Navigating the Hospital Readmission Reduction Program

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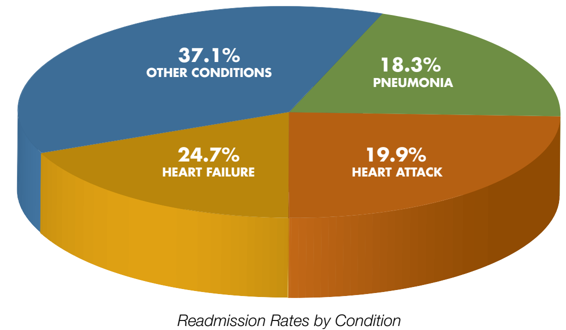
For many, a hospital's 30-day readmission rate is a proxy for quality patient care. Since October 2012, the Centers for Medicare and Medicaid Services (CMS) have been reducing Medicare payments for hospitals that have very high readmission rates for some of the most common and expensive conditions for Medicare beneficiaries – heart attack, heart failure, and pneumonia. This comes out of the many changes to payment and assessment of quality from the Affordable Care Act passed into law in 2010, and in the initial penalty phase, 2,217 hospitals experienced reduced funding because their 30-day readmission rates were too high.

Prior to implementing the readmission penalties, nearly one in five Medicare patients returned to the hospital within a month of discharge, costing the government an extra $17.5 billion in 2010. By condition, as of 2010 readmission rates were 19.9% for heart attack, 24.7% for heart failure, and 18.3% for pneumonia.



Readmission Rates by Condition

While penalties for high readmissions have only been in effect for a short while, hospitals began preparing for it in 2010, and according to recent data the initiative is having an impact.

At the U.S. Senate hearing in March 2013, a top Medicare official testified that while readmission rates had remained steady for the past five years at nearly 20%, the last three months of 2012 saw a significant drop in the national readmission rate to 17.8%. In the testimony, the CMS's Jonathan Blum pointed to the newly implemented readmission penalty as well as other provisions in the Affordable Care Act as to why this improvement occurred.

According to research released in February 2013 by the Robert Wood Johnson Foundation (RWJF) many factors aside from the hospital contribute to rehospitalization rates. In updating the Dartmouth Atlas Project, the RWJF report concluded that the region – state and community – in which a beneficiary lives is a strong predictor of higher rates of returning to the hospital within 30 days.

The report *The Revolving Door: A Report on U.S. Hospital Readmissions* also noted that other factors across the care continuum influence the rate of readmissions – specifically effective care transitions. They note that high readmissions are the result of a "fragmented system of care."

Patients who require ongoing care to fully recover after a stay in a hospital should be transitioned to the post-acute setting that is best suited to their specific needs to prevent the risk of return to acute. 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.

STRATEGIES FOR SUCCESS

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.

RWJF recognizes that providers across the care continuum are essential partners in addressing readmission rates. Hospitals and post-acute care settings together need to carefully monitor patients' conditions for risk of rehospitalization.

HOW KINDRED CAN HELP

Kindred offers a strong continuum of care for patients with optimal coordination between settings. Kindred implements tools to reduce rehospitalization.

- 24/7 RN coverage
- Consistent assignment of CNAs
- Tracking tools for rehospitalization analysis
- Physician and nurse practitioner support
- Common changes in condition guidelines from the American Medical Directors Association (AMDA)
- 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 paths to guide the nurse in evaluating specific symptoms that commonly cause a transfer to the hospital
  - Stop and Watch Tool – guidelines for observational reporting that staff and family can use

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

Kindred Transitional Care Hospitals and Transitional Care and Rehabilitation Centers offer more specialized services and provide targeted, optimal care for patients' individual needs and conditions.

**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.*

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

Kindred Healthcare

"From 2009 to 2012, we reduced rehospitalizations by 16.7% from our Transitional Care Hospitals and 7.2% from our Nursing and Rehabilitation Centers."

KINDRED'S CONTINUUM OF CARE

Transitional Care Hospitals

Transitional care hospitals (certified as long-term acute care 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 care needs helps to ensure a full recovery and discharge home or to a less intensive level of care, instead of a return to the hospital.

Subacute Unit

Situated within a transitional care hospital, our Subacute Unit is designed to successfully transition patients to a less intense level of service, such as a skilled nursing center, or home with additional services. The unit provides comprehensive inpatient medical care and rehabilitation for those patients with an acute illness, injury or exacerbation of a disease who no longer require the high intensity, aggressive medical care provided in a hospital. Being co-located within a transitional care hospital enables care and treatment by the same physicians, therapists and care professionals, helping to ensure a coordinated transition and improved outcomes.

Transitional Care and Rehabilitation Centers

Kindred Transitional Care and Rehabilitation Centers provide specialized short-term inpatient rehabilitation, skilled nursing care and a full range of medical and social services. Our goal is to help patients achieve positive outcomes, regain function and safely return home as quickly as their recovery allows. Our services include physical, occupational and speech-language therapy and respiratory therapy by Kindred-employed therapists. In addition, we specialize in the care of patients with: IV medication needs, COPD, pneumonia, congestive heart failure (including IV Inotropics at certain centers), sepsis, complex medical conditions, transplants, wound care, stroke recovery, orthopedics, diabetes, and dementia/Alzheimer's Disease. Our specialized short-term rehabilitative programs for pulmonary, advanced cardiac needs, wound care, orthopedic and stroke recovery provide an individualized patient/family centered approach to care.

From 2009 to 2012, we reduced rehospitalizations by 16.7% from our Transitional Care Hospitals and 7.2% from our Nursing and Rehabilitation Centers. And from 2011 to 2012, patients in our home health programs through Kindred at Home were readmitted to the hospital in numbers at or below the national average. We continue to employ innovative strategies to reduce rehospitalizations even further.

Kindred Healthcare

Home Health, Palliative and Hospice

Our Kindred at Home homecare services offer medical interventions including wound care and rehabilitation therapy that are delivered in the comfort of a patient's home. Experienced nurses, therapists and aides work with each individual to maximize physical abilities, improve health and well-being, assist with a variety of daily activities including bathing, and provide essential education and management of medications and medical conditions.

Palliative care is a type of care focused on providing comfort and promoting quality of life through pain and symptom management. It can be accessed while patients are still receiving aggressive, curative treatment. Our palliative care team, including physicians, nurse practitioners and other specialists, coordinates healthcare resources and provides assistance with decision making and advance directives.

Hospice provides a family-oriented model of care designed to meet the spiritual, emotional and physical needs of patients in life's final transition. Our hospice care provides essential respite care for family caregivers while keeping the patient in a familiar and comfortable environment. The goals of all three programs are to safely care for these patients at home and to reduce avoidable hospitalizations.

Rehabilitation Therapies

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

"The focused interventions of Kindred's RehabCare therapists enable patients to improve function and regain independence."

Kindred Healthcare

Kindred's Boston Continuum

Our goal is to provide superior clinical outcomes, transition patients home more quickly and safely, and lower costs by reducing lengths of stay and reducing unnecessary rehospitalizations. We do this by providing the right care, at the right place, at the right time.

- Transitional Care Hospitals
- Subacute Unit
- Nursing and Rehabilitation Centers
- Home Care
- Assisted Living

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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 78,000 employees in 46 states. Kindred provides healthcare services in over 2,000 locations, including 121 transitional care hospitals, 224 transitional care and rehabilitation centers, six inpatient rehabilitation facilities, 113 acute rehabilitation units, over 100 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 five 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.

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