Avoiding Rehospitalizations in LTC
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Objectives

• Understand the new consequences to hospitals for discharged clients being re-admitted within selected time parameters

• Develop quality management tools to track and trend new SNF admissions who return to the hospital

• Review the use of tools and resources to prevent resident re-hospitalizations
The Accountable Care Act (ACA)

Improving Care after Hospitalizations to Reduce Readmissions

• Nearly 18 percent of hospitalizations of Medicare beneficiaries are the result of the readmission of patients who had been discharged from the hospital within the previous 30 days.

• Sometimes the readmission could not have been prevented, but many of these readmissions are avoidable with better discharge planning and follow-up care.
How ACA Will Help

• To improve this situation, hospitals will receive bundled payments covering not just the hospitalization, but care for the 30 days after the hospitalization.

• Hospitals with high rates of readmission will be paid less if patients are re-admitted to the hospital within the same 30-day period.
Furthermore

- This combination of incentives and penalties should lead to better care after a hospital stay and result in fewer readmissions – saving roughly $25 billion of wasted money over 10 years.

Whitehouse.gov
Improving Medicare and Medicaid Payment Accuracy

• The Government Accountability Office (GAO) has labeled Medicare as “high risk” due to billions of dollars lost to overpayments and fraud each year.

• The Centers for Medicare and Medicaid Services (CMS) will address vulnerabilities presented by Medicare and Medicaid, including Medicare Advantage and the prescription drug benefit (Part D).
Hoped-For Results

CMS will be able to respond more rapidly to emerging program integrity vulnerabilities across these programs through an increased capacity to identify excessive payments and new processes for identifying and correcting problems.

Whitehouse.gov
Pay for Performance

Expanding the Hospital Quality Improvement Program

• The health care system tends to pay for quantity of services not quality.

• Experts have recommended that hospitals and doctors be paid based on delivering high quality care, or what is called “pay for performance.”

Whitehouse.gov
Raising the Bar

- The President’s Budget will link a portion of Medicare payments for acute in-patient hospital services to hospitals’ performance on specific quality measures.

- This program will improve the quality of care delivered to Medicare beneficiaries, and save over $12 billion over 10 years.

Whitehouse.gov
• The new law provides incentives for physicians to join together to form “Accountable Care Organizations.”

• In these groups, doctors can better coordinate patient care and improve the quality, help prevent disease and illness, and reduce unnecessary hospital admissions.
Benefits of Saving

If Accountable Care Organizations provide high quality care and reduce costs to the health care system, they can keep some of the money that they have helped save.
First regulation effective October 1, 2012

• Health care remains one of the few industries that relies on paper records.

• The new law institutes a series of changes to standardize billing and requires health plans to begin adopting and implementing rules for the secure, confidential, electronic exchange of health information.
Using electronic health records will reduce paperwork and administrative burdens, cut costs, reduce medical errors and, most importantly, improve the quality of care.
SNF will provide enhanced clinical services

- Nurse Practitioners and Physician’s Assistants in SNF
- Support transitions between hospital and SNF
- Implement best practices to prevent re-hospitalizations caused by:
  - Acute myocardial infarctions
  - Pneumonia
  - Heart Failure
Expected Outcomes - Financial Goals

Implementation Plan:

Year 1: reduce Medicare payment to hospital by 1%

Year 2: reduce up to 2%

Year 3: reduce up to 3%

More diseases/conditions will be added to the list over time

- Acello, Barbara "Ending Hospital Readmissions A Blueprint for SNF’s" HCPro Copywrite March 2011
OIG Compliance Plan 2012: Address Rates of Adverse Events & Preventable Readmissions

There are many ways to work together
Safety & Quality of Post Acute Care

Focus on the transfer process from acute care to post-acute care facilities

Communication & cooperation between skilled nursing facility & other post-acute venues during discharge process directly impacts on the safety & success of the transfer

Office of Inspector General (OIG)
Hospitals Rely on Transfer Success

• Hospitals will want to work with facilities that readmit less often to avoid losing reimbursement

• This means more than just taking what comes

• What can you do to become a trusted partner?
Hospitals are tracking Nursing Facility readmission rates

# of residents re-hospitalized
(within 30 days of admission to the nursing facility)

\[ \frac{5}{25} = 0.2 \]
\[ 0.2 \times 100 = 20\% \]
Determine your equal to or less than 30 day current readmission rate and details regarding diagnoses and reasons for re-admissions

Look for areas of improvement and trends

• Why are readmissions happening?
• Analyze each one for ideas regarding how it could have been prevented...
Causes Determine Solutions
• Start now
  – Learning needs assessment
  – Your 24-Hour Report format & effectiveness
  – Process barriers
  – Whiteboard
  – Morning meeting
  – Continuous risk management
• Review and re-educate clinical skills

• Teach new skills to accept sub-acute patients

• Find out your community post acute needs & develop services

• Train and use tools to cue, document and report

• Interact II

• Hospital-created tools

• Evidence-based research
Is Early Identification a Problem?

