates adjusted for risk using a claims-based model are now publicly reported as a measure of institutional quality (www.HospitalCompare.hhs.gov). As of October 2012, the Patient Protection and Affordable Care Act’s (PPACA) value-based purchasing policies began reducing Medicare payments to hospitals with “excess” HF readmissions and offered new funding opportunities for innovative approaches to reduce HF readmissions.

Despite the obvious value of reducing unnecessary readmissions, the way forward is not as clear as these policies might suggest. An increasing segment of the medical community is voicing concern with the extent to which public reporting and financial penalties positively influence institutional HF readmission rates. Value-based purchasing may unfairly punish hospitals that provide care to socioeconomically disadvantaged patients and incentivize the avoidance of high-risk patients due to perceived inadequacies of current risk standardization models. In addition, effective interventions to prevent unnecessary readmissions remain elusive.

Prior efforts to identify risk factors for HF readmission have put an inordinate priority on the convenience of data collection. The vast majority of existing risk models employ administrative billing and inpatient clinical data from a single episode of care that are not designed to fully elucidate the breadth of potential causes of readmission. Notably missing are factors reflecting the patient’s postdischarge environment. Recent literature suggests that “social instability”—a term which reflects a relative lack of social support, education, economic stability, access to care, and safety in the patient’s environment—is an important mediator of readmission risk.

Within this context, we set out to (1) review what is known about the postdischarge environment and its relationship to HF readmission, and (2) propose a new conceptual model for HF readmission that integrates patient, provider, health system, and environmental factors. Doing so has the potential to improve the predictive capacity of HF readmission risk models, thereby making quality measures fairer, and to guide us in improving transitions of care, and ultimately leading toward reductions in unnecessary readmissions.

Literature Search

The concept of the postdischarge environment has not been a clearly defined domain in current readmission literature. Therefore, the approach taken was to systematically identify all readmission models and then manually extract factors that were perceived to represent the postdischarge environment. Systematic reviews of the literature regarding HF readmission risk models have been performed previously by Kansagara et al (2011) and Ross et al (2008). We used the published Kansagara search algorithm to capture newer literature published up to November 15, 2012. In addition, we supplemented the Kansagara search algorithm with an additional search focusing specifically on the postdischarge environment using the terms “postdischarge environment,” “environment, social, social instability,” “education, poverty, economic, and socioeconomic” in combination with “readmission and/or rehospitalization” and any medical or surgical.
condition. We then reviewed abstracts and included studies which explored the relationship of readmission to one or more aspects of the postdischarge environment.

Models identified from these searches that included any factor representing the postdischarge environment are summarized in the Table.

Using these results we then attempted to synthesize the information into a conceptual model of HF readmission (Figure), paying special attention to postdischarge environmental factors.

The State of Heart Failure Readmission Risk Modeling

Prediction models play a vital role in our understanding, interpretation, and reaction to HF readmissions. They provide insight into the primary factors that underlie readmission, and as such, point toward new and more focused interventions. Furthermore, an understanding of individual patient risk allows hospitals to triage costly, high-intensity interventions. As such, point toward new and more focused interventions.

A second study by Arbaje et al further supports this hypothesis. Using Medicare claims data as well as the Current Beneficiary Survey, this group looked at the relationship between socioeconomics, the postdischarge environment, and the likelihood of early hospital readmission over a range of diseases, including HF. In the study’s population, being unmarried, living alone, lacking “self-management skills”, and having an unmet activity of daily living and lower level of education put a patient at increased risk for readmission.

A variety of studies have shown that indigent populations tend to have higher rates of HF readmission. An analysis of national Medicare data showed that 30-day HF readmission rates for Medicare beneficiaries were higher among black patients than white patients, and that patients from minority-serving hospitals had higher readmission rates than those from nonminority-serving hospitals. Even after adjustment for measured clinical factors, Medicaid populations had higher HF readmission rates than their commercially insured counterparts. Some portion of these differences may be due to inferior health care for these populations, but differences in

The Importance of the Postdischarge Environment

Although easily captured measures of a patient’s postdischarge environment have been considered in some existing models (eg, income, marital status, insurance status; Table), a systematic approach to this domain has been largely absent from the HF readmission discussion. New data are emerging to indicate that stability in the postdischarge environment plays a critical part in HF readmission.

