

Strategies for Reducing the Hospital Readmission Rates of Heart Failure Patients

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ABSTRACT

About 1 in 4 Medicare patients with a discharge diagnosis of heart failure (HF) are readmitted within 30 days of discharge. With the Affordable Care Act that was passed into law in 2010, a section in the Social Security Act established a program called the Hospital Readmissions Reduction Program. This program requires the Centers for Medicare and Medicaid Services to reduce payments to hospitals for HF patients who are readmitted within 30 days of discharge. The purpose of this article is to review current HF readmission prevention strategies for effectiveness.

Keywords: failure, heart, prevention, readmission

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It is estimated that nearly 5 million Americans are living with heart failure (HF), and a staggering 550,000 new cases are diagnosed each year.¹ The diagnosis of HF has been associated with impaired functional status and premature death, with mortality rates as high as 50% within 5 years of diagnosis.²

The incidence of HF increases with age, approaching approximately 10 per 1,000 people after age 65.² HF is the leading diagnosis and cause of hospitalization among patients 65 and older, comprising 80% of all HF-related hospitalizations.³ HF is the most expensive diagnosis-related group, translating into 5 million hospital stays per year at an estimated cost of \$8 billion.² The 90-day readmission rate for an HF patient is in the range of 15%-30%, and recent data suggest that approximately one half of those readmissions are preventable.² The purpose of this article is to review current HF readmission prevention strategies for effectiveness.

READMISSION STATISTICS

HF is the only cardiac disease continuing to increase in prevalence, which makes it a major public health problem.² Additionally, HF is a complex, progressive disease that often results in an adverse outcome. The most costly outcome is hospital readmission.⁴ One

fifth of Medicare beneficiaries are rehospitalized within 30 days of discharge, and more than one third are readmitted within 90 days.⁵ The overall average 90-day readmission rate is in the range of 15%-30%.² Approximately 90% of the readmissions attributed to HF are not planned and potentially preventable, translating into \$17 billion or nearly 20% of Medicare's hospital payments.⁵

One method being implemented by Medicare in an effort to reduce the cost of readmission is to lower the reimbursement rates. Medicare recently proposed a payment reform that affects hospitals with high readmission rates. Twenty percent of the original admission payment will be withheld if a patient is readmitted within 7 days, and 10% will be withheld if readmission occurs within 15 days of discharge.¹ Despite the potential loss of repayment, no evidence has been gathered that shows any substantial decline in the HF readmission rates over the past 2 years.

A national cross-sectional study was conducted by Bradley et al⁶ that examined 594 hospitals and the use of reported key practices intended to reduce readmissions for HF patients. The study concluded that most of the hospitals examined had no comprehensive set of practices in place to reduce readmissions.⁶

Unfortunately, even hospitals with recommended practices and early follow-up procedures in place have readmission rates of up to 20%.⁵

INPATIENT MEASURES

Comprehensive medication reconciliation to ensure an optimal pharmacologic regimen before discharge from the hospital is believed to be effective in reducing readmission rates. Communicating the most recent medication list at admission as well as going over the current list at discharge is important to both adherence and compliance.¹ According to Bradley et al,⁶ the responsibility for medication reconciliation was not formally assigned at 14% of hospitals studied, yet nearly three quarters reported having an electronic medical record to facilitate the reconciliation of patients' medications. Despite the 77% of hospitals in the Bradley et al study reporting patients received all medication details at discharge, there was a lack of standard processes for both reconciliation and patient education regarding medications.

Another measure discussed in the literature focused on the need for adequate discharge planning to ensure home needs will be met. According to the study by Annema et al,⁴ one of the main conclusions for readmission was the fact that patients, their caregivers, and health care providers do not share the same perspective on the cause for readmission. Judgment on readmission was based on individual perception. The study also found that insufficient professional help, nonadherence, and knowledge deficit are important factors in preventing readmission but confirmed that education alone is not enough to prevent readmission. Unfortunately, there is a disconnect in communication between the patient, family, and their health care team; a realization that chronically ill patients will be readmitted regardless of the intervention is echoed throughout medical literature (Table 1).

OUTPATIENT MEASURES

There has been a shift in care from the hospital to the clinic and home that includes outpatient measures and multidisciplinary follow-up. According to Di Salvo and Stevenson,³ many types of interventions have reduced HF readmissions by 14%–87%. These interventions include case management, HF clinics,

Table 1. Effective Inpatient Measures

One hour of heart failure education before discharge
Comprehensive medication reconciliation
Adequate discharge planning to ensure home care needs are met
Communication between patient, family, and health care team

mailings, telemonitoring, and home health. Data on prespecified program outcomes, such as the Partners Heart Care Program, provide benchmark information for continuous quality improvement. The data collected focus on quality of care, mortality, hospital admission, functional status, and procedure costs. The most critical lesson learned in development to date is the necessity of precise tailoring of the program to each patient and providing needs with local oversight and management. Di Salvo and Stevenson reported that through self-monitoring and education, patients should move toward ever-increasing self-empowerment in their management of HF. Unfortunately, recent studies suggest that patients have inadequate information, and this area of readmission prevention has rarely been studied.⁷ This simple yet vital aspect of care can help improve adherence to an aftercare regimen. Subramanian et al⁷ looked at HF disease management programs that emphasized dietary counseling and/or sodium intake reduction and improved functional capacity. Even though patients reported receiving education about salt restriction (87%) and exercise (78%), they reported adhering to a low-salt diet for a mean of 4.9 days and exercising for a mean of 2.2 of 7 days.⁷ This statistical information supports that education is only a part of the puzzle for complex HF patients.

Timely follow-up by primary care physicians, specialists, or any member of the health care team is important. The days immediately after discharge are very critical and can have a direct impact on rehospitalization rates.⁸ The Hospital to Home is a national quality improvement initiative by the American College of Cardiology and the Institute for Healthcare Improvement. The “See You In 7” was the first Hospital to Home challenge launched in March 2011 to focus on improving early follow-up by ensuring

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