

The IRFs Role in Reduction of Acute Care Admissions

An Analysis of Medical Transfers and Return to Acute
Within 30 days of Discharge



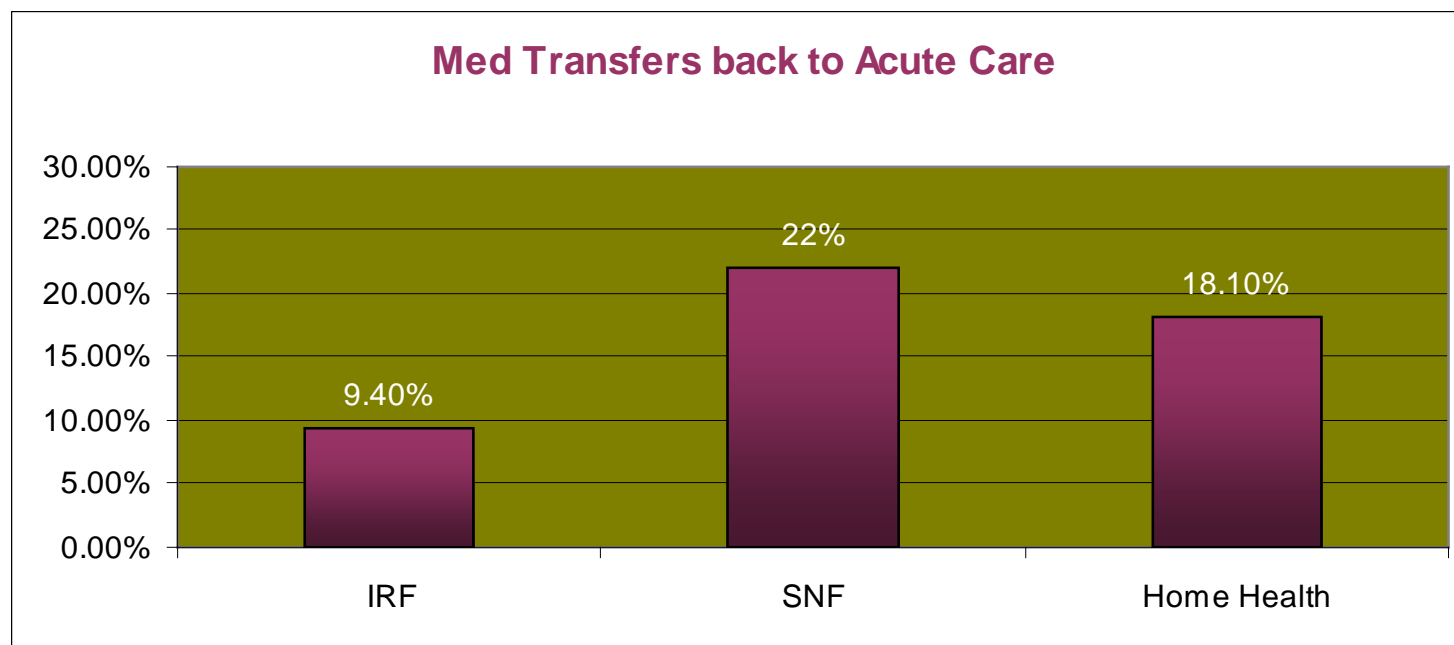
Susan M. Keeker
Director, Performance Support
Hospital Rehabilitation Services Division
RehabCare Group, Inc

- Participants will understand common reasons for return to acute
 - During the IRFstay
 - Within 30 days post discharge
- Presenter will benchmark current performance against national data.
- Participants will identify how to use discharge to acute data to impact unit/hospital processes
- Participants will identify factors that correlate with return to acute within 30 days
- Participants will identify how to use the data to drive referral patterns

- In the current healthcare environment it is vital that IRF administrators, directors and staff understand the outcomes of those patients served.
- Discharge to Community, Case Mix Index, FIM gain tend to be the key performance indicators evaluated most often by IRF programs.
- With the promise of healthcare reform, the likelihood of a change in payment process or a penalty for poor outcomes is all but a certainty.
- Understanding transfers to acute and return to acute care within 30 days will provide IRFs with the information they need to not only market their programs to physicians and discharge planners, but it will also be beneficial information if a change in healthcare reimbursement becomes a reality.

