Reduce Re-hospitalization Rates:

Executive Interventions to Protect Top-Line Health

Teresa Chase, President, American HealthTech
Executive Summary

The Challenge

About 90% of readmissions within 30 days of hospital discharge appear to be unplanned. Beginning in fiscal year 2012, CMS will rank hospitals for “frequent flyers” for the top three diagnoses. Across-the-board Medicare payments for the worst-performing hospitals will be curtailed in fiscal year 2013 by 1%, in 2014 by 2%, and in 2015 by 3%. Post-acute providers that fail to help hospitals address readmissions will see census dwindle.

The Takeaway

Results from pilot programs suggest that 20% to 50% of hospital readmissions are preventable with coordinated care around discharge. This briefing will:

- **Survey your playing field.** Using simple math, you’ll measure the status quo and calculate a skilled-nursing readmission rate that uses the same formula that AHCA uses as a baseline for nationwide comparisons. You’ll learn where to find the rates of SNFs by region and nationwide, for free.

- **Shore-up your defense.** You’ll get three tools you can immediately adopt to address and continuously improve your outcomes, including re-hospitalizations.

- **Play offense.** You’ll get a sample pitch to promote your rates and outcomes to hospitals, drive referrals, and protect your top line.

The Bottom Line

It is critical to understand where you stand against re-hospitalization performance measurements and to strengthen your relationships with your key feeder hospitals. The revenues and reputations of both organizations will increasingly depend on joint programs to eliminate friction across the continuum of care, backed by data-driven facts.
Step 1: Survey Your Playing Field

First, you need to measure and take control of the status quo. Outcomes experts recommend you focus on the resident, not the condition.

Getting started

- Know your data
- Establish success benchmarks
- Form a cross-continuum team
- Enhanced care and support during transition
- Create resident- and patient-centered care planning which includes families in the process
- Communicate, communicate, communicate

Calculate your re-hospitalization rate

There are many ways to calculate re-hospitalization rates; see Appendix 1 for a partial listing. Bottom line, there is no industry standard. AHT uses the same mathematical calculation as AHCA for re-hospitalization rates:

\[
\% = \frac{\text{Numerator}}{\text{Denominator}} = \frac{\# \text{ of persons sent to hospital}}{\# \text{ of persons admitted to SNF}}
\]

At the time of this writing, AHCA uses claims data and AHT uses MDS data as variables. AHCA is moving toward an MDS-based formula and plans to launch it soon. AHT clients use Outcomes Reporting to achieve fully automated re-hospitalization rate calculations using the math above.

Get competitor re-hospitalization rates, for free

Using AHCA’s Trend Tracker, you can get reports to benchmark your performance compared to other SNFs in your region and nationwide for re-hospitalizations, survey history, star-ratings, costs, readmissions, resident characteristics, staffing, and more. Trend Tracker is free to AHCA members. AHT customers can automatically load RUG data to Trend Tracker with a push of a button.
Identify Steps to Prevent Re-hospitalizations

Now that you know your rates and those of your regional competitors, it’s time to do a root cause analysis for each case to identify where processes can break down. This exercise creates an objective foundation you can use to manage process improvement and staff accountability.

Drill into each resident episode to discover what happened.

1. Was the re-hospitalization avoidable?
2. Were there early warning signs of a decline condition? When?
3. Could additional precautions have been taken in the SNF?
4. When was the doctor first notified?
5. Was the SNF equipped to provide the acute care needed?
6. What time of day was the decision made to re-hospitalize?
7. Who made the decision to send the resident back to the hospital? Family, physician, resident, or other?

Hospitals will expect you to have this level of detail per episode. Be ready.

Push Continuous Improvement

- Give special focus attention to any admission with a “top three” diagnosis: pneumonia, heart attack, heart failure.
- Ensure nursing staff is adequately trained.
- Facilitate family confidence by providing education.
- Build cross-continuum team management, which facilitates communication.
- Continuously review and add quality improvement programs.
- Review opportunities to add specialists to facility staff.
- If practical, engage a Nurse Practitioner to perform higher-level assessments.
- Review opportunities to expand on-site specialty services.
Step 2: Shore-up Your Defense

Now that you know your outcome rates, know your regional competitors’ rates, know your strengths and weaknesses by episode; it’s time to switch to defense and hold staff accountable.

