Tackling Avoidable Readmission through Care Transition:

PART I

HARMONY UNIVERSITY
The Provider Unit of
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Tackling Readmission through Care Transition

Course Objectives
- Learner will be able to summarize the CMS quality initiative for Healthcare Reform related to hospital readmissions
- Identify underlying causes and barriers related to readmission
- State current CMS research projects and pilot programs.
- The learner will be able to identify hospital and SNF strategies for collaboration
- Discuss Interact Tool and other Initiatives to Reduce readmissions
June 2007 & 2008 Medicare Payment Advisory Commission (MedPAC) Report to Congress highlighted avoidable Rehospitalizations as an area of high cost and low quality. Prompted leaders of healthcare systems across the country to focus on avoidable Rehospitalizations in anticipations of potential changes in the market.
Tackling Readmission

- Payers & Policymakers are targeting Readmissions to reduce healthcare expenditures & improve quality of care and patient outcomes

Tackling Readmission

- 2009 Re-Admissions emerged as a Major Quality Initiative of Healthcare Reform
- Reducing Re-hospitalization is an important element of President Obama’s February 2009 proposal for financing Health Care Reform

Tackling Readmission

- The Affordable Care Act
  - From a Policy perspective performance variation indicated lack of reliable attention to executing successful transition out of the hospital and into the next care setting
  - Several provisions regarding improving Care Transition, Care Coordination and Reducing readmissions
Besides the penalties, the Obama administration is ramping up other efforts to reduce readmissions. Giving out $500 million to help hospitals and other healthcare providers improve the transitions of patients out of hospitals. And the administration has approved 154 “Accountable Care Organizations,” which are collaborations of hospitals, doctors and other healthcare providers that receive financial incentives for preventing costly episodes such as readmissions.

High rates of readmissions have gained attention due to cost and quality concerns. 1 in 5 Medicare patients discharged from the hospital is readmitted within 30 days. A cost of over $17 billion each year.
Tackling Readmission

- 90% Re-hospitalizations within 30 days are unplanned
- 75% of Readmissions preventable equating to $12 Billion a year to Medicare spending

Tackling Readmission

- 34% of Re-admissions within 90 days
- 56.1% within one year
- 68.9% of patients discharged with a medical condition, were re-hospitalized or died within one year of discharge
- 53% re-hospitalization of Discharges after a surgical procedure

Tackling Readmission

- 50% of re-admissions within 30 days had no bill for a physician visit
- 70% surgical patients were admitted for a medical condition such as pneumonia and UTI
- 19% of Medicare discharges are followed by an adverse advent with 30 days:
  - 2/3 Drug Events that are preventable
Tackling Readmission

- Some Readmission to the hospital are planned
- Other are avoidable and the result of
  - Poor quality of care/ uncoordinated care
- Variation in readmission rates by hospitals and geographical regions
- Readmissions rates can be reduced with application of evidenced based guidelines and enhanced care coordination

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Tackling Readmission

- **Five** most common Medical condition for Readmission:
  - Heart Failure
  - Pneumonia
  - COPD
  - Psychoses
  - GI problems

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Tackling Readmission

- **Five** most common surgical procedures:
  - Cardiac stent placement
  - Major hip or knee surgery
  - Vascular surgery
  - Major bowel surgery
  - Other hip or femur surgery
Tackling Readmission

- **Research Recommendations:**
  - Interventions at time of Discharge
  - Reliable & prompt follow-up care by primary care physicians
  - Aggressive Management of chronic illness

CMS included a **Care Transition** in its 9th **Statement of work** (started in 2008)
- Quality Improvement Organizations (QIOs) in 14 communities are working to coordinate care and promote seamless transitions across settings
- Specifically focusing on reducing unnecessary readmissions to the hospital by improved transitions of care and greater coordination among providers

**Medicare 9th Scope of Work**
- Began investigating 30-day Re-Admissions
- CMS Fiscal Intermediaries and state based QIOs began flagging 30-day readmissions to the same facility and for same diagnosis
  - AMI
  - Heart Failure
  - Pneumonia
- QIOs reached out to hospitals and conducted reviews of discharge plans and other documentation to identify patterns of preventable readmissions
IHI (Institute for Healthcare Improvement) on May 1, 2009 launch the State Action on Avoidable Rehospitalizations (STAAR) Initiative
- Grant support from the Commonwealth Fund.
- Initial phase, Two year Multi state project to reduce avoidable Rehospitalizations focusing on two components

