TOPIC: **IN SUPPORT OF DECREASING THIRTY-DAY HOSPITAL READMISSION RATES THROUGH THE IMPLEMENTATION OF TRANSITIONAL CARE TEAMS**

SUBMITTED BY: **Maryland Association of Nursing Students Board of Directors**

WHEREAS, "from 2007 through 2011, the national 30-day, all cause, hospital readmission rate averaged 19 percent"; and

WHEREAS, "nearly one in five Medicare patients discharged from the hospital—approximately 2.6 million seniors—is readmitted within 30 days, at a cost of over $26 billion every year"; and

WHEREAS, "in addition to adversely affecting beneficiaries' health and peace of mind, the failure to adequately attend to the care transition at discharge from the hospital results in additional Medicare spending…"; and

WHEREAS, "the Medicare Hospital Readmissions Reduction Program (HRRP) established in the Affordable Care Act (ACA) provides a financial incentive to hospitals to lower readmission rates… One of the provisions establishes the HRRP to provide a financial incentive for hospitals to reduce preventable readmissions. Beginning in fiscal year 2013 (October 1, 2012), the HRRP imposed a financial penalty on hospitals with excess Medicare readmissions"; and

WHEREAS, "unplanned rehospitalizations may signal a failure in hospital discharge processes, patients' ability to manage self-care, the quality of care in the next community setting (office practices, home health care, and skilled nursing facilities), and lack of appropriate care resources for high-risk patients"; and

WHEREAS, "discharging patients from the hospital is a complex process that is fraught with challenges. Preventing avoidable rehospitalizations has the potential to profoundly improve both the quality of life for patients and the financial well-being of healthcare systems "; and

WHEREAS, "poorly executed care transitions negatively affect patients' health, well-being, and family resources and unnecessarily increase health care system costs. Continuity in patients' medical care is especially critical following a hospital discharge. For individuals with multiple chronic conditions, this transition takes on even greater importance"; and

WHEREAS, the landmark Institute of Medicine report, *Crossing the Quality Chasm: A New Health System for the 21st Century,* asserts that our national system of healthcare delivery requires a fundamental change and proposes "safe, effective, patient-centered, timely, efficient, and equitable healthcare… Care for the chronically ill needs to be a collaborative, multidisciplinary process. Effective methods of communication, both among caregivers and between patients, are critical to providing high-quality care"; and

WHEREAS, "delivering high-quality, patient-centered health care requires crucial contributions from many clinicians and staff across the continuum of health care, including the effective coordination of transitions between providers and care settings. Poor coordination of care across settings too often results in rehospitalizations, many of which are avoidable. Importantly, working to reduce avoidable rehospitalizations is one tangible step toward the dramatic

improvement of health care quality and the experience of patients and families over time"; and

WHEREAS, "…rehospitalizations are costly, potentially harmful, and often avoidable… evidence suggests that the rate of avoidable rehospitalization can be reduced by improving core discharge planning and transition processes out of the hospital; improving transitions and care coordination at the interfaces between care settings; and enhancing coaching, education, and support for patient self-management"; and

WHEREAS, to improve the discharge planning process and reduce 30-day hospital readmission rates, transitional care teams "…should take into account multi-component and multi-disciplinary interventions incorporating several single interventions combined. Finally, an important step is to introduce and highlight transitional care knowledge in curricula for both nurses and physicians in addition to multidisciplinary training at an early stage of their education"; therefore be it

RESOLVED, that the National Student Nurses' Association (NSNA) encourage its constituents to collaborate with nursing education programs to emphasize the importance of decreasing thirty-day rehospitalization rates and implementing transitional care teams; and be it further

RESOLVED, that the NSNA encourage its constituents to work with hospitals and nurses in order to encourage them to evaluate their discharge processes and readmission rates and consider the implementation of transitional care teams within their hospitals; and be it further

RESOLVED, that the NSNA publish a fact sheet or article about decreasing thirty-day readmission rates and the implementation of transitional care teams in *Imprint* and offer a breakout session on this topic at the Annual Convention, if feasible; and be it further

RESOLVED, that the NSNA send a copy of this resolution to the American Nurses Association, the National League for Nursing, the American Association of Colleges of Nursing, the National Organization for Associate Degree Nursing, the American Heart Association, the American Stroke Association, the Institute for Healthcare Improvement, and all others deemed appropriate by the NSNA Board of Directors.