Keep 'Em Out of the Hospital—Easier Said than Done!

Pennsylvania Healthcare Association
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Key Takeaways for this Session

- At the conclusion of this activity, participants will be able to:
  - Demonstrate an understanding of the current initiatives affecting facilities related to rehospitalization of residents;
  - Give examples of methods the facility can employ to work toward reducing rehospitalizations; and
  - Understand the role of education and competency assessment related to prevention of rehospitalization.

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Rehospitalization

According to the Institute for Healthcare Improvement, hospitalizations account for nearly one-third of the total $2 trillion spent on health care in the United States.

In the majority of cases, hospitalization is necessary and appropriate; however, a substantial fraction of all hospitalizations occur when patients return to the hospital soon after their previous stay.

These hospitalizations are costly, potentially harmful, and often avoidable.

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Program	Nursing Home Compare	SNF QRP	VBP
Measure	Percentage of Short Stay Residents Who Were Re-Hospitalized After a Nursing Home Admission	Potentially Preventable 30-Day Post-Discharge Readmission Measure	Skilled Nursing Facility 30-Day All-Cause Readmission Measure
Purpose	The percent of short-stay residents who entered or reentered the nursing home from a hospital for an unplanned inpatient stay or observation stay within 30 days of the nursing home stay.	Percentage of Medicare residents who are readmitted to an acute care hospital or LTCH with a diagnosis considered to be potentially preventable.	Risk-adjusted estimate of the number of Medicare residents who have an unplanned readmission to the acute care hospital within 30 days of discharge from the prior hospitalization.

Readmission Measures

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Approximately one in four Medicare beneficiaries discharged from an acute care hospital are admitted to a skilled nursing facility instead of a discharge directly to home.

Of these patients, one in four will be readmitted to an acute care hospital within 30 days.

This is a significantly higher rate than of the inpatient population as a whole.

Rehospitalization

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Impact of Increased Readmission Rates to the Resident

- **Functional decline in status;**
- **Falls;**
- **Pressure ulcers;**
- **Adverse drug events;**
- **Increase in delirium;**
- **Increased risk of healthcare-associated infections.**

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- Commonly cited causes of readmission included:
  - A lack of coordination between emergency departments and skilled nursing facilities (SNFs);
  - Poorly defined goals of care at the time of hospital discharge;
  - Acute illness at the time of hospital discharge;
  - Limited information between a SNF and hospital; and
  - SNF process and cultural factors.

Rehospitalizations

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Why Do Rehospitalizations Occur?

Lack of Coordination Between Skilled Nursing Facility (SNF) and Emergency Department (ED):

- **Lack of communication between SNF and ED at time of transfer**
- **ED unaware of SNF capabilities**

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Measures for Improvement

Ensure	Educate	Elicit
Ensure that hospital emergency departments are aware of the capabilities of your staff. Don't be afraid to share success stories with hospital personnel.	**Educate your nurses on how to give a comprehensive report to the ED, including what the facility is able to provide for the resident.** • **Are your nurses competent in communication skills with physicians and hospital personnel?**	**Elicit intervention from your attending physicians and/or physician extenders.**

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Why Do Rehospitalizations Occur?

Goals of Care Not Adequately Addressed

- Code status and resident goals of care not discussed prior to discharge from the hospital or as soon as possible at time of admission to the nursing home.
- Resident and/or family not aware of current medical condition or unable to accept current medical condition.

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Measures for Improvement

- Communication from the physician/extender with the resident and/or family regarding the resident's current medical condition. This should occur as soon as possible after admission to the SNF.
- Discussion with the resident on goals of care with education provided and reinforced as often as necessary.
- Education for families on medical condition and what can be expected.
- Support for residents and families on accepting medical condition.
  - Do you have a Family Group at your facility? This is a good avenue for providing education and support.

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Why Do Rehospitalizations Occur?

