Since the Affordable Care Act passed in 2010, a hospital’s 30-day readmission rate has become synonymous with quality of care. Beginning in 2012, the Centers for Medicare and Medicaid Services (CMS) started to assess penalties for hospitals with “excessive” rates for three of the most common and expensive conditions for Medicare beneficiaries – heart attack, heart failure, and pneumonia.

The phase-in of the penalties began October 1, 2012 with a 1% maximum reduction for FY 2013, with the penalty increasing to 2% in FY 2014, and will further increase to 3% in 2015. In the initial penalty phase, 2,213 hospitals – roughly 2/3 of the hospitals whose readmission rates were reviewed – received reduced Medicare funding because their 30-day readmission rate was too high.

This poses a significant financial impact to hospitals. Consider that a hospital with an average annual Medicare payment of $100 million could lose up to $3 million in 2015 if the maximum penalty is imposed.

In fact, at a 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.

A February 2013 report by the Robert Wood Johnson Foundation entitled The Revolving Door: A Report on U.S. Hospital Readmissions found that many factors outside the hospital contribute to rehospitalization rates, specifically a “fragmented system of care” with care silos and poor transitions between care settings.

Additional ongoing research indicates that other obstacles to reducing readmission rates include lack of access to real-time data and the lack of procedures and infrastructure within a hospital to provide appropriate care coordination and post-discharge monitoring.
Navigating the Hospital Readmission Reduction Program

The CMS rehospitalization reduction initiative has already shown some success in lowering rates of 30-day hospital readmissions and has led hospital systems and managed care organizations to improve their partnerships with post-acute care providers. This trend will likely increase, particularly as new initiatives to lower rates of hospital readmission are targeted at those providers delivering care post-discharge. This is apparent in ongoing recommendations by the Medicare Payment Advisory Commission and in President Obama’s FY 2015 budget, which includes a proposal to apply a similar rehospitalization reduction program for skilled nursing facilities.

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.

Evidence-based research indicates that standardization of processes and programs help reduce errors, sub-optimal care, and poor transitions between sites of care – thus helping to reduce unnecessary returns to acute hospitals within 30-days post discharge. Additionally, tracking tools are helpful in readmission analysis and performance improvement.

How Kindred Can Help
Throughout our continuum, Kindred implements many processes and tools to reduce rehospitalization and ensure coordinated care transitions. We also utilize strategies tailored to the specific site of service.

Across the Continuum:
• Tracking tools for readmission analysis and monthly performance improvement review meetings
• Interventions to Reduce Acute Care Transfers (INTERACT)* tools and processes which include:
  – SBAR – Situation, Background, Assessment, Recommendation – uniform and standard communication guidelines for managing changes in condition
• Clinical liaisons to identify patients for the most appropriate level of post-acute care
• Integrated and interdisciplinary care management teams
• Patient-centered care tailored to the medically complex patient
• On-site case management services providing patient education and support for transition home or to a less complex care setting
• Collaboration with area healthcare systems and agencies for continuity of care
• Weekend and evening admissions accepted
• Clinical experience and best practices leveraged from our national network of Kindred facilities

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Additional Strategies Tailored by Site of Service

**Transitional Care Hospitals:**
- Annual gap analysis for service line development, staff development and patient care delivery systems
- 24-hour physician availability in our hospitals

**Nursing and Rehabilitation Centers:**
- Utilization of care pathways for common changes in condition according to the American Medical Directors Association (AMDA)
- Stop and Watch Tool – guidelines for observational reporting for staff and family
- Consistent assignment of CNAs
- We strive for 24/7 RN coverage
- Home assessments by therapy team to ensure safe discharge home

**Home Health and Hospice:**
- Works with patient, family and physician on appropriate level of care post hospital or SNF stay, taking personal preference and disease progression into account
- Facilitates coordination of care between facility physician and patient’s primary or specialist physicians
- Thorough medication reconciliation and teaching on importance of adherence of medication regimen
- Coordinate timely follow-up physician appointment post discharge from facility
- Patient-centered, goal-directed approach creates patient and family engagement for improved ongoing self-management of condition
- Identify barriers to care, education and adherence – followed by an individualized, comprehensive plan of care
- Use of Teach-Back method for improved retention
- Teaching of Red Flags for symptom recognition and early intervention
- Education and coaching on SBAR communication for improved patient/family communication with other healthcare providers
- 24/7 on-call staff to address concerns, advise on issues and come to the home when needed
- Discharge Liaisons maintain contact with patients post discharge for continued adherence to their plan of care and coaching for improved self-management

To speak with someone today about how you can partner with Kindred to reduce readmissions, please contact your Kindred clinical liaison or contact any of our area facilities.

**Kindred’s Continuum of Care**

**Transitional Care Hospitals**
Our transitional care hospitals (certified as long-term acute care hospitals) are unique in their ability to care for critically ill patients who require specialized, aggressive, goal-directed care over an extended period of recovery time. Our hospitals are licensed as acute care hospitals with an additional Medicare certification that supports a longer length of stay – usually weeks, not days – as compared to the typical five-day stay for patients in traditional hospitals.

We offer specialized services and extended care for medically complex patients who are unable to fully recover in the short-term setting. Our hospitals have 24-hour physician support and the ancillary services found at an acute care hospital, including laboratory, radiology, pharmacies, operating or procedure rooms, special care units and telemetry units. Our specialized care includes pulmonary care (ventilator management and weaning), complex wound care, dialysis, IV antibiotic therapy and pain management.

From 2009 to 2013, Kindred reduced rehospitalizations by 14% from our Transitional Care Hospitals and by 15% from our Nursing and Rehabilitation Centers.
Home Health
The home health professionals with Kindred at Home provide medical care and services — including nursing care, wound care and rehabilitation therapies — delivered in the comfort of a patient’s own home.

Experienced nurses, therapists and aides work to maximize physical abilities, improve health and well-being and to provide essential education and management of medications and medical conditions. The goal of this program is 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 and contribute to reduced hospital readmissions.