Strategies for Reducing Hospital Readmission Rates in Sulu: A Basis for Patient-centered Care Model

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*ABSTRACT***.** Hospital readmissions associated with Home Against Medical Advice (HAMA) pose a significant challenge in resource-limited settings. This qualitative phenomenological study explored the strategies, challenges, and system-level barriers influencing HAMA-related readmissions in Level 1 hospitals in Sulu, Philippines. Semi-structured interviews were conducted with nine purposively selected hospital administrators and key healthcare stakeholders. Thematic analysis revealed that while hospitals employ patient preparation, follow-up monitoring, and care coordination to reduce readmissions, these strategies are frequently hindered by patient knowledge limitations, noncompliance, and severe systemic resource constraints. To address these gaps, a context-specific Patient-Centered Care Model was developed. The model integrates culturally grounded communication, structured continuous monitoring, and robust inter-facility coordination to actively mitigate systemic barriers. Implementing this model can improve discharge preparedness, strengthen patient compliance, and reduce preventable HAMA-related readmissions in geographically isolated healthcare settings.

KEYWORDS: hospital readmission, medical advice, patient-centered care, continuity of care, resource-limited settings

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Introduction

Hospital readmissions associated with Home Against Medical Advice (HAMA) have emerged as a significant global healthcare concern, serving as an important indicator of healthcare quality, continuity of care, and healthcare system efficiency. Across healthcare systems worldwide, patients who leave hospitals against medical advice are at a higher risk of complications, premature discontinuation of treatment, and unplanned readmissions. These readmissions not only compromise patient outcomes but also place substantial financial and operational burdens on healthcare institutions (Southern, Nahvi, & Arnsten, 2012; Spooner et al., 2020). Home Against Medical Advice (HAMA), also referred to as Discharge Against Medical Advice (DAMA), occurs when patients decide to leave the hospital before the attending physician recommends discharge. This situation is frequently associated with incomplete treatment, poor adherence to medical recommendations, unresolved clinical conditions, and inadequate continuity

of care (Alfandre & Schumann, 2013; Auerbach et al., 2021). Existing literature suggests that patients discharged against medical advice are more likely to experience adverse health outcomes and hospital readmissions due to interruptions in treatment and follow-up care (Alagappan et al., 2023; Choi et al., 2011; Tan et al., 2020).

Factors contributing to HAMA commonly include financial difficulties, family obligations, cultural beliefs, fear of hospitalization expenses, dissatisfaction with care, and a limited understanding of the severity of the illness. In the Philippine context, particularly in geographically isolated and disadvantaged areas such as Sulu, these challenges are further intensified by structural and systemic limitations (Abiiro, McIntyre, & Meyer-Weitz, 2021). Limited healthcare infrastructure, transportation difficulties, poverty, restricted access to follow-up services, and shortages of healthcare professionals significantly affect patients' ability to continue treatment and recover after discharge. Furthermore, cultural and religious considerations, as well as strong family involvement in healthcare decision-making, deeply influence patients' decisions to leave the hospital against medical advice. In some cases, patients prioritize family responsibilities, financial survival, or cultural preferences over continued hospitalization. These contextual realities increase the likelihood of premature discharge and readmission, emphasizing the need for localized and culturally responsive healthcare strategies.

In response to these complex realities, healthcare systems have increasingly adopted patient-centered care approaches, which emphasize individualized care, patient engagement, collaborative decision-making, effective communication, and continuity of care (Bokhour et al., 2018). Patient-centered care is particularly relevant in the context of HAMA because patients' decisions to leave the hospital prematurely are profoundly influenced by personal, cultural, social, and economic conditions. Studies have shown that patient-centered care improves treatment adherence, enhances patient satisfaction, and contributes to better health outcomes (Davis et al., 2020; Santana et al., 2022; Yu et al., 2023). By strengthening patient understanding, trust, and participation in healthcare decisions, these approaches may help reduce premature discharge (Kwame & Petrucka, 2021). Furthermore, emphasizing continuity of care ensures seamless healthcare delivery across different stages of patient transition, particularly during discharge and post-discharge follow-up, which are critical points where complications and treatment interruptions are most likely to occur (Godard-Sebillotte et al., 2021; Gustafsson et al., 2017).

