Hospital readmission rate varies following care at rehabilitation facility

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Among rehabilitation facilities providing services to Medicare fee-for-service patients, 30-day hospital readmission rates vary, from about 6 percent for patients with lower extremity joint replacement to nearly 20 percent for patients with debility (weakness or feebleness), according to a study in the February 12 issue of *JAMA*.

The Centers for Medicare & Medicaid Services (CMS) recently identified 30-day hospital readmission as a national quality indicator for inpatient rehabilitation facilities; reporting will be required in 2014 by the CMS, according to background information in the article.

Kenneth J. Ottenbacher, Ph.D., of the University of Texas Medical Branch, Galveston, Texas, and colleagues conducted a study to determine 30-day readmission rates and factors related to readmission for patients receiving postacute inpatient rehabilitation. The study included records for 736,536 Medicare fee-for-service beneficiaries discharged from 1,365 inpatient rehabilitation facilities to the community between 2006 and 2011. Readmission rates were examined for the 6 most common reasons for receiving inpatient rehabilitation: stroke, lower extremity fracture, lower extremity joint replacement, neurologic disorders, brain dysfunction and debility.

Average rehabilitation length of stay was 12 days. The overall 30-day readmission rate was 11.8 percent, with rates ranging from 5.8 percent for patients with lower extremity joint replacement to 18.8 percent for patients with debility. Rates were highest in men, non-Hispanic blacks, and for persons with longer lengths of stay. Higher motor and cognitive ratings, indicating better patient function, were consistently related to lower readmission rates across all 6 categories. Rates were similar for rural vs urban facilities and freestanding vs hospital-based facilities.

Approximately 50 percent of patients rehospitalized within the 30-day period were readmitted within 11 days of discharge. The most common reasons for readmission (per diagnosis codes) were heart failure, urinary tract infection, pneumonia, septicemia (blood poisoning), nutritional and metabolic disorders, esophagitis (inflammation of the esophagus), gastroenteritis, and digestive disorders.

The authors write that Medicare is currently examining bundled payment models designed to improve quality and contain costs. "The payment options cover different periods and include multiple health care professionals and settings. In the context of bundled payment, what happens to patients during post-acute care becomes important in the management of resources, quality, cost, and readmissions. Recent research has demonstrated that most of the variation in Medicare spending across geographic areas is attributable to postacute care. Readmission will likely add to the cost variation."

"Questions regarding the validity of readmission as a quality indicator are likely to increase as the accountability for readmission expands to include postacute care settings. Although readmission is an imperfect quality indicator, it has the potential to serve as a platform for efforts to improve patient transitions and care continuity associated with bundling and other initiatives proposed by the Affordable Care Act to reduce cost and improve health outcomes."

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