Closing the Door to Inpatient Readmission
High quality care in the SNF

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The hospital: Skilled Nursing Facilities (SNF) Cycle

[Image with cycle diagram]
The hospital: SNF Cycle (continued)

• Incomplete discharge summary
• Problem focused vs. patient focused care
• Medication reconciliation
• Unnecessary procedures
• Inattention to chronic care needs
• Premature discharge
• Psychosis
• Poor family communication
• Advance care planning
• Acute change in condition: Recognition and assessment
• Poor communication
• Interdisciplinary team collaboration

• Appropriate plan of care/monitoring
• Stakeholder alignment
• Lack of contingency planning
• Execution/implementation of plan
• Multiple consultants
• Hospitalist vs. primary care provider
• Nosocomial infections/complications
• Medical Errors
• Ambulatory care sensitive conditions
• 911 reflex
• Regulatory concerns
• “When in doubt…”
• Inadequate clinical professional engagement

Scope of the problem

• More than 20% of all Medicare beneficiaries re-hospitalized within 30 days
• 90% unplanned
• Cost to Medicare = $17.4 billion
• 40% of Medicare beneficiaries discharged to receive post acute care (SNF, IRH, home health)
• Half of the above enter a nursing home
• 23.5% re-hospitalization rate from SNFs
• Even higher (26%) for those who previously resided in nursing home
• Medicare costs $4.34 billion
• High proportion are avoidable
  – Considerable geographic variation
  – High prevalence of preventable conditions
• Correlated with negative health outcomes, e.g., delirium, functional decline

What can happen to your hospitalized residents

Poor oral care/ teeth problems
Poor hearing
Lost teeth, hearing aids and glasses
ADLs
Outpatient (clinic) visits get scheduled when not necessary or appropriate
Increased confusion
—‘out of sorts’
MRSA and or VRE
Incontinence
Over sedation/lethargy
UTIs secondary to catheter
Weight loss/ loss of appetite
New physical or chemical restraint
Bad memories/ waiting in ER for up to 18 hours
Physically unkempt
Broken bones from falls in hospital
Advance directives NOT followed
Death or poor quality death
Lack of discharge summary and info related to hospitalization
Lost equipment: (splints/braces)
Resident not a priority to acute care staff
Initial problem not fully investigated/resolved
Heel ulcers
Eccymosis from IV/ lab sticks
Fecal impaction
Phlebitis
Relocation trauma
Psychiatric exacerbation
Altered functional status/ weakness
Decreased activity
Increased anxiety/agitation
Case #1

- 89-year-old female with dementia, HTN, CKD, eats independently but requires assistance with all other ADLs.
- Hospitalized nine days ago with acute cardiac ischemia, change in level of consciousness, and suspected aspiration pneumonia.
- After seven days in acute care returned to SNF with significant functional decline and increased confusion. Family was informed of sequence of events. Patients was DNR/DNI.
- 48 hours later at 2 a.m., she developed tachypnea and O2 sat 87% on 2L/min. Staff concerned about recurrent cardiac event. Covering physician unfamiliar with case ordered nurse to call 911.
- Patient re-hospitalized with suspected aspiration pneumonia, given supportive care.

Why do admissions/readmissions occur?

- Fundamental system issues related to transitions
- Physician presence in SNFs and coverage issues
- SNF technical capabilities
- ACP/Family dynamics
- Staffing
- Education/training in SNFs
- Regulatory environment
- Patient mix
- Fragmentation in system/information systems

Who’s at risk?

- Age/demographics
- Medical conditions: CHF, pneumonia, COPD, psychosis, GI issues
- Surgical procedures: Cardiac stent placement, hip/knee surgery, vascular surgery, bowel surgery
- Dialysis
- Previous re-hospitalization
- Longer index hospitalization
- SNF discharge: compare to community or IRF
Rehospitalization

Highest rates of rehospitalization and most frequent reasons for rehospitalization, according to condition at index discharge

<table>
<thead>
<tr>
<th>Condition</th>
<th>Reason for Rehospitalization</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atrial Fibrillation</td>
<td>Heart Failure</td>
<td>15.3%</td>
<td>15.5%</td>
<td>15.7%</td>
<td>16.0%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Infection</td>
<td>20.4%</td>
<td>20.6%</td>
<td>20.8%</td>
<td>21.0%</td>
</tr>
<tr>
<td>COPD</td>
<td>COPD</td>
<td>12.3%</td>
<td>12.5%</td>
<td>12.7%</td>
<td>13.0%</td>
</tr>
</tbody>
</table>

Where do they live?

