SNF REHOSPITALIZATIONS
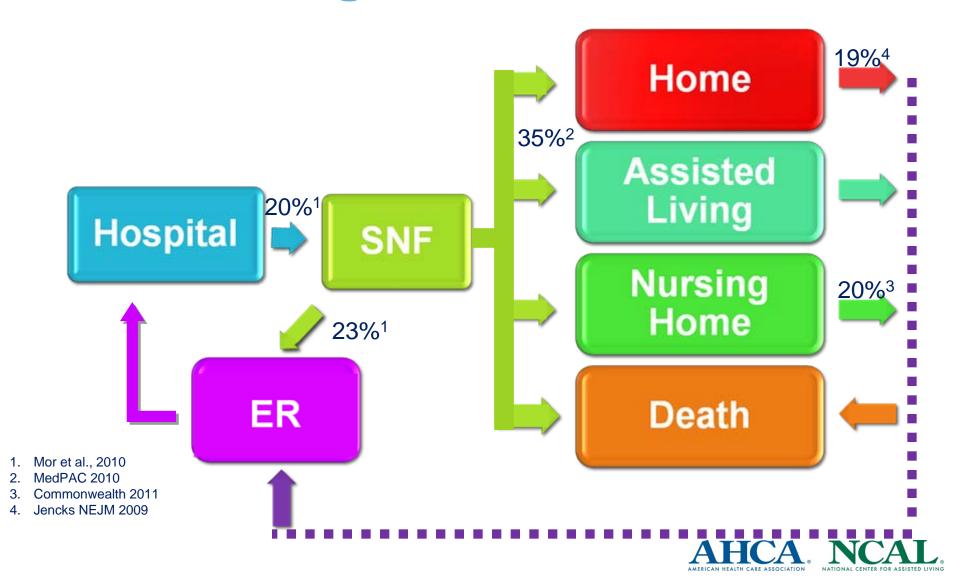
David Gifford MD MPH
SVP Quality & Regulatory Affairs

National Readmission Summit
Arlington VA
Dec 6th, 2013

Use of Long Term Care Services

Hospital → 20%[1] → SNF

SNF → 23%[1] → ER

ER → Hospital

SNF → 35%[2] → Home, Assisted Living, Nursing Home, Death

Home → 19%[4]

Nursing Home → 20%[3]

1. Mor et al., 2010
2. MedPAC 2010
3. Commonwealth 2011
4. Jencks NEJM 2009

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Hospital Readmissions:
The Business Case

- Hospital readmission penalty = Hospitals are searching for partners with low rates = steady/increased referrals

- Accountable/integrated care models will seek partners with good outcomes in this area

- Managed Care seeking networks for providers with low rehospitalization rates

- Better outcomes for individuals
  - Decreases hospital acquired infections
  - Decrease delirium, ADL decline, pressure ulcers and other iatrogenic illnesses

- Decreases stress and workload for nurses associated with transfer & admission paperwork

Linking Quality & Payment

- Senate Finance & House Ways and Means Committees:
  - Request for stakeholder input on reforming PAC payment
  - Core questions – focus on quality measures and finding ways to better incentivize quality performance, pay based on value rather than volume

- Rehospitalization Incentives
  - Some form of SNF rehospitalization penalties and/or incentives expected to be a part of SGR fix bill

- States planning to develop three-way managed care contracts for dual eligible beneficiaries

CMS's State Integrated Care Demonstration for Dual Eligible

- CMS required states to submit proposals and sign MOU
  - 26 States submitted proposals
  - 8 States signed MOU
    - CA, MA, VA, IL, OH, WA, MN, SC
  - MOUs require collection and use of quality measures for short and long stay individuals and to link with payment

  http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsinCareCoordination.html

