Preventing the Boomerang of Rehospitalization

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Session Objectives

- Gain perspective on how we can partner with other providers to reduce unnecessary ER transfers and hospital readmissions
- Learn how the use of RN “Care Navigators” and INTERACT tools can improve resident care outcomes
- Appreciate the critical nature of interdisciplinary team collaboration before, during, and after the resident’s stay
- Identify legal risks related to poorly executed transitions of care

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Introduction and Why This Matters…….

Dr. Sara Elizabeth Hamm, DNP, RN

Senior Vice President of Successful Aging and Health Services

Lifespace Communities

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This we know: Aging adults are at significant risk of hospital readmissions

- 25% of Medicare beneficiaries are readmitted to hospitals within 30 days of discharge
- Most readmissions occur within the first 72 hours
- The majority of Medicare dollars are spent for end-of-life care
- Many older adults fail to execute advance directives or end-of-life care planning

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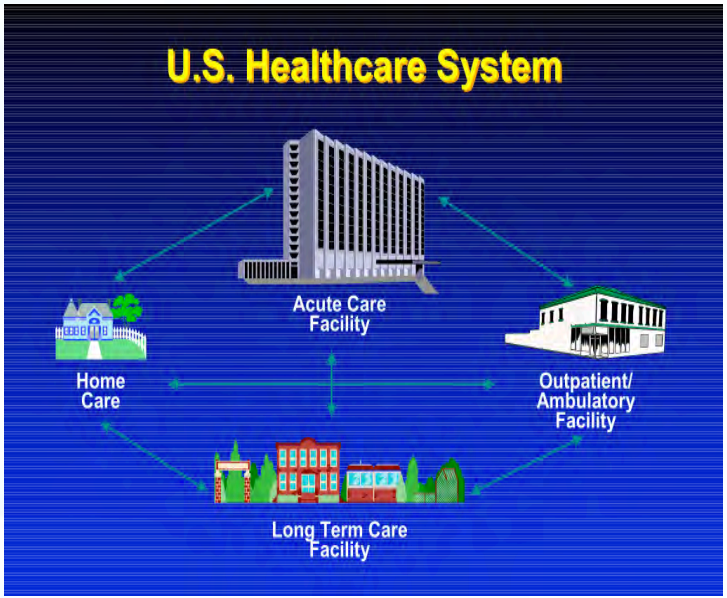
Why Does This Matter?

A Substantial Proportion of Hospitalizations of Aging Adults are Potentially Avoidable

Several studies suggest that a substantial percent of hospital transfers , admissions, and readmissions are ***unnecessary*** and can be prevented



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The Human Aspect of The Boomerang: Relocation Stress Syndrome

Transfer Trauma

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Why Do We Fail??

Lack of collaboration between all health care providers

Lack of processes that facilitate safe transitions

Lack of interoperability of E.H.R. systems

Lack of focus on medication management/drug reconciliation

Lack of admission and DC planning and follow-up care

Sadly: Failure to address end-of-life care & individual choice

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Additional Problems

- We forget: Older adults are often at significant risk of physiological ***and*** psychosocial complications during multiple transitions of care
- Lack of focus on other levels of care: Residential/Independent Living, Assisted Living, Memory Care, Home Care
- Over 50% of healthcare costs are directly related to Medicare readmissions of aging adults, most during the final weeks of life…..

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Group Questions

- Do you know how many admissions and discharges you process each day, and do you schedule your nurses and nursing assistants differently on high volume days??
- How many of you have a dedicated RN, Nurse Practitioner or have “concierge” nursing assistants assisting with care management in your health centers?
- Do you solicit feedback from your short-stay residents to determine their overall satisfaction with the admission and discharge process??
- Who discusses end-of-life care planning with the resident?

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Recent CCRC QI Study

Clinical Question: “Compared to traditional admission and discharge processes utilized in hospitals and SNFs across the United States, will focused interventions by RN care navigators reduce 30-day hospital readmission rates over a three-month period among geriatric patients admitted to three CCRC health centers?”