Tackling Readmission

IHI (Institute for Healthcare Improvement)
Focusing on Two components:
- A multi-state learning community to Improve Transition of Care
- Targeted Technical Assistance to address systemic barriers to reducing avoidable Rehospitalizations

Tackling Readmission

Reducing Rehospitalizations in a state or region will require coordinated efforts among:
- Clinicians and providers engaged across organizational and service delivery types
Tackling Readmission

- **Hospitalizations and Rehospitalizations**
- are symptomatic of multi process defect in the health care system **due to lack of**:
  - Timely or equitable access to care
  - Effective handoffs and coordination of care
  - Safe care
  - Patient centered and appropriate end of life care

Tackling Readmission

- **Resources consumed by Rehospitalizations**
  - 5 million Rehospitalizations per year
  - 14% to 19% Rehospitalization rate
  - 25% of Medicare hospital costs
  - 12% rate of Rehospitalization of post-acute or nursing home patients occur even before the actual **transfer process** out of the hospital can be **completed**

Tackling Readmission: Skilled Nursing Facilities

- **The Frequent Causes** identified:
  - Pneumonia
  - Urinary Tract Infections
  - Heart Failure
  - Dehydration
  - Pressure Ulcers
  - Injuries due to falls
Tackling Readmission: Skilled Nursing Facility

- Medicare readmission rates for Skilled Nursing Facilities to hospitals increased 30% from 2000 to 2006

Tackling Readmission
Why do Readmissions happen?

- Discharge from Hospital is critical and requires adequate planning and preparations to avoid
  - Medication errors
  - Poor discharge planning
  - Inadequate arrangements
  - Poor communication
  - Adverse events

Tackling Readmission
Inappropriate Hospitalizations

- Occur with uncertain frequency in the general population
- There is data suggesting that 40% of nursing-home to hospital transfers were considered inappropriate
Tackling Readmission

The Care Transition Theme

- CMS funded initiative for Medicare QIOs to measurably improve the quality of care in the transitions among care settings
  - Fourteen QIOs worked with target communities (Aug 1, 2008-August 2011)
  - QIOs selected target geographical areas
  - No stipulation on specific interventions strategies QIOs and the communities should or should not use
  - Goal to develop local solutions and strategies

The Care Transition Theme:
Programs to Improve Care Transitions

Group 1: Programs/Toolkits:
- Care Transitions Interventions
- Bridging Nursing Support/Transitional Care Model
- Better Outcomes for Older Adults Through Safe Transition (BOOST)
- Best Practices Intervention Package (BPIP): Transitional Care Coordination. Intervention to Reduce Acute Care Transfers (INTERACT)
- Transforming Care at The Bedside (TCAB)
- Re-engineered Discharge (RED)
Programs to Improve Care Transitions: Cross-Setting Care Standardization:

Group 2:
- Enhanced information transfer at Discharge
- Follow-up care established at Discharge
- Medication Management
- Plan of Care
- Telemicine
- Telephone follow-up
- Electronic health record/electronic medical record

- Multidisciplinary team, multifaceted interventions
- Clinical protocols, best practices and regional guidelines
- Enhanced palliative care consultation/support
- Education
- Coaching
- Personal Health Record (PHR)
- Community Supports

Tackling Readmission

- Evidence suggest several specific interventions reduce the rate of avoidable Rehospitalizations:
  - Improving core discharge planning and transition processes out of the hospital
  - Improving transition and care coordination at the interface between care settings
  - Enhance coaching, education, and support for self management
  - Focus on both the senders and receivers of patients transitioning from the acute care setting

Tackling Readmission

INTERACT (Interventions to Reduce Acute Care Transfers)

- Joseph Ouslander, MD, Director of Boca Institute for Quality Aging at Boca Raton Community Hospital, created a program aimed at reducing the number of hospital admission from nursing homes
Tackling Readmission
INTERACT (Interventions to Reduce Acute Care Transfers)

- **Interventions to Reduce Acute Care Transfers**
  - Reducing Avoidable Hospitalization of Nursing Home Residents
  - Pilot project
  - Goal to develop and implement strategies and tools that will reduce potentially avoidable Acute Care Transfers (ACT) from Nursing homes

**Rational:**
- Transfer to an acute care facility is essential for the health and well being of acutely ill nursing home residents
- Many ACTs are potentially avoidable while safely treating in the nursing home

**Reducing potentially avoidable ACT will:**
- Decrease emotional trauma to the resident and the family
- Decrease complications of hospitalization, such as de-conditioning, pressure ulcers, indwelling bladder catheter use, injurious falls, and polypharmacy
- Reduce overall health care costs
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INTERACT (Interventions to Reduce Acute Care Transfers)