- Resident Medically Unstable at Time of Discharge from Hospital
  - Discrepancies between referral information provided by the hospital and the clinical reality of resident upon arrival.
  - Hospital stays becoming shorter

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Measures for Improvement

Communication with the hospital on the resident's condition, especially just prior to discharge. Educate your nurses on what questions they should ask the hospital nurses at time of resident being discharged to your facility.

Use of nurse navigators who are able to visit the patient/resident in the hospital and provide assessment findings to SNF nursing administration.

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- Lack of Proper Assessment and Care Planning at Time of Admission
  - Resident not adequately assessed by SNF nurses at time of admission.
  - Care plan addressing resident's risk factors for rehospitalization not developed and implemented.
  - Documentation incomplete or does not represent resident's actual condition.

Why Do Rehospitalizations Occur?

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Measures for Improvement

- Education for all licensed nurses on assessment/ observation of residents.
- Registered Nurse assessment upon admission or readmission.
- Education for all nurses and nurse aides on recognition of risk factors for rehospitalization and how to incorporate into the resident's care plan.
- Education and reeducation on the importance of complete and accurate documentation.

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Why Do Rehospitalizations Occur?

- Lack of Medication Reconciliation at time of Admission or Readmission
  - Medications given in the hospital are not reconciled with medications taken at home prior to admission or medications taken at the SNF prior to a hospitalization.

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Measures for Improvement

All medications should be reconciled for all residents.

Review medications taken prior to admission with residents and/or families.

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- Lack of Timely Assessment and Identification of Change in Condition
  - Poor communication between licensed nurses and nurse aides regarding subtle changes in condition.
  - Change in condition not identified and reported to physician/extender for intervention at the facility.

Why Do Rehospitalizations Occur?

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Staff Competency and Change in Condition

F726 states that a key component of competency is the ability to identify and address a resident's change in condition.

Facility staff should be aware of each resident's current health status and regular activity, and be able to promptly identify changes that may indicate a change in health status.

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Staff Competency and Change in Condition

- These competencies are critical in order to identify potential issues early, so interventions can be applied to prevent a condition from worsening or becoming acute.
- Without these competencies, residents may experience a decline in health status, function, or need to be transferred to a hospital.
- Not all conditions, declines of health status, or hospitalizations are preventable.

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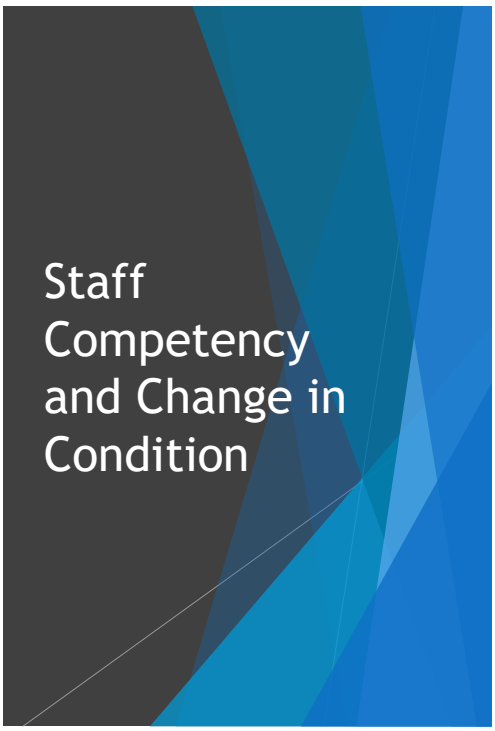
- However, through the facility assessment, facilities are required to address the staff competencies that are necessary to provide the level and types of care needed for the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population.



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Measures for Improvement

- Staff education on communication with each other. Nurses need to listen to nurse aides when changes are reported and perform a thorough assessment.
- Frequent communication with the physician/extender must occur when changes in condition are identified. Early identification may prevent a trip to the hospital.