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RN “Care Navigators”:

Provide the IDT transition of care leadership and collaboration

Provide critical patient and family education

Ensure patient/family understanding of DC instructions

Ensure compliance with follow-up appointments/meds

Complete post-discharge follow-up calls and/or visits

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Methods and Procedures

- Introduction of an RN Care Navigator and team protocols
- Therapy team collection of Functional Improvement Measures
- Social service department discussion with patient/family about importance of end-of-life care planning and advance directives
- Completion of discharge satisfaction survey (Care Transition Measure scores: Dr. Eric Coleman)
- DC education and completion of post-discharge follow-up call at 48 hours, seven days, and 30 days

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Analysis and Results (n=165)

Average age of participants was 84 years (65-95)

93% (13/14) readmits were over 80 years old

Mean length of stay in SNF was 22.4 days

Hospital readmissions decreased from 14% to 8.5%

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Analysis and Results

Average satisfaction score was 3.8 out of 4

Completion of Advance Directives increased from 52% on admit to 72% at discharge

67% Improvement in Functional Improvement Measures

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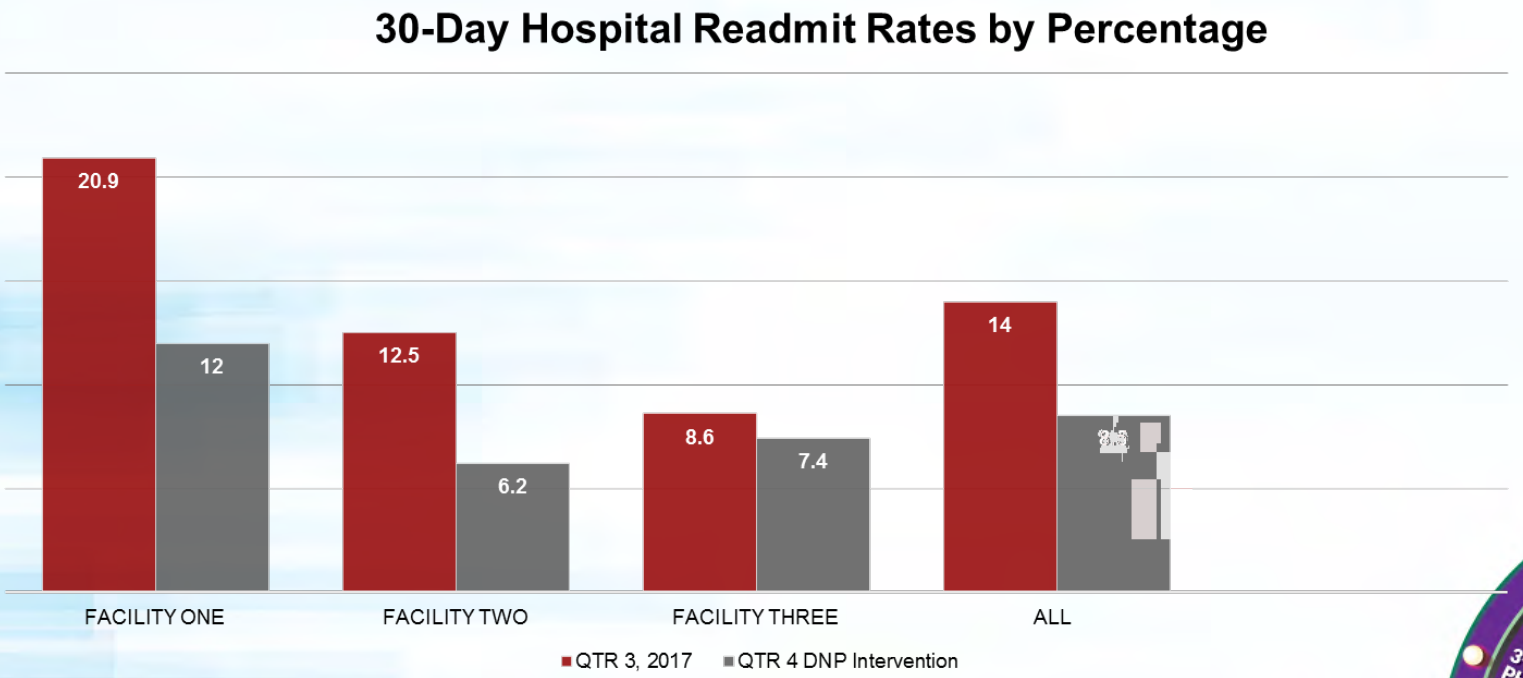
Reduction in 30-Day Readmission Rates