- Pre-hospital living situation
  - Impact of nursing home vs. community setting prior to the post hospital SNF admission
  - Rate higher for those previously in NH
- Differences between short term rehab or medically complex and permanent NH residents
- Readmit rates?
  - What is scope of problem
- Financial implications for health system

Rates of rehospitalization within 30 days after hospital DC

- [Map showing rates across different states]
SNF hospital readmission levers

**LOWER RATE**
- Genetic assessment
- NP involvement
- Facility factors

**HIGHER RATE**
- Lack of medication reconciliation
- Clinical instability
- Depression

All readmissions not created equal

**Expected readmission**
- Planned; unrelated
- Planned; related

**Unanticipated readmissions**
- Unplanned; unrelated
- Unplanned; related (preventable vs. all-cause readmissions)

Potentially preventable readmissions (PPR)

- Same Medicare payment diagnostic category
- Medical vs. surgical readmission (MedPAC)
- Condition specific (78% — can be managed in SNF)
  - CHF
    - Respiratory infection
    - UTI
  - Sepsis
  - Electrolyte imbalance
- Evercare TAP criteria
  - Later slides
Other factors that drive readmissions

- System drivers, e.g. SNFs lack incentive to coordinate care
- Medicaid is typically the primary payer so SNFs have incentive to shift costs to Medicare or Medicaid payment policies may be driving care process failures (Medicaid payment levels and bed hold rates are factors)
- Transformation of nursing homes from long term to post acute
- Consider LOS in SNF — the longer one stays the more the SNF is accountable
- Provider practice patterns, willingness to use hospice
- FFS rewards more care rather than coordination and quality

Case #2

- 79-year-old male, hospitalized two weeks earlier with COPD exacerbation, was discovered to have urinary retention and BPH. Had indwelling urinary catheter x 4 days, treated with IV steroids, nebs, and Abx. Started on alpha blocker and returned to SNF.
- Experienced weakness, fatigue, decreased appetite. C/o not feeling well, temp 99.8 oF, WNL. Several days ago was unable to participate in activities; stayed in bed.
- Physician called and discontinued alpha blocker, slowed steroid taper. Yesterday patient had temp 100.3.
- This morning developed hypotension, HR 119, unable to obtain O2 sat.
- Sent to ER where found to have pyuria, sepsis, and dehydration. Admitted to ICU for further care.

Why should we care?

- PPACA
- HCERA
- Public reporting for hospitals
- Demonstrations and pilots
- Quality of Care
- Patient outcomes
- Payment system reform
  - Denials for 30 day same diagnosis
  - Med-PAC recommends that Medicare reduce payment to hospitals with relatively high risk-adjusted readmission rates for select conditions
  - RHQDAPU Program
  - Bundled payments
Hospital readmissions measures (continued)

Readmission is when patients who have had a recent stay in the hospital go back into a hospital again. The information on this website shows how often patients are readmitted within 30 days of discharge from a previous hospital stay for heart attack, heart failure, or pneumonia. Patients may have been readmitted back to the same hospital or to a different hospital or acute care facility. They may have been readmitted for the same condition as their recent hospital stay, or for a different reason.

This website shows how different hospitals' rates of readmission for heart attack, heart failure, and pneumonia patients compared to the U.S. National Rate. You can see whether the 30-day risk-adjusted rate of readmission for a hospital is lower, higher, or no different than the national rate, or higher compared to the national rate, given how sick patients were when they were admitted to the hospital.

For some hospitals, the number of cases is too small (fewer than 25) to reliably tell how well the hospital is performing, so no comparison to the national rate is shown.
**Readmission reduction strategies**

- Service delivery reform
- Financing reform
- Medicare and Medicaid integrated service and financing reform

**Some elements of care common to most transitions models**

- Medication management/reconciliation
- Assessing patient’s understanding/ability to follow care plan
- Discharge support
- Coaching for primary care physician visit
- Use of home visits
- Screening for cognitive ability
- Use of centralized health record
- Involving family and other caregivers
- Arranging community-based support services

**Shoring up SNF capabilities**

- IV fluids
- Hypoderomolysis
- Labs/diagnostics
- Pharmacy
- Palliative care and hospice availability
Health and safety laboratory (HSL) trial

- Physician history and physical template
  - Care guidelines for common geriatric syndromes
  - Med reconciliation template
  - Goals of care
  - Advance directives
  - Number of hospitalizations in the past six months
- Palliative Care Consults: three or more hospitalizations total
- TIPS conferences
- Readmission to acute care declined from 16.5% to 13.3% (20% decline)
- Patients more likely than baseline to die on unit in accordance with wishes vs. transfer to the hospital

Evercare approach

- Toolkit
  - ACP
  - Getting the discharge summary
  - Med records (HEDIS requirement)
  - Timely initial visit
- Transfer envelope
- Discussion guide
- Out patient consultation form
- Nurse practitioner expectations for emergency department and post-hospital
- TAP

Retrospective data collection tool/TAP
Was there a clinically responsible alternative to hospitalization to manage Change In Condition (CIC) at time of transfer?