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Measures for Improvement

- Use of SBAR format to notify physician/extender of changes in condition.
- Change in Condition guidelines for physician notification.
- Stop and Watch tool for nurse aide and nurse communication.
- Don't forget to acknowledge family communication regarding changes in condition.

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Measures for Improvement

- What is your process for reviewing transfers and rehospitalizations?
- Are you calculating your rehospitalization rates?
- Are the hospitals in your area familiar with your facility's rehospitalization rates? Is the information they are using accurate?
- Have you met with hospital administration to discuss your facility's capabilities?

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- Is education on how to perform a root cause analysis provided to your licensed nurses during initial orientation, periodically, and when necessary?
- Do all members of your QAPI team understand what root cause analysis is?
- Is reviewing hospitalizations part of your QAPI program?

Measures for Improvement

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Root Cause Analysis

Why did Mr. Jones fall?

He didn't have his shoes on.

Why didn't he have shoes on?

The nurse aide stated he did not have any shoes at the facility.

Why were his shoes not available?

The family was unaware that therapy recommended tennis shoes at all times when out of bed.

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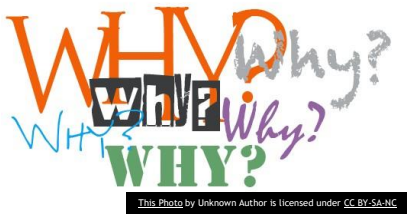

Root Cause Analysis

Why didn't the family know about the therapy recommendation?

The nurse that sees the family each evening didn't know about the recommendation.

Why didn't the nurse know about the recommendation?

It was not communicated by the therapist to the nurses and the nurses didn't have access to the therapy documentation.

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Resident and/or family is not adequately prepared by the SNF staff for discharge.

Resident and/or family has not received education to make the transition from SNF to home as smooth as possible.

Rehospitalization After SNF Discharge

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Remember that resident education starts on day one of admission to the SNF and is ongoing.

Education must be provided at a level that the resident is able to understand.

Do all of the nurses understand the procedure to be taught to the resident?

Have you educated your nurses on how to provide education to adult learners?

Does the resident understand what signs and symptoms need to be reported to the primary care physician?

Measures for Improvement

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- Assess the resident's self-care capacity
  - Does the resident understand the recommended treatment plan?
  - Has the resident been able to provide return demonstrations of care?
  - Is the resident able to safely perform all activities of daily living after discharge?

Measures for Improvement

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Measures for Improvement

- Therapy department conducts home safety evaluation and interdisciplinary team reviews resident needs for equipment prior to discharge.
- Fall prevention interventions are taught to the resident prior to discharge.
- Assist with making home care services prior to discharge.

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Measures for Improvement

- Connect the resident with community resources prior to discharge and assist where needed with making appointments.
  - Transportation programs
  - Senior center activities
  - Meals on Wheels
  - Cultural and religious centers
  - Food pantries
  - Condition-specific organizations such as the Alzheimer's Association, American Cancer Society, Blind Association, etc.

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Measures for Improvement

- Post-Discharge Telephone Calls for the First Thirty Days
  - Day Two Post-Discharge Questions
    - How are you feeling?
    - Do you understand why you were in the hospital and skilled nursing facility?
    - Do you understand your discharge instructions? If not, what questions do you have?
    - Were you able to get all of your prescriptions filled? Are you taking your medications as ordered?
    - Is someone helping you at home?
    - Do you know when to call the doctor? Reeducate on signs and symptoms or change in condition if needed.
    - Do you have a follow-up appointment scheduled with your physician?

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Measures for Improvement

- Post-Discharge Telephone Calls for the First Thirty Days
  - Day Seven Post-Discharge Questions
    - How do you feel—better, worse, same?
    - Which nurses or therapists have visited you? Are you receiving any other home services?
    - Do you have transportation to and from your appointments?
    - Have you been seen by your physician? How did the visit go?