Despite the growing implementation of patient-centered care approaches, evidence regarding their effectiveness in reducing hospital readmissions associated with HAMA remains limited and inconclusive, particularly in geographically isolated and resource-constrained settings (Ewunetu et al., 2023). Existing healthcare models are often developed in highly resourced environments and may not adequately address the socioeconomic, cultural, and institutional realities of provinces such as Sulu. There remains limited qualitative evidence regarding how healthcare institutions manage cases of HAMA and prevent readmission among these patients. Understanding the perspectives and lived experiences of hospital administrators and key healthcare stakeholders is essential in identifying existing strategies, system gaps, and opportunities to develop localized, context-responsive healthcare interventions.

Research Questions

To address the objectives of the study, the following objectives were formulated to guide the qualitative exploration and phenomenological analysis:

1. To explore and describe the lived experiences and perspectives of hospital administrators and key healthcare stakeholders regarding the strategies employed to

reduce hospital readmission associated with Home Against Medical Advice (HAMA) in Level 1 hospitals in Sulu, Philippines.
2. To analyze the challenges that influence the effectiveness of these strategies in reducing HAMA-related hospital readmission.
3. To develop a Patient-Centered Care Model, grounded on the identified strategies, challenges, and system gaps, aimed at reducing hospital readmission associated with Home Against Medical Advice (HAMA) in the local healthcare context of Sulu.

Methods

This study employed a qualitative research design using a phenomenological approach to explore the lived experiences and perspectives of hospital administrators and key healthcare stakeholders regarding hospital readmission associated with Home Against Medical Advice (HAMA) in Level 1 hospitals in Sulu, Philippines. This approach enabled an in-depth understanding of institutional practices, discharge management strategies, continuity-of-care processes, challenges, and system gaps within the local healthcare context.

Purposive sampling was utilized to identify individuals with direct knowledge and experience related to HAMA, discharge management, continuity of care, and hospital readmission practices within the selected settings (Ahmad & Wilkins, 2024; Campbell et al., 2020). A total of nine key informants were purposively selected for one-on-one semi-structured interviews. The participants consisted of professionals engaged in hospital administration, management, strategic planning, and healthcare coordination. The selection was guided by specific inclusion criteria: current employment in a Level 1 hospital in Sulu Province, direct involvement in decision-making processes or policy implementation related to HAMA and hospital readmission, and a minimum of one year of professional experience.

Data were collected through one-on-one semi-structured interviews utilizing a researcher-developed interview guide. The development of the instrument was aligned with the objectives of the study and informed by relevant literature to identify key areas of inquiry (Kallio et al., 2016). The interviews focused on participants' lived experiences regarding patient-centered practices, discharge planning, follow-up systems, and coordination challenges. Interviews were conducted within an average duration of 20–30 minutes, providing sufficient opportunity for participants to share meaningful, context-specific experiences while accommodating their professional responsibilities. With participants' consent, the interviews were audio-recorded and brief field notes were taken.

The gathered data were analyzed using thematic analysis within a phenomenological framework. The analytical process involved the verbatim transcription of all recorded interviews, followed by a careful review to ensure accuracy. Significant statements relevant to the phenomenon under study were extracted, coded, and organized into meaning units by grouping similar ideas. Finally, thematic clustering was conducted to identify recurring patterns and synthesize the essence of the participants' lived experiences regarding HAMA-associated hospital readmission.

Ethical principles were strictly observed to ensure the protection, rights, and welfare of the participants. Prior to data collection, permission was secured from the concerned hospital authorities, and informed consent was obtained from all participants. The voluntary nature of participation and the confidentiality of responses were clearly explained. Participants' identities and institutional affiliations were anonymized through the use of respondent labels (e.g., R1, R2), and all collected data were securely stored and utilized strictly for academic purposes.

Results and Discussion

The analysis of the lived experiences and perspectives of the nine hospital administrators and key healthcare stakeholders revealed distinct themes concerning the strategies and challenges associated with Home Against Medical Advice (HAMA) readmissions in Level 1 hospitals in Sulu.

1. To explore and describe the lived experiences and perspectives of hospital administrators and key healthcare stakeholders regarding the strategies employed to reduce hospital readmission associated with Home Against Medical Advice (HAMA) in Level 1 hospitals in Sulu, Philippines.

