Be Proactive and Prevent Unnecessary Hospital Readmissions

Almost one in four people admitted to a skilled nursing facility in the U.S. is rehospitalized in less than 30 days at an estimated cost of $14.3 billion per year. Research has shown that many of these rehospitalizations are avoidable if the change in the resident's condition is noted soon enough, if treatment can be provided in the nursing home and/or if a resident has advance directives in place. Skilled nursing facilities (SNFs) can receive a penalty on their Medicare payments for fiscal year 2019 for poor 30-day readmission rates back to hospitals, and several will be impacted according to new CMS data. Critical points for your facility to know include the following:

- Evaluated on a hospital readmission measure after a patient is discharged and has a hospital admission within 30 days
    - All-cause, risk-adjusted, unplanned hospital readmissions within 30 days of discharge
- Receive a performance score based on their individual performance and a performance score based on their comparison to other SNFs in the country
- Receive confidential quarterly and annual reports about their performance on the program's measure
- Receive payment incentives based on their performance
    - Begins fiscal year (FY) 2019 payments on or after October 1, 2018
    - Reduction amount is up to 2% of Medicare claims.
    - Readmissions to a hospital within the 30-day window are counted if the beneficiary is readmitted directly from the SNF or had been discharged from the SNF
    - Excludes planned readmissions
    - Is risk-adjusted based on, patient demographics, a principal diagnosis from the prior hospitalization, comorbidities, and other health status variables that affect the probability of readmission
    - Rates will be compared to thresholds and benchmarks and will be awarded points for either **achievement or improvement**, whichever is higher

Establish a Plan

Start by building a solid plan to prevent unnecessary readmissions with a readmissions prevention team that includes active leadership involvement. It is vital to track and trend Medicare Fee-for-Service 30-day readmissions data and improve staff members' knowledge of strategies and clinical skills to prevent readmissions. Use Quality Assurance & Performance Improvement (QAPI) techniques and seek guidance from Kentucky's Quality Improvement Organization (QIO) to implement interventions to decrease the rate of readmissions. It is also critical to partner with acute care providers and dynamically share successes and lessons learned.

New Tool Available

Remarkably, 16% to 18% of preventable readmissions are due to the resident or family members' insistence on going to the hospital. The new Decision Guide for residents, families, caregivers, and friends is now available. The guide provides information to assist in understanding why transfers are made and how residents can be involved in the decision-making

process for going to the hospital or staying at the facility. It's designed to educate residents and families and help them decide if the Emergency Department/Hospital is the right place for them, or if the SNF can still take care of them. The Decision Guide website provides the guide, data collection tools and training resources. Each nursing home in the Centers for Medicare & Medicaid Region IV should have received a packet of information and are highly encouraged to integrate the use of the Decision Guide into your care routines.

Reach out to Qsource for Guidance

Scott Gibson

Scott Gibson is a Qsource Quality Improvement Advisor for Kentucky. Scott is an expert on quality improvement and offers education on a wide variety of topics, including reducing avoidable readmissions, end-of-life conversation facilitation, and Nursing Home Compare. He and others at Qsource are also available to provide education on the Decision Guide and implementation to incorporate into your care routines. Please contact Scott by email at scott.gibson@area-G.hcqis.org or by phone at 502-680-2669 to receive free technical assistance. Also available are past articles on other health care related issues, such as Composite Scores, pain management, and behavioral health strategies. Connect with Scott for copies of previous articles on these topics and more.

Learn More About atom Alliance

Formed as a partnership between three leading healthcare consultancies, atom Alliance is working under contract to CMS throughout Alabama, Indiana, Kentucky, Mississippi and Tennessee to improve quality and achieve better outcomes in health and healthcare and at lower costs for the patients and communities. Through atom Alliance, AQAF in Alabama, IQH in Mississippi and Qsource in Indiana, Kentucky and Tennessee are carrying out an exciting strategic plan, with programs in place to convene, teach and inform healthcare providers, engage and empower patients, and inspire, share knowledge and spread best practices with communities across the entire healthcare continuum. Please visit the atom Alliance website for helpful educational resources on various topics.

Residents are at risk for pneumococcal disease. Encourage everyone who is 65 years or older and those 19 through 64 years old with certain health conditions or who smoke cigarettes to receive a pneumococcal vaccine!

Resources:

1. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/SNF-VBP-FAQs-Final.pdf
2. https://www.modernhealthcare.com/article/20181128/NEWS/181129930/most-skilled-nursing-facilities-penalized-by-cms-for-readmission-rates
3. http://decisionguide.org/