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Measures for Improvement

- Post-Discharge Telephone Calls for the First Thirty Days
  - Day Fourteen Post-Discharge Questions
    - Are you able to do more for yourself each day? Each week?
    - What is your goal(s) for the next two weeks?

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- Post-Discharge Telephone Calls for the First Thirty Days
  - Day Thirty Post-Discharge Questions
    - Were you able to achieve the goal(s) we discussed earlier?
    - How are you feeling today compared to the day you were discharged from the SNF?

Measures for Improvement

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Staff Competency

The definition of competency according to the American Nursing Association: an expected level of nursing performance that integrates knowledge, skills, abilities, and judgment.

The definition of competency according to F726: a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual needs to perform work roles or occupational functions successfully.

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- F726 The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment.

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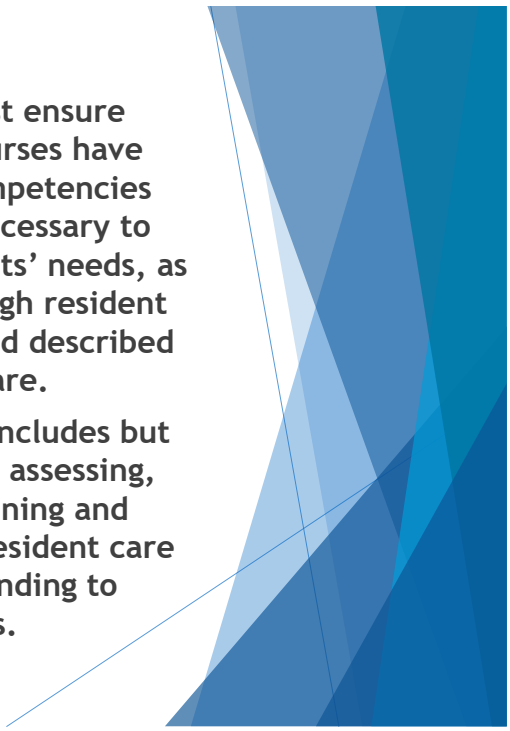
Staff Competency

- The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.
- Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.



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- Proficiency of nurse aides—the facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

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Staff Competency

- Competency in skills and techniques necessary to care for residents' needs includes but is not limited to competencies in areas such as:
  - Resident Rights;
  - Person-centered care;
  - Basic nursing skills;
  - Basic restorative services;
  - Skin and wound care;

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Staff Competency

- Competency in skills and techniques necessary to care for residents' needs includes but is not limited to competencies in areas such as: (continued)
  - Medication management;
  - Pain management;
  - Infection control;
  - Identification of changes in condition; and
  - Cultural competency.

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Staff Competency

- Facilities must determine the amount and types of training based on the facility assessment.

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Staff Competency

Demonstration of Competency

Competency may not be demonstrated simply by documenting that staff attended a training, listened to a lecture, or watched a video.

A staff's ability to use and integrate the knowledge and skills that were the subject of the training, lecture, or video must be assessed and evaluated by staff already determined to be competent in these skill areas.

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- **Examples for evaluating competencies may include, but are not limited to:**
  - Lecture with return demonstration for physical activities;
  - A pre- and post-test for documentation issues;
  - Demonstrated ability to use tools, devices, or equipment that were the subject of training and used to care for residents;
  - Reviewing adverse events that occurred as an indication of gaps in competency; or
  - Demonstrated ability to perform activities that is in the scope of practice an individual is licensed or certified to perform.

Staff Competency

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Staff Competency

Nursing leadership with input from the Medical Director should delineate the competencies required for all nursing staff to deliver, individualize, and provide safe care for the facility's residents.

There also should be a process to evaluate staff skill levels, and to develop individualized competency-based training, that ensure resident safety and quality of care and service being delivered.

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Staff Competency

- A competency-based program might include the following elements:
  - Evaluates current staff training programming to ensure nursing competencies. Examples include skills fairs, training topics, and/or return demonstration.
  - Identifies gaps in education that is contributing to poor outcomes, such as potentially preventable rehospitalization, and recommends educational programming to address these gaps.