AHCA Quality Initiative Goals

Safely reduce 30-day hospital readmissions by 15% by 2015

Reduce nursing staff turnover by 15% by 2015

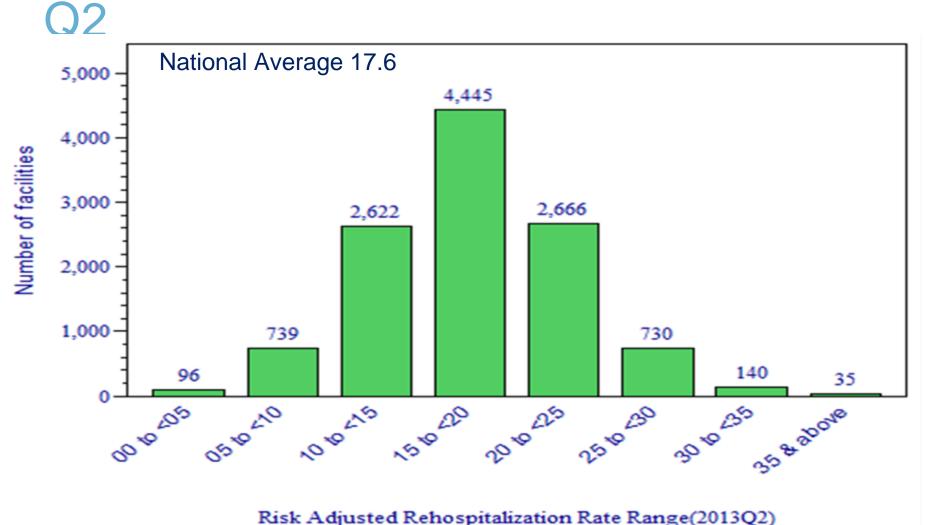Increase customer satisfaction to 90% by 2015

Safely reduce the off-label use of antipsychotics by 15% by the end of 2013
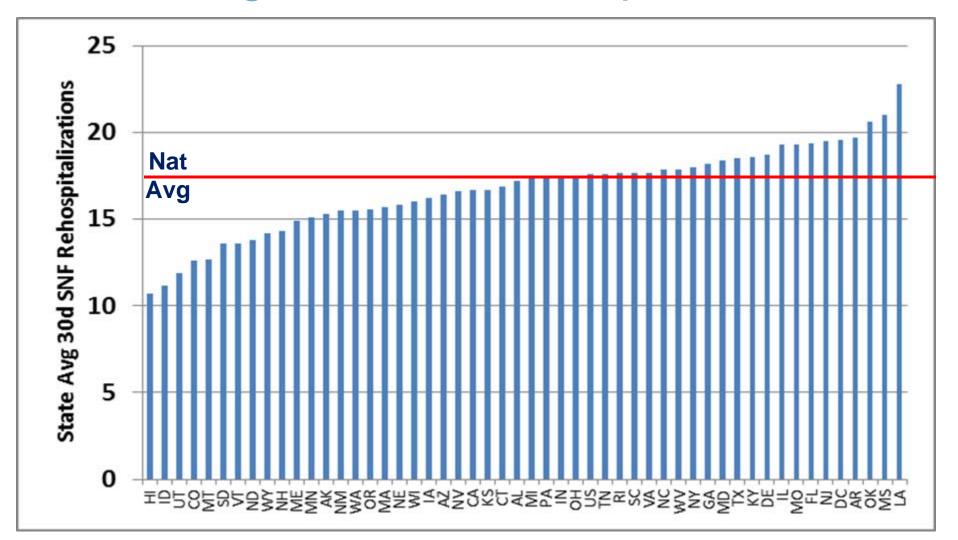
QualityInitiative.ahcancal.org

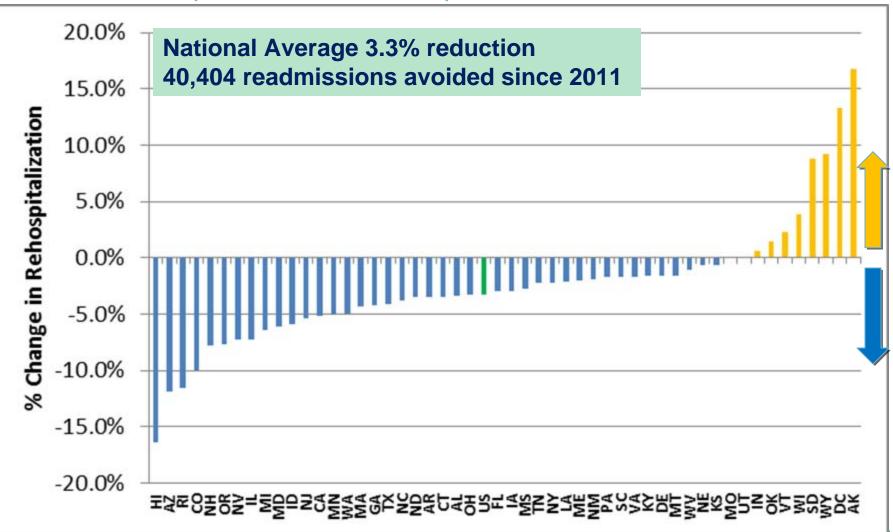# National Rehospitalization Rates 2013 Q2

National Average 17.6

Risk Adjusted Rehospitalization Rate Range(2013Q2)

State Avg 30d SNF Rehospitalizations

Change in State Rehospitalization 2011 Q4 to 2013 Q2

National Average 3.3% reduction
40,404 readmissions avoided since 2011

USE DATA TO DRIVE CHANGE

Measure & Track

1. **RISK-ADJUSTED MEASURES**
   - Use when comparing or benchmarking yourself to others

2. **UNADJUSTED ACTUAL RATES**
   - Use for internal tracking & Quality Improvement

3. **COUNTS OF # OF EVENTS, TIME BETWEEN EVENTS**
   - Use for rapid cycle improvement
   - Track # of hospitalizations, in past month

Where Can I Get Data on My Rates?