To address the risk of readmission among patients discharging against medical advice, hospitals employed interventions that integrated baseline programs with specific care coordination practices. These efforts consolidated into three primary strategies:

Theme 1: Patient Preparation and Education Quality

Patient preparation emerged as a critical strategy, emphasizing the need for clear, culturally grounded communication to ensure patients and their caregivers fully understood post-discharge instructions. Effective preparation extended beyond merely providing information to verifying comprehension and building practical skills. As one respondent explained, "*The cornerstone of our patient education is the Tagubilin, which is explained to the watcher together with the follow-up date*" (R1). This approach was often utilized as a practical orientation where "*the watcher is taught wound management and hygiene*" (R1). To reinforce understanding, structured planning and verification strategies were employed, such as "*written discharge instructions, medication review, and follow-up scheduling*" (R2) and the use of the "*teach-back method [to ensure] patients understand instructions and improves follow-up compliance*" (R9).

Theme 2: Follow-up Systems and Monitoring Effectiveness

Structured monitoring systems were identified as essential for maintaining continuity of care and preventing the worsening of a patient's condition after premature discharge. Hospitals implemented systematic follow-up mechanisms to track recovery and reinforce treatment adherence. This included routine clinical monitoring, where "*follow-up check-ups in the outpatient department help prevent worsening of the illness by providing intervention medications at home*" (R3). Timely interventions were highly prioritized, with respondents noting that "*post-discharge follow-up is conducted through outpatient department appointments within 7 to 14 days*" (R8). To maximize the effectiveness of these systems, hospitals relied on standardized procedures, such as "*standardized discharge protocols, follow-up calls, and case management for high-risk patients*" (R5), alongside strict preventive measures to "maintain zero infection" (R2).

Theme 3: Support Systems and Care Coordination Strength

The final strategy focused on integrating hospital-based care with community support and multidisciplinary teamwork to build a safety net for vulnerable patients. Institutional support mechanisms facilitated patient access to continued care, with respondents highlighting that "*the public health unit provides patient navigation for referral clients*" (R6) and the Health Education and Promotion Officer provides "*patient education, caregiver support, and community outreach*" (R7). Internally, care coordination was strengthened by a "*multidisciplinary team approach and strong communication between providers*" (R8) and "*shared decision-making between healthcare*

provider, patient, and caregiver" (R6). Externally, "*inter-facility communication helps improve referral systems and coordination among institutions*" (R7), ensuring that patients leaving against medical advice were not lost in the transition between hospital and home.

2. To analyze the encountered challenges that influence the effectiveness of these strategies in reducing hospital readmission associated with Home Against Medical Advice (HAMA).

Despite the implementation of strategic interventions, the effectiveness of reducing HAMA-related hospital readmissions was hindered by several interconnected challenges. These barriers, spanning both patient behaviors and system-level gaps, were consolidated into three primary themes:

Theme 4: Knowledge Limitations and Information Gaps

Insufficient knowledge and a lack of practical understanding among patients and caregivers emerged as a critical barrier to post-discharge recovery. The findings indicate that these information gaps hinder the effective execution of discharge instructions, resulting in poor follow-up and incomplete treatment. One respondent stated, "*Patients return because their families or watchers were not fully equipped to handle surgical wounds at home*" (R1). This deficit is often exacerbated by a disconnect between hospital instructions and caregiver capability, characterized as a "*gap between discharge protocols and family's ability to execute them… no return-demonstration verification*" (R1). Consequently, "*patients struggle to understand discharge instructions and warning signs of complications*" (R9), and there remains "*limited knowledge of patients and caregivers on the importance of continuity of medications*" (R3).

Theme 5: Patient Compliance and Clinical Issues

Difficulties in adhering to prescribed treatments, medications, and follow-up schedules significantly contribute to the worsening of health conditions and subsequent readmissions. The findings reveal that noncompliance is a multifaceted issue. Clinically, premature discharge leaves patients vulnerable to "*complications during hospital stay and unresolved clinical issues upon discharge*" (R2). Once home, treatment adherence drops significantly, with respondents noting that "*poor medication adherence and inability to sustain long-term medication led to worsening condition*" (R3) and "*noncompliance to treatment and loss to follow-up appointments are major causes*" (R5). Furthermore, behavioral and cultural factors heavily influence these compliance issues, as "*cultural beliefs and poor self-management affect health practices*" (R7).

