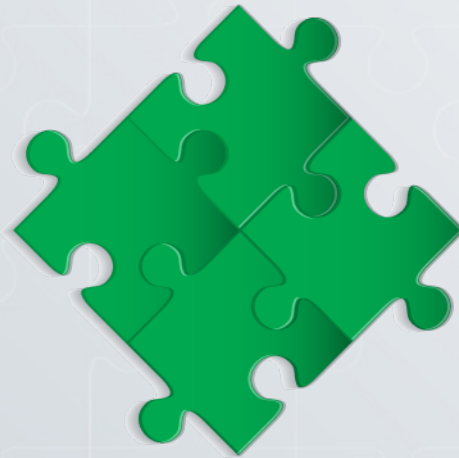


Reducing Hospital Admission and Readmissions



PREMIER
healthcare resources

SOLUTIONS FOR SENIOR CARE PROVIDERS

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
 - $\text{VB Incentive Percentage} \times \text{Medicare Per Diem}$



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

[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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