Amarasingham et al derived and validated an HF readmission risk model within a large, inner city, safety-net hospital, using a wide range of automated data gleaned from the electronic medical record. In this multivariable analysis, several factors emerged that were associated with 30-day readmission, including being single, male, using Medicaid, having an increased number of address changes, average income level for zip code of residence, and time of presentation to the ED (between 6 AM and 6 PM). When these markers of “social instability” were included as a group into a previously validated model, the 30-day risk prediction improved markedly (C-statistic from 0.61 to 0.72). This suggests that social environmental factors are important determinants of readmission.
<table>
<thead>
<tr>
<th>Year</th>
<th>Model</th>
<th>Patient Demographic Covariates</th>
<th>Indicator of Frailty or Functional Status</th>
<th>Comorbidities</th>
<th>Markers of Illness Severity</th>
<th>Use Patterns</th>
<th>System Hospital Characteristics and Postdischarge Services</th>
<th>Readiness for Discharge or Inpatient Quality</th>
<th>Environment Finances, Education, Stability, and Support</th>
<th>Patient Behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td>1985</td>
<td>Predicting hospital readmissions in the Medicare population⁴⁵</td>
<td>Age, sex, race</td>
<td>Disability status</td>
<td>None</td>
<td>None</td>
<td>No. of discharges in previous 60 days, no. of discharges with same dx in past 60 days, LOS, hospital reimbursement</td>
<td>Hospital based characteristics, region of the country</td>
<td>None</td>
<td>Disability status, supplemental Medicaid coverage</td>
<td>None</td>
</tr>
<tr>
<td>1988</td>
<td>Identifying factors associated with health care use: A hospital-based risk screening index⁴⁶</td>
<td>Age &gt; 75</td>
<td>Dependent ambulation, incontinence, poor mental status, terminal illness</td>
<td>2+ chronic condition, terminal illness, psychiatric disease</td>
<td>None</td>
<td>Emergency admission, prior hospitalization within the past 2 months</td>
<td>None</td>
<td>None</td>
<td>Unmarried, less than subsistence level income, lives alone or in SNF, dependent self care (requires help with ADLs), unemployment or receiving disability, poor social support</td>
<td>History of alcoholism</td>
</tr>
<tr>
<td>1988</td>
<td>Postdischarge care and readmission⁴⁷</td>
<td>Age, sex, race</td>
<td>None</td>
<td>None</td>
<td>BUN, paO₂, WBC, hemoglobin</td>
<td>ER visits in previous 6 months</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>1990</td>
<td>Risk Factors for early readmission among veterans⁴⁸</td>
<td>Age, sex, race, period of military service, county of residence</td>
<td>None</td>
<td>Spinal cord injury, number of surgeries performed, risk</td>
<td>None</td>
<td>LOS, unit type (medical, intermediate, neurological, surgical), discharged</td>
<td>VA auspices, place and type of disposition</td>
<td>None</td>
<td>Compensation/pension status, distance from hospital services, marital</td>
<td>None</td>
</tr>
<tr>
<td>Year</td>
<td>Model</td>
<td>Patient</td>
<td>System</td>
<td>Environment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>-------</td>
<td>---------</td>
<td>--------</td>
<td>-------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1991</td>
<td>Factors predicting readmission of older general medicine patients</td>
<td>Age, race</td>
<td>Cognition (MMSE)</td>
<td>Emergent hospitalization, no. of hospitalizations in the last year, LOS, admitted from home</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1992</td>
<td>Contribution of a measure of disease complexity (COMPLEX) to prediction of outcome and changes among hospitalized patients</td>
<td>Age, sex</td>
<td>None</td>
<td>None</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1996</td>
<td>Does risk-adjusted readmission rate provide valid information on hospital quality</td>
<td>Age, sex</td>
<td>None</td>
<td>None</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1997</td>
<td>Correlates of early hospital readmission or death in patients with Congestive Heart Failure</td>
<td>Age, sex, race</td>
<td>None</td>
<td>None</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year</td>
<td>Model</td>
<td>Patient</td>
<td>System</td>
<td>Environment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>-------</td>
<td>---------</td>
<td>--------</td>
<td>-------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Demographic Covariates</td>
<td>Indicator of Frailty or Functional Status</td>
<td>Comorbidities</td>
<td>Markers of Illness Severity</td>
<td>Use Patterns</td>
<td>Hospital Characteristics and Postdischarge Services</td>
<td>Readiness for Discharge or Inpatient Quality</td>
<td>Finances, Education, Stability, and Support</td>
<td>Patient Behavior</td>
</tr>
<tr>
<td>1999</td>
<td>Prediction of hospital readmission for heart failure: development of a simple risk score on administrative data&lt;sup&gt;22&lt;/sup&gt;</td>
<td>Age, sex, race</td>
<td>None</td>
<td>Charlson Comorbidity Index, specific comorbid conditions</td>
<td>See use pattern</td>
<td>LOS, total hospital discharge dollars, use of an ICU, procedural complication, discharge to SNF, transfer to acute care hospital, home health services after discharge, discharged AMA, Cardiology service, PT/OT, specific noninvasive cardiology procedures (echo, telemetry monitoring, EST, etc.), invasive cardiac procedures (PCI, CABG, etc.), critical care procedures (pulmonary artery catheterization, inotropic agents, mechanic ventilator support, HD, etc.)</td>
<td>Hospital location, hospital type</td>
<td>None</td>
<td>Insurance type</td>
<td>History of drug or alcohol abuse</td>
</tr>
<tr>
<td>2000</td>
<td>Predicting nonelective hospital readmissions: A multi-site study&lt;sup&gt;23&lt;/sup&gt;</td>
<td>Age, gender, race</td>
<td>SF-36 score physical component summary</td>
<td>SF-36 mental component summary</td>
<td>Disease specific severity markers (eg, insulin dependence, home O&lt;sub&gt;2&lt;/sub&gt; use, NYHA class),</td>
<td>No. of ED visits in previous 6 months, no. of admissions in previous 6 months, LOS,</td>
<td>None</td>
<td>None</td>
<td>Marital status, highest grade completed, distance from VAMC, employment</td>
<td>None</td>
</tr>
<tr>
<td>Year</td>
<td>Model</td>
<td>Demographic Covariates</td>
<td>Indicator of Frailty or Functional Status</td>
<td>Comorbidities</td>
<td>Markers of Illness Severity</td>
<td>Use Patterns</td>
<td>System Characteristics and Postdischarge Services</td>
<td>Readiness for Discharge or Inpatient Quality</td>
<td>Finances, Education, Stability, and Support</td>
<td>Patient Behavior</td>
</tr>
<tr>
<td>------</td>
<td>-------</td>
<td>------------------------</td>
<td>------------------------------------------</td>
<td>---------------</td>
<td>-----------------------------</td>
<td>-------------</td>
<td>---------------------------------</td>
<td>---------------------------------</td>
<td>---------------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>2000</td>
<td>Predictors of readmission among elderly survivors of admission with heart failure&lt;sup&gt;24&lt;/sup&gt;</td>
<td>Age, sex, race</td>
<td>Discharge mobility</td>
<td>Specific comorbid conditions</td>
<td>Presence of PND, orthopnea, chest pain, systolic/diastolic blood pressure, respiratory rate, pulmonary edema on CXR, LVEF, occurrence during hospitalization of a major complication (cardiac arrest, shock, MI, stroke), major procedure during hospitalization (CABG, cardiac catheterization), labs at discharge including: sodium, BUN, creatinine, BUN/CR ratio, ACE inhibitor prescription, digoxin prescription</td>
<td>patient satisfaction scores from survey data</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>2004</td>
<td>Posthospital care transitions: patterns, complications, and risk identification&lt;sup&gt;25&lt;/sup&gt;</td>
<td>Age, sex</td>
<td>Premorbid functional status score, self-rated general health, visual impairment, need for assistance with ADLs</td>
<td>Charlson Comorbidity Index, specific comorbid conditions, Alzheimer's disease</td>
<td>None</td>
<td>Previous admission and average LOS in the previous 6 months, number of prior SNF stays and average LOS in previous 6 months</td>
<td>None</td>
<td>None</td>
<td>Medicaid status, unmarried</td>
<td>None</td>
</tr>
</tbody>
</table>