- Nursing homes currently do not directly receive the benefits
- ACT is likely to be a major focus with Medicare’s Pay for Performance

INTERACT Tool Kit Focus three specific areas:
- Communication
- Care Paths
- Advance Care Planning

Focus Areas:
- Communication: Focus is on communication of residents with acute changes in condition between staff at the nursing home as well as between the nursing home and hospital
- Care Paths: For common acute conditions in nursing home residents that guide treatment in the nursing home when feasible
- Advance Care Planning: Will assist in reducing potentially avoidable acute care transfers of residents who are terminally ill and/or on a palliative care plan
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INTERACT (Interventions to Reduce Acute Care Transfers)

Main Goals:
- Improve the process and effectiveness of communication:
  - Among nursing home staff
  - Primary Care Clinicians
  - Between nursing home and acute hospitals by using INTERACT communication tools

Main Goals:
- Improve the management in the nursing home of carefully selected residents with conditions that commonly result in ACT:
  - Including altered mental status
  - Fever, dehydration
  - Urinary tract infection
  - Pneumonia
- Using INTERACT care paths

Main Goals:
- Improve the process of advance care planning in the nursing home and increase the number of residents who have advance directives, palliative/comfort care plans, and who are enrolled in hospice when appropriate by using INTERACT tools.
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INTERACT (Interventions to Reduce Acute Care Transfers)

**Communication:**
- SBAR communication tool disease specific and corresponds with a Care Path
- CNA Early Warning tool was printed on 3x5 cards and laminated for all CNA staff
- Acute Change in Condition Tool was printed on 3x5 cards and laminated and placed in file box. (Instructions of when to report changes)
- Acute Care Transfer Checklist
- Case Examples for staff awareness
- Unplanned Acute Care Transfer Review used as a QI tool. (Evaluation of strategies and results)

“Handoff Communication”

**SBAR**

A Communication Strategy Designed to Enhance Patient Safety By Standardizing the way Caregivers Talk to Each Other
Tackling Readmission
What is Meant By “Handoff Communication”?

- The process of providing patient specific information from one caregiver to another, or from one team of caregivers to another
  - Patient’s current condition
  - Ongoing treatment
  - Recent and possible changes in condition
  - Complications to watch out for
  - A system to enhance the continuity and safety of patient care

Tackling Readmission
SBAR Communication

S: Situation
  Why are you placing the call?

B: Background
  What happened leading up to the situation?

A: Assessment
  What did your assessment reveal?

R: Recommendation
  What are you asking the physician to do?

Tackling Readmission
SBAR Communication Tool

- Before calling MD/NP/PA:
  - Assess the patient, including recent vital signs
  - Review the chart for the appropriate physician/caregiver to contact
  - Know the admitting diagnosis
  - Read the most recent Progress Notes and the assessment from the nurse on the previous shift
Tackling Readmission
SBAR Communication Tool

- **Before calling MD/NP/PA:**
  - Have **All** information **available** when speaking with the physician/caregiver: chart, allergies, meds, IV fluids, labs/results, vital signs, code status
  - If physician/caregiver unavailable and you are expecting a return call, notify coworkers that you are expecting the call and where you can be located

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INTERACT Focus Areas: Disease Specific Care Paths Tools

- **Disease Specific Care Paths:**
  - Printed on bright paper and placed in sheet protectors and mounted on clipboards. (Care Paths: Include a pathway of clinical assessment, observations and interventions)
  - All licensed staff **were trained** in the **use of Care Paths.**
    - Acute Mental Status change
    - Fever
    - Lower Respiratory Infection
    - Hydration
    - UTI
    - CHF

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INTERACT Focus Areas: Advanced Care Planning Communication Guide Tools

- **Advanced Care Planning Communication Guide:**
  - **Notebook** with materials for **Social Workers** and **DON's** with materials for use when talking with **residents**
    - Tips for starting conversations.
    - Helpful Language for discussing End of Life Care.
    - Identifying Residents at high risk for Entering the Actively Dying Process.
    - Comfort Care Order Set.
  - **Display rack in Social Workers office** with materials for **families**
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INTERACT (Interventions to Reduce Acute Care Transfers)

**Results**: rated by an expert panel
- The group evaluated the number of potentially **avoidable hospitalizations** from three nursing homes
- Results suggest that the proportion of **avoidable hospitalizations dropped** due to the intervention from **23 of 30 (77%) avoidable admissions** to **32 of 65 (49%) avoidable admissions** after 6 month intervention