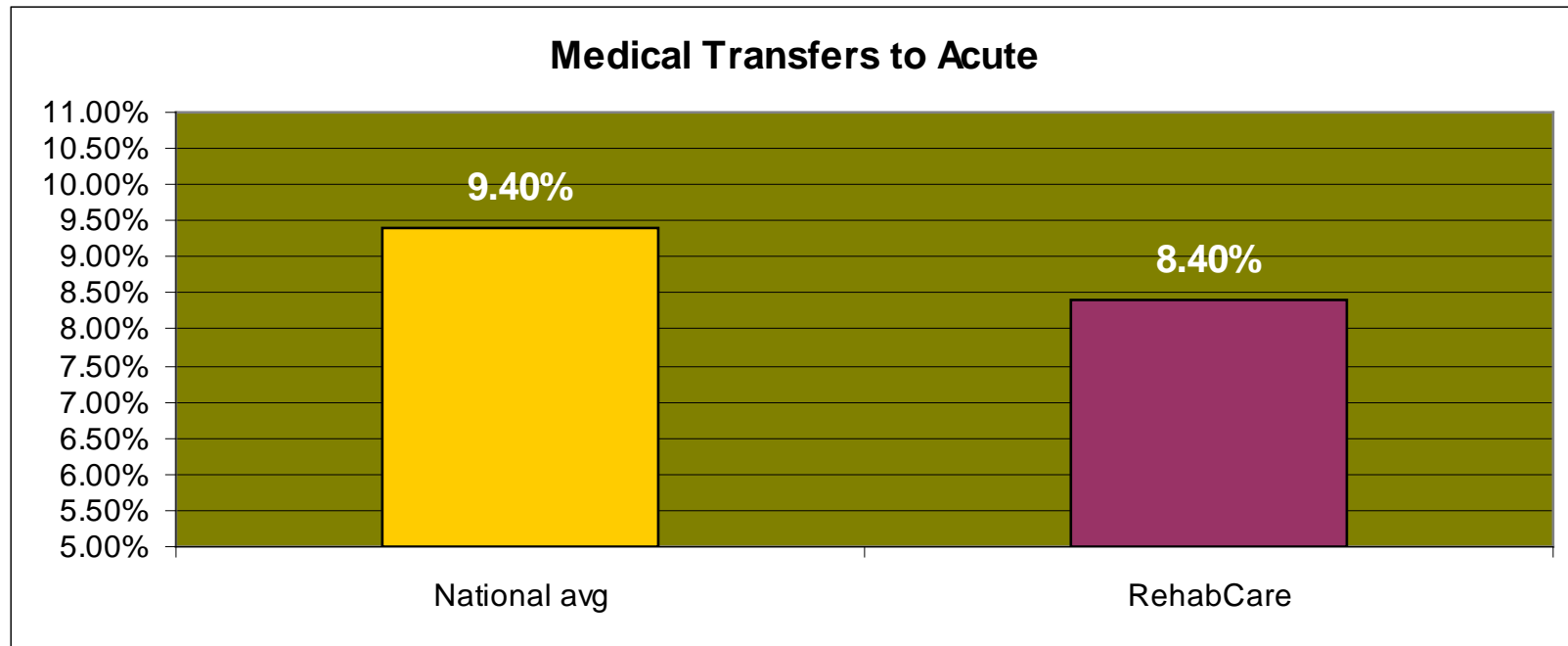
- Patients actively participating in a post acute care program (IRF, SNF, Home Care, LTACH), who experience a medical complication or condition, warranting a return to the acute care environment.
- Includes program interrupts and full discharge to acute

- Transfers to acute from a post acute environment differ greatly from one setting to another.
- How does your unit compare to these percentages?



* 2006 Medpac data

- Make a comparison of your unit(s) with the national average of return to acute.



- On a unit level, a high discharge to acute percentage can indicate a need to better manage medically complex patients.
- Develop a tool to track and evaluate the reasons for return to acute.

