Reducing Readmissions
How to Prepare Your Team

Susan LaGrange, RN, BSN, NHA
Director of Education
Pathway Health
Objectives

1. Describe the consequences to skilled nursing facilities with hospital readmissions

2. Verbalize key facility implementation factors that can assist in positive positioning with strategic partners

3. Identify how to proactively put a plan in place to prepare your team for success
Challenges – Post Acute Care

• Government Unrest
• Reform of Health Care as we know
• Reimbursement Changes
• Increased Costs
• Regulatory Changes
• External Oversight
Reform Health Care

• Decrease Costs
• Decrease Reimbursement
• Increase Quality
• Increase Access
Patient Protection and Affordable Care Act (PPACA)

- Signed into effect March 23, 2010
- Reform Private Insurance
- Reform Public Insurance
- Improve coverage to those with pre-existing conditions
- Expand access to care
- Reduce long term costs of health care
Accountable Care Act (ACA)

• Increase access for healthcare
• Decrease high costs of Medicare and Medicaid
• Improve efficiency and effectiveness of Medicare and Medicaid
• Increase HCBS (home care based services)
Accountable Care Act (ACA)

- Link reimbursement to quality outcomes
- Move from Fee for Service to Bundled Payment methods
- Person Centered Care
- Consumer engagement and access to data
Quality + Value = Lower Cost

Start 2010

Arrival 2015 and beyond
Initiatives in motion

- Hospital Readmission Reduction Program
- Fraud and Abuse
- QAPI
- Corporate Compliance
- Bundle Payment Demonstration
- Community Based Services
- Enhancing Patient Safety
• Sustainable Growth Rate – SRG
• “Doc” fix – repeals the 24% cut for Physicians
• Extension of Therapy Caps
• Extension of the two –midnight rule for acute care
• Skilled Nursing Facility Readmission Measure (10/1/15 – All Cause All condition hospital readmission factor) must be specified by the Secretary phase in 2016 and beyond
• Public Reporting of SNF – Readmission and other performance measures
Section 215, Skilled Nursing Facility Value-Based Purchasing:

“(1) READMISSION MEASURE,-Not later than October 1, 2015, the Secretary shall specify a skilled nursing facility all-cause all-condition hospital readmission measure (or any successor to such measure)”

“(2) RESOURCE USE MEASURE.- Not later than October 1, 2016, the Secretary shall specify a measure to reflect an all condition risk-adjusted potentially preventable hospital readmission rate for skilled nursing facilities.”
• Beginning October 1, 2016, and with each quarter thereafter, the Secretary will provide confidential feedback reports to SNF’s on the performance of the Readmission Measure.

• Public reporting: the Secretary will establish procedures for public reporting of the measures on Nursing Home Compare.

• SNF’s will have opportunity to review and submit corrections prior to information becoming public.
You can access H.R. 4302 at:

http://www.gpo.gov/fdsys/pkg/BILLS-113hr4302enr/pdf/BILLS-113hr4302enr.pdf
Assess Organizational Readiness

Assess Organization Systems

– Corporate Programs and Outcomes
– Facility specific protocols

• Assess need to change
• Benchmark internal systems for review
  – Current status
  – Industry standards
  – Best practice approach
• Identify opportunities
Assess Organizational Readiness

• Assess Clinical Readiness
  – Your Role
  – Industry initiatives
  – Market initiatives and expectations
  – Quality Outcomes
    • Payer and External Expectations
    • Consequences
  – Internal competency process
  – Right People and Right Roles
Medicare spends
– > $25 billion/year on unnecessary readmissions from SNFs and other post-acute care providers
– About 18% of all Medicare hospitalizations are “re-hospitalizations.”
  • Being admitted to the same or to a different hospital within 30 days of discharge, for certain applicable conditions

Goal
– Reduce hospital readmission rates
  • Reduce rates by 25% and save over $2 billion annually
If You Remember……..Effective October 1, 2012

• Diagnoses and conditions
  – 258 reviewed
  – First 3 to be monitored
    • Heart Failure (CHF)
    • Pneumonia
    • Heart Attack (AMI)
  NOW
  • Septicemia
  • UTI