Tackling Readmission
Programs to Improve Care Transition

**Care Transitions Intervention Model**

Patient with **chronic illness** often require care from a **variety of practitioners in multiple settings**
- Primary care physician
- Specialist in ambulatory care
- Hospitalist physician and nursing team during in-patient admission
- Different physician and nurses during SNF admission
- Visiting nurse at home
Tackling Readmission
Care Transitions Intervention Model

- Systems of care often fail patients by **not ensuring** that:
  - Critical elements of the care plan developed on one setting are transferred to the next
  - Essential steps before and after transfer, by default become the responsibility of patient and their caregivers who often do not possess the necessary health care self management skills or confidence to assume this role

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Tackling Readmission
Care Transitions Intervention Model

- **Care Transitions Intervention** begins with admission to the hospital
  - Interventions focus on care transitions between hospital and home, or nursing home and home

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Tackling Readmission
Care Transitions Intervention Model

- **Goal** of Care Transition Interventions are achieved through a patient centered model comprising **two components**
  - Patient Centered Record
  - Transition Coach
Tackling Readmission
Care Transitions Intervention Model

- **Patient Centered Record** that consists of essential elements for facilitating productive communication during care transition
  - List Patient’s **Medical Conditions** in his/her own words
  - Space for patient concern for **follow up doctor visit**
  - **Warning signs** that might indicate the patient’s condition is worsening
  - List of **Medications and Allergies**

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Tackling Readmission
Care Transitions Intervention Model

- **Patient Centered Record**
  - List of structured intervention activities
    - **Discharge checklist** designed to empower patients to acquire knowledge and self management skills needed throughout the transition

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Tackling Readmission
Care Transitions Intervention Model

- **A Transition Coach**
  - Designed to help patient and their caregivers apply the principles of the program
    - Coaching sessions include a follow up visit in the home
    - Phone calls designed to provide continuity across the transition
Tackling Readmission
Care Transitions Intervention Model

**Interventions** focuses on 4 pillars:

1. Medication self-management
2. Use of patient-centered record (a user-friendly booklet for the patient to record a brief patient history, medications, allergies, immediate health goals and questions for the doctor)
3. Primary care and specialist follow up
4. Knowledge of red flags – signs that the patient's condition is getting worse and how to respond

Coaching patients during and after their hospital stays can reduce readmissions by as much as 50%.

- Coach calls patient three times
- Coach is not providing care but is engaging the patient in his/her own recovery and self-management
- Coach quizzes the patient on each medication, sorts out the duplicates and discrepancies and has them call their primary care physician
- Coaching is completed in fewer than 28 days after discharge

**Coaching Results**

- **14 days after discharge:** 8% of coached patients were readmitted, compared with 17% of un-coached patients
- **30 days after discharge:** 13% of coached patients were readmitted, compared with 20% of un-coached patients
- **60 days after discharge:** 15% of coached patients were readmitted, compared with 29% of un-coached patients
- Coached patients were half as likely to have been readmitted as the un-coached patients
Mary Naylor, PhD, RN, and colleagues at the University of Penn. School of Nursing created and tested this model which provides:

- **Pre and post discharge coordination of care** for high risk, elderly patient's with chronic illness by advanced practice nurses

**Nurse Care Coordinators:**

- Visit patient's every day in hospital
- Make follow up appointments with primary care providers & specialist
- Accompany patients on those visits to hand off information
- Aide with asking questions and understanding response

**Nurse Care Coordinators:**

- Teach patients to assess their own symptoms using a traffic light model
  - **Green:** feeling fine
  - **Yellow:** small weight increase or mild swelling that means call nurse practitioner
  - **Red:** shortness of breath or other severe symptoms that indicate 911 or go to ED
Tackling Readmission Naylor’s Model

- Nurse works with patient up to **12 weeks**
- Studies have shown an average savings of **$5,000 per patient one year after hospitalization**
- Naylor’s Model **one of the most intensive of readmission prevention projects**

Healthcare Priority Policy Reducing Readmissions

- **Regulatory attention** indicating **potential financial penalties** for avoidable 30-Day Readmissions
- Federal payment linked to Readmission rates
- SNF Medicare payment may be reduced

Healthcare Priority Policy Reducing Readmissions

- **CMS** hopes to lower **Hospital readmissions Rate** by **20% by 2013** utilizing **evidenced based interventions**
The Affordable Care Act established the Hospital Readmission Reduction Program (HRRP) which ties payment to performance on measures. HRRP begins October 1, 2012. Lowers Medicare payment rate for hospitals with greater than expected readmission rates for specific conditions.