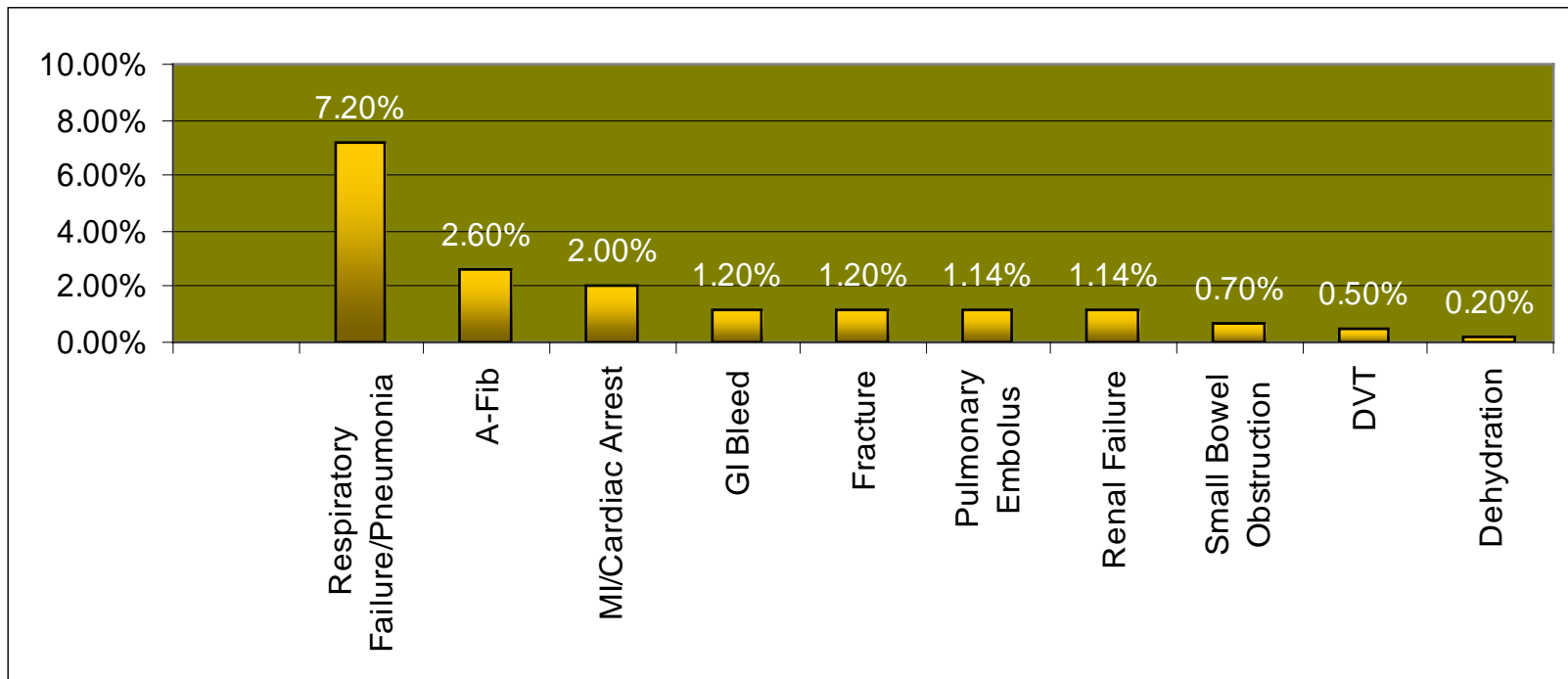


- Access to this data allows for identification of trends that may require a change in process or a significant level of education, whether that be for staff, unit physicians or consulting physicians.
- The tool should include identification of key factors such as:
 - RIC
 - Reason for Transfer
 - Day of Week
 - Nurse
 - Shift
 - Physician

