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Come On Admit it! We can Do Better to Prevent Readmissions

Readmission metrics continue to be very important in regards to defining quality of care for patients that are discharged from hospitals and skilled facilities (SNFs). A large proportion are avoidable as many factors impact readmission rates e.g. disease severity, facility performance, nurse and doctor beliefs etc. A recent study explored the reasons behind avoidability for early and late readmissions and found interesting results.

In the study published by Graham et al. researchers studied >800 general medicine patient discharges from the hospital and compared readmissions within 7 days of discharge to those between days 8 to 30. They used evidence-based tools to assess avoidability and the factors that led to readmissions. They found that almost 30% readmissions were avoidable; avoidability being twice as higher among early (<8 days) than late readmissions (days 8-30).

Researchers also reviewed interventions that could have prevented these readmissions. Interestingly, hospitals were the ideal location for interventions that would have prevented early readmissions; two most common issues being premature hospital discharge and physician decision-making. In regards to late readmissions, researchers concluded that post-discharge monitoring, end of life care, and advance care planning could have prevented a large proportion of the avoidable readmissions.

The study highlights the key issues SNF physicians and medical directors could focus on, to prevent avoidable readmissions. For example, they should establish systems for timely and accurate communication with local hospitals to prevent premature discharges of complex patients to the SNFs. They should also lead efforts to set systems for meaningful and timely advance care planning discussions, and to refer patients with advanced illnesses for end-of-life care and hospice services.

Graham, K. L., Auerbach, A. D., Schnipper, J. L., Flanders, S. A., Kim, C. S., Robinson, E. J., ... & Fletcher, G. S. (2018). Preventability of Early Versus Late Hospital Readmissions in a National Cohort of General Medicine Patients. Annals of internal medicine.

Ignorance is Bliss; Updated Guidelines on Prostate Screening

The decision to screen for prostate cancer, like any other disease needs to take into account many key factors e.g. the cost of screening, false positive rates, undue anxiety from screening, side effects from the treatment and so on. JAMA recently published updated guidelines from USPTF on this issue.

Detailed review of the randomized controlled data showed that PSA-based screening programs in men aged 55 to 69 years may prevent approximately 1.3 deaths from prostate cancer over approximately 13 years per 1000 men screened. They also discovered many serious side effects from screening and treatment including false positive-related anxiety, erectile dysfunction, urinary incontinence, and bowel symptoms. About 1 in 5 men who undergo radical prostatectomy develop long-term urinary incontinence, and 2 in 3 men will experience long-term erectile dysfunction. The harm among men >70 years is higher as they have higher false-positive rates and the side effects from treament.

Based on their review the USPTF recommended that for men aged 55 to 69 years, the decision to undergo periodic PSA-based screening for prostate cancer should be an individual one and should include discussion of the potential benefits and harms of screening with their clinician. Clinicians should not screen men who do not express a preference for screening (C recommendation). The USPSTF recommends against PSA-based screening for prostate cancer in men 70 years and older (D recommendation).

These guidelines are very clear regarding my SNF patients. Majority of my patients are above 70 years of age and have co-morbidities and should not be offered the PSA-based screening. In a few patients who are younger, the decision to screen should be made after patient education and understanding of their goals of care.

US Preventive Services Task Force. Screening for Prostate Cancer: US Preventive Services Task Force Recommendation Statement. JAMA. 2018;319(18):1901–1913. doi:10.1001/jama.2018.3710

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Management of Patients with Atrial Fibrillation; Are there Irregularities?

Atrial Fibrillation (AF) is a common diagnosis among the elderly with >70% cases occurring in patients between 65-85 years. Based on its duration, AF is categorized as permanent (>12 months), persistent (>7 days) or paroxysmal (episodes that terminate in <7 days).

Stroke continues to be the most feared complication of AF (5-folds increase in risk) but studies confirm that heart failure is also a very common outcome, resulting in morbidity and mortality. AF increases the risk of death by 1.5 and 1.9 times among males and females respectively. The risk of death with AF is highest in the first year after diagnosis.

CHA2DS2-VASc score recommends that all patients >75 years should be anticoagulated unless there is a strong contraindication. Warfarin or the newer agents such as rivaroxaban (20 mg PO daily) or dabigatran (150 mg PO bid),with renal adjustments in dosing if needed, are great choices.

Majority of patients with permanent or persistent AF need lifelong anticoagulation but what about those that have a "resolved AF" diagnosis? A recent study published in BMJ explored risk of strokes and TIAs in such patients. In this retrospective chart review, researchers studied >11,000 patients with this diagnosis and compared them with patients with permanent AF and with controls without AF.

The results from the study were very important as authors concluded that "patients with resolved atrial fibrillation remained at higher risk of stroke or TIA than patients without atrial fibrillation. The risk is increased even in those in whom recurrent atrial fibrillation is not documented". Moreover, it was found that these patients were only 20% likely to receive appropriate anticoagulation versus those with documented persistent or permanent AF.

This study reminds us that the decision against anticoagulating patients with any history of AF must be very well thought out i.e. stopping anticoagulation only in patients with clear contraindications (e.g. recent major bleed, end-of-life care, patient choice etc.). Most elderly, SNF patients have high risk of AF and the worst possible outcomes. Patients with resolved AF continue to be at a high risk of poor outcomes and it is prudent that they and their families understand the risks involved before making a decision to discontinue anticoagulation.

Adderley, N. J., Nirantharakumar, K., & Marshall, T. (2018). Risk of stroke and transient ischaemic attack in patients with a diagnosis of resolved atrial fibrillation: retrospective cohort studies. bmj, 361, k1717

ASA or Rivaroxaban after lower extremity arthroplasties? What's the Bloody Difference!

DVTs and/ or pulmonary embolisms, collectively referred to as venous thromboembolism (VTE) are common complications after lower extremity arthroplasties. Thus, current guidelines recommend that patients undergoing total hip or knee arthroplasty receive, at least 14 days of anticoagulation, and it may be extended to 35 days.

For prophylaxis of VTE in patients with lower joint arthroplasties, use of warfarin can be cumbersome, and direct oral anticoagulants incur high expenses. IN that regard, what could be the role of ASA? ASA is widely available over-the-counter, is easy to administer, has limited side effects and is relatively inexpensive.

A randomized control trial published in the New England Journal of Medicine compared the use of once-daily oral rivaroxaban 15mg to ASA 81 mg orally (after all patients received 5 days of post-operative rivaroxaban). The duration of anticoagulation was a total of 14 days for total knee, and total of 35 days for total hip arthroplasty patients.

More than 3200 patients were enrolled and randomized. Only 11 and 12 patients were diagnosed with VTE in ASA and rivaroxaban groups, respectively (P-value was signficant for non-inferiority). Clinically significant bleeding occurred among 22 patients in the ASA group and among 17 patients in the rivaroxaban group but was statistically insignificant. Authors concluded that ASA was at least as effective as rivaroxaban in preventing VTE in these patients.

This study is an important one, as it confirmed that ASA and rivaroxaban both have similar outcomes for patients after major lower extremity arthroplasties as long as they receive a 5-day starting dose of rivaroxaban after the surgery. This could have significant implications for many post-hip/knee arthroplasty patients we provide care for in our SNFs. ASA can be an effective and easy to administer choice for preventing VTE after patients complete 5 days of post-surgery rivaroxaban.

Anderson, D. R., Dunbar, M., Murnaghan, J., Kahn, S. R., Gross, P., Forsythe, M., ... & Crowther, M. (2018). Aspirin or rivaroxaban for VTE prophylaxis after hip or knee arthroplasty. New England Journal of Medicine, 378(8), 699-707

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