Conditions beginning FY 2013:
- Heart Failure
- Acute Myocardial Infarction
- Pneumonia
These three conditions made up approximately 10% of hospital discharges in 2009.

Conditions Beginning FY 2015:
- Chronic Obstructive Pulmonary Disease
- Coronary Bypass Graft
- Percutaneous Transluminal Coronary Angioplasty
- Other Vascular Conditions
Payment reduction is determined by an adjustment factor based on an assessment of excess readmissions.

Hospitals with excessive readmission rates will have their Medicare payments reduced by up to:
- 1% in fiscal year 2013
- 2% in 2014
- 3% by fiscal year 2015 and beyond

Hospitals with risk adjusted 30 day readmission performance in the lowest quartile will incur penalties against their total Medicare Payment beginning in fiscal year 2013 (starting October 1, 2012).

CMS will evaluate prior year’s readmission data starting October 1, 2011.
Revenue at Risk Penalty Calculation (2 Methods):

- **Method 1:**
  - 1% Medicare payment reduction across all DRGs in fiscal year 2013, increasing to 2% in 2014 and 3% in 2015
  - Example: If a hospital total inpatient payment from Medicare totaled $50 million in FY 2012, the hospital would lose $500,000 (1% of $50 million) of its inpatient operating payments in FY 2013

Revenue at Risk Penalty Calculation (Method 2):

- Total excessive payments of less than the cap, Medicare payments will be reduced by that percentage
- To determine the potential penalty the amount of excessive payments made for each of the 3 conditions must be calculated
- Example:
  - \( \text{Excessive Payment for Condition} = \text{(number of patients with condition)} \times \text{(Average reimbursement for condition)} \times \text{(% Higher than expected)} \)

**Revenue at Risk Penalty Calculation:***

<table>
<thead>
<tr>
<th>Condition</th>
<th># of Patients</th>
<th>Avg Reimbursement</th>
<th>% Higher Than Expected</th>
<th>Excessive Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHF</td>
<td>500</td>
<td>$5,000</td>
<td>20%</td>
<td>$500,000</td>
</tr>
<tr>
<td>AMI</td>
<td>400</td>
<td>$4,000</td>
<td>10%</td>
<td>$160,000</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>300</td>
<td>$5,000</td>
<td>5%</td>
<td>$45,000</td>
</tr>
<tr>
<td><strong>Total Excess Payment</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>$705,000</strong></td>
</tr>
</tbody>
</table>
Revenue at Risk Penalty Calculation:

- **Example cont:** FY 2012 payment for Medicare were $50 million, then their excessive payments were 1.4% of total operating payments ($705,000 divided by $50 million)
- However the maximum penalty in FY 2013 is 1% of total operating payments, which is less than the hospital’s total excessive payments. Based on this example this hospital would lose $500,000 (1% of $50 million) of its inpatient operating payments for FY2013

Preparing for Payment Penalties:

- Know your readmission metrics including original discharge disposition and origin of readmission
- Calculate readmission rates by condition, physician performance and post acute care facility
- Identify opportunities based on patient demographics and common readmissions
- Screen and target patients based on risk assessments
- Compare disease specific outcome measures to national and local competitor rates

Tackling Readmission

- **Four stages** of care that allow effective interventions
  - Preparation for discharge, a process starting on admission making staff aware of home environment
  - Hand-off to the outpatient physician
  - Medication reconciliation to make sure new prescriptions are filled and that patients are not falling back on their old medication routines
  - Home visits and/or phone call, daily or weekly for first 30 days
Healthcare Policy Priority Reducing Readmissions

DATA

- Acute Myocardial Infarction Rate
- Pneumonia Rate
- CHF Rate
- Readmission Rates (Hospital)
- Readmission Rate (SNF)

American Healthcare Association Goal:
- Reduce Hospital Re-admissions within 30 days during a SNF stay by 15% by March 2015

30-Day Readmission Measure

- Definition of Readmission
  - Readmission occurs when a patient is discharged from the applicable hospital to a non-acute setting and then is admitted to the same or another acute care hospital within 30 days for any reason
30-Day Readmission Measure

Exclusion to Readmission Definition:
- Transfers and planned readmissions are excluded
- An exception for AMI for planned readmission for revascularization procedures (CABG PTCA)