Medical Transfers to Acute

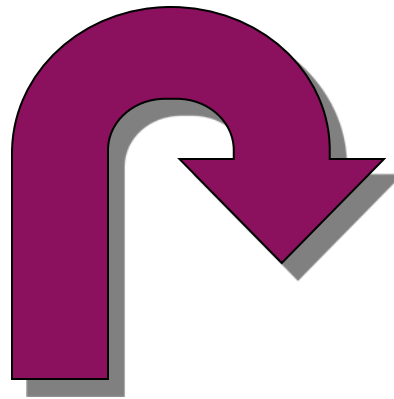
<i>Date</i>	<i>Patient Name RIC</i>	<i>Reason for Transfer</i>	<i>Physician Ordering transfer</i>	<i>Nurse</i>	<i>Day of Week</i>	<i>Shift</i>
<i>1-1-10</i>	<i>Cook/Cardiac</i>	<i>A-Fib</i>	<i>Pyles</i>	<i>Tammy</i>	<i>F</i>	<i>Day</i>
<i>1-13-10</i>	<i>Gregg/Pulmonary</i>	<i>Resp Failure</i>	<i>Shapiro (Pulm)</i>	<i>Cortney</i>	<i>W</i>	<i>Day</i>
<i>2-6-10</i>	<i>Rowan/Debility</i>	<i>Agitation</i>	<i>Bailey (MD partner)</i>	<i>Nancy</i>	<i>Sat</i>	<i>Night</i>
<i>3-7-10</i>	<i>Jett/Amputee</i>	<i>Renal Failure</i>	<i>Bailey (MD partner)</i>	<i>Tim</i>	<i>Sun</i>	<i>Day</i>
<i>3-24-10</i>	<i>Rector/Debility</i>	<i>Nausea/Vomiti ng</i>	<i>Barnes</i>	<i>Nancy</i>	<i>Wed</i>	<i>Night</i>
<i>3-26-10</i>	<i>Beam/Hip Fx</i>	<i>SOB</i>	<i>Barnes</i>	<i>Steve</i>	<i>F</i>	<i>Night</i>
<i>4-3-10</i>	<i>Martin/CVA</i>	<i>A-Fib</i>	<i>Baily (MD Partner)</i>	<i>Pat</i>	<i>Sat</i>	<i>Day</i>
<i>4-13-10</i>	<i>Ball/Cardiac</i>	<i>Chest pain</i>	<i>Pyles</i>	<i>Tim</i>	<i>Tu</i>	<i>Day</i>
<i>4-18-10</i>	<i>Zappo/Debility</i>	<i>Wound dehiss</i>	<i>Stein (MD partner)</i>	<i>Julie</i>	<i>Sun</i>	<i>Day</i>
<i>4-22-10</i>	<i>Brea/Hip Fx</i>	<i>DVT</i>	<i>Barnes</i>	<i>Nancy</i>	<i>Th</i>	<i>Night</i>
<i>5-4-10</i>	<i>Dankin/ Cardiac</i>	<i>CHF</i>	<i>Pyles</i>	<i>Tammy</i>	<i>T</i>	<i>Day</i>

- Brake down further into diagnostic and/or complicating factors to gain further insight into IRF practices.



- Steps to evaluate Medical Transfers to Acute
 1. Determine overall percentage of patients medically transferred to acute
 2. Create tracking tool to capture the specific data desired
 3. Evaluate trends in data obtained
 4. Determine education needs
 5. Evaluate need for process change or program enhancement
 6. Implement 1-2 strategies to reduce transfers to acute

Re-admission to Short Term Acute Hospital within 30 Days



- On a national basis, approximately 18 percent of hospitalized Medicare patients are re-hospitalized within 30 days.
- Medicare and non-Medicare recipients as a whole have a slightly lower recidivism rate, in the range of 14-19%
- Up to 50% of acute care re-admissions within 30 days are considered preventable
- This recidivism rate is foremost in the regulatory discussions surrounding healthcare reform

- As the government begins to evaluate options of reducing healthcare costs, a couple different models are strongly favored by MedPAC.
- MedPac has recommended that hospitals with high readmission rates for certain conditions be assessed a penalty
- MedPac has also recommended a bundled payment system

