HDMS℠ Health Data & Management Solutions

Reducing Readmissions from Skilled Nursing Facilties

Background

In an effort to improve health care quality, safety, and outcomes, a large Midwestern health system representing 720,000 attributed members (including commercial, Medicare, and Medicaid populations) collaborated with Health Data & Management Solutions, Inc. (HDMS) to examine transition of care (TOC) data. This assessment examined discharges from skilled nursing facilities (SNF) that resulted in readmission to an acute care hospital within 30 days.

The Need

Hospitalizations associated with long-term care residents can be expensive and lead to negative outcomes for individuals in skilled nursing facilities, especially for the elderly and people with disabilities. Research has shown nearly a fourth of SNF stays result in a hospital readmisson within 30 days of the initial admission, costing an average of $10,000 per hospitalization.[1]

To provide residents with better care experiences and outcomes, the health system sought to assess all of its SNF stays taking place between the first acute and second acute stay. This measurement would provide the health system's clinical leaders with a more complete picture of the number of admissions from or into a SNF. In addition, this patient-level data would provide the health system with actionable insights for advancing their quality initiatives and improving care, as well as identify preferred facilities based on their success in keeping patients from returning to the hospital.

The Analytic Challenge

The challenge the health system faced was linking several clinical events at the patient level and across time. To appropriately assess TOC data, the health system needed to identify all SNF stays, including transfers and multiple admissions. Using this information, they pinpointed the initial acute care hospitalization and determined if there was a subsequent readmission to an acute care facility within 30 days of the discharge date of the initial hospitalization. Further analysis required readmission rates—defined by the number of readmissions to acute care facilities divided by total SNF stays—to be broken out by patient type, facility, etc., to develop and drive quality improvement programs.

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[1] *Mor, V., Intrator, O., Feng, Z., et al.: The revolving door of rehospitalization from skilled nursing facilities. Health Aff. (Millwood) 29(1):57-64, Jan.-Feb. 2010.*

The Solution

Working closely with the health system, HDMS created new metrics to account for and identify all SNF transfers. These new metrics counted readmissions starting with the initial acute admission, SNF stay, and subsequent acute readmission within 30 days of initial discharge. HDMS' flexibility in identifying all necessary SNF transfers data provided the health system with a comprehensive view of acute readmissions. The adjusted logic—including a SNF transfer in between admissions—resulted in more meaningful data to support the measurement and analysis of SNF quality and performance.

The Results

Upon implementation of the metrics, the health system was able to identify key insights that allowed for actions to reduce readmission rates. By expanding the analytic parameters for SNF readmission measure, the health system could more accurately assess readmissions, trends and SNF quality.

For example, the health plan uncovered overlooked readmissions that were not factored into the overall readmission rate. This data enabled the health plan to determine the true overall readmission rate, which was higher than previously understood. Armed with this new insight, the health system was able to better align resources and reduce its list of SNFs from approximately 100 facilities to a preferred set of 41 facilities with the best performance. This intiative increased the quality of care for the health system's patients while reducing readmissions to acute care facilities and costs. The new SNF readmission measure has also been used in profiling quality across more than 400 physician groups within the health system's network—resulting in similar positive changes being observed across the entire network.

About HDMS
Health Data & Management Solutions, Inc. (HDMS) sits at the intersection of providers, payers and employers, putting unparalleled analytic power into the hands of its customers and utilizing its extensive industry expertise to help them better manage their business and improve health outcomes.

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