- Use Long Term Care Trend Tracker
  - See Appendix for OnPoint-30 risk adjusted measure from PointRight
  - www.ltctrendtracker.com
- Real-time internal data collection & analysis
  - Advancing Excellence free excel tracking tool
  - www.nhqualitycampaign.org/star_index.aspx?controls=HospitalizationsIdentifyBaseline

Advancing Excellence
in America's Nursing Homes

Making nursing homes better places to live, work and visit.

HOME	ABOUT THE CAMPAIGN	RESOURCES	PROGRESS	FOR PARTICIPANTS

Getting Started

Explore Goals

Process Goals:

Consistent Assignment

Hospitalizations

Person Centered Care

Staff Stability

Clinical Outcome Goals:

Infections

Medications

Mobility

Pain

Pressure Ulcers

Hospitalizations

Explore Goal	**Identify Baseline**	Examine Process	Improve	Leadership	Monitor & Sustain	Celebrate

Now that you know what you want to improve, it's important to identify your starting point or baseline. Download the data tracking tool and collect data for a month or so to determine your starting point.

Safely Reduce Hospitalizations Tracking Tool

This tool calculates rates for 30-day Readmission, Hospital Admissions, Transfers to Emergency Only, and Transfers Resulting in Observation Stay. This tool also has features that allow you to track patterns and processes affecting your hospital transfers.
AE_SafelyReduceHospitalizationsTrackingTool_v3.0_5-21-13.xls

This tool has been updated to be compatible with Excel 2010. If you are using Excel 2010 and still experience issues, please email help@nhqualitycampaign.org.

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Using Counts & "Time Between Events"

- Simple counts
  - # of hospitalizations last week/last month
- Time between events (e.g. OHSA employee injuries)
  - # of days since last hospitalization
- Use for any clinical measure
  - As you increase the time between events you will improve on any quality measure risk adjusted or not
  - Simple
  - Easy to display where all staff can see
  - Rapid feedback

Tracking Counts & Time Between Events

Tracking Counts & Time Between Events

Using Measurement isn't enough

"You can't fatten a cow by weighing it."*

--*Ancient Proverb*

WORKING TOGETHER TO REDUCE REHOSPITALIZATIONS

Factors associated with Top vs Bottom Performing Hospitals

Qualitative study of staff interviews comparing top vs bottom performing hospitals based on CMS quality measures over two year period.

- No differences in clinical protocols and processes for AMI care

- Staff at high-performing hospitals
  - shared the common organizational values of providing high-quality care, expressed as "a common vision and purpose," the "glue" of the organization, and "the driving force behind everything."
  - used root-cause analysis to learn from experiences and improve care.

- At low-performing hospitals
  - problem-solving was less constructive and finger-pointing was more common

Curry LA et al. Ann of Int Medicine 2011; 54(6):384–90

Factors Associated with Low Rehospitalizations

- 47 Nursing homes in NY (N=26,746 patients)
- Measured Clinical and non-clinical factors associated with rehospitalization rates
- Three strongest predictors:
  1. Training provided to nursing staff on how to communicate effectively with physicians about a residents condition
  2. Physicians who practice in this nursing home treat residents within the nursing home whenever possible, saving hospitalization as a last resort
  3. Provided better information and support to nurses and aides surrounding end-of-life care

[1]Young Y et al. Clinical and Nonclinical Factors Associated with potentially preventable hospitalizations among nursing home residents in NYS. JAMDA 2011;12:364-371.