FUTURE: All-Cause
CMS will recover/reduce payments for readmissions

- 2013 – up to 1% total Medicare billings
- 2014 -- up to 2%
- 2015 – up to 3%
- www.medicare.gov/hospitalcompar/search
• For fully integrated providers that form accountable care organizations—teams of providers that coordinate care—payments will be bundled to cover all of a patient’s care

• But for most providers—which are not integrated—payments must be bundled for an episode of care, with providers dividing the payment among themselves

Accountable Care Organizations

• Variety of Health Care Providers working together
  – As a Group – Accountable for the quality and the $$ of care
  – Quality outcomes will be rewarded
• Will choose providers wisely
• Will evaluate your quality data

Goal: Better Outcomes at a Lower Cost
CMS Action Plan 3 Part AIM:

1. Improving the individual experience of care;
2. Improving the health of populations; and
3. Reducing the per capita cost of care for populations.

Office of Inspector General
MEDICARE NURSING HOME RESIDENT HOSPITALIZATION RATES MERIT ADDITIONAL MONITORING

November 2013

Findings

• FY 2011: ¼ of Medicare Residents transferred to hospitals for inpatient admissions
• Medicare spent $14.3 billion on those hospitalizations
• Septicemia most common reason
Recommendations

OIG recommended to CMS (and CMS concurred):

1. develop a quality measure that describes nursing home resident hospitalization rates

2. instruct State survey agencies to review the proposed quality measure as part of the survey and certification process
Work Plan for Fiscal Year 2014:

### Medicare Part A and Part B

- **Hospital-Related Policies and Practices**
  - Reconciliation of outlier payments
  - New inpatient admission criteria (new)
  - Medicare costs associated with defective medical devices (new)
  - Analysis of salaries included in hospital cost reports (new)
  - Impact of provider-based status on Medicare billing
  - Comparison of provider-based and free-standing clinics (new)
  - Critical access hospitals—Payment policy for swing-bed service
  - Critical access hospitals—Beneficiary costs for outpatient services
  - Long-term-care hospitals—Billing patterns associated with interrupted stays

- **Hospitals—Billing and Payments**
  - Inpatient claims for mechanical ventilation
  - Selected inpatient and outpatient billing requirements
  - Duplicate graduate medical education payments
  - Outpatient dental claims
  - Outpatient evaluation and management services billed at the new patient rate (new)
  - Nationwide review of cardiac catheterization and heart bypass (new)
  - Payments for patients diagnosed with HIV/AIDS (new)
  - Bone marrow or stem cell transplants (new)
  - Indirect medical education payments (new)

- **Hospitals—Quality of Care and Safety**
  - Participation in projects with quality improvement organizations
  - Oversight of pharmaceutical compounding (new)
  - Hurricane Sandy—Case study of hospital’s emergency preparedness and response (new)
  - Oversight of hospital privileging (new)
  - Insufficient rehabilitation facilities—Adverse events in post-acute care for Medicare beneficiaries

- **Nursing Homes**
  - Medicare Part A billing by skilled nursing facilities (new)
  - Questionable billing patterns for Part B services during nursing home stays
  - State agency verification of deficiency citations
  - Program for national background checks for long-term-care employees
  - Hospitalizations of nursing home residents for manageable and preventable conditions

- **Hospices**
  - Hospice in assisted living facilities (new)
  - Hospice general inpatient care

- **Home Health Services**
  - Home health prospective payment system requirements
  - Employment of individuals with criminal convictions
Reducing Hospital Readmissions will benefit facilities by:

• Promoting a quality system
• $$$$$$
• Regulatory compliance
• Impressions: How other entities view you! (and possibly choose to work with you)
• It is the right thing to do
Key Facility Implementation Strategies: Successful Planning
Key Steps

• Begin a Quality Assurance/Performance Improvement project on re-hospitalization
• Begin gathering and analyzing data
• Identify trends
• Search for gaps in care
• Review any advanced care planning steps
Operations

- Weak QA&A
- Head in the Bed Mentality
- MD's refuse calls after 10 pm
- No transitional planning
- Staff don't know how to use equipment
- Respiratory equipment broken
- Medical equipment not always on site

Supplies and Equipment

- No Scope of Care Policy
- SS behind in advance directives
- Outdated assessment forms
- Improper use of 24 hour report

People Human Resources

- No competency training on top Dx
- RN costs not in budget
- High turnover on 3-II
- New DON from out of area