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- A competency-based program might include the following elements: (continued)
  - Outlines what education is needed based on the resident population (such as geriatric assessment, mental health needs) with delineation of licensed nursing staff versus non-licensed nursing and other staff of the facility.
  - Delineates what specific training is needed based on the facility assessment (such as ventilators, IV's, trachs).

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- A competency-based program might include the following elements: (continued)
  - Details the tracking system or mechanism in place to ensure that the competency-based staffing model is assessing, planning, implementing, and evaluating effectiveness of training.
  - Ensures that competency-based training is not limited to online computer-based, but should also test for critical thinking skills as well as the ability to manage care in complex environments with multiple interruptions.

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Staff Competency

The Centers for Medicare & Medicaid Services (CMS) recently released a toolkit, the *Nursing Home Staff Competency Assessment*.

This toolkit describes four purposes of a competency assessment, including:

- Identifying individual strengths;
- Detecting both individual and the nursing team's learning needs;
- Boosting professional development; and
- Increasing job satisfaction.

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Staff Competency

Competency assessments are available in the toolkit for both frontline and management staff.

There are two frontline competency assessments. These assessments are used to evaluate behavioral, technical and resident-based competencies for these positions:

- Certified Nursing Assistants
- Registered Nurses
- Licensed Practical Nurses.

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- There is one management competency assessment. This assessment is used to evaluate behavioral and technical competencies for these positions:
  - Administrator
  - Director of Nursing
  - Assistant Director of Nursing

Staff Competency

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Staff Competency

In order to understand the competency growth areas for your facility, once all assessments have been completed, the facility-wide results are aggregated and the data is reviewed.

The next step is to conduct one-on-one meetings with staff to discuss their assessment results and address competency growth areas at both the individual and facility-wide levels.

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- The results should be used on a continual basis to track the progress of competency growth areas and to support staff development, facility performance and overall quality of care and quality of life for residents.

Staff Competency

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Programs to Assist with Preventing Rehospitalizations

- INTERACT Version 4.0
  - SBAR Communication Form and Progress Note
  - Decision Support Tools
    - Change in Condition File Cards
    - Care Paths
  - STOP AND WATCH
  - Advance Care Planning Tracking Tool
  - Quality Improvement Tool
  - Medication Reconciliation Worksheet for Post-Hospital Care

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Programs to Assist with Preventing Rehospitalizations

INTERACT also includes Quality Improvement Tools for review and root cause analysis.

INTERACT has tools available for communication between the nursing facility and acute care hospital that include:

- Engaging Your Hospitals
- SNF Capabilities List
- SNF-Hospital Transfer Form
- Acute Care Transfer Checklist
- Hospital-Post-Acute Transfer Form

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- RAFT—Reducing Avoidable Facility Transfers
- Consists of four components:
- 1. Small team of providers who manage care and after-hours call.
  - Physicians, physician assistants, nurse practitioners, advance practice nurses.
  - At least one provider is on site every business day.
  - After hours call is managed exclusively by this team.

Programs to Assist with Preventing Rehospitalizations

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RAFT

- 2. Systematic elicitation of advance care plans including acute care preferences.
  - Provider Orders for Life-Sustaining Treatment (POLST) are presented to residents as standard practice.
  - Early on in care, providers are encouraged to prioritize the need to conduct a goals of care meeting.
  - Higher priority is assigned to residents deemed to have a poorer understanding of their condition or a higher risk of an acute decline.