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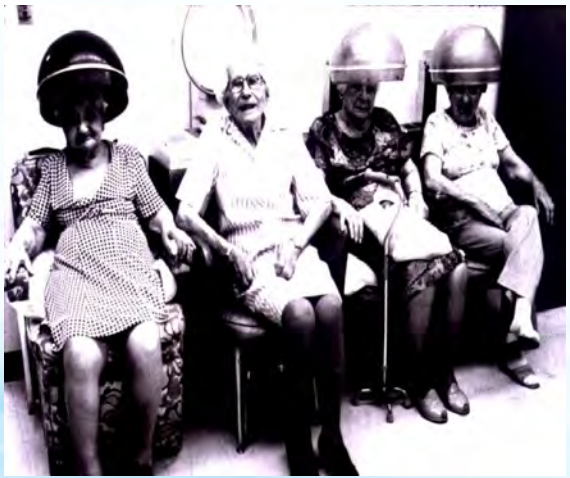
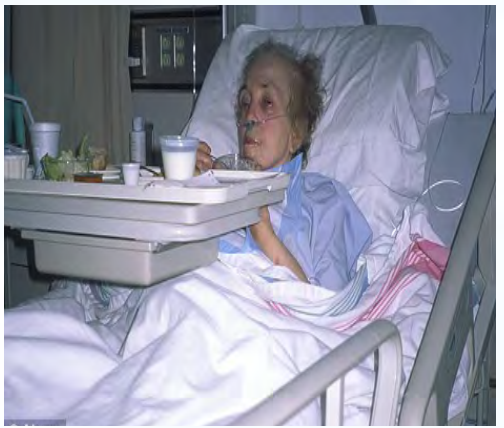
Why Does This Matter?



At the beauty salon

Hospitalization



At risk for complications

- **Delirium and/or depression**
- **Polypharmacy**
- **Falls**
- **Incontinence and catheter use**
- **Hospital acquired infections**
- **Immobility, de-conditioning, pressure ulcers**

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Long Wait to Continue Care

Primary Care Follow-Up Critical to Long-Term Patient Outcomes

3 Week Wait Time for Primary Care

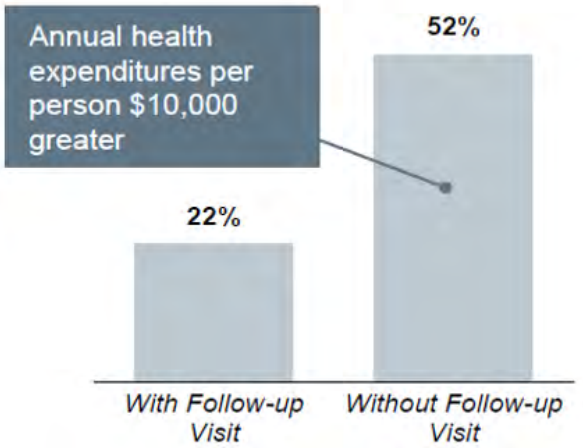
20.3 Days

National average wait time for a new patient primary care appointment

Relationship Between Physician Follow-Up, 90-Day Readmissions

Low-Risk Elder Adult Sample, Home Discharge

N = 326



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INTERACT®

Is a quality improvement program designed to improve the care of older people with acute changes in condition in nursing homes, assisted living facilities, and home health care

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INTERACT®

The INTERACT Program is free for clinical and educational use at:

http://www.interact-pathway.com

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INTERACT Strategies

1. ***Prevent*** conditions from becoming severe enough to require hospitalization through ***early identification and evaluation*** **of** changes in resident condition
2. ***Manage*** some conditions without transfer when this is feasible and safe
3. ***Improve advance care planning*** and the use of palliative care plans when appropriate as an alternative to hospitalization
4. ***Improve communication and documentation*** within PAC/LTC facilities and programs, and between PA/LTC and acute care
5. ***Integrate into ongoing QI initiatives***
6. ***Combine*** INTERACT with other care transitions interventions
7. ***Embed in Health Information Technology*** across care settings

