WebinarPLUS⁺

REDUCING PREVENTABLE READMISSIONS FROM SNFS

The good news for skilled nursing operators is that by focusing their efforts on preventable hospital readmissions, not only will they provide better care to their residents, but they also will be rewarded by current and future policy. Even better, Providigm researchers and software developers have teamed to help SNFs identify risk and execute smart readmission reduction initiatives. Tailored solutions can flag hospitalization risk factors so that providers can proactively adjust care processes. In the end, both patient and skilled nursing provider come out ahead.

Reducing hospital readmissions is a big challenge, but skilled nursing facilities can achieve significant success by applying proven, data-driven quality improvement strategies.

Long-term care professionals learned about this approach to reducing readmissions in a recent Medline-sponsored *McKnight's* webcast featuring two leaders at quality management solutions company Providigm: Chief Executive Officer Andrew M. Kramer, M.D., and Chief Scientific Officer Michael K. Lin, Ph.D.
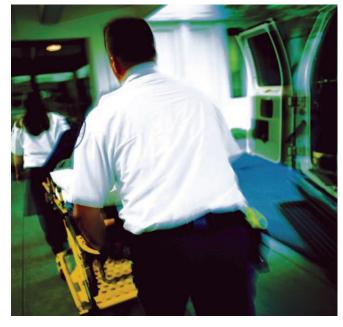
Know where to focus

Readmissions have become an increasingly urgent concern for SNFs, Kramer emphasized. One reason: Under the Affordable Care Act, hospitals' Medicare reimbursements have been tied to readmission rates. For the past few years, skilled nursing facilities have tried to attract referrals by showing that they can help hospitals keep readmissions low.

The Protecting Access to Medicare Act of 2014 recently made the issue even more pressing. Under the law, skilled nursing facilities will have Medicare reimbursements linked to their own readmissions rates starting in 2018. The language of that law should guide SNFs' readmission reduction efforts, Kramer said.

The law ties Medicare payments to the number of "potentially preventable" readmissions, he noted. So, first providers need to understand what potentially preventable readmissions are, and then they need to prevent them.

By focusing on preventable readmissions, operators can get maximum results with the greatest efficiency, Kramer said. To underscore his point, he quoted

> ## "Go where the money is in preventing readmissions."

Willie Sutton, who explained that he robbed banks because "that's where the money is."

"Go where the money is in preventing readmissions," Kramer urged. "Understand what are preventable readmissions … and target your efforts on those."

The alternative — trying to bring down readmissions "for every kind of individual" — could lead facilities to overcommit resources to reducing rehospitalizations, he cautioned. Readmissions are important, but Kramer

said SNFs need to keep things in perspective. "There is a whole lot more to providing care in skilled settings," he said.

Define 'preventable'

A basic definition of potentially preventable readmissions is that they can be reduced "at a relatively high rate" through improvements in care, Kramer said. This separates them from purely elective or unforeseeable reasons that SNF residents are hospitalized. To get a clearer understanding of potentially preventable readmissions, Kramer advised looking at a February 2014 Office of the Inspector General report on adverse events in skilled nursing facilities.

It stated that 22% of Medi-

care SNF residents experienced an adverse event in fiscal year 2011, and over half of those people were hospitalized. Almost 60% of the adverse conditions were deemed "clearly or likely preventable" by physicians who reviewed patient charts. The report listed these preventable conditions, which included medication-induced delirium, fluid and electrolyte disorders, and catheter-associated urinary tract infections.

The Medicare Payment Advisory Commission, working with Providigm, also has performed research to define potentially preventable readmissions, Kramer explained. Looking at the primary hospital discharge diagnoses of patients readmitted from skilled nursing facilities, MedPAC generated a list of conditions associated with potentially preventable hospitalizations. It is very similar to the list of preventable conditions in the OIG report, as well as lists that other groups have proposed, Kramer noted.

Using this categorization method, MedPAC calculated that about half of all hospital readmissions from skilled facilities are potentially avoidable.

Adjust for risk

The Protecting Access to Medicare Act of 2014 also states that risk adjustment will be used in calculating SNFs' potentially preventable readmissions, Providigm's Lin pointed out.

Risk adjustment is intended to account for resident characteristics unrelated to the nursing home's quality of care. Comorbidities present on admission was one example Lin gave. If risk adjustment works as intended, SNFs that admit many patients at high risk for rehospitalization won't be unfairly penalized.