Continued
<table>
<thead>
<tr>
<th>Year</th>
<th>Model</th>
<th>Patient</th>
<th>System</th>
<th>Environment</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>Risk stratification after hospitalization for decompensated Heart Failure</td>
<td>Age, gender, race</td>
<td>Duration of HF diagnosis, HF etiology, history of PCI, presence of peripheral edema, S3 murmur, EF, NYHA class, JVD, HJR, NYHA class, systolic BP, diastolic BP, respiratory rate, K, BUN, Cr, Na, platelets, Hb</td>
<td>Number of prior HF hospitalizations in the previous 12 months</td>
</tr>
<tr>
<td>2006</td>
<td>Identifying patients at high risk of emergency hospital admissions: A logistic regression analysis</td>
<td>Age, sex, ethnicity, admission rate</td>
<td>Duration of hospitalization, number of ED visits in the past 365 days, number of ED visits in the past 366 days to 36 months</td>
<td>Number of prior HF hospitalizations in the previous 12 months</td>
</tr>
<tr>
<td>2006</td>
<td>Validation of the potentially avoidable hospital readmission rate as a routine indicator of the quality of hospital care</td>
<td>Age, sex</td>
<td>Duration of hospitalization, number of ED visits in the past 365 days, number of ED visits in the past 366 days to 36 months</td>
<td>Number of prior HF hospitalizations in the previous 12 months</td>
</tr>
<tr>
<td>2007</td>
<td>Improving the management of care for high-cost Medicaid patients</td>
<td>Age, sex, race/ethnicity</td>
<td>Duration of hospitalization, number of ED visits, primary care visits, and specialists care visits in previous 3 years, Use of</td>
<td>Number of prior HF hospitalizations in the previous 12 months</td>
</tr>
</tbody>
</table>
Table. Continued