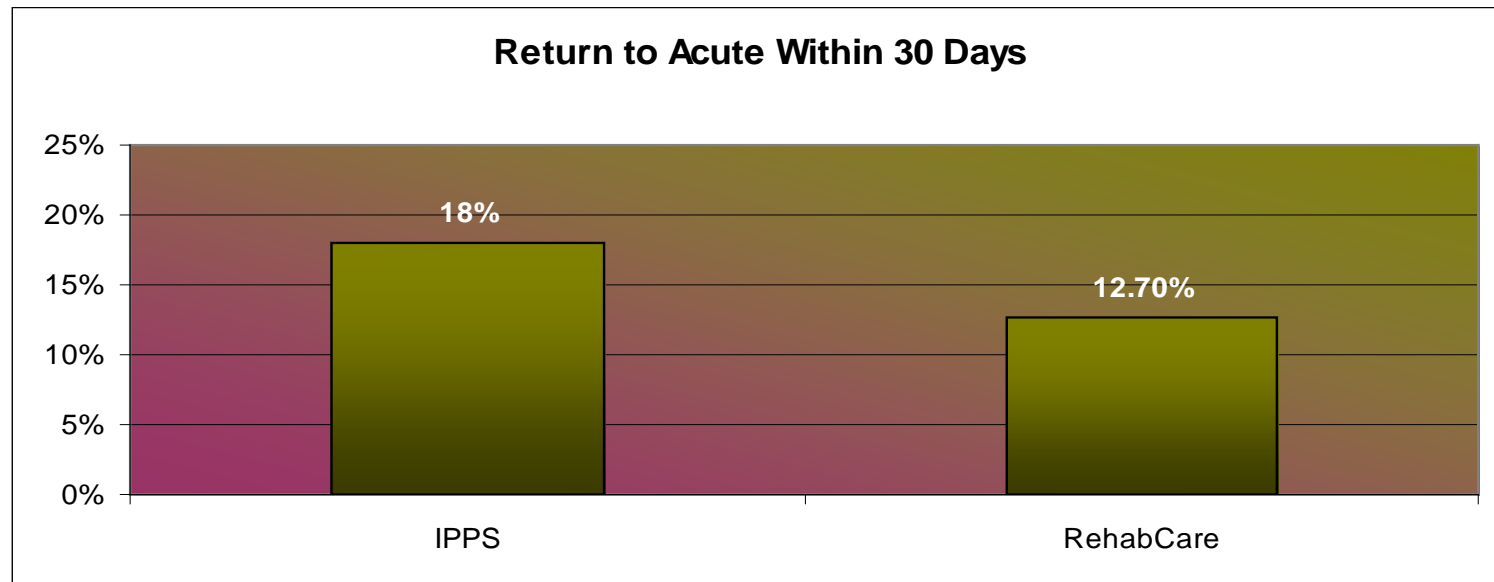


- What might a bundled payment style of plan look like?
 - The acute care hospital might become the gatekeeper of a patient's post acute services?
 - The hospital might receive a higher reimbursement?
 - The hospital might be responsible for payment of the post acute care services used?
 - Post acute care services might be provided by the hospital or by an agency under a contractual agreement with the hospital?

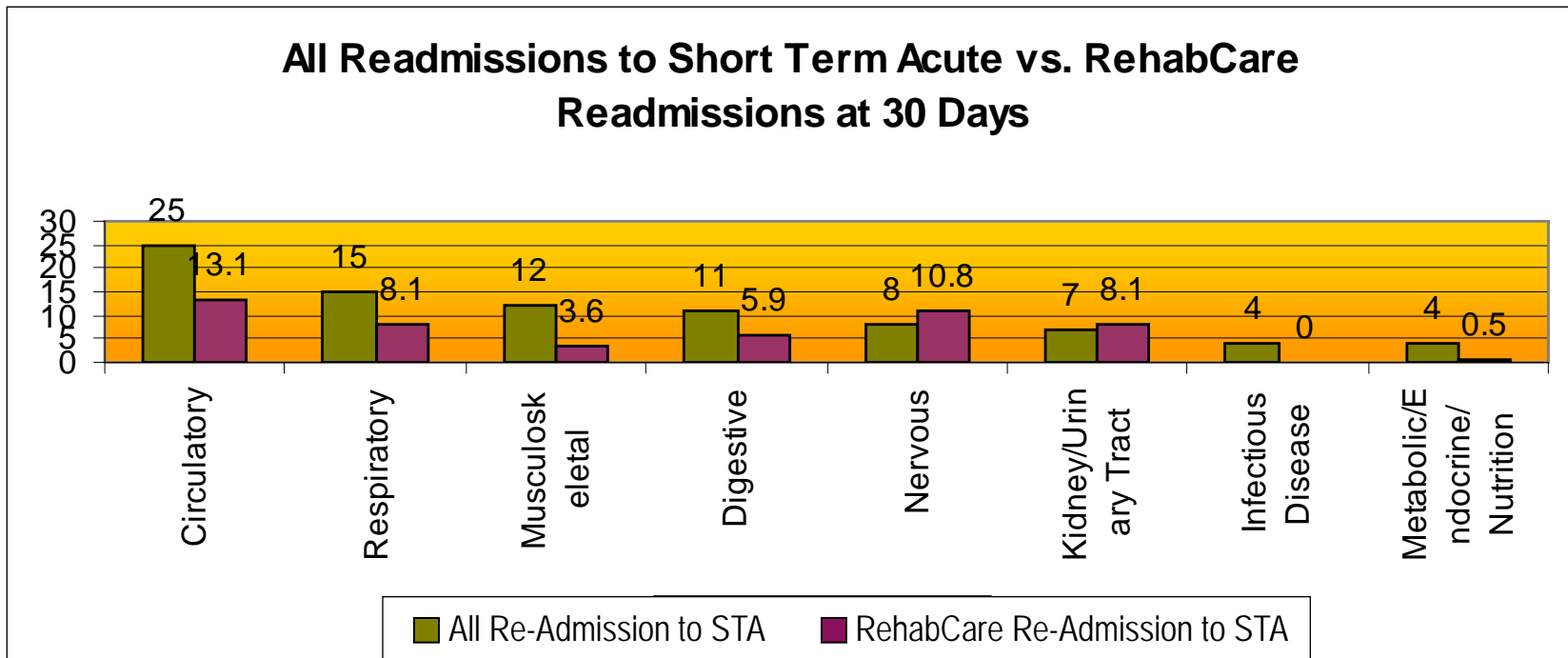
- At this point, no one suggestion has been adopted by the Congressional Budget Office
- Even in state of flux, IRFs should begin to evaluate their recidivism rate, and develop a plan to educate hospitals, physicians, and insurance companies on how they compare to alternate post acute venues.