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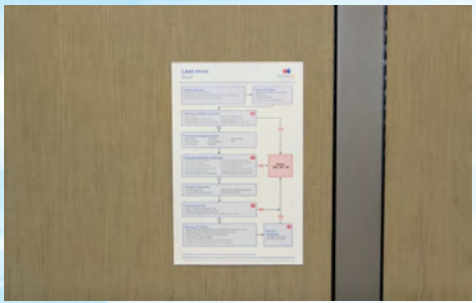
Interact and Technology

INTERACT Tools Must be Visible and Accessible in Everyday Care



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Nursing and Rehabilitation Therapy -Collaboration for a Safer Transition

Stacey Hodgman, MS, RN-BC,CMAC

DVP Care Management, Kindred Healthcare

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Readmissions:
Impact on quality and revenue

The Protecting Access to Medicare Act of 2014 (PAMA) impacted changes to the SNF reimbursement rate	• Began in October, 2018
SNFs receive a quarterly performance score based on	• Individual performance • Achievement/comparison to other SNFs across the country
SNFs will either receive a payment incentive or a reduction - based on their performance	• SNFs with the highest rankings receive the highest incentive payments • SNFs with a zero or low ranking receive the lowest incentive payments

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/SNF-VBP-FAQs-Final.PDF

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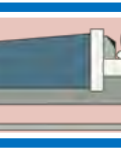
The Numbers

CMS is withholding 2% of Medicare payments to SNFs and will redistribute 50-70% of the withhold back into SNF's via the incentive payments.

CMS will keep the balance - 30-50% savings to Medicare!

The vast majority of skilled nursing facilities will face a penalty on their Medicare payments for fiscal year 2019 for poor 30-day readmission rates (the bottom 40% performers)

Of the 14,959 skilled nursing facilities subject to CMS' Skilled Nursing Facility Value-based Purchasing Program, 73% received a penalty and 27% received a bonus payment (2015:2017 data comparison)



The Patient Driven Payment Model (PDPM) which goes into effect fiscal year 2020 replaces the PPS model and will decrease reimbursement even more over the course of the patient's stay depending on their reason for admission

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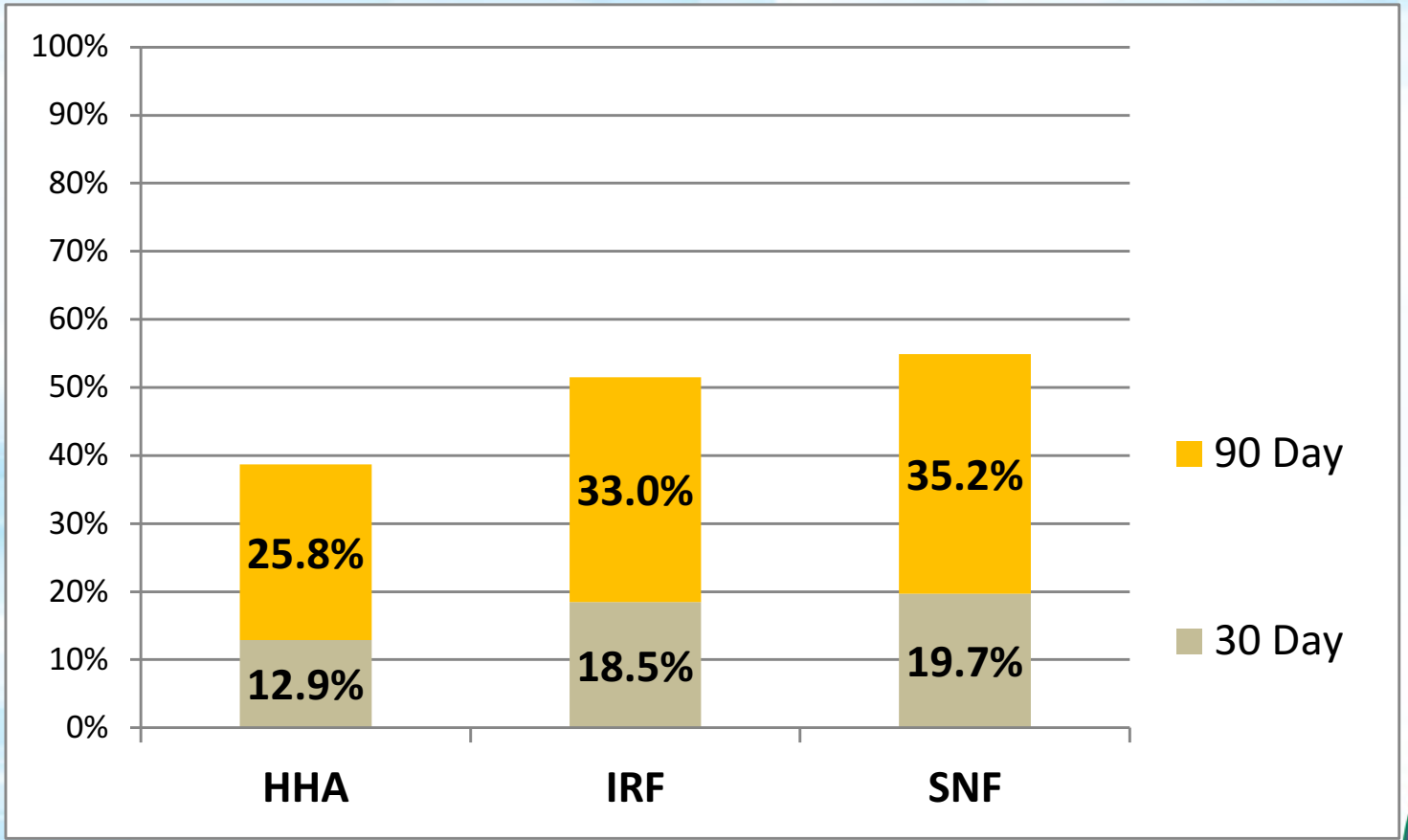
MCR-A 30-Day and 90-Day Readmission, Q1 2017