Methods Policies and Procedures

Rehospitalization
Comprehensive Communication
Coordination of Care
Resident/Family Teaching with evidence of understanding
Will work towards:
- Decreased chance of medication errors
- Hospital readmissions

GREAT resource-AMDA Clinical Practice Guideline: Transitions of Care in the Long-Term Care Continuum:

https://www.amda.com/members/flashpapers/papers/TOC/
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 enough data accessible to answer questions
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
INTERACT Program

- Designed to improve the quality of nursing home care
- Provides tools, resources to staff to reduce avoidable acute care transfers
- Supported by Centers for Medicare and Medicaid Services
- Early identification of change in resident status
- Improved documentation
INTERACT Program

• Enhances communication
• Guides nursing home staff when there is a change in the resident status
• Provides an opportunity to improve quality of care
• Advanced care planning

http://interact2.net/
Successfully integrate a system to improve care.

• Reduce hospital admissions when possible
• Develop a win-win relationship with strategic partners
• Utilize system management for marketing strategies
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
• Medical Director to assist with training
• Facility review of Interact clinical pathways
• Pharmacy management and training on high risk medications
• Additional education provided by Lab, therapy, or physician extenders
• The complexity of services provided and the skill level of nursing
• SBAR was developed by our United States Navy
• Submariners use this communication tool.
• It was adopted by the airline industry after investigations of crashes in the 70’s showed the main cause was a breakdown in communication between the pilots in the cockpit
• Works well in their stressful, time-critical, emergency situations
The SBAR technique provides a framework for communication between members of the health care team about a patient's condition. It allows for an easy and focused way to set expectations for what will be communicated and how between members of the team, which is essential for developing teamwork and fostering a culture of patient safety.
• The situation describes the problem
• It is a to-the-point punch-line
• Communicated in 5-10 seconds to get the attention of the receiver
• Included are:
  – Identification of yourself – your name and unit
  – Patient’s name, physician, and room number
  – Brief and to-the-point statement of your concern
Prior to calling the physician

- Have I seen and assessed the patient myself before calling
- Has the situation been discussed with resource nurse or nurse manager
- Review the chart for appropriate physician to call
- Know the admitting diagnosis and date of admission
- Have I read the most recent MD progress notes and notes from the nurse who worked the shift ahead of me
Have available the following when speaking with the physician:

- Resident chart
- List of current medications, allergies, IV fluids, and labs
- Most recent vital signs
- Reporting lab results: provide the date and time test was done and results of previous tests for comparison
- Code status AND Advance Care Planning Decisions
Once Again - When calling the physician:

**Situation:** What is the situation you are calling about?

- Identify self, unit, patient, room number
- Briefly state the problem, what is it, when it happened or started, and how severe
**Background:** Pertinent background information related to the situation could include the following:

- The admitting diagnosis and date of admission
- List of current medications, allergies, IV fluids, and labs
- Most recent vital signs
- Lab results: provide the date and time test was done and results of previous tests for comparison
- Other clinical information
- Code status
• **Assessment**: What is the nurse’s assessment of the situation?
• Be precise on the assessment
• Review the advanced care plan
• **Recommendation**: What is the nurse’s recommendation or what does he/she want?
  • Examples:
    • Notification that patient has been admitted
    • Patient needs to be seen now
    • Order change
The Benefits of SBAR

• (SBAR) provides a standardized way of communicating
• It promotes patient safety through efficient and accurate communication
• It helps facilitate a shared set of expectations
• Staff and physicians can use SBAR to share patient information in a concise and structured format
Why Physicians Like SBAR

• The nurse gets straight to the point
• It has essential pieces of information
• The guessing game is eliminated
• Nurses are trained to write care plans more
• Narrative in nature. Physicians, however, are trained to use “headlines” or bullet point notations
• SBAR gets to the point
First Steps with Implementation

- Review your current communication systems
- Complete an analysis of problem areas with the current communication
- Review your current documentation systems
- Identify any opportunities for improvement prior to initiating the SBAR form
First Steps with Implementation

• Take the opportunity to participate in daily report and shift to shift report for at least 7 days on all shifts
• Review the 24-hour report
• Complete walking rounds with the nursing assistants
• Develop an interdisciplinary team of nurses from all shifts to review the current gaps in communication
Steps to Put an Effective Plan in Place
Determine which tools you will use
  – Facility Specific designated tools