<table>
<thead>
<tr>
<th>Year</th>
<th>Model</th>
<th>Patient</th>
<th>System</th>
<th>Environment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Demographic Covariates</td>
<td>Indicator of Frailty or Functional Status</td>
<td>Comorbidities</td>
</tr>
<tr>
<td>2007</td>
<td>Prediction of Rehospitalization and Death in Severe Heart Failure by Physicians and Nurses of the ESCAPE Trial&lt;sup&gt;30&lt;/sup&gt;</td>
<td>Age, sex, race</td>
<td>6 minute walk distance</td>
<td>None</td>
</tr>
<tr>
<td>2008</td>
<td>Hospital 30-day Heart Failure readmission measure: methodology&lt;sup&gt;31&lt;/sup&gt;</td>
<td>Age, sex</td>
<td>Protein calorie malnutrition</td>
<td>Specific comorbid conditions</td>
</tr>
<tr>
<td>2008</td>
<td>Risk factors for 30-day hospital readmission in patients ≥ 65 years of age&lt;sup&gt;32&lt;/sup&gt;</td>
<td>Age, sex, race/ethnicity</td>
<td>None</td>
<td>Specific comorbid conditions</td>
</tr>
<tr>
<td>2009</td>
<td>Using routine inpatient data to identify patients</td>
<td>Age, sex, indigenous status</td>
<td>None</td>
<td>Specific comorbid conditions</td>
</tr>
</tbody>
</table>

Home health care, personal care, rehab services, substance abuse services, prescription medications, inpatient spending.
<table>
<thead>
<tr>
<th>Year</th>
<th>Model</th>
<th>Patient Covariates</th>
<th>System Covariates</th>
<th>Environment Covariates</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>An automated model to identify heart failure patients at risk for 30-day readmission or death using electronic medical record data[^3]</td>
<td>Age, sex, race, see markers of severity</td>
<td>Depression or anxiety</td>
<td>Tabak Mortality Risk Score (derived from albumin, total bilirubin, CK, creatinine, sodium, BUN, Pco2, WBC, troponin-I, glucose, INR, BMP, ph, temperature, pulse, diastolic BP, systolic BP)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Number of prior admissions, ED visits, and outpatient visits, presentation to ED from 6 AM to 6 PM</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>None</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Cocaine use, history of leaving AMA, missed outpatient appointments, number of home address changes</td>
</tr>
</tbody>
</table>