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Planned Readmissions

- Bone marrow, kidney, or other transplants
- Maintenance chemotherapy
- Rehabilitation
- Pregnancy diagnoses and procedures such as normal pregnancy, Cesarean section; forceps delivery, vacuum, and breech
- Readmissions to psychiatric hospitals or units
- CMS' Table of potential planned readmissions

The principal diagnosis and all of the procedure codes from a readmission are used to identify planned readmissions- if an acute diagnosis is present, even for a planned procedure, the readmission is considered unplanned

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30 Day Window

The 30-day readmission rate is the 30-day window after a patient is discharged from a hospital and admitted to a SNF.

The SNF is still on the hook for a readmission penalty even if the patient is discharged before the 30 days are over

Be proactive to get your patient back quickly!

Optimal transitions matter!

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Impact of Functional Impairment

Functional impairment is associated with an increased risk of 30-day, all-cause hospital readmissions in aging individuals, especially those admitted for heart failure, myocardial infarction or pneumonia.

The most functionally-impaired patients are 42% more likely to be readmitted compared to those with no impairments

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National Transitions of Care Coalition Seven Essential Interventions

NATIONAL TRANSITIONS OF CARE COALITION

- Medication Management
- Transition Planning
- Patient and Caregiver Education & Engagement
- Information Transfer
- Follow up Care
- Healthcare Provider Engagement
- Shared Accountability Across Providers and Organizations

http://www.ntocc.org/Home/tabid/55/Default.aspx

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Impact of the Physical Therapist

- Readmission rates are 3 times higher if physical therapist discharge recommendations are replaced with less intensive interventions- only 55% of DC summaries include these recommendations
- Few discharge planning processes include a therapy handoff
- Only 19% of DC summaries include information about functional abilities
- Older adults who discharge home with unmet needs for assistance with ADLs have a 66% higher readmission rate than those with the same functional level whose needs were addressed prior to discharge
- Non-homebound patients must have information and access to community outpatient therapy if care plan goals not met

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Impact of the Occupational Therapist

- Address medication non-adherence through medication labs
- Identify problems with medication management; dexterity, vision, understanding of medication schedule, health literacy, etc.
- Bring insight into the patient's discharge needs and help prevent unsafe discharges related to inability to perform ADLs
- Coordinate training sessions with patient and caregiver prior to discharge
- Identify and address functional limitations and environmental hazards to prevent falls through a pre-discharge home assessment
- Encourage participation in activities to promote community reintegration

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Impact of the Speech Therapist