Staff Education

Implementation of Program

Evaluation
Policy and Procedure

• From Preadmission to Discharge!
  – Assessment Forms (Preadmission -> Discharge)
  – Monitoring requirements
  – Staff Training
  – Care Planning
  – Documentation
  – Notifications
Auditing Tools

• Preadmission Audits
• Admission Documentation Audits
• Assessment Audits
• Re-hospitalization Root Cause Audits
• Documentation Audits
• Care Planning Audits
Quality Mapping

• Assess need to change
• Benchmark internal systems for review
  – Current status
  – Industry standards
  – Best practice approach
• Identify opportunities
<table>
<thead>
<tr>
<th>AREA OF CONCERN</th>
<th>RECOMMENDATIONS</th>
<th>GOAL DATE</th>
<th>RESPONSIBLE PERSON</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lung Assessment not completed with resident s/s</td>
<td>1. Nurse re-educated in assessment process with return demonstration of lung</td>
<td>8/5/14</td>
<td>DON or Nurse Manager</td>
</tr>
<tr>
<td>“productive cough” (Pneumonia dx)</td>
<td>assessment process with return demonstration of lung assessment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Nurse re-education in documentation requirements.</td>
<td>8/5/14</td>
<td>DON or Nurse Manager</td>
</tr>
<tr>
<td></td>
<td>3. Follow up review of assessment and documentation each shift</td>
<td>Beginning 8/5/14</td>
<td>DON or Nurse Manager</td>
</tr>
</tbody>
</table>
Quality Mapping

- Training Plan
  - Educate all levels
  - Why change is needed
  - Process changes
  - Roles and Responsibilities
- Measurement and Communication of Success
- Not a “quick fix”
Develop quality strategy

• Goals
  • Prioritize
  • Impact
• Systems and tools needed to change processes
• Resources applied or needed
• Time frames
• Approval/Agreement
Together, Quality Assessment and Process Improvement provide the model for:
  • effective problem identification
  • root cause analysis
  • system and culture changes

Establish care delivery improvements to realize healthcare consumer defined goals.
Establish Leadership Accountability

Establish commitment of:

• Executive leadership, including the board of directors in non-profit homes, owners of other homes, and the directors of publicly traded nursing homes

• Corporate leadership personnel set a climate and provide resources to help leadership flourish in each home
QAPI Must Include:

- Ongoing & organized use of data and feedback from multiple sources
- Approach to early problem identification
- Root Cause Analysis
- Performance Improvement projects
- Understanding how systems of care might affect quality outcomes
- Systemic Action
- Involvement of all staff in quality mission
  - University of MN, Division of Health Policy and Management and Stratus Health
Rewards of QAPI

• Competencies that equip you to solve quality problems and prevent further occurrences
• Competencies that allow you to seize opportunities to achieve new goals
• Staff fulfillment when goals are achieved
• Better Care for residents
• Better quality of life for residents

  University of MN, Division of Health Policy and Management and Stratus Health
Keep the Team Informed

• Celebrate small successes
• Post the data
• Keep accountability by ongoing review
• Develop a standard of excellence
HR 4302

- Value-Based Incentive Payment Percentage
- Based on “the SNF performance score of the skilled nursing facility”
- Value-based incentive payment

Quality Performance Standards = $$

**Hospital Readmissions will be part of this!**
In Summary:

- Prepare ALL staff now
- Look at your data
- Develop an Action Plan
- Consider a QAPI, PIP
- Involve the ENTIRE team
- Ongoing re-evaluation
- Monitor Data
- Ongoing Communication
- Always Follow up
- Position Yourself Successfully for the Future
Resources

Advancing Excellence in America’s Nursing Homes
http://www.nhqualitycampaign.org/

CMS-QAPI:
http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/NHQAPI.html

Stratis Health

Oklahoma Foundation for Medical Quality
http://www.ofmq.com/
Questions?
Thank You For Attending Today’s Webinar!

Sue LaGrange, RN, BSN, NHA
Director of Education
Pathway Health
Please see our website for excellent resources!

Quick Paths

Manuals

Pathway Health Services

651-407-8699

**Please check our website for additional educational opportunities!**