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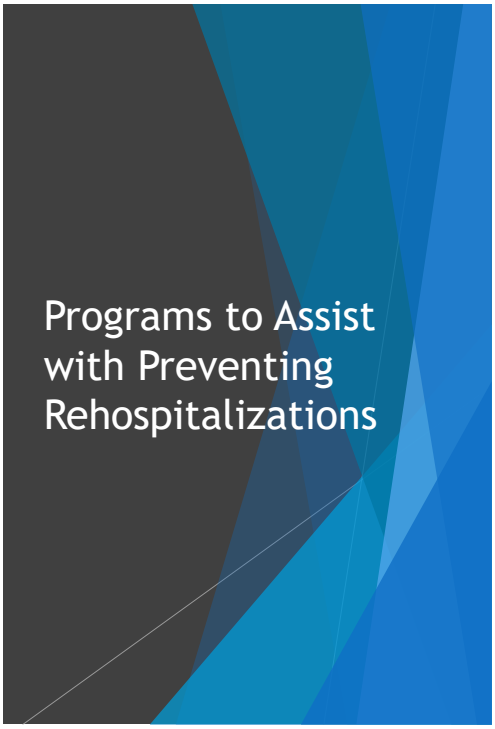

RAFT

- 3. Increased engagement of the provider during an acute care event.
  - Nurse-led education session held with all nursing staff to explain benefits of engaging the provider early.
  - Nurses are strongly urged to call the provider before contacting the family or arranging for transfer.
  - When appropriate, providers are encouraged to engage with the resident.

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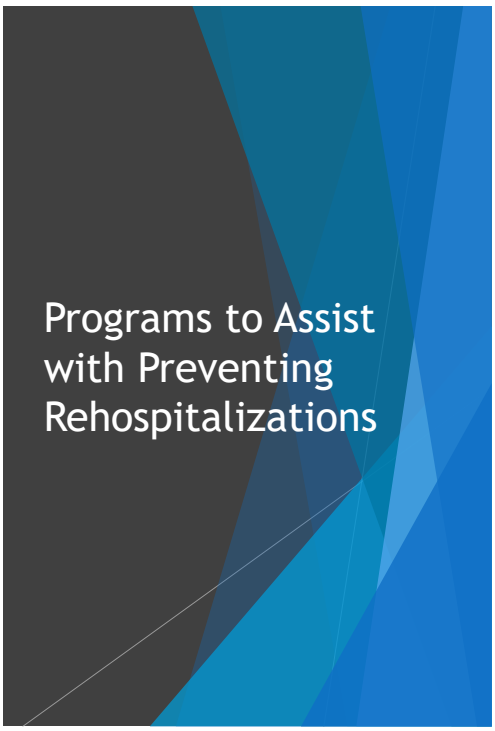

RAFT

- Providers are encouraged to communicate directly to the family as clinicians often receive calls stating the family wants the resident sent to the ED.
- At this point, it is generally too late to do otherwise as the family was sufficiently alarmed so that keeping the resident at the facility can seem negligent and also conveys a lack of confidence in the nurse's assessment of the situation.

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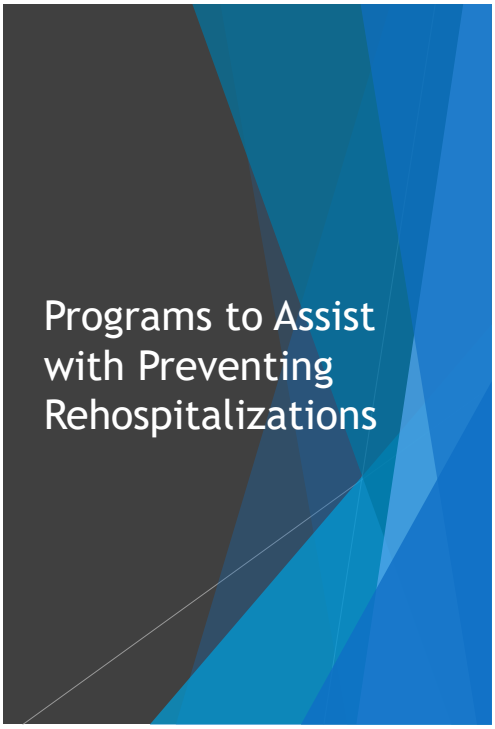

RAFT

- Engaging the provider early provides time to attempt "gentler" interventions, carefully assess goals, and strengthen families' confidence that a reasonable and safe plan is in place.