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Strategies to Reduce Hospitalizations

- Track your rehospitalizations

- Improve Communication
  - Externally (e.g. with hospital/ER)
  - Internally (e.g. between nursing & physicians)

- Identify small changes in a resident's status early on

- Change Staffing
  - Consistent Assignment
  - Reduce staff turnover
  - Utilize nurse practitioners

- Promote Advance Care Planning

INTERACT III

Is a comprehensive program that uses these strategies

INTERACT II Program

- Comprehensive approach to reduce hospitalizations
  - Acute care transfer log to track/measure rehospitalizations
  - Standard Transfer Form
  - Communication Tool with Physicians (SBAR)
  - Resident assessment tool & algorithms
    - Stop & Watch and Care Paths
  - QI Improvement review tool
    - Evaluation to assess each hospitalization (Root cause analysis)
  - Advance care planning resources

http://www.interact2.net

INTERACT Effectiveness

Facilities	Mean Hospitalization Rate per 1000 resident days (SD)		Mean Change (SD)	p value	Relative Reduction
	Pre intervention	During Intervention			
All INTERACT facilities (N = 25)	3.99 (2.30)	3.32 (2.04)	- 0.69 (1.47)	0.02	17%
Engaged facilities (N = 17)	4.01 (2.56)	3.13 (2.27)	- 0.90 (1.28)	0.01	24%
Not engaged facilities (N = 8)	3.96 (1.79)	3.71 (1.53)	- 0.26 (1.83)	0.69	6%
Comparison facilities (N = 11)	2.69 (2.23)	2.61 (1.82)	- 0.08 (0.74)	0.72	3%

Ouslander et al, J Am Geriatr Soc 59:745–753, 2011

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Innovative Hospital – SNF strategies #1

- Hospital encouraged SNF to submit near miss reporting in their medical error reduction program when information on SNF transfer was missing.

- Hospital added SNF staff to QA review of all rehospitalizations

- Hospital was so enthusiastic about the INTERACT Transfer Checklist envelopes that they had them printed in orange and distributed to all SNFs in the community

Innovative Hospital – SNF strategies #4

- Hospital worked with local SNF to develop checklist of items that SNF needed from the hospital when a patient was discharged.
  - They used it for every discharge and
  - Director of Case Management from the hospital called every time the resident was discharged to this particular SNF to be see how the transfer went and what processes needed to be modified.

Innovative Hospital – SNF strategies #2

- Hospitals placing NPs in SNFs
- Hospitals and SNFs used staff for in-service training
  - Hospitals for CHF, Cardiac Surgery, COPD management
  - SNFs for pressure ulcers, restraint free practices
- ACOs using risk adjusted rehospitalization measure to evaluate overall program AND INTERACT tracking tool from Advancing Excellence for QA review
- SNFs using CMS antipsychotic data to review with the hospital all discharges on an antipsychotics
  - Note: >40% increase risk of rehospitalization for individuals on antipsychotics

Innovative Hospital – SNF strategies #3

- **<u>Patient Tracer Experience</u>**: a hospital nurse follows discharged patient to SNF and serves as observer only
  - to see the experience through the eyes of the patient,
  - to see/appreciate/develop new respect for the SNF setting
- This was "a real eye opener for our [hospital] staff"
  - when they saw the quality of the medical information sent to the SNF
  - what it means for the SNF nurse to reconcile all of the discharge paperwork and medications
  - to see what the experience of the patient is like
    - if the pain med is missed prior to discharge,
    - if meds or equipment aren't at SNF,
    - if resident isn't adequately prepared for what to expect at SNF

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Appendix A:

AHCA OnPoint 30 Risk-Adjusted Rehospitalization Measure

AHCA SNF 30-Day Rehospitalizati[On Point 30 logo]

- **Readmissions** = all patients admitted to a SNF from a hospital for SNF Part A services who are sent back to <u>any</u> hospital for <u>any</u> reasons within the next 30 days for either inpatient admission or observation status

- Exclusions
  - No individual resident's are excluded for any reasons
  - All rehospitalizations for any reason are included.

- A facility's rehospitalization rate is not reported if they,
  - do not have at least 95% or greater rate of completing a MDS discharge assessment for residents who do <u>not</u> stay in the facility following an admission
  - Do not have at least 30 admissions to the facility over 12 months

Risk Adjustment Variables Used

- **Demographic**
  - Age >65
  - Male
  - Medicare as Primary Payor
- **Functional Status**
  - Total Bowel Incontinence
  - Eating dependent
  - Needs 2 person assistance in ADLs
  - Cognitive Impairment (Dementia)
- **Prognosis**
  - End Stage prognosis poor
  - Recently rehospitalized
  - Hx of Respiratory Failure
  - Receiving Hospice Care
- **Clinical Conditions**
  - Daily pain
  - Pressure Ulcer Stage >2 (split into 4 variables)
  - Venous Arterial Ulcer
  - Diabetic Foot Ulcer