Theme 6: System Resource Constraints and Coordination Gaps

Structural and institutional limitations within the healthcare system severely disrupt continuity of care. The findings highlight that resource constraints manifest physically, operationally, and logistically. Physically, a "*shortage of essential items like oxygen, medicines, and faulty medical equipment contributes to readmissions*" (R1), compounded by a "*lack of specialty services due to absence of practitioners and facilities*" (R6). Operationally, heavy workforce burdens strain the quality of care, resulting in "*poor communication between providers and inadequate discharge planning due to workload pressure*" (R5) and "*limited staffing, poor interdepartmental communication, weak referral systems*" (R4). These internal strains create wider coordination gaps, where "*poor communication between care providers and inadequate discharge planning processes*" (R2) weaken patient transitions. Externally, an "*inter-facility coordination gap due to inadequate workforce across health facilities*" (R6) and "*limited coordination between*

departments and community services" (R7) leave patients isolated. Logistically, patients face basic accessibility barriers, highlighting the need to "*facilitate transportation where needed*" (R9) to prevent delayed care.

3. What Patient-Centered Care Model can be developed, grounded on the identified strategies and challenges, to address hospital readmission associated with Home Against Medical Advice (HAMA) in Sulu?

Grounded on the identified strategies, best practices, and organizational challenges, a context-specific Patient-Centered Care Model was developed to address hospital readmissions associated with Home Against Medical Advice (HAMA) in Sulu (Figure 1). The model presents an integrated framework demonstrating that reducing HAMA-related readmissions requires the combined effect of patient preparation, follow-up monitoring, and care coordination, while actively addressing the systemic barriers that contribute to premature discharge and incomplete treatment.

The model is structured around four interconnected healthcare components leading to a final outcome. The first component, *Patient Preparation and Education*, emphasizes the importance of equipping patients and caregivers with adequate knowledge and practical skills prior to discharge. In the context of Sulu, where family members or "watchers" play a significant role in post-discharge care, effective communication strategies such as the Tagubilin, medication counseling, return demonstrations, and teach-back methods are foundational to the model.

The second component, *Follow-up and Monitoring Systems*, highlights the need for structured and continuous post-discharge care. Because access to healthcare services is often limited due to geographic constraints, the model integrates outpatient follow-up visits, scheduled monitoring, compliance tracking, and continuity-of-care mechanisms to enable early detection of complications and reinforce treatment adherence.

The third component, *Support and Care Coordination*, underscores the importance of integrating hospital-based care with community health services. It maps the necessity of patient navigation, caregiver involvement, community-based health education, interdepartmental coordination, and inter-facility communication to ensure patients are safely transitioned from the hospital to their homes.

The fourth component explicitly integrates the institutional and structural Challenges that hinder effective healthcare delivery. It recognizes that information gaps, patient noncompliance, coordination breakdowns, and resource constraints must be actively accounted for and mitigated by the first three components.

When the core components are successfully integrated and the systemic challenges are mitigated, the model leads to the targeted expected outcomes. These include improved continuity of care, increased patient compliance and self-management, and a definitive reduction in hospital readmission rates associated with HAMA. The model reflects a patient-centered and systems-based approach, providing a practical framework tailored to the specific healthcare realities and resource limitations of Level 1 hospitals in Sulu.

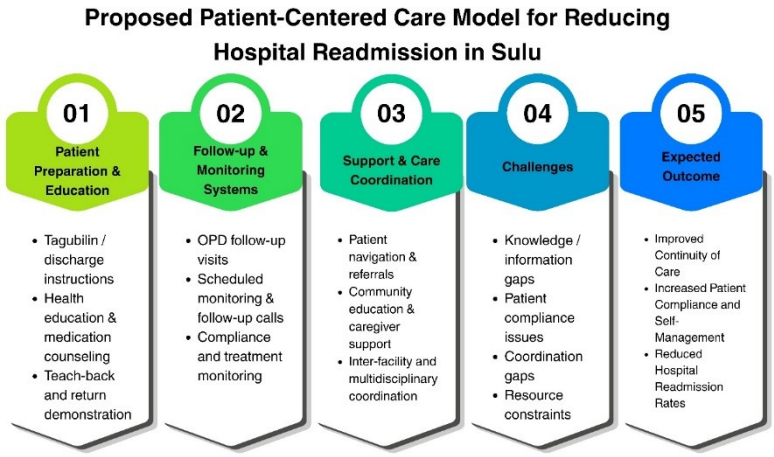

Figure 1. Proposed Patient-Centered Care Model for Reducing Hospital Readmission in Sulu

