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Putting a stop to the revolving door of rehospitalizations

Overview

Post-acute care providers are under increasing pressure to improve clinical outcomes and reduce hospital readmissions.

One in five Medicare patients sent from the hospital to a nursing home bounces back within 30 days – often for potentially preventable conditions. Such rehospitalizations occur 27 percent more frequently in SNFs than for the Medicare population at large in other care settings, leaving considerable room for improvement.[1] Hospital readmissions of Medicare patients alone cost the government $26 billion a year, according to the Robert Wood Johnson Foundation. Worse, $17 billion of that cost could have been avoided if patients had received proper care in the first place.

Nursing homes with high rehospitalization rates face several consequences. For one, the Centers for Medicare and Medicaid (CMS) have created financial disincentives that can amount to a significant loss of revenue. Moreover, hospitals are far less likely to refer patients needing rehabilitation to underperforming nursing homes. Since rehospitalization rates are publicly available online, consumers are increasingly more discerning when planning their post-acute care as well.

But by far the most devastating effects of readmissions are experienced by the patients themselves. Not only do they endure the health decline that sent them back to the hospital, older adults who are rehospitalized are more likely to experience longer-term functional decline and have higher mortality rates.

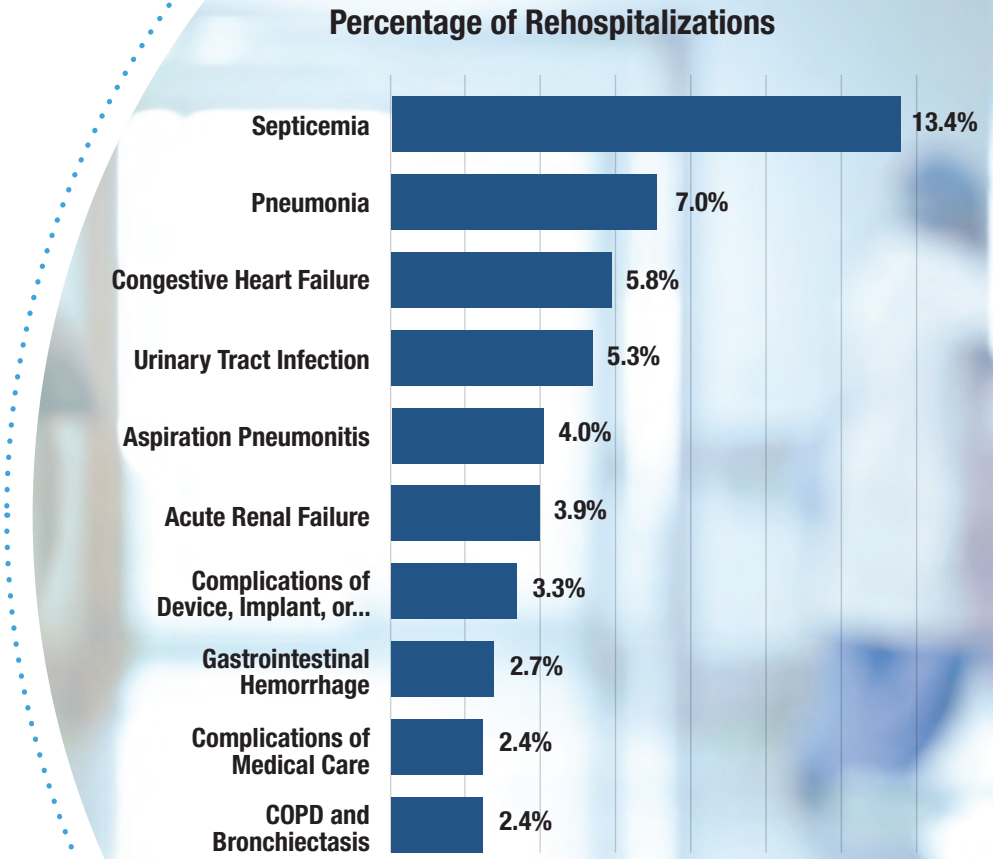
[1] https://www.npr.org/sections/health-shots/2018/06/13/619259541/medicare-takes-aim-at-boomerang-hospitalizations-of-nursing-home-patients

Clinical Perspective

Skilled nursing patients who return to the hospital are especially vulnerable to the risks associated with hospital stays, including medication errors and hospital-acquired infections.[2] They also face a 35 percent mortality rate within one year of the rehospitalization and 33 percent suffer from functional decline.[3]

These rehospitalizations are often avoidable. A study by the Health and Human Services' Office of Inspector General (OIG) examined the diagnoses responsible for readmissions in nursing homes. Of all diagnosis categories, 10 diagnoses represent nearly 50 percent of skilled nursing rehospitalizations.