Challenge Assessments and Treatments

Nursing staff should always know each resident’s diagnosis; medication used to treat conditions, and the effectiveness of medication regimen by documenting improvements in condition.

- Challenge established protocols on how to assess for signs and symptoms of an impending acute episode to possibly prevent re-hospitalizations.
- Educate residents and families to increase confidence in the skilled nursing staff’s abilities.

Three Tools

Here are three tools you can immediately adopt to address and continuously improve outcomes, including re-hospitalizations.

- **INTERACT tool** (Interventions to Reduce Acute Care Transfers). INTERACT is a quality improvement program for improving the early identification, assessment, documentation, and communication about changes in status of residents in SNFs. AHT software is increasingly incorporating INTERACT protocols.

- **SBAR tool** is part of INTERACT and stands for Standard Communication among Staff and Caregivers. It facilitates communication between a resident’s attending physician and nurses at the facility. If the resident goes to the hospital, SBAR data can be helpful and incorporated into transfer documentation.

- **Outcomes Reporting** from AHT. With Outcomes Reporting, you can show how you consistently produce cost-effective, high-quality care: to staff for continuous improvement, to families, to auditors, and importantly—to hospitals sizing up your performance. You’ll mix and match reports in dozens of ways for cost, quality, and re-hospitalizations.
Step 3: Play Offense and Market Your Outcomes

Hospital Re-admission Rates

*USA Today* offers an interactive map where you can zoom in on the country’s worst-performing hospitals:

http://yourlife.usatoday.com/health/story/2011/07/Compare-hospitals-on-heart-attack-heart-failure-and-pneumonia/49683752/1

Having this data positions you as an empathetic, trusted partner when calling on a local hospital. The extent to which you can help a struggling hospital overcome readmission pain can win you Medicare referral traffic.

What Hospitals Will Demand from You

Denver-based Catholic Health Systems, for example, evaluates post-acute partners with these additional measures:

- Beds, census, discharge status, LOS
- Functional Independence Measures (FIM) Scores
- Patient and family satisfaction
- Emergency department visit rates
- Infection rates

AHT clients rely on Outcomes Reporting to deeply dive into outcomes measures like these in facilities or across the corporation; while AHCA’s Trend Tracker gives you clues regarding how your high-level performance compares to regional peers.

For more information, refer to the paper “Marketing Your Outcomes: How to Make Your Most Strategic Information Assets Work to Your Competitive Advantage to Win Medicare Census.”

http://www.healthtech.net/outcomesmarketing/

“Knowledge is power, and we’re well positioned to compete with Outcomes Reporting in the regions we serve.”

Dearl Layton, Director of IT, Presbyterian Homes & Services of Kentucky
Appendix 1: Other Re-Hospitalization Rates

There is no industry standard for calculating re-hospitalization rates. Here is a listing of a few we’ve found:

- AHCA (same as American HealthTech – note AHCA uses claims, AHT uses MDS but the underlying formula is the same.)
- MedPAC 100d Potentially Avoidable Hospitalizations
- CMS Value-Based Purchasing Demo 30d SNF Re-hospitalization
- CMS QIS re-hospitalization measure

“I love the breadth. I can run reports 80 different ways to look at 30-day discharges, declining ADLs, falls, and much more. With Outcomes Reporting we now have a great tool to drive continuous improvement for our staff and residents.”

Lance Long, VP Clinical American Healthcare
About the Author

**Teresa Chase** is President of American HealthTech. With over 30 years of leadership roles in healthcare, Teresa is passionate about helping providers form the alliances, access, and answers on which quality outcomes depend in the new era of post-acute care. Chase empathizes with the demands of a people-intensive business in hiring, motivating, and devoting one’s life to helping others. Prior to American HealthTech, Chase served 21 years at Blue Cross & Blue Shield, including VP of Customer Relations and HR.

About American HealthTech

American HealthTech is **Your Ultimate Connectivity Partner**, connecting caregivers, partners, and healthcare networks to drive higher outcomes in the new era of post-acute care. Coast to coast, a fifth of the nation’s providers depend on AHT daily for innovations that free hands to care for others. For more information, visit [www.healthtech.net](http://www.healthtech.net).

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