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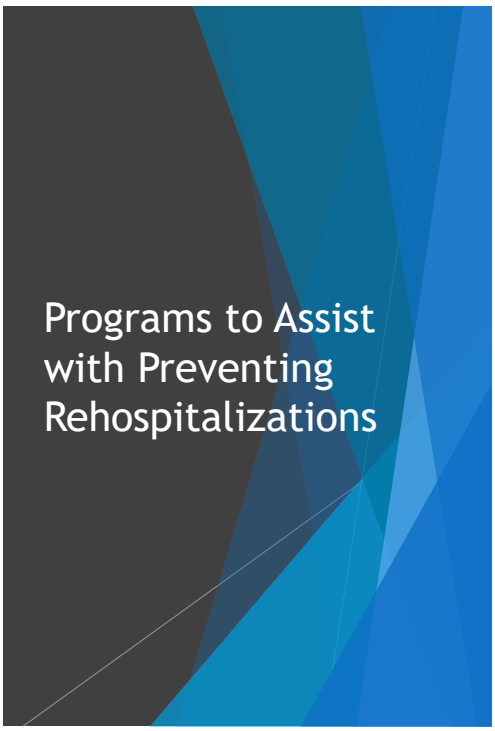
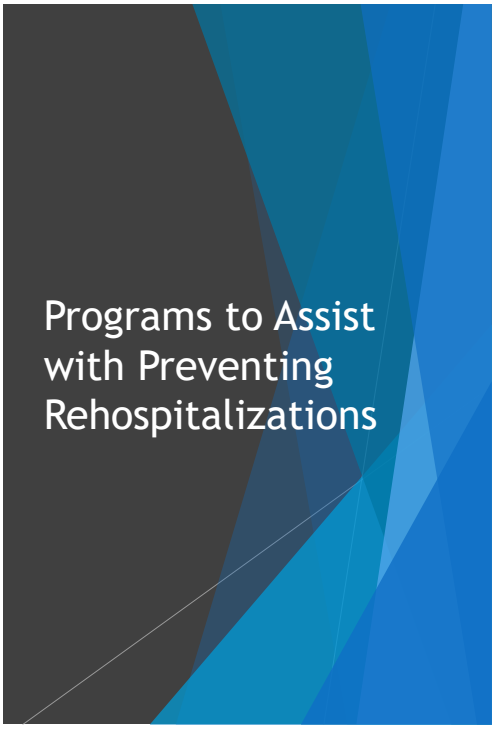


RAFT

- 4. Case Review
- Team meets twice monthly to discuss most recent hospital transfers.
- Focus of the meeting is to exchange skills for managing an acute decline within the context of resident goals and to identify missed opportunities to safety and reasonably prevent ED transfers.



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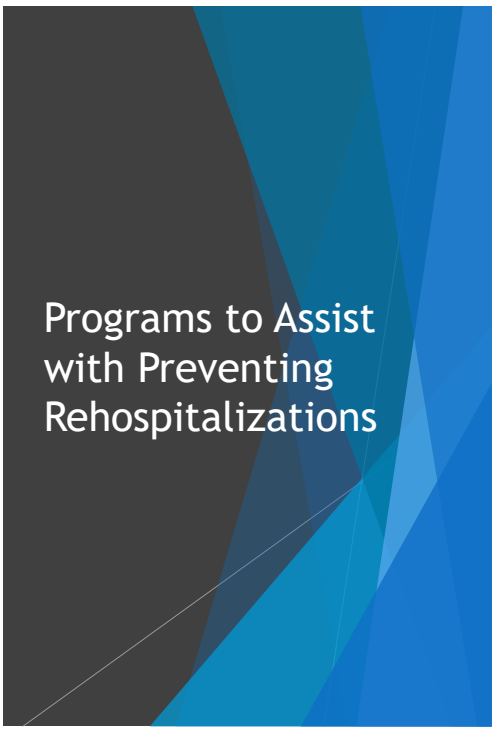
RAFT