Category I: Transfer

No answer to CIC question or "YES" to No Reasonable Opportunity.

Identify Root Cause

Category II: Transfer

No answer to CIC question or "YES" to No Reasonable Opportunity.

Identify Root Cause

Category III: Transfer

No answer to CIC question or "YES" to No Reasonable Opportunity.

Identify Root Cause

TAP categories

<table>
<thead>
<tr>
<th>Category</th>
<th>Hospital Transfer</th>
<th>Transfer Avoidable Hospital Transfer</th>
<th>Transfer Unavoidable But Potentially Preventable Hospital Transfer</th>
<th>Transfer Appropriate Hospital Admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Clinically responsible alternative to hospitalization does not exist at the time of transfer and all elements of evaluation/management of change in condition were completed or there was no reasonable opportunity to complete them.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>II</td>
<td>Inpatient care is consistent with the member/family/representative wishes and/or expressed goals of care as documented in the medical record.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>III</td>
<td>Inpatient-based treatment was needed to:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preserve or increase function</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Optimize pain control</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Provide surgery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Inpatient diagnostics</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Reduction in unnecessary hospitalizations

The University of Minnesota School of Public Health found that the incidence of hospitalizations among nursing home populations was twice as high in control residents as in Evercare residents.

Members in the control group were also twice as likely to go to the emergency room than Evercare members.

Evercare had half the hospitalizations compared to fee-for-service Medicare (Control 1 and 2).
Reduction in unnecessary hospitalizations (continued)

Effect of Evercare on Hospital Use

Effect of Evercare Hospital admissions and Emergency room visits:

- Evercare: 45
- Control 1: 50
- Control 2: 55

Source: Dr. Robert Kane et al, University of Minnesota, 2003

Evercare readmission rate

Evercare 30 Day Readmission Rate:
- Evercare: 10.6%
- Medicare SNF Patient Data: 23.5%

Case #3

- 89-year-old female with severe degenerative arthritis R hip R duodenal ulcer related to NSAID use now s/p R THR returned to SNF not anticoagulated due to recent GI bleed
- Developed acute onset dyspnea, hypoxia and tachycardia
- BP 84/60 HR 126 RR 28 T 100.6
- Staff called 911. Patient readmitted to hospital with acute PE
Project RED (re-engineered discharge)

- Discharge Advocate to perform:
  - Education regarding disease and meds
  - Preparation and reinforcement of after hospital care plan
  - Review procedures for handling unanticipated problems
  - Transmission of written plan to care providers
- Nurse avatar used successfully as patient advocate alongside Discharge Advocate
- Initial research shows 30% reduced likelihood of re-hospitalization within 30 days
- More than 50% of discharged patients had medication problem requiring corrective action post discharge
- 91% of receiving physicians had discharge summary within 24 hours of discharge
- Savings of $380 per patient (includes cost of nursing time)

Transitional Care Model

- Advance Practice RNs: Transition Nurse Managers
- Comprehensive discharge planning and home visits
- Active engagement/support of families and caregivers
- Collaboration with physicians

Transitional Care model

TCM’s impact on Hospital Readmission Rates

<table>
<thead>
<tr>
<th>% of Patients</th>
<th>within 6 weeks</th>
<th>within 24 weeks</th>
<th>at 52 weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>TCM Group</td>
<td>12%</td>
<td>28%</td>
<td>43%</td>
</tr>
<tr>
<td>Control Group</td>
<td>18%</td>
<td>33%</td>
<td>48%</td>
</tr>
</tbody>
</table>

Readmission After Hospital Discharge
Transitional Care Model

TCM's Impact on Total Costs (Reimbursements) for Rehospitalizations

Reduction After Hospital Discharge

- 52 weeks
- 24 weeks

Dollars (US)

TCM Group
Control Group

Interact II

Using the INTERACT™ Toolkit to Support the Nursing Home

Other approaches

- POLST/MOLST
- Project BOOST
- Lean Healthcare
- Care Transitions Program
  - Self management model/transition coaching
Conclusions

• SNFs need to improve technical capabilities, staff training and education to prevent readmissions
• We need to continue to understand who is at highest risk for re-hospitalization
• Early recognition of decline/early intervention
• Contingency planning
• Family communication/involvement/support
• Advance Care Planning is critical
• Many tools/resources available
• No excuses!

Thank you.
Any questions?

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