The prospect of penalties and reimbursement model changes based on hospital readmission rates has galvanized many hospitals and nursing homes into taking action to lower their rehospitalization rates. Tina Thomas, a VP of operations for Revera Health Systems discusses the problem of rehospitalization and how Revera centers are meeting the challenge.

Reducing Readmission Rates from Skilled Nursing Centers

By Tina Thomas ▪ Regional VP of Operations, Revera Health Systems

About 40% of Medicare patients who are discharged from hospitals are admitted to a skilled nursing or rehab facility to complete their recovery. But within 30 days, nearly one in five of these patients will wind up back in the hospital.[1]

The "revolving door" of rehospitalization from nursing facilities is a growing problem in the U.S. A study conducted by the Medicare Payment Advisory Committee found that up to two-thirds of these readmissions are unnecessary and avoidable, with potentially serious health risks for patients—and significant financial implications for both hospitals and nursing facilities.[2]

A $17 billion dollar problem—and growing

In 2010, researchers at Brown University examined the frequency of patient readmissions from skilled nursing centers. They focused on Medicare recipients who were transferred from a hospital to a nursing home and rehospitalized within 30 days of discharge. The study found that readmission rates increased by 29% between 2000 and 2006.

In 2006, Medicare expenditures for rehospitalizated patients totaled $4.3 billion. Today, that cost is closer to $17 billion.[2] Numbers like these tend to get the attention of government policymakers, and with health care reform on the minds of legislators and consumers alike, the issue of rehospitalization has come under close scrutiny. The Patient Protection and Affordable Care Act of 2010 specifically addresses the problem, and starting in 2013, allows Medicare to level financial penalties for hospitals based on readmission rates. Medicare is also considering "pay for performance" incentives and new payment models for hospitals that may require changes in how hospitals make discharge decisions.[3]

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The Costs of Rehospitalization

Rehospitalization exacts significant costs from patients, particularly elderly patients. The stress of a transfer can lead to medical and emotional setbacks that can delay and extend recovery. For this reason alone, reducing the rate of readmissions is important.

But there are fiscal threats for hospitals and nursing homes as well. As a result of health care reform legislation, hospitals with higher-than-average rates of readmission may soon face financial penalties. By 2013, the Patient Protection and Affordable Care Act will allow the CMS to withhold a percentage of inpatient Medicare payments based on a hospital's aggregate Medicare payments for all discharges. Penalties start at up to 1% in 2013; by 2015 penalties can be leveled up to 3%. In today's economy, no hospital can afford such losses.

And there's a reputational cost to rehospitalization as well. High readmission rates imply poor quality of care, communication and coordination, and can have a negative effect on an institution's image and ability to attract patients.

For all these reasons, a growing number of health care executives and analysts are working to develop systems and policies that will reduce readmission rates.

New ideas, protocols and tools

Reducing hospital readmissions from nursing centers starts with analyzing the continuum of care—from the hospital setting to the nursing home transfer, through any events and decisions that may lead up to readmission. Several health care associations, policy institutes and think tanks have already taken the initiative and are creating tools to help hospitals and nursing homes reduce rehospitalization. A program called Interact II, created at the Georgia Medical Care Foundation under a special study contract with CMS, offers a comprehensive array of communication tools and checklists for nursing home staffers. Tools include questionnaires and guidelines to help staff members make informed decisions at every step of the care continuum.[4]

The tools of Interact II help nursing home staff members to:

- Identify residents with the highest risk for developing acute change of condition.
- Better identify acute changes of condition and elevated risk levels
- Identify the causes of an acute change of condition and the feasibility of managing the resident within the nursing home setting
- Effectively manage acute changes in condition

The Interact II toolbox also includes a quality improvement tool for reviewing acute care transfers, which asks caregivers to consider a number of questions, such as:

- Could this transfer have been avoided?
- Were there "early warnings" of a decline in the patient's condition?
- Could precautions have been taken?
- Could the nursing home have provided the acute care the patient needed?

Probing questions like these are designed to shift the thinking patterns of the nursing staff. The goal is to address one of the fundamental reasons why patients are needlessly transferred to hospitals—the assumption that certain status changes automatically require that a patient be rehospitalized. In reality, there are many medical scenarios that skilled nursing centers can address competently and successfully. If a facility is prepared with the right equipment, if the staff has the right training, and if the right procedures are followed, then many nursing home-to-hospital transfers could be avoided.