Discussion

The findings of this study highlight that reducing hospital readmission associated with Home Against Medical Advice (HAMA) requires an integrated approach that addresses both patient-level behaviors and system-level constraints. The results demonstrated that strategies such as structured patient preparation, continuous follow-up, and strong care coordination are essential for preventing readmissions. These findings align with existing literature, which emphasizes that effective discharge planning and continuity-of-care interventions significantly improve patient transitions from the hospital to the home (Godard-Sebillotte et al., 2021). Furthermore, the study confirms that strong interdisciplinary communication and collaborative practices among healthcare providers are foundational to establishing this continuity (Gustafsson et al., 2017).

However, the findings also revealed that in resource-limited settings like Sulu, these patient-centered strategies are frequently undermined by structural limitations, knowledge gaps, and poor treatment adherence. Patients and caregivers often struggle to comprehend complex medical instructions, echoing broader evidence that inadequate discharge communication and limited health literacy directly increase the risk of post-discharge complications and readmissions (Auerbach et al., 2021; Kwame & Petrucka, 2021). Compounding these patient-level barriers are severe systemic challenges. The identified resource constraints—such as workforce shortages, equipment deficits, and heavy clinical workloads—mirror global findings that structural limitations in low- and middle-income healthcare settings severely disrupt the delivery of patient-centered care (Abiiro, McIntyre, & Meyer-Weitz, 2021; Ewunetu et al., 2023).

To bridge the gap between these strategic goals and systemic realities, this study developed the context-specific Patient-Centered Care Model (Figure 1) detailed in the Results section. The model posits that isolated interventions are insufficient; reducing HAMA-related readmissions requires the synchronized effect of patient education, robust monitoring, and community support to actively buffer against existing resource constraints. Transitioning to such a model requires a large-scale cultural and operational shift within healthcare organizations (Bokhour et al., 2018). When these components are effectively integrated, the expected outcome is improved continuity of care, strengthened patient compliance, and a definitive reduction in preventable hospital readmissions, confirming that patient-centered strategies directly yield better healthcare outcomes (Davis et al., 2020; Santana et al., 2022).

Conclusion and Recommendations

Reducing HAMA-related hospital readmission in Level 1 hospitals in Sulu demands a patient-centered, coordinated healthcare approach that is highly responsive to local resource constraints. While baseline strategies such as structured discharge planning and standardized monitoring exist, their success relies entirely on execution quality, patient comprehension, and the strength of inter-facility coordination. HAMA-related hospital readmission can be effectively reduced through a balanced approach that strengthens patient-centered communication while systematically actively mitigating organizational limitations.

To operationalize the findings and the proposed model, healthcare institutions and policymakers in Sulu are recommended to implement several targeted actions. First, hospitals should standardize localized communication by formalizing the use of the Tagubilin in simple language and local dialects, utilizing teach-back methods and return demonstrations to ensure patients and caregivers fully comprehend medication continuity and warning signs before discharge. Second, institutions must establish low-cost monitoring systems, utilizing accessible mechanisms like SMS reminders, mobile calls, and strengthened coordination with Barangay Health Workers (BHWs) to monitor recovery and improve compliance at the community level.

Furthermore, there is a critical need to strengthen inter-facility coordination by enhancing referral pathways and communication loops between hospitals and Rural Health Units (RHUs), preventing vulnerable HAMA patients from experiencing fragmented care during their transition home. Finally, hospitals and Local Government Units (LGUs) must actively address structural gaps, such as providing transportation support for isolated patients and maximizing the available healthcare workforce to alleviate discharge planning pressures. Future research should focus on evaluating the empirical effectiveness of the proposed Patient-Centered Care Model using quantitative or mixed-method approaches, particularly assessing digital follow-up strategies and community-based interventions applicable to geographically isolated healthcare settings.

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