



Long-Term Care is a Critical Partner for Reducing Hospital Readmissions

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Although there's been a decrease in length of stay and mortality among heart failure patients, it has been accompanied by a rise in readmissions according to the authors of "Trends in Length of Stay and Short-term Outcomes Among Medicare Patients Hospitalized for Heart Failure, 1993-2006," which appeared in the June 2, 2010 edition of the *Journal of the American Medical Association*. However, a recent Treo Solutions' analysis shows that this is only part of the story—evidence points to the increase in readmissions being driven, in part, by the changing nature of long-term care and the increasing complexity of today's skilled nursing facility patients.

Our analysis reinforces the need to consider long-term care as an integral part of any improvement initiative—whether focused on reducing readmissions or preparing for accountable care initiatives such as ACOs, medical homes, and bundled payments.

The Treo Solutions analysis looked at heart failure (HF) patients, 65 years and older discharged from New York hospitals in 2007 (APR-DRG 194). Discharges for heart failure patients were 5.3% of all inpatient discharges for persons 65 and older, with 21 percent of these patients being discharged to skilled nursing facilities (SNFs). It is this population that is experiencing higher rates of both hospital readmissions and length of stay than patients who were discharged home. Our analysis, which used 3M Health Information Systems™ All Patient Refined-DRGs and Potentially Preventable Readmissions (PPRs), shows that readmission rates for HF patients discharged to SNFs increased with severity level, with a 40% readmission rate for SNF patients in Severity Level 4.

Readmission Rates (PPRs) and Length of Stay for Heart Failure Patients, 65+ NYS, 2007				
Patient Discharge Status	Readmission Rate For Discharges From		Length of Acute Stay (days) For Discharges To	
	Home	SNF	Home	SNF
All Heart Failure	24.87%	32.09%	5.15	8.65
Severity Level 1	18.00%	25.69%	3.43	5.61
Severity Level 2	24.67%	28.75%	4.6	6.65
Severity Level 3	28.76%	35.02%	6.9	9.69
Severity Level 4	33.13%	40.14%	12.06	16.21

The issue here is not that acute care discharges for medical cardiac patients are being rushed out of the hospital into nursing homes. In fact, a look at length of stay (LOS) shows that the average LOS for heart failure discharges to SNFs is longer than for those discharged to home, and this holds true within all severity levels. Indeed heart failure patients discharged to nursing homes are in the hospital an average of nearly 3.5 days longer than other discharged heart failure patients.

The Treo analysis highlights that issues like Potentially Preventable Readmissions are not just a hospital problem—they are a system problem that must be addressed by all providers in all settings. Together, SNFs, hospitals, physicians, and other providers will need to identify and then address the underlying reasons for PPRs. In particular, for heart failure patients, the hospital discharge follow-up and SNFs need to be prepared to deal with the key reasons for Potentially Preventable Readmissions for patients admitted to the SNF following a heart failure hospitalization. In this case, the top three diagnostic categories for PPRs returning to a hospital from a SNF are: cardiac, respiratory, and infection-related problems. The reasons for those returns may be found in discharge and follow-up processes, care capacity and quality in the SNF, and the patients' disease progression.

Just as Diagnosis Related Groups (DRGs) drove many changes in acute care, reimbursement policies are driving changes in long-term care—most notably the growth of short stay admissions and overall clinical complexity of all SNF residents over the last two decades. These changes will continue to impact performance improvement initiatives related to readmissions and other preventables as well as strategies for succeeding in the era of accountable care.

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About Treo Solutions

Treo Solutions is an innovative health care business intelligence firm that works with health care payers and providers to develop and implement data-driven strategies for strengthening financial performance, improving quality care and outcomes, and managing population health. Based on decades of experience, and in partnership with 3M Health Information Systems™, Treo built a powerful and flexible analytics service that offers health care organizations the actionable information they need to understand and impact their costs of doing business.