Reducing Hospital Admission and Readmissions
CMS Data

• NF Resident Hospital Admissions
  – 45% Could Have Been Avoided
    • 314,000 Admissions Eliminated
    • Savings - $2.6 Billion

• Hospital Readmissions Within 30 Days
  – National Average - 19%
CMS Initiatives

• Hospital Readmission Reduction Program
• SNF Value Based Purchasing Program
Hospital Readmission Reduction Program

• Mandated by Affordable Care Act
• Measures Readmission Rates
  – Acute Myocardial Infarction
  – Heart Failure
  – Pneumonia
• Readmission Within 30 Days
  – Any Reason
  – Any Hospital
Hospital Readmission Reduction Program

• Readmission Penalty
  – No Reward for Better Performance

• Reduces Base DRG Payments
  – October 2012 - 1%
  – October 2013 - 2%
  – October 2014 - 3%
Hospital Readmission Reduction Program

• October 2014 Additional Conditions
  – Acute COPD Exacerbation
  – Elective Total Hip Arthroplasty
  – Elective Total Knee Arthroplasty
Hospital Readmission Reduction Program

• Nursing Home Impact
  – Hospital Identifying Preferred Facilities
    • Low Readmission Rates
    • Continuity of Relationship with Physicians
    • Ability to Provide Higher Acuity Services
      - Avoid Rehospitalizations
SNF Value Based Purchasing Program

• Mandated by Congress - April 1, 2014
  – Protecting Access to Medicare Act of 2014

• Establishes Measures
  – Readmission Measure
    • “All Cause – All Condition”
  – Resource Use Measure
    • “Risk adjusted potentially preventable”
SNF Value Based Purchasing Program

• Timeline for Implementation
  10/1/2015 - Specify Readmission Measure
  10/1/2016 - Specify Resource Use Measure
  • Provide Quarterly Confidential Feedback to SNF
  10/1/2017 - Public Disclosure of Measures
  • Provided on Nursing Home Compare
  10/1/2018 - Implement VB Incentive Payments
SNF Value Based Purchasing Program

• VB Incentive Payments
  – Reduce Medicare Payments by 2%
    • 50%-70% will be used for VB Incentive Payment
  – Rank SNF on Readmission Measure
    • Identify Performance Score based on ranking
    • Based on Improvement or Achievement whichever is higher
  – Payment Based on Performance Score
    • VB Incentive Percentage X Medicare Per Diem
Nursing Facility Initiatives

• Reducing Preventable Hospital Transfers
  – Unplanned Admissions
  – 30 Day Readmissions
  – Emergency Room Visits Without Admission
  – Observation Stays
Impact of Preventable Hospital Transfers

• Resident Impact
  – Functional Decline - Cognitive Decline
  – Adverse Outcomes - Wounds, Infections

• Customer Service Impact
  – Loss of Trust by Resident/Family
  – Loss of Trust by Referral Sources

• Financial Impact
  – Bed Hold Payments
  – Empty Beds
Contributing Factors
Hospital Transfers

- Physician Involvement and Availability
- Diagnostic Testing Availability
- Nursing Staff Assessment Skills
- Clinical Competency
- Nurse/Physician Communication
- Transition Issues
Goal of Program to Reduce Preventable Hospital Transfers

- Identify Acute Change in Condition EARLY
- Increase Staff Clinical Competency
  - Assessment Skills
  - Treatment Modalities
- Improve Communication Between Staff
  - Shift to Shift Communication
- Improve Communication with Physician
  - Increase Physician Confidence
INTERACT 3.0
Interventions to Reduce Acute Care Transfers

• Goal is to Improve Care and Reduce Unnecessary Hospital Transfers
• Developed in 2007 Through Grant with CMS
• Free Tool Kits to be Used by Facilities
• Developed into QI Program That Meets the QAPI Requirements
• Updated in 2013 - Version 3.0
INTERACT 3.0
Interventions to Reduce Acute Care Transfers