Studies have shown that LOS is > in patients who do not participate in goal setting	•Related to impaired ability to communicate •Caregiver engagement is critical
Cognitive Impairment Identification	•Health Literacy, ability to understand and follow prescribed treatment plan & problem solve- must involve caregiver early in stay •Teach back-implications for the care team in transition planning and patient engagement
Speech/Aphasia/Language Barriers	•Methods for contacting emergency help •Teach alternative methods of communication aids to patient and caregiver. •Referrals to social supports to help prevent isolation •Assess & recommend need for interpretive services
Swallowing Defects and Potential Problems	•Prevent aspiration pneumonia •Provide education on proper swallowing techniques •Patient teaching to prevent dehydration due to fear of swallowing liquids

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Patient & Caregiver Education and Engagement

Nursing

- Patient centered teaching techniques
- Assess readiness to learn
- Identify social determinants of health
- Provide disease management education
- Review Yellow & Red Zones
- Provide a written easy to understand discharge plan
- Provide a written easy to understand medication plan

Therapist

- Assess patient's health literacy
- Assess patient's understanding of home modifications
- Educate re: risks associated with functional decline
- Provide written illustrated home exercises
- Promote community integration
- Provide resources for communication disorders
- Ensure understanding of medication regime

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Follow Up Care

Nurse's Role

- Confirm patient is established with a PCP
- Confirmation of and/or schedule follow-up appointments
- Confirm patient's understanding of required follow up care
- Confirm HH Clinician available to see patient within 24 hrs. of discharge
- Ensure patient has access & means to obtain medications
- Ensure patient understands who to call when
- Teach self management
- Provide warm handoffs to the receiving provider
- Follow up call post discharge

Therapist's Role

- Utilize a standardized handoff tool
- Promote patient engagement and self management
- Provide therapist provider continuity of care from hospital to home
- Confirm patient's understanding of required follow up care
- Early engagement of caregiver training to ensure support
- Provide information to patient on how to obtain rehabilitation therapy post discharge
- Confirm outpatient therapy scheduled if no HHS

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Take Aways to Reduce Readmissions

- Warm Handoffs, discipline specific
- Scheduled follow up appointment(s)
- Post discharge follow up calls
- Post discharge availability
- Best possible medication reconciliation; consider a discharge educator role
- Easy to read written discharge instructions
- Consider Palliative Care referrals for patients with chronic non- curative illnesses
- Advance Directives; patients may prefer 'DNH'
- Readmission workgroup, physician led
- Mindset that *all* patients will likely benefit from home health services or outpatient therapy
- Develop preferred provider networks for HHS, OP, etc.
- Readmit directly to the SNF
- Weekend discharges- ensure thorough clinical oversight
- If patient is rehospitalized while a patient at the SNF, take proactive measures to return patient quickly

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Legal Aspects of Ineffective Transitions of Care

Kimberly C. Gordy, JD, MA - Clinical Ethics
Attorney, Baker Hostetler LLP

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Negligence & Wrongful Death Claims

Case Study: Joyce Oyler's Medication Errors

- Joyce Oyler was hospitalized for congestive heart failure and discharged home. The prescriptions were transferred by telephone to the local pharmacy. The pharmacy technician mis-transcribed the diuretic, Metolazone for the high-alert drug Methotrexate.
- Joyce was seen daily by home health nurses post-discharge, but the mistake was not caught. She died 18 days from the Methotrexate.
- Her husband successfully sued Hy-Vee for wrongful death. The hospital and hospital-owned home health agency were dismissed from the lawsuit as part of a settlement.

Carl Oyler, et al., Appelants, v. HY-VEE, INC., Respondent , 539 S.W.3d 742 (2017)

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Data Privacy Issues Related to Transitions of Care

Privacy issues arise when communication improves

- **Software as a Service (SaaS) and Platform as a Service (PaaS) distribution models**
  - SaaS-based services can streamline care and improve convenience.
  - App developers are targeting senior housing and long term care providers
- **Reinforcing training with employees:**
  - Secure transfer of information – are your SaaS and PaaS providers HIPAA compliant?
  - The cost of a lost tablet, laptop or smartphone
  - Family members connecting with providers on apps – when to obtain authorizations

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Closing: Optimal Transition Planning = Improved Patient Outcomes

- **Decreased readmission rates**
- **Higher patient experience scores**
- **Higher provider experience scores**
- **Shorter lengths of stay**
- **Improved patient engagement and adherence to treatment plan**
- **Quicker recovery times**
- **Sustainability in the community**

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Questions?

Our Sincere Thanks

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