- **Diagnoses**
  - Anemia
  - Asthma
  - Diabetes Mellitus
  - Hx of Viral Hepatitis
  - Hx of Septicemia
  - Hx of Heart Failure
  - Hx of Internal bleeding
- **Services & treatments**
  - Dialysis
  - Insulin prescribed
  - Ostomy care
  - Cancer Chemotherapy
  - Receiving Radiation Therapy
  - Continue to receive IV Medication
  - Continue to receive oxygen
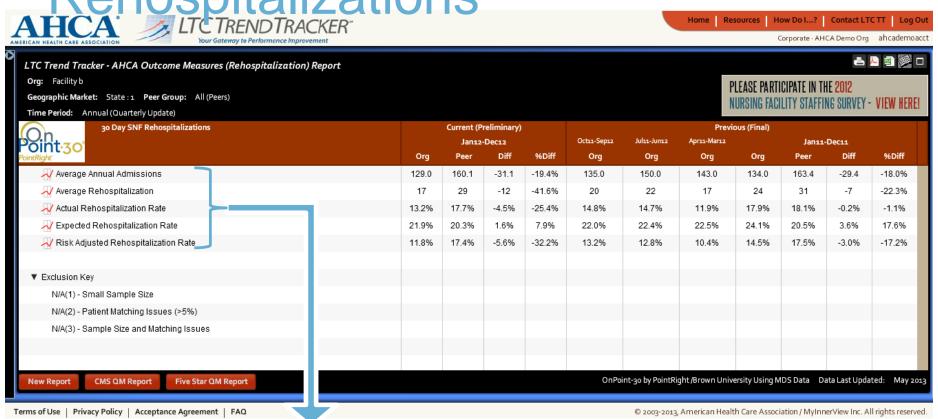 - Continued tracheostomy care

LTC Trend Tracker
Rehospitalizations

- Total # of Admissions in last 12 months
- National Average Rehospitalization Rate
- Actual Rehospitalization Rate
- Expected Rehospitalization Rate
- Risk-adjusted Rehospitalization Rate

Risk Adjustment Calculation

$$\left(\frac{\text{Actual Rehospitalization}}{\text{Expected Rehospitalization}} \right) \text{x} \begin{array}{c}\text{National}\\ \text{Average}\end{array} = \begin{array}{c}\text{Risk Adjusted}\\ \text{Rate}\end{array}$$

- National Average = 18.0
- Example 1: Actual > Expected
  - (actual 20.0) ÷ (expected 15.0) = 1.33 * 18.0 = 24.0
- Example 2: Actual < Expected
  - (actual 20.0) ÷ (expected 30.0) = 0.66 * 18.0 = 12.0

Actual to Expected Ratio >1 you need to make changes

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Interpreting Risk Adjusted Data

- Actual to Expected Ratio >1
  - Rehospitalizing more people than expected given the type of individuals and acuity of patients you admit
- Actual to Expected Ratio < 1
  - Rehospitalizing fewer people than expected given the type of individuals and acuity of patients you admit

Appendix B:
Key Themes & Practices in High Performing Hospitals

Factors associated with Top vs Bottom Performing Hospitals

Qualitative study of staff interviews comparing top vs bottom performing hospitals based on CMS quality measures over two year period.

- No differences in clinical protocols and processes for AMI care

- Staff at high-performing hospitals
  - shared the common organizational values of providing high-quality care, expressed as "a common vision and purpose," the "glue" of the organization, and "the driving force behind everything."
  - used root-cause analysis to learn from experiences and improve care.

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  - problem-solving was less constructive and finger-pointing was more common

Key Themes in High Performing Hospitals

- Hospital uses protocols to improve AMI care

    Clinical order sets, rapid-response teams, discharge planning practices, medication reconciliation practices, cardiac rehabilitation and support programs, patient and family education programs, coordination with pre- and post-hospital providers, and participation in quality collaboratives and campaigns

- Organizational values and goals

    Shared values to provide exceptional, high-quality care and alignment of quality and financial goals of the organization

- Senior management involvement

    Provision of adequate financial and nonfinancial resources, use of quality data in management decisions, and holding staff accountable for quality

- Broad staff presence and expertise in AMI care

    Sustained physician champions, empowered nurses, involved pharmacists, and high qualification standards for staff

- Communication and coordination among groups

    Diverse skills and roles, recognizing interdependencies, and smooth information flow among groups

- Problem solving and learning

    Diverse events seen as opportunities to learn, use of data for non-punitive learning, innovation and creativity in trial and error, and learning from outside sources

Curry LA et al. **What Distinguishes Top-Performing Hospitals in Acute Myocardial Infarction Mortality Rates? A Qualitative Study** *Ann Intern Med.* 2011;154:384-390.