Healthcare Policy Priority
Reducing Readmissions

1 in 5 Medicare FFS Beneficiaries are Readmitted to the hospital within 30 days

<table>
<thead>
<tr>
<th>Hospital Discharge Condition</th>
<th>30-Day Rate for Re-hospitalization</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMI</td>
<td>19.8</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>24.8</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>18.4</td>
</tr>
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</table>

Tackling Readmission:
National Transitions of Care Coalition

Medicare Transitional Care Act of 2012
- Improve transition of care for high risk Medicare beneficiaries at high risk for readmission as they move from the hospital setting to
  - Home
  - Skilled Nursing facility
  - Next point of care
- The bill is step in improving patient outcomes and reducing unnecessary health-related expenses
Tackling Readmission:
National Transitions of Care Coalition

- The Medicare Transitional Care Act puts in place an **infrastructure** to **promote care transition interventions** that have been proven successful
  - **Seven key elements** found in evidence-based care interventions

Seven Essential Intervention Categories

- Medication Management
- Transition Planning
- Patient and Family Engagement/Education
- Information Transfer
- Follow-Up Care
- Healthcare provider Engagement
- Shared Accountability across Providers and Organizations

National Transitions of Care Coalition:

**Medication Management**

- **Ensuring the safe use of medications** by patient and their families and based on patients’ plan of care
  - Assessment of patient’s medication intake
    - Medication review (all medications)
    - Identify problem medications
    - Identify poly-pharmacy
    - Adherence and medication schedules
National Transitions of Care Coalition: Medication Management

- Patient and Family Education and Counseling about medications
  - Teach back method to establish understanding of medication plan
  - Explain what medication to take, emphasizing any changes in the regimen
  - Review each medication’s purpose, how to take each medication correctly, and important side effects to watch out for

National Transitions of Care Coalition: Medication Management

- Development and Implementation of a plan for Medication Management as part of the patient’s overall plan of care
  - Medication Reconciliation including pre-hospitalization and post-hospitalization medication lists
  - Be sure patient has a realistic plan about how to get medications
  - Confirm Medication Plan - pharmacist follow-up telephone calls after intensive nurse-based patient education upon hospital discharge or transfer
  - Coordinated and integrated team approach to medication management, involving pharmacists and/or physicians

National Transitions of Care Coalition: Transition Planning

- A formal process that facilitates the safe transfer of patients from one level of care to another including home or from one practitioner to another
  - Clearly identified practitioner (or team depending on setting) to facilitate and coordinate the patient’s transition plan
  - Use of Transitional Care Nurse (TCN) or Advanced Practice Nurse (APN), who conducts a comprehensive assessment of patient and family/caregiver needs, coordinates the patient’s discharge or transition plan with the family and healthcare provider team
  - Assessment of patient’s and family/caregiver’s post-episode of care needs, by a specific member of the healthcare team in collaboration with the others on the team
National Transitions of Care Coalition: Transition Planning

- Management of Patient and Family Transition needs
  - Performing an enhanced assessment, including hospital assessments and comprehensive home assessment to ensure safe transition
  - Provision of coaching, counseling and support to patients and their families/caregivers regarding healthy lifestyle and health regimen
  - Education of patient and families/caregiver about self-care management skills
  - Consideration for the patient's and family/caregiver's literacy level

National Transitions of Care Coalition: Transition Planning

- Use of formal transition planning tools
  - Universal Discharge or Transition Checklist
  - Standard Plan of Care
  - Electronic transfer of information from one level of care, setting or provider to another

National Transitions of Care Coalition: Transition Planning

- Completion of a Transition Summary
  - Expedited transmission, preferably an electronic transfer, of the Discharge or Transition Summary to the physician (and other services, such as visiting nurses) accepting responsibility for the patient's care after discharge
  - Give the patient a written Discharge or Transition Plan at the time of discharge/transition, written at the patient's appropriate literacy level and assess the patients' degree of understanding by asking them to explain the details of the plan in their own words
National Transitions of Care Coalition: Patient/Family Engagement/Education

Education and counseling of patients and families to enhance their active participation in their own care including informed decision making

- Patients and families are knowledgeable about condition and plan of care
  - Patient is knowledgeable about indications that their condition is worsening and how to respond using knowledge of “red flags”
  - Provision of education using appropriate health literacy materials and language
  - Use of patient and family education and counseling guides

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National Transitions of Care Coalition: Patient/Family Engagement/Education

Patient and family-centered transition communication

- “Translating” information between the provider and the patient to ensure that each really understands what the other has communicated
- Conducting real time patient and family-centered handoff communication

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National Transitions of Care Coalition: Patient/Family Engagement/Education

