Preparing for the Hospital Readmission Reduction Program

Preparing for the Hospital Readmission Reduction Program

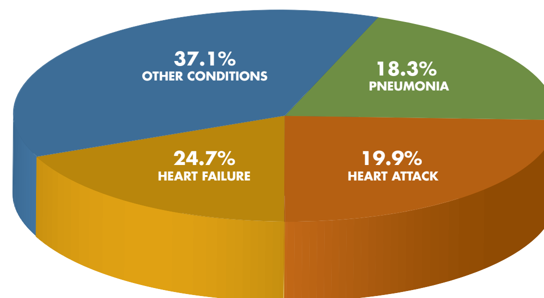
Hospital readmission rates have been rising throughout the years, and the cost of healthcare with them. According to a study conducted by Vincent Mor and other colleagues, published in 2010 in *Health Affairs*, almost one fourth of Medicare beneficiaries discharged from the hospital to a skilled nursing facility were rehospitalized within 30 days. Nearly one in five Medicare patients return to the hospital within a month of discharge, costing the government an extra $17.5 billion in 2010.

Readmissions are thus costly, and also detrimental to the health of patients. Moving into and out of hospitals repeatedly is emotionally taxing, encourages medical errors, and signals poor quality care, especially when the readmissions are preventable.

The Patient Protection and Affordable Care Act provides hospitals with additional incentives to focus on reducing preventable readmissions. The new law contains a Hospital Readmission Reduction Program, which imposes penalties of up to 3% by 2015 of regular Medicare reimbursements on hospitals with high readmission rates. The program is to go into effect by the end of 2012.

> *"The Patient Protection and Affordable Care Act's Hospital Readmission Reduction Program imposes penalties of up to 3% by 2015 of regular Medicare reimbursements on hospitals with high readmission rates. The program is to go into effect by the end of 2012."*

Skilled nursing facilities are one of the most common hospital discharge sites, after home discharge. Unfortunately, with hospital stays growing shorter and medical needs growing more complex, patients may be discharged in frailer condition, heightening the likelihood for rehospitalization. Moreover, the transition between care settings is often a time of great vulnerability for patients due to fragmented information, poor communication, and lack of proper preparation for the transition. By condition, readmission rates are 19.9% for heart attack, 24.7% for heart failure, and 18.3% for pneumonia.



Readmission Rates by Condition

Much research has been conducted to identify successful action that hospitals and post-acute care sites can take to reduce readmission. Great emphasis has been placed on a solid, patient-centered continuum of care across different settings in order to prevent the errors and vulnerabilities that occur in transitions. Strong preparations prior to discharge are important for bridging the gap between sites. Consistency and continuity in care and information across different settings prevents medical errors due to miscommunication and allows patients to receive better care – preventing rehospitalizations.

Kindred
Healthcare

Additionally, a focus on patients' personal needs is important to optimize care for full recovery. Hospitals and post-acute care settings need to carefully monitor patients' conditions for risk of rehospitalization. Patients should be transitioned to the post-acute setting that is best suited to their specific needs.

Kindred is able to offer a strong continuum of care for patients with optimal coordination between settings. Kindred implements many tools to reduce rehospitalization.

- Interventions to Reduce Acute Care Transfers (INTERACT II)* tools and processes which include:
  - SBAR – Situation, Background, Assessment, Recommendation – uniform and standard communication guidelines for managing changes in condition
  - Care pathways for common changes in condition according to the American Medical Directors Association (AMDA)
  - Stop and Watch CNA Tool – guidelines for observational reporting
- Tracking tools for rehospitalization analysis
- Consistent assignment of CNAs
- 24/7 RN coverage

Again, standardization provides continuity that prevents errors and sub-optimal care due to fragmentation and inconsistency. Tracking tools are also used for readmission analysis.

Because Kindred Long-Term Acute Care (LTAC) Hospitals and Nursing and Rehabilitation Centers offer more specialized care, they can provide targeted, optimal care for patients' individual needs and conditions. Our hospitals and nursing and rehabilitation centers provide 24/7 RN coverage, physician support and consistent assignment of CNAs in order to best assess patients' needs.

"Kindred is able to offer a strong continuum of care for patients with optimal coordination between settings. Kindred implements many tools to reduce rehospitalization."

**The current version of the INTERACT Program, including the INTERACT II Tools, educational materials, and implementation strategies were developed by Drs. Joseph G. Ouslander, Gerri Lamb, Alice Bonner, and Ruth Tappen; Mary Perloe, MS; and Laurie Herndon with input from many direct care providers and national experts in a project based at Florida Atlantic University supported by The Commonwealth Fund.*

Some materials herein are © Florida Atlantic University 2011. Such materials and the trademark INTERACT may be used with the permission of Florida Atlantic University

Kindred
Healthcare

LTAC hospitals offer interdisciplinary care and services to meet patients' complex needs with a wide array of skilled staff expertly trained in respiratory care, infection control, nursing, nutrition, and more. Services such as radiology and special care units are offered as well. The focus on patient needs helps to ensure a full recovery and discharge home or to a lower level of care, instead of a return to the hospital.

From specialized short-term rehab to long-term care, Kindred's Nursing and Rehabilitation Centers provide a full range of medical and social services to treat and each of our patients and residents. Many of our patients go home each year, and for those who are unable to return home, we provide safe, compassionate care in an environment that fosters independence and dignity.

Throughout the entire post-acute delivery system, rehabilitative therapies are an essential component to improve the well-being and physical abilities of each patient. Kindred's RehabCare therapists enable patients to improve function and regain independence with focused interventions. Because RehabCare therapists treat patients across the Kindred continuum, they are able to facilitate effective care coordination, management of patient episodes, and contribute to reduced hospital readmissions.

Since 2008, Kindred Long-Term Acute Care Hospitals reduced rehospitalization rates by more than 16% and Kindred Nursing and Rehabilitation Centers have reduced rehospitalizations by 10%. We continue to employ innovative strategies to reduce them further.

> *"Since 2008, Kindred Nursing and Rehabilitation Centers and Kindred Long-Term Acute Care Hospitals have reduced rehospitalization rates by over 8%."*

Kindred
Healthcare

ABOUT KINDRED HEALTHCARE

Kindred Healthcare, Inc., a top-150 private employer in the United States, is a *Fortune* 500 health care services company based in Louisville, Kentucky, with approximately 75,000 employees in 46 states. Kindred provided healthcare services in over 2,000 locations, including 121 long-term acute care hospitals, 224 nursing and rehabilitation centers, six inpatient rehabilitation facilities, 113 acute rehabilitation units and 19 hospice and home care locations and manages approximately 1,870 rehabilitation therapy service contracts in hospitals, skilled nursing and assisted living facilities across the country.

Ranked as one of *Fortune* magazine's Most Admired Healthcare Companies for four years in a row, Kindred's mission is to promote healing, provide hope, preserve dignity and produce value for each patient, resident, family member, customer, employee and shareholder we serve.

For more information, please visit us at www.kindred.com.

© 2012 Kindred Healthcare Operating, Inc. CSR 158531-01, EOE