[^3]: Hersh et al.
### Table. Continued

<table>
<thead>
<tr>
<th>Year</th>
<th>Model</th>
<th>Patient Covariates</th>
<th>System Covariates</th>
<th>Environment Covariates</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>Hospital readmission in general medicine patients: A prediction model</td>
<td>Age, sex, race/ethnicity</td>
<td>SF-12 physical component, MMSE, presence of functional limitation</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Charlson Comorbidity Index, SF-12 mental component</td>
<td>Number of admissions in the previous year, LOS, need for extra day stay during current admission</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Has a PCP</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>None</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>None</td>
</tr>
<tr>
<td>2011</td>
<td>Inability of providers to predict unplanned readmissions</td>
<td>Age, sex</td>
<td>Poor self-rated general health</td>
<td>Admission in prior year, more than 6 doctor visits in prior year</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>CAD, DM2</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>None</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>None</td>
</tr>
<tr>
<td>2011</td>
<td>Incremental value of clinical data beyond claims data in predicting 30-day outcomes after heart failure hospitalization</td>
<td>Age, sex</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Diagnoses at admission including psychiatric diagnoses</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>None</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>None</td>
</tr>
<tr>
<td>2011</td>
<td>Unplanned readmissions after hospital discharge among patients identified as being at high risk for readmission using a validated predictive algorithm</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Charlson Comorbidity Index</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>LOS, number of ED in the previous 6 months, emergent admission</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>None</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>None</td>
</tr>
</tbody>
</table>

Bolded covariates were included in the final model. Non-bolded covariates were proposed, but not included. LOS indicates length of stay; SFN, skilled nursing facility; ADL, activities of daily living; WBC, white blood cell; MMSE, mini-mental state examination; CHF, congestive heart failure; HF, heart failure; VT, ventricular tachycardia; EF, ejection fraction; PCP, primary care provider; EST, exercise stress test; PCI, percutaneous coronary intervention; CABG, coronary artery bypass graft; HD, hemodialysis; Hb, hemoglobin; LVEF, left ventricular ejection fraction; ACE, angiotensin-converting enzyme; CK, creatine kinase; INR, International Normalized Ratio; BNP, brain natriuretic peptide; CAD, coronary artery disease. BUN, blood urea nitrogen; RN, registered nurse; VA, Veteran’s Administration; POW, prisoner of war; COPD, chronic obstructive pulmonary disease; PMC, patient management category; MI, myocardial infarction; VF, ventricular fibrillation; DM, diabetes mellitus; BP, blood pressure; CR, chest x-ray; NSR, normal sinus rhythm; EKG, electrocardiogram; ST-T, ST or T segment; ICU, intensive care unit; PT/OT, physical therapy/occupational therapy; SF-36, Short Form-36; NYHA, New York Heart Association; ED, emergency department; VAMC, Veteran’s Affairs Medical Center; PND, paroxysmal nocturnal dyspnea; CR, creatinine; JVD, jugular venous distention; HJR, hepatojugular reflux; ESCAPE, Evaluation Study of Congestive Heart Failure and Pulmonary Artery Catheterization Effectiveness; HR, heart rate; NA, sodium; CPR, cardiopulmonary resuscitation.
patient and environmental factors not captured by existing models are likely to contribute as well. At least among the Medicare population, community measures explain far more of the variance in institutional HF readmission rates than do hospital process performance measures.41

Recent analyses that have specifically collected data on social factors not captured by traditional databases (a "hypothesis first" approach) have helped expand our view of the mediators of readmission. Peterson et al showed in a series of papers derived from prospective health survey information that health literacy42 and acculturation43 were strong predictors of adverse outcomes after discharge among patients hospitalized with HF, and Tao et al44 suggest a scoring system that might be used to predict patients whose social situation place them at higher risk for readmission.

As further evidence of the influence of the postdischarge environment on readmission, successful interventions that have effectively reduced readmissions have generally done so by altering the patient’s postdischarge environment or the patient’s ability to manage his/her own environment. For example, comprehensive discharge planning (including education of the patient and family), social-service consultation, and intensive follow-up were components of the earliest successful HF readmission interventions.45,46 More recently, transition coaches who go directly into the home environment to support a variety of patient needs have been shown to be effective.47 Unlike successful interventions that use trained personnel to broadly support patients in their transition to home, unimodal interventions11 and those focused primarily on the physiology of HF48 have consistently failed to reduce HF readmission rates.

**A New Conceptual Model for HF Readmission**

HF readmission is an event that occurs, by definition, in the postdischarge environment. As such, it is reasonable to surmise then that this environment would act as a mediator. Based on our current understanding of readmissions, we propose a new explicit paradigm of HF readmission that
positions patient and health system factors within their relevant environment (Figure). The patient interacts with the provider and health system all within the context of the surrounding environment. This conceptualization moves the postdischarge environment from a peripheral (or ignored) role to an encompassing one. Changing our conceptualization transforms our view of readmission from a biological, hospital-based event to a “sociobiological” process. This new model also helps reconcile how patient factors and provider/health system factors relate to each other through the postdischarge environment. Concretely, this reframing suggests how new lines of research into the postdischarge environment may lead to further improvements in our ability to predict and mitigate risk of readmission.

