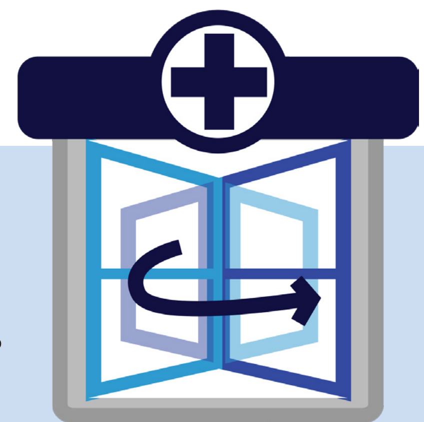
# Skilled Nursing Facility Resident Rehospitalization Tip Sheet

## Measure Overview

- The skilled nursing facility (SNF) readmission measure estimates risk-standardized rate of all-cause, unplanned hospital readmissions of Medicare SNF beneficiaries within 30 days of discharge from their prior proximal acute hospitalization.
- Hospital readmissions are identified through Medicare claims. Readmissions within a 30-day window are counted regardless of whether the beneficiary is readmitted to the hospital directly from the SNF or has been discharged from the SNF.
- These are risk-adjusted based on patient demographics, principal diagnosis in prior hospitalization, comorbidities, and other health status variables that affect probability of readmission and excludes planned readmissions since these are not indicative of poor quality.
- This measure will be a part of the new Value-Based Purchasing program from Medicare. For more information, visit: https://goo.gl/JBMSjn
- Hospitals and other acute care providers currently track SNF rehospitalization rates to ensure quality of life/care during transfers from one care setting to another.
- The State Survey and Certification Agency pays attention to rehospitalization under Ftag 483.12: Admission, Transfer, & Discharge.

## How to Find Your Measure

- Contact Health Services Advisory Group (HSAG) for an in-depth analysis of your resident rehospitalization score.
- Keep a running log of your discharges/hospitalizations. Remember this data is not official nor risk-adjusted. If you like you can use the Interventions to Reduce Acute Care Transfers (INTERACT) Transfer Log.
- You can access your rehospitalization score through the CASPER system. Use HSAG's *Accessing Official Rehospitalization Data Tip Sheet* to help you determine your rate. Available at: https://goo.gl/voeVr4



## Ask These Questions ...

**In the pre-admission process:**

- Do you have a listing of services/capabilities to ensure your facility meets the specific acuity level of the resident?
- Are the hospital discharge instructions complete and include advance directives?
- Does your facility have a process in place to ensure readiness for admissions?

**In the post-admission process:**

- Are you doing quality rounding for at least the first 7 days? Is upper management involved?
- Are nurses proficient in clinical assessment skills? How do you educate your staff members?
- Are you using Situation, Background, Assessment, Recommendation (SBAR) or an equivalent system to ensure proper/informed communication?

**In the discharge planning process:**

- Are you starting the discharge process upon admission? Is it interdisciplinary?
- Are you properly discharging residents with clear/concise instructions?
- Is social services completing a post-discharge follow-up to ensure resident well-being?

**Should I reference the INTERACT program to help me address these questions?**
INTERACT is a quality improvement program that focuses on the management of acute change in resident condition. It includes clinical and educational tools and strategies for use in every day practice in long-term care facilities.

**For more rehospitalization resources, visit the HSAG website at www.hsag.com/snf-cc-resources**

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