For more information

The original webcast is available at www.mcknights.com

It's helpful to first look at how preventable readmission rates are measured "raw," without the adjustment. The raw rate is a simple ratio, Lin said. The numerator is the SNF's number of hospital readmissions for potentially preventable conditions during a given time period. The denominator is the number of relevant skilled nursing facility stays, such as Medicare fee-for-service stays, during the same period.

Risk-adjusting that raw rate involves determining each resident's risk profile, Lin said. To do this, a facility needs to weigh factors such as a resident's medical comorbidity index.

From there, things only get more complex. Coming up with a true risk-adjusted potentially avoidable readmissions rate involves calculating an observed rate of potentially avoidable readmissions, calculating an expected rate of potentially avoidable readmissions by adding up the probabilities of rehospitalization for each resident, using logarithmic transformation to manage outliers, and multiplying this number by the national rate.

Facility leaders probably will be tearing their hair out doing this math without specialized software, Lin said.

However, facilities that don't have this software should not throw in the towel, he advised.

"Regardless of how technically difficult it may be to calculate these rates, the important thing is to pay attention to it," he said. "Even if you're going to track your raw rates, it's important to know how you compare to others. These data are available, so you can get a sense of how you compare to your peers, whether it's on a national or state level."

EMPOWERED BY DATA
Long-term care providers can maximize reimbursements and improve care if they are strategic about readmissions. They should leverage data to focus on high-risk residents and improve clinical processes.

Take action for improvement
"The best way to prevent potentially preventable readmissions is to become a hospital-based facility," Kramer joked.
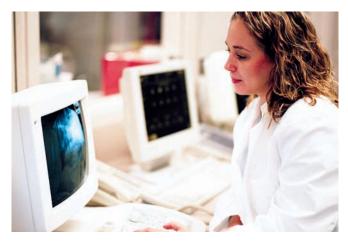
Hospital-based SNFs do have low average readmission rates, for obvious reasons (such as the proximity of doctors), he said. Of course, a free-standing SNF can't simply morph into a hospital-based facility. It's also difficult to boost staffing, although this is associated with lower rehospitalization rates. So what can facilities do to improve?

Targeted performance improvement projects are the answer, Kramer said.

Again, having the right software can make a huge difference, Kramer and Lin stressed. They made their point by sharing screenshots from the abaqis® Quality Management System, which allows SNF leaders to see at a glance residents' specific readmission risk factors, determined through sophisticated predictive models. These models beat the traditional assessment method, in which a clinician comes up with a relatively subjective risk categorization for residents, Kramer and Lin said.

The abaqis® resident risk profiles can be used to identify the clinical risks associated with potentially avoidable readmissions so that providers can proactively address these issues.

For example, an operator might discover a "very high rate of readmission for sepsis that seems secondary to urinary tract

infections," Kramer said. A root-cause analysis should follow. He described how it might unfold: "UTIs often begin with indwelling catheters. How aggressive are we at removing these catheters, which often can be done right at admission? What alternatives are we considering? How rapidly are we moving to reduce catheter-associated UTIs leading to sepsis?"

A system such as abaqis® includes a wide array of data to inform performance improvement projects. For example, facility leaders can use the program to quickly see whether a resident is being treated by an on-call or attending physician. If having an on-call doctor is associated with readmissions, the facility might intervene with the physicians.

QAPI to the rescue
The data-driven method that Kramer and Lin described follows the principles of Quality Assurance & Performance Improvement. Nursing homes are preparing for a forthcoming Centers for Medicare & Medicaid Services rule that will formally replace current quality assurance regulations with QAPI. So, following the Providigm leaders' advice would put facilities ahead of the curve both for future readmis-

sions penalties and the upcoming QAPI regulation.

Even the Inspector General believes QAPI is the best approach to reducing adverse events and related hospitalizations, the watchdog agency made clear in its February report.

So there's good news for skilled nursing operators facing the intimidating task of reducing readmissions: There is an alignment between policy and providing good clinical care to skilled nursing residents, and there are powerful software tools that can give providers a distinct advantage.

Kramer re-emphasized the advantage of having robust analytics available.

"There is an understanding that this issue is complex and requires customized performance-improvement activities directed at where your risks are." ∎

Editor's note
This McKnight's *Webinar Plus* supplement is based on a similarly named webinar McKnight's presented on June 18. The event was sponsored by Medline. The full presentation is available at www.mcknights.com/webcasts/section/297.