Developing self-care management skills

- Improving patient and family education practices to encourage use of the teach-back process around specific issues
- Assess the patients’ degree of understanding by asking them to explain the details of the plan in their own words
Information Transfer

- Sharing of important care information among patient, family, caregiver and healthcare providers in a timely and effective manner
  - Implementation of clearly defined communication models
  - Communication infrastructure that will enhance communication with other healthcare providers about a patient (or resident in certain settings) change of status
  - Timely feedback and feed-forward of information by utilizing specific communication models that support consistent and clear communication among healthcare practitioners and caregivers

Use of formal communication tools

- Use of personal health record
- Implementation of specifically designed tools, i.e. Transfer Tool, Transition Record, Transition Summary
- Utilization of an integrated electronic medical record and a web based care management tracking tool, i.e. electronic transfer of the Discharge or Transition Instruction Form to the receiving healthcare provider

Clearly identified practitioner to facilitate timely transfer of important information

- Timely transfer of critical patient information, preferably within 24 hours
- Care coordinators actively facilitating communications among providers and between the patient and the providers
- Conduct real time patient and family handoff communication with accepted handoff communication techniques
National Transitions of Care Coalition: Follow-Up Care

- Facilitating the **safe transition** of patients from **one level of care** or **provider** to another through **effective follow-up care activities**
- Patient and families timely access to key healthcare providers after an episode of care as required by the patient's condition and needs
  - Confirmation of Primary Care and Specialist Follow-Up
  - Make appointments for clinician follow-up and post discharge testing prior to discharge

National Transitions of Care Coalition: Follow-Up Care

- **24 hours a day, seven days a week** access to **Health Services Access Line**
- Post-acute care follow-up, including **face-to-face visit at home and/or with a doctor, within 48 hrs of discharge**
- Enhanced access and not having **long wait times** to get in to see a provider
- **Appointment within first 5-10 days post an acute care episode**

National Transitions of Care Coalition: Follow-Up Care

- **Communicating with patients and/or families** and other healthcare providers **post transition** from an episode of care
- A primary-care RN to call the patient by the **next business day** to monitor his or her condition
- **Telephone re-enforcement of the Discharge or Transition Plan** and problem solving 2 to 3 days after discharge/transition from an episode of care
National Transitions of Care Coalition: 
Follow-Up Care

- One in home follow up visit to assess safety
- Telephone calls or face to face contact with the patient and family
- Healthcare provider teams have frequent contacts with their patients and their families/caregiver (or enrollees in payor-based settings). This helps them to detect subtle changes in their patients’ or enrollees’ conditions and they can react quickly to changing medical, functional, and psycho-social problems.

National Transitions of Care Coalition: 
Healthcare Provider Engagement

- Demonstrating ownership, responsibility and accountability for the care of the patient and family/caregiver at all times
- Clearly identified patient’s personal physician (primary care provider)
  - Personal physician - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care (Patient-Centered Medical Home Model)
- Enhanced access to services and provision of follow up appointments without long wait times

National Transitions of Care Coalition: 
Healthcare Provider Engagement

- Use of Nationally recognized practice guidelines (evidence-based guideline)
  - Reconciliation of the Discharge or Transition Plan with national guidelines and critical pathways
  - Implementation of evidence-based care tools or plans
National Transitions of Care Coalition: Healthcare Provider Engagement

- **Hub of Case Management Activities**
  - Improve documentation around change in patient’s (or resident’s) condition
  - Improve flow of information between hospital and outpatient physicians and access to timely information on hospital and emergency room admissions
  - Being a communication hub
  - Reconcile pre-hospitalization and post-hospitalization medication lists

- **Patient and family education and counseling activities**
  - Coaching patients on self-care management with attention to “Red flags”
  - Giving the patient and family/caregiver a written Discharge or Transition Plan and Instructions at the time of discharge/transition

- **Open and Timely communication among healthcare providers, patients, and families**
  - Enhanced communication with other health care providers about change in a patient’s (or resident’s) status
  - Close interaction between care coordinators and primary care physicians
  - Care is coordinated and/or integrated by coordinating patient care in a team based approach
National Transitions of Care Coalition:
Shared Accountability Across Providers and Organizations

- Enhancing the transition of care process through accountability for care of the patient by both the healthcare provider (or organization) transitioning and the one receiving the patient
  - Clear and timely communication of the patient’s plan of care
    - Sending healthcare provider must communicate plan of care to patient and to receiving provider before handoff is completed
    - The sending provider must be available to the receiving provider for any questions and clarifications regarding the patients’ care after the handoff