The ability to detect subtle changes in condition are key to intervening early, treating in place, and avoiding the hospital. Moreover, looking for factors that are not directly related to a patient's condition is also key. Research indicates that rehospitalizations can be caused by factors other than a recurrence of the original health event.[4] With so many factors to consider, detecting and preventing clinical decline is a formidable challenge for the clinical team.



[2] https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/InitiativetoReduceAvoidableHospitalizations/AvoidableHospitalizationsamongNursingFacilityResidents

[3] https://www.mcknights.com/blogs/the-real-nurse-jackie/getting-nurses-to-rethink-rehospitalization

[4] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7326238/

Financial Impact

With a 30-day rehospitalization rate of 20 percent among nursing home Medicare patients, reversing the trend has become a national priority. Under its Value-Based Payment (VBP) initiative, CMS withholds 2 percent of each facility's reimbursement to encourage improvement in this area. The withheld funds are used to reward or penalize a skilled nursing facility based on its rehospitalization performance.

In addition to VBP incentives, a nursing home's hospital readmission rate has several other ramifications for the bottom line:

- **Hospital referrals decline** as discharge planners are much less likely to refer patients to a nursing home with a high return-to-hospital rate. This can have a dramatic impact on revenue over time.
- **Consumer demand is negatively impacted.** Rehospitalization factors into a facility's 5-Star rating in the Nursing Home Compare rating system. A lower rating is less appealing to consumers researching care options.
- **Revenue is lost** every day a patient is being cared for in the hospital, instead of the skilled nursing facility.
- **Opportunity cost mounts** if the skilled nursing facility is required to maintain open beds while readmitted patients spend time in the hospital.

Factored collectively, the financial implications associated with rehospitalization are substantial. Even a subtle change to clinical performance can have a dramatic effect on the bottom line.

Risk Management

Nursing homes struggling with unnecessary rehospitalizations also face reputation management issues and considerable exposure to legal liability. A resident subjected to such a readmission might sue the skilled nursing facility in question and pursue damages for adverse events or decline caused by negligence. If settled, a single lawsuit averages $400,000 and considerably more if a case is lost at trial.[5]

Regulatory Compliance

If hospital readmissions are high, it likely indicates that a skilled nursing facility needs to address its level of compliance with federal and state regulations.

- **QAPI** (Quality Assurance and Performance Improvement): The coordinated application of a QAPI quality management system is now required of all nursing homes, promising a systematic, data-driven, proactive approach to performance management and improvement. High rehospitalization rates may well indicate that a nursing home's QAPI program is insufficient to result in quality clinical care.
- **Facility Assessment:** This document is expected to outline the resources (equipment, staff, policies) needed to properly care for residents' specific health issues and needs. Poor clinical performance that leads to patients returning to the hospital likely indicates that the facility assessment needs improvement as well.

[5] https://www.nursinghomeabuse.org/legal/settlements/#:~:text=The%20exact%20dollar%20figure%20for,Wrongful%20death

Strategies to Prevent Rehospitalization

The post-acute care team needs an arsenal of strategies to enhance patient care, improve outcomes, and reduce avoidable readmissions. By catching even a few cases early enough to successfully intervene, operators can reduce their readmission rate in a meaningful way, helping their patients and bottom line in the process. This requires a few important competencies:

1. **Identify early signs and symptoms of risk** for the most common causes of hospital readmissions. Exacerbations in pneumonia, COPD, and CHF are known to be preceded by recognizable changes in patient condition which are often overlooked until they become acute.
2. **Train the care team to assure they have the assessment and clinical skills necessary to act** when early signs and symptoms of risk are identified. Train on these skills, then follow up at regular intervals with a skills checklist to verify nursing competency.
3. **Analyze rehospitalization performance over time.** Ongoing analysis is a critical component of successful continuous quality improvement and should be used to benchmark and track QAPI initiatives.
4. **Leverage technology.** Several solutions are available to curate clinical data. Look for one that uses artificial intelligence to make the right connections between data points, reveal the key indicators that identify at-risk patients, and propose interventions for triage.

Develop and Implement an Effective Strategy

Avoidable rehospitalizations remains a major challenge for many post-acute organizations – and they can have devastating and long-lasting effects.

The ramifications for patient health and safety are sobering. And the consequences are many for providers who fail to provide quality clinical care that prevents readmissions. In addition to payment disincentives, nursing homes face decreased volume from referral sources and consumers themselves – not to mention the lost revenue and potential cost each time a patient winds up back in the hospital.

Take affirmative steps to master effective clinical protocols and nursing competencies. Dramatically improve care quality and operational performance by effectively using technology to identify at-risk patients before they become acute.

SAIVA

Learn how SAIVA can help you reduce rehospitalizations by as much as 50 percent.

Schedule a free consult today.

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ABOUT SAIVA

SAIVA uses artificial intelligence to improve outcomes and unnecessary hospitalizations by identifying your patients most at risk for near-term decline.