- During the case review, two questions are routinely asked:
  - Before the acute event, were there actions the provider team could have safely and reasonably taken to have prevented the transfer?
    - Examples: treating symptoms earlier, clarifying goals
  - During the acute event, were there actions the provider team could have safely and reasonably taken to have prevented the transfer?
    - Examples: treating on site, engaging directly with the resident or family



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- The pilot study of the RAFT intervention found a statistically significant reduction in ED and hospital use among residents of SNFs.

Programs to Assist with Preventing Rehospitalizations

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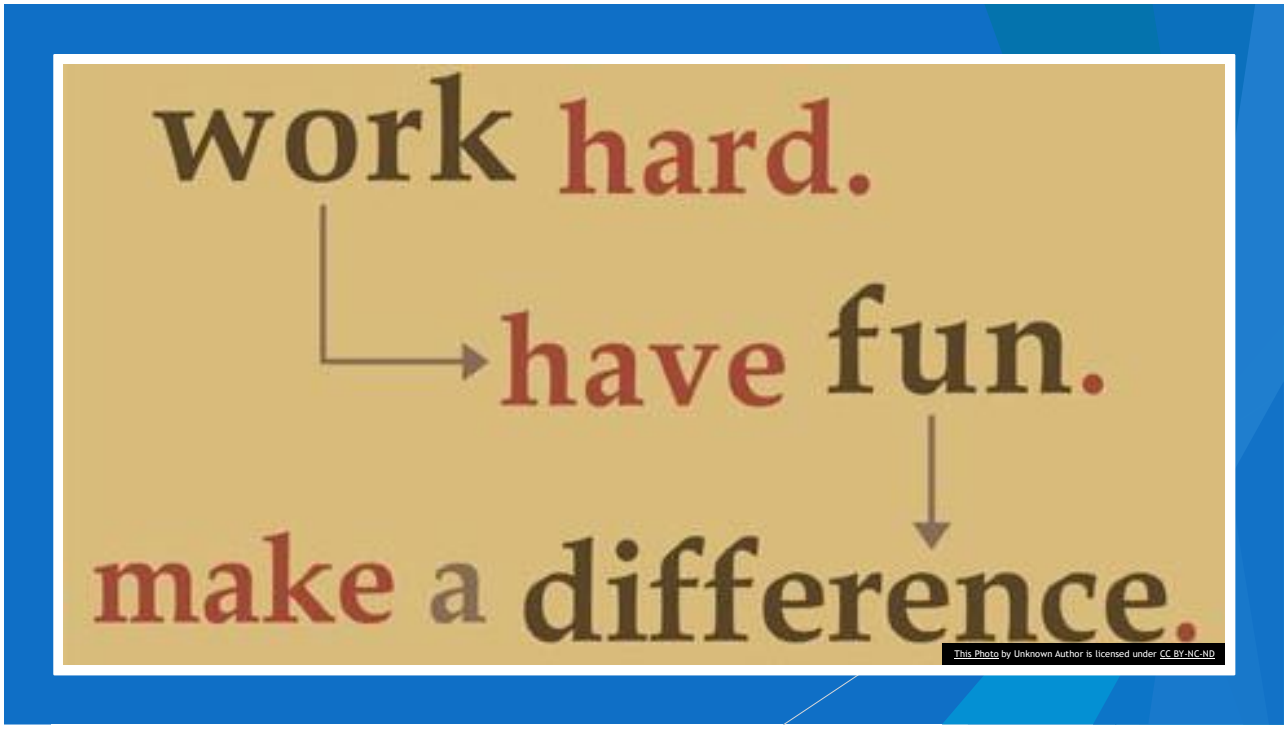
work hard.
have fun.
make a difference.
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