Another rehospitalization reduction program, at the University of Minnesota, focused on identifying risk factors and designing a protocol around an interdisciplinary team approach for high-risk patients. In this approach, any

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member of the facility care team could take a leadership position depending on the needs of the patient and the skill sets required for effective care. Testing this approach at Minnesota nursing home, researchers were able to lower rehospitalization rates by 20%, 33% lower than the national average.[5]

Accountable care organizations as drivers for reducing readmissions

The movement to reform health care in America has also given rise to the concept of the accountable care organization (ACO), a system in which groups of physicians share the responsibility for a large group of patients, with their reimbursement at least partially contingent on their ability to control costs and improve outcomes.

For the Obama administration, which has embraced the ACO concept as part of its reform proposals, this incentivizing of physicians is seen as key to improving the quality and coordination of care. And while there is still some debate on the effectiveness of the ACO model, there is no question that it is forcing health care institutions to make changes in a wide range of areas. One change that is likely to be a "win-win" for all parties is improved communications between hospitals and nursing homes. Under the ACO model, when patients who are transferred to skilled nursing facilities are able to fully recover in the nursing home—in other words, when both hospitals and nursing homes are successful in delivering quality care—everyone benefits.

Revera steps up to the plate

Here in the U.S., it's still early days for health care reform, and most health care organizations are taking a cautious approach. I recently spoke with the CEO of a private hospital who told me, "At this point, we don't know what we don't know." That's a fairly good assessment of what many health care professionals are feeling.

Nevertheless, here at Revera Health Systems, we are taking a proactive approach to change, because we believe there is an opportunity for improving both patient care and our relationships with referring hospitals. If our nursing centers can create an environment that reduces the need for rehospitalizations, then our partner hospitals will also benefit.

With that in mind, our centers have launched several initiatives designed to reduce readmissions. These include:

- Quality improvement programs
- More specialists on staff
- More nurse practitioners on staff to perform higher level assessments
- Expanded on-site specialty services including pulmonology and dialysis units in selected markets

At Revera, we believe that having specialty services in house and specialists on staff—at least in certain strategic areas—is one key to reducing rehospitalization. Some physicians and hospitals have even approached us to see if we could provide more specialized care services, particularly pulmonary care. Since many patients today have COPD as a secondary diagnosis, but don't meet the criteria to be admitted to a hospital unit, our centers could be the ideal solution.

In addition to offering more specialty staff and services, we have also launched a pilot program in which a consulting hospitalist works with the patients in one of our centers. The hospitalist's main responsibility is to ensure the continuity of care for our patients, from hospital discharge and transfer through their recovery and discharge from our center. The hospitalist, who is also the attending physician in this case, also consults with and educates our nursing staff so that we can make better assessments and care decisions.

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Although the pilot program has only been running for a few months, the rehospitalization rates for patients who are being followed by our hospitalist are lower than the industry average. His services are an investment, but his patients stay with us for the whole payment period, and we don't lose them to the hospital due to a preventable condition.

Every patient. Every day. Any change.

Here at Revera, we have found that one of the most effective ways to reduce rehospitalization is to make sure that the entire nursing home staff understands the goal and knows how to contribute. And while electronic medical records and cutting edge equipment are very useful, they're no substitute for clear, ongoing communication. Much has been written in recent years about the effectiveness of the simple checklist in improving quality, and we use checklists everywhere. "Every patient, every day, any change," is our mantra.

We also encourage everyone in our centers to be alert to changes in patients' status. Volunteers, nursing assistants, social workers—we have a wide variety of people who interact with our residents and may see subtle changes that could indicate an underlying problem. We welcome their observations, because it's much easier to address a medical issue in the early stages. And because a team effort is probably the single most important factor in reducing hospital readmission rates from nursing homes.

Tina Thomas is a regional VP of operations for Revera Health Systems, which includes 30 skilled care centers across the United States offering subacute and short-stay rehab care, as well as long-term care. Revera Health Systems is part of the Revera, one of North America's leading providers of accommodation, care and services for seniors.

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