The question of how the postdischarge environment affects readmissions is important. Readmission is typically a multifactorial process. We hypothesize that increased stability in the postdischarge environment can positively affect a variety of domains related to readmission. Social stability has the potential to improve dietary compliance and fluid restriction, increase medication adherence, increase access to health care and improve compliance with appointments, raise levels of exercise, reduce tobacco and alcohol use, etc. Together, these factors may positively influence HF severity and disease progression. In addition, they may decrease comorbidity number and severity and even help bolster a patient’s physiologic reserve. These domains may remove barriers to, or combine with, provider and systems-based factors to synergistically influence rates of readmission.

Environmental Factors and Public Policy

It has been has been argued that socioeconomic factors have a limited place in risk modeling because adjusting for them may “excuse” substandard care for indigent and impoverished populations. To the contrary, acknowledging that the patient and health system reside within a larger environment counters this argument. Including environmental factors in risk-standardization models for public reporting and value-based purchasing recognizes the unique challenges posed by patients with significant environmental instability. In addition, this perspective lends support to incentives that would foster the development of innovative transitional care programs in order to accommodate social instability or directly enhance the patient’s ability to navigate the postdischarge environment. Moving from the overly simplistic, dichotomous, patient-hospital construct to consideration of the patient, clinician, and hospital as members of the community in which they all reside promotes a more integrated approach to health. Ultimately, major improvements in the health of patients with chronic, progressive diseases (like HF) will require coordinated efforts among patients, families, providers, health systems, governmental agencies, and community organizations. This integrated approach should be properly incentivized by sound public policy.

As the Centers for Medicare and Medicaid Services scale up performance-based payments, it must consider the potential influence of socioeconomic factors on outcomes to ensure that hospital payment penalties do not exacerbate disparities in care. Although outcome measures designed to reduce unnecessary hospital readmissions may be an important step forward in advancing quality in some respects, the failure to incorporate environmental factors could influence hospitals’ ability and willingness to serve vulnerable populations. Stratifying institutional readmission results by important environmental factors may be one way to “level the playing field” when assessing hospital performance and encourage hospitals to maintain access to care for vulnerable populations.

Future Research

Factors related to the postdischarge environment need to be better explored, measured, and integrated into risk models and interventions. Without a comprehensive and systematic analysis of the postdischarge environment, we are unlikely to realize reductions in unnecessary HF readmissions. Such an approach would involve a number of steps, including the development of definitions and an associated taxonomy around relevant factors in the postdischarge environment followed by surveillance of these factors through an explicit mechanism.

Research by Ross et al and Arbaje et al provides an example of how to assess the incremental value of “factors of social instability” by assessing risk model performance before and after inclusion of these factors. In the meantime, institutions that are seriously working to improve their HF readmission rates should recognize that interventions that ignore the environment into which a patient is discharged are unlikely to significantly impact their readmission rates.

Conclusions

A variety of forces, including passage of the PPACA and its linkage of HF readmission to reimbursement, have placed HF readmissions at the forefront of quality improvement efforts in medicine. However, the poor performance of existing HF readmission risk models combined with our failure to significantly impact HF readmission rates should give us pause. HF readmission consists of a complex interplay between patient, health system, and the environment. We
believe that conceptualizing HF readmission as a sociobio-
logical process rather than a discrete physiologic occurrence
will help us to better characterize, predict, and ultimately
mitigate risk. Further research into the exact mechanisms by
which the postdischarge environment affects readmission will
improve quality measures and future interventions designed to
keep HF patients out of the hospital.

Acknowledgments
We sincerely thank C. David Kosakowski for his technical
revision of the text.

Sources of Funding
Dr. Allen is currently supported by grant 1K23HL105896-
01A1 from the National Heart, Lung and Blood Institute.

Disclosures
None.

