Preventing 30-day Readmissions

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KEYWORDS

• Readmissions • Discharge teaching • Health literacy • Compliance • Telehealth

KEY POINTS

- Preventing 30-day readmissions is a top priority nationally because of federal guidelines and regulations under the Patient Protection and Affordable Care Act of 2010.
- Improved methods of discharge teaching must be established for patients transitioning out of hospitals and into their homes or the community.
- Reasons for 30-day readmissions include ineffective communication affecting the transition of care, health literacy, and compliance.
- Telehealth and electronic use of health resources enhance new methods of patient treatment and education.

INTRODUCTION

Preventing 30-day readmissions to hospitals is a top priority in the era of health care reform. A national study conducted in 2009 analyzing Medicare data for the year 2003 to 2004 revealed that readmission rates were 19% for Medicare recipients with a cost more than $17 billion annually.[1] Since the Patient Care Affordability Act became law in 2010, requirements for health care facilities to comply with new regulations and guidelines pertaining to readmissions have been established. Recurring readmissions have been problematic through the years, but new regulations will be costly to health care facilities because of payment guidelines. Hospitals are focused on improving the transition of care to avoid 30-day readmissions and provide quality care. Sources have identified patients covered by Medicare and Medicaid as being readmitted at very high rates compared with patients covered by private insurance.[2,3] This article reviews some of the issues concerning discharge planning, compliance, and telemedicine as ways to prevent 30-day readmissions.

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PROBLEM

According to the Affordable Care Act of 2010, Section 3025,[4] criteria for the US Centers for Medicare and Medicaid Services (CMS)[5] define the mandated requirements for decreasing Medicare payments to hospitals with high rates of readmissions. The Hospital Readmissions Reduction Program section of the Affordable Care Act outlines plans for reducing payments to hospitals based on readmissions of acute myocardial infarction (AMI), heart failure (HF) and pneumonia. The financial reductions placed on high rates of readmissions for Medicare recipients began in 2013 with a 1% reduction increasing to 2% in 2014 and 3% by 2015.[6] The Hospital Compare Web site has been developed through efforts from the CMS, the Department of Health and Human Services, and the Hospital Quality Alliance to categorize and publish data regarding 30-day readmissions to hospitals.[7] National data indicate that 1 in 4 patients with HF are readmitted, and that for AMI readmissions are 1 in 5 within 30 days of discharge from a hospital.[1,8] The costs of pneumonia readmissions may exceed $6 billion annually.[9] Readmissions within 30 days can be the result of gaps in the care provided by hospitals as well as the transition process for patients.[1,10,11] There will be new medical conditions added to the 30-day readmission reduction list beginning in 2015, including chronic obstructive pulmonary disease, hip arthroplasty, and knee arthoplasty.[5] Scheduled to be added to the list in 2017 is coronary artery bypass surgery.[5] The readmission penalties to hospitals will affect hospital Medicare reimbursements but will save Medicare millions of dollars.[12] Readmission rates for established criteria have been categorized as quality indicators regarding hospitalizations according to The Hospital Quality Alliance, Institute for Healthcare Improvement, and other organizations.[13] Many health care facilities are scrambling to focus on methods to reduce readmissions but provide quality care in an era of limited financial resources.

From the moment a patient is discharged from a hospital until the patient returns home and begins self-care responsibility is a time of transition. The transition from hospital to home has been classified as a vulnerable time for many patients. During the transition of care, instability and lack of care coordination have contributed to unexpected events affecting the outcome for many patients. On returning home, patients must become responsible for their health and be able to recall all instructions that were given to them while hospitalized. To recall details about care and medications may be difficult for patients after returning to their home environments. It is common for patients to be discharged from health care facilities with intravenous access devices, complex wound care, enteral feeding devices, self-catheterization, surgical drains, and other types of devices that require care management. Patients and family members have the responsibility of learning how to manage the patient as well as the extra equipment, medications, and treatments. During this time of transition patients may fail to fully understand their discharge instructions.

DISCHARGE TEACHING

There are many variables in the concept of discharge teaching. While in hospital, patients are often taught important facts pertaining to disease management, medications, and home care by supporting members of the health care team. Often patients are not in prime learning mode for clearly grasping critical components for maintaining self-care beyond the hospital walls. The acutely ill individual may be recovering from a life-altering event such as an AMI, traumatic injury, or major surgical intervention, and is potentially focused on basic needs such as comfort. It may be difficult for a patient to learn and retain clear details because of physiologic conditions. Although hospital