- Are assessments prompt and complete?

- Do you know baseline parameters for the individual?

- Do staff know what to look for?

- Have you communicated with resident and family about signs of change to report?

- Is your staff customer service oriented?

**USE AN EARLY WARNING TOOL**
Communication Tools

• How are changes reported and investigated?
• Is physician/ extender notification timely?
• Anticipate the weekend – review at-risk residents daily
Are Weekends a Problem?

Ask WHY - Common causes include:

- Changes in MD coverage - alternate unfamiliar with resident
- Nurse Practitioner less available
- Unfamiliar weekend staff
- Staffing levels
- Assessment skill levels – fewer nursing leadership staff available for direction & decision making
Is there trust in the skills of corresponding staff? If not, WHY?

Common causes include:

• Lack of assessment skill
• Lack of thorough communication of details and analysis at facility level
• Call without data accessible to answer questions
Resident and Family

- Incomplete advance directives
- Lack of trust in facility staff
- Poor communication of options
- Uninformed about risks/benefits
- Unresolved acute care or transition problems

Cover all bases with family in person or by phone – find out fears and expectations
Patient Unstable at Time of Transfer?

Common issues

• Temperature of unknown or unresolved origin
• Constipation unresolved by time of transfer
• Pre-transfer medical oversight issues
• Lack of on-site observation and discussion with acute care staff

Work with hospital directly to iron out issues
• Share findings of readmission rate and identified causes

• Plan for improvement at facility level

• Each factor suggests a solution
• Review diagnoses and reasons, as well as parameters with physician

• Guessing which diagnoses medications are prescribed for is dangerous

• Correspond assessment with medications
  – Effects, side effects
  – Potential interactions
  – Order pertinent laboratory tests
  – Ask patient & family for feedback
  – Monitor conditions
  – Anticipate risks
Get It Together

• Establish a core committee
• Develop and reinforce communication with referral sources
• Establish your mutual goals – patient stability and management without readmission to hospital
• Meet face to face to identify what each of you need to do to make it happen
TEAMWORK

• Can Medical Director, other physicians or extenders assist with training?

• Can Hospice help with training?

• Should more complex services be added to facility scope?

• Partner with Acute care to share skills

• Obtain literature for patient, family and staff education

• Don’t forget dialysis and other out patient clinics

• Healthcare can be a very small world
Use SBAR Format

• **Situation** – status of conditions (changes) and what prompted notification, interventions thus far, patient response

• **Background** - vital signs, system review, labs, meds, allergies, etc. & advance directives

• **Assessment or Appearance** – Sum up what is happening, what findings suggest

• **Request** – What should happen next

*Don’t wait for critical events to use SBAR*
• Use residents as case studies to debrief and learn

• When changes occur, regardless of perceived emergency, do thorough assessment

• Use tools such as SBAR routinely
IF Emergency Transfer is Necessary

- Use transfer form preferred by hospital if possible
- Call for status/follow up
- Send more information if requested
- Read everything upon return
- Look for commentary on condition upon arrival to ED
CMS supported study – Quality assurance logs and analysis tools

Tools and guidelines to assist in reducing re-hospitalizations

- Early identification of changes in condition
- Assessment guidelines and decision trees
- Transfer data communication tools
- Advance directives educational materials for staff and patients and their families

http://www.interact2.net/
Use the INTERACT Tools Daily

- ADVANCED CARE PLANNING TOOLS
- TRANSFER CHECKLIST (Envelope)
- RESIDENT TRANSFER FORM
- QUALITY IMPROVEMENT TOOL FOR REVIEW OF ACUTE CARE TRANSFERS
- CARE PATHS
- ACUTE CHANGE IN CONDITION File Cards
- SBAR Form & Progress Notes
- EARLY WARNING “Stop and Watch Tool”

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How Do I Make This Happen?
Pathway Health Services can provide assistance onsite or from afar!

- HRRP (Hospital Readmission Reduction Program) Readiness Assessment
- Hospital Re Admission Consultation – from A to Z
- Onsite education (customized)
- Web based Facility Consultation
- Upcoming Webinars
The Road to Success Is Almost Always Under Construction
Resources

- [http://www.whitehouse.gov/healthreform/downloads](http://www.whitehouse.gov/healthreform/downloads)
- [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html?redirect=/ACO/](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html?redirect=/ACO/)
- [http://interact2.net/](http://interact2.net/)
Thank You!

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