References
1. Roger VL, Go AS, Lloyd-Jones DM, Benjamin EJ, Berry JD, Borden WB, Bravata
DM, Dai S, Ford ES, Fox CS, Fullerton HJ, Gillespie C, Halpern SM, Heit JA,
Howard VJ, Kissela BM, Kittner SJ, Lackland DT, Lichtman JH, Lisabeth LD,
Makuc DM, Marcus GM, Marelli A, Matchar DB, Moyer VA, Mozaffarian D,
Mussolino ME, Nichol G, Pyment NP, Soliman EZ, Sorlie PD, Sotoodehnia N,
Turan TN, Virani SS, Wong ND, Woo D, Turner MB. Heart disease and stroke
2. Jencks SF, Williams MV, Coleman EA. Rehospitalizations among patients in the
Mattera JA, Krumholz HM. An administrative claims measure suitable for
profiling hospital performance on the basis of 30-day all-cause readmission
Stat. 119, 318
5. Joynt KE, Jha AK. Thirty-day readmissions–patterns, complications, and
risk identification. Health Serv Res. 2004;39:
1449–1465.
6. Felker GM, Leimberger JD, Califf RM, Cuffe MS, Massie BM, Adams KF Jr,
Huey JM, Hynes DM, Dao AM, Winter MK, Geraci D. Predictive factors for 30day
7. Weinick RM, Hasnain-Wynia R. Quality improvement efforts under health
8. Byrd RB, Schuur JD, Normand SL, Gheorghiade M, O’Connor CM, Horwitz RI.
Predictors of readmission among elderly survivors of admission with heart failure.
Mussolino ME, Nichol G, Paynter NP, Soliman EZ, Sorlie PD, Sotoodehnia N,
Turan TN, Virani SS, Wong ND, Woo D, Turner MB. Heart disease and stroke
Prediction of hospital readmission for heart failure: development of a simple risk
Validation of the potentially avoidable hospital readmission rate as a routine
13. Williams J, Mijanovich T. Improving the management of care for high-cost
14. van WALRAVEN C, Dhalla IA, Bell C, Binanay C, Conway GA, Glotzer JM,
Billings J, Mijanovich T. Using routine inpatient data to identify patients at risk
for 30-day readmission or death using electronic medical records. Arch Intern
Factors of readmission among elderly survivors of admission with heart failure.
17. Williams J, Mijanovich T. Improving the management of care for high-cost
18. Byrd RB, Schuur JD, Normand SL, Gheorghiade M, O’Connor CM, Horwitz RI.
Predictors of readmission among elderly survivors of admission with heart failure.
19. Kripalani S. Risk prediction models for hospital readmission: a systematic
20. Naessens JM, Leibson CL, Krishan I, Ballard DJ. Contribution of a measure of
disease complexity (complex) to prediction of outcome and charges among
21. Chin MH, Goldman L. Correlates of early hospital readmission or death in
Factors of readmission among elderly survivors of admission with heart failure.
24. Naessens JM, Leibson CL, Krishan I, Ballard DJ. Contribution of a measure of
disease complexity (complex) to prediction of outcome and charges among
25. Chin MH, Goldman L. Correlates of early hospital readmission or death in
Factors of readmission among elderly survivors of admission with heart failure.
28. Williams J, Mijanovich T. Improving the management of care for high-cost
29. van WALRAVEN C, Dhalla IA, Bell C, Binanay C, Conway GA, Glotzer JM,
Billings J, Mijanovich T. Using routine inpatient data to identify patients at risk
for 30-day readmission or death using electronic medical records. Arch Intern
Factors of readmission among elderly survivors of admission with heart failure.
32. Williams J, Mijanovich T. Improving the management of care for high-cost


Key Words: heart failure • patient readmission • quality improvement
Postdischarge Environment Following Heart Failure Hospitalization: Expanding the View of Hospital Readmission
Andrew M. Hersh, Frederick A. Masoudi and Larry A. Allen

*J Am Heart Assoc.* 2013;2:e000116; originally published April 11, 2013;
doi: 10.1161/JAHA.113.000116

The *Journal of the American Heart Association* is published by the American Heart Association, 7272 Greenville Avenue,
Dallas, TX 75231
Online ISSN: 2047-9980

The online version of this article, along with updated information and services, is located on the World Wide Web at:
http://jaha.ahajournals.org/content/2/2/e000116

Subscriptions, Permissions, and Reprints: The *Journal of the American Heart Association* is an online only Open Access publication. Visit the Journal at http://jaha.ahajournals.org for more information.