A RESIDENT'S PERSPECTIVE

Reducing the likelihood that a patient will be readmitted

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Over the past year, as a part of a treatment team, I encountered many discharged patients who did not heed their physician's instructions—be it rehabilitation advice, follow-up appointments, or adherence to a drug regimen. Consequently, these patients found themselves back in the inpatient unit a few days later. A cycle of admission–discharge–readmission began for them.

I have witnessed conflicting emotions on the part of the staff (nurses and residents) toward these patients. Some staff are empathetic to their needs; others see the recurrent admissions as a ruse to find food and shelter and get attention.

In this article, I explore several aspects of this behavioral pattern and possible reasons for it, and describe the staff's reaction to a returning patient in one case.

CASE REPORT

Depressed and heavily intoxicated

Mr. R, age 35, with a history of major depressive disorder and nonadherence to treatment, is brought to the emergency room (ER) by emergency medical services because he is heavily intoxicated (blood alcohol level, >200 mg/dL). Mr. R has had 4 admissions to the inpatient psychiatry unit in the past 6 months, including 2 in the past 30 days.

After a few hours' stay in the ER, Mr. R's blood alcohol level drops to <100 mg/dL. He is being prepared for discharge to follow-up with outpatient psychiatric services when he begins complaining of chest pain. A cardiac workup is negative; he is again prepared for discharge when he begins reporting suicidal ideation, with a plan to jump in front of traffic.

Mr. R is admitted to the inpatient psychiatry unit.

During Mr. R's hospitalization, he admits that he lied about being suicidal because he recently lost his job and is homeless and in dire need of food and shelter. He stays in the inpatient unit for 6 days.

An unexpected 'adverse reaction'

During the hospital stay, staff members, who initially were concerned about Mr. R's condition, underwent a striking transformation in their attitude toward the patient once his suicidal ideation was exposed as a hoax: They became less receptive to his needs.

The staff's experience with Mr. R also altered their approach to other patients, who were put under unnecessary scrutiny in response to heightened suspicion of feigned illness—a classic case of "once bitten, twice shy." The staff felt betrayed by Mr. R's false claim of being suicidal.

Furthermore, I noticed self-doubt creeping into the minds of the residents who had admitted Mr. R. Consequently, they advocated that he should be discharged

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Disclosure

Dr. Sharma reports no financial relationships with any company whose products are mentioned in this article or with manufacturers of competing products.

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immediately because he was depriving sick patients of an acute care bed.

The attending physicians and other members of the staff remained compassionate toward the patient, however; instead of condemning him, they tried to understand the root cause of why he sought admission: Was it nonadherence with his medication regimen? Substance abuse? Social issues? These staff members were opposed to discharging Mr. R because they believed that forced discharge would encourage him to further manipulate the system—and he would be back in the ER.

CASE CONCLUDED

The medical team concludes that it is prudent to prepare a well-thought-out discharge plan for Mr. R. He is allowed to remain as an inpatient until his social issues are addressed; he is plugged into the rehabilitation program for his alcohol addiction, with a plan for close outpatient psychiatry follow-up.

One year later, Mr. R has not been admitted again.

How to tackle shortcomings of the system

Because of changing hospital policies, an acute shortage of psychiatry inpatient beds, and the reluctance of insurance companies to reimburse for an extended stay, these beds are often hurriedly evacuated and patients are discharged prematurely to make room for acutely ill patients.[1] Such policies can lead to failure to reach a therapeutic medication dosage or establish an appropriate disposition plan. Patients might relapse and find their way back to the inpatient unit.

Even though this is a system—not a personal—shortcoming, these patients are viewed negatively and are unwelcome when they return to the hospital. Notably, longer hospital stays do not necessarily lead to better care or fewer readmissions. Patients who have a longer length of stay are, in fact, sicker and have inadequate community and social support.[1,2]

After a year's experience as a psychiatry resident, I came to understand that, before discharging a patient from the inpatient unit, a resident should pose a few questions to himself (herself), including:

- What is the likelihood that the patient will adhere to his (her) medication regimen?
- Where is the patient going to get his medications? Will he (she) be able to pay for them?
- Does he have a substance use disorder?
- Have the patient's personal circumstances changed since he was admitted? If so, how?

Finding answers to these questions and working on solutions can help minimize the readmission rate.

The post-discharge component of care has a significant role, too, including psychoeducation of the patient and the family regarding:

- ongoing psychiatric disease
- potential side effects of medications
- post-discharge telephone calls
- timely follow-up (within 2 or 3 weeks)
- good communication with the outpatient provider, through telephone calls or a faxed discharge summary.[2,3]

I've learned that it isn't uncommon for health care providers to give in to negative emotions and become frustrated. For residents and other members of the team alike, it is important to talk to one's supervisor and colleagues about that frustration. It is the duty of every member of the treatment team to support each another and maintain a therapeutic posture on the unit.

At the end of every day, of course, what matters is the well-being of our patients.

Clinical Point

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