- Currently there is very little available information regarding return to short term acute following an IRF discharge
- RehabCare has begun a preliminary look at this issue.
- The analysis was not comprehensive and was based on a limited number of sites.

- An preliminary analysis of re-admission to acute within 30 days of discharge from RehabCare's Inpatient Rehab Facilities was conducted.
- 1749 patients, discharged between March and July, were contacted between 30 and 60 days post discharge. (10%)
- Of these patients 222 had been readmitted to the acute care hospital within 30 days of discharge from the IRF (12.7%)



- The reasons for Short Term Acute re-admissions within 30 days of discharge from IRFs were evaluated and compared to ALL re-admissions to the acute care hospital in a similar time frame



- What does this preliminary analysis tell us about re-admission patterns of patients discharged from RehabCare IRFs?
 - Patients from IRF have a lower re-admission rate to acute at 30 days than patients discharged from a short term acute care hospital
 - The diagnostic categories of those readmitted to acute at 30 days are quite similar to hospital admissions as a whole
 - There is a slightly higher risk that IRF patients will be re-admitted with problems associated with the nervous system or kidney/UTI difficulties.

- Though the preliminary data indicates IRF patients have a lower return to acute rate than Short Stay Acute Care patients, there are still indications that can be addressed as part of the IRF process.
 - Patient/family Education
 - Coordination of care across service line
 - Provider to provider communication
 - Discharge Planning

- Patient Care
 - Inpatient Rehab Facilities have a unique opportunity to provide patient and family with increased education to help prevent avoidable re-admissions
 - Medications
 - Lifestyle Changes
 - Family/Caregiver training

- Better coordination of Follow-up Care
 - Studies have shown that half of all re-admitted Medicare patients had not seen their primary care or specialist for follow-up since their first hospitalization
 - Assist with setting follow-up physician visits
 - Identify the person responsible for coordinating and ensuring follow-up care. Make sure they understand discharge and follow-up instructions
 - Portable Medical Passport
 - Encourage physician to physician communication at discharge
 - Follow-up phone call to patient within one week of discharge

- Use outcome information in marketing for appropriate placement in the continuum of care
 - Discharge Planners
 - Physicians
 - Families
- Use outcome information to educate persons who will potentially influence use of post-acute services
 - Hospital Administrators
 - Discharge Planners

Summary for Re-admission to Acute within 30 Days

- Establish a system to determine your unit's rate of return to short term acute within 90 days of discharge
- Use the information to improve referral trends
- Use the information to establish buy-in from hospital “gatekeepers” in the event of bundling
- Implement unit processes that will help prevent re-admission to acute care