• Nursing Home Capabilities List 2013
  – Identify What Services Are Available
  – Identify Focus For Clinical Program Development
  – Use As a Communication Tool To Referral Sources
INTERACT 3.0
Interventions to Reduce Acute Care Transfers

• Nursing Home Capabilities List 2013

[Embedded link to Nursing Home Capabilities List]
INTERACT 3.0
Interventions to Reduce Acute Care Transfers

• Early Identification of Change in Condition
  – Stop and Watch Early Warning Tool
  – Available for all Staff Who Observe Resident
    • CNA
    • Housekeeping
    • Maintenance
    • Dietary
  – Documents Change and Communicates to Nurse for Follow-up and Assessment
INTERACT 3.0
Interventions to Reduce Acute Care Transfers

• Stop and Watch Early Warning Tool

Stop and Watch Tool
INTERACT 3.0
Interventions to Reduce Acute Care Transfers

• Nursing Assessment
  – Guidelines for the Assessment Process
  – Guidelines for Physician Notification
    • Based on the acute change in condition
  – SBAR Communication Form
    • Assures all appropriate data is available for notifying Physician
INTERACT 3.0
Interventions to Reduce Acute Care Transfers

• Care Paths
  – Identifies Nursing Assessment Process
  – Provides a Decision Tree for Care
  – Provides the Interventions for Care in Facility Versus Hospitalization
INTERACT 3.0
Interventions to Reduce Acute Care Transfers

• Care Paths

  Care Path UTI

  Care Path - Mental Status Change
INTERACT 3.0
Interventions to Reduce Acute Care Transfers

• Acute Change in Condition File Cards
  – Adopted from AMDA Clinical Practice Guidelines
  – Defines Immediate vs. Non-immediate Notification of Physician
  – Can be Adopted by Facility as Policy for MD Notification
INTERACT 3.0
Interventions to Reduce Acute Care Transfers

• Acute Change in Condition File Cards

Change in Condition File Cards
INTERACT 3.0
Interventions to Reduce Acute Care Transfers

• SBAR Communication Form
  – Completed before calling Physician
  – Provides guidelines for Nurse to gather information to report to Physician
  – Gives update not only on situation but recent changes
  – Identifies what is being requested
  – Can be used as the Progress Note in Chart
INTERACT 3.0
Interventions to Reduce Acute Care Transfers

• SBAR Communication Form

SBAR Form
INTERACT 3.0
Interventions to Reduce Acute Care Transfers

• Quality Improvement Activities
  – Tracking/Trending Hospital Transfer Rates
    • INTERACT Excel Spreadsheet Tool
  – Root Cause Analysis
    • QI Tool for Review of Hospital Transfers
INTERACT 3.0
Interventions to Reduce Acute Care Transfers

- INTERACT Excel Spreadsheet Tool

Hospital Tracking Tool
INTERACT 3.0
Interventions to Reduce Acute Care Transfers

• QI Tool for Review of Hospital Transfers

QI Tool for Review of Acute Care Transfers
INTERACT 3.0
Interventions to Reduce Acute Care Transfers

- Key Implementations Steps
  - Leadership Support
  - Physician Buy In
  - Staff Education
  - QI Focus on Tracking and Root Cause Analysis
  - Sharing Outcomes with Staff
Strategies for Reducing Hospital Transfers

• Routine Meetings with Medical Director
  – Review all Hospital Transfers
  – Identify Issues and Plans for Resolution

• “On Call” Consultation
  – Notifies Nursing On Call Person Before Non-emergent Transfer for Consultation
Strategies for Reducing Hospital Transfers

• Ongoing Staff Education
  – Clinical Competencies
  – Cost of Transfer vs. Cost of In-Facility Care
Parting Thoughts

• Prepare Now
• Assess Where You Are Today
• Develop a Plan for Improvement
• Monitor Your Progress
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