- Ensuring that a healthcare provider is responsible for the care of the patient at all times
  - Sending healthcare provider must remain responsible for the patient’s care until the receiving provider has acknowledgement that he/she can effectively assume the care of the patient
  - The receiving provider has to acknowledge the receipt of transferred information in a timely manner, understand the plan of care for the patient and be prepared to assume responsibility for patient’s care

- Assuming responsibility for the outcomes of the care transition process by both the provider (or organization) sending and the one receiving the patient
  - If the provider who has assumed care of the patient determines that the patient should go to another level of care than that provider, the provider is responsible for communicating with the receiving provider before handoff
  - Post-transition patient’s safety and outcomes report
CMS: Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents

- CMS research on Medicare/Medicaid enrollees in nursing facilities
  - 45% of hospital admissions were receiving Medicare or Medicaid nursing facility services and could have been avoided
  - Accounting for 314,000 potentially avoidable hospitalizations and $2.6 billion in Medicare expenditures in 2005

CMS: Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents

- Collaboration of the CMS Innovation Center and the CMS Medicare/Medicaid Coordination office
  - Aims to improve the Quality of Care of Residents Residing in Nursing Facilities
  - Will support organization that partner with SNF to implement Evidence-Based Interventions that improve care and lower costs

CMS: Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents

- Focus is on Long-stay residents enrolled in Medicare-Medicaid programs
- Supports the Partnership for Patients goal of reducing hospital readmission rates by 20% by the end 2013
CMS: Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents

- **7 Organizations Participating**
  - Alabama: Alabama Quality Assurance Foundation
  - Nebraska: Alegent Health
  - Nevada: HealthInsight of Nevada
  - Indiana: Indiana University
  - Missouri: The Curators of the University of Missouri
  - Pennsylvania: UPMC Community Providers Services

- **Alabama: Alabama Quality Assurance Foundation**
  - 23 Facilities
  - RN's deployed to implement INERACT
  - “EMPOWER” (Enhancing My Profession and Organization with Empathy and Respect)
    - Training program to help nursing facility staff enhance their skills for managing workplace demands and professional relationships
  - Advancing Excellence in Nursing Home Campaign
    - Reducing staff turnover & increasing staff awareness of resident's status and needs
    - Improve staff's ability to implement care plans and notice change in resident's health

- **Nebraska: Alegent Health**
  - 15 Facilities
  - Deploy Nurse Practitioners
  - Implement INTERACT
  - Program to Improve Medication Management (Beers Criteria for Potentially Inappropriate Medication Use in Older Adults)
    - One aspect of the program uses dentist and dental hygienist to improve oral care
CMS: Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents

- **Nevada: HealthInsight of Nevada**
  - 25 Facilities
  - "Nevada Admission & Transitions Optimization Program" (ATOP)
  - Creation of PODS that include physician extenders (NP/PA) and 2 RN's who will be on site providing enhanced care and coordination
  - INTERACT
  - Medication Management Program to reduce Polypharmacy & inappropriate use of antipsychotics

- **Indiana: Indiana University**
  - 20 Facilities
  - "OPTIMISTIC" ("Optimizing Patient Transfers, Impacting Medical Quality, and Improving Symptoms: Transforming Institutional Care")
  - RN's and Advanced Practice Nurse (APNs) on site
  - For enhanced recognition and management of acute changes in medical conditions.
  - Coordinated with staff and PCP's
  - INTERACT and other evidenced-based models

- **Missouri: The Curators of the University of Missouri**
  - 16 Facilities
  - Advanced Practice RNs (APRNs) assigned to facilities to provide direct services to residents, mentoring and role modeling, and educating the nursing staff about early symptom/illness recognition, assessment and management of health conditions
  - Social worker to work with facility social worker
  - INTERACT
  - Quality Improvement Program of Missouri: programs that have demonstrated positive results in the nursing facility environment
CMS: Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents

- New York: The Greater New York Hospital Foundation
  - 30 Facilities
  - RNs deployed to train nursing facility staff on INTERACT tools and
  - American Medical Director Association Clinical Practice Guidelines on Acute Change in Condition
  - eINTERACT system

- Pennsylvania: UPMC Community Providers Services
  - 16 Facilities
  - RAVEN Program (Reduce Avoidable hospitalizations using Evidenced-based interventions)
    - Facility based Nurse Practitioners to assist with determining residents
    - Care plan goals
    - Conduct acute change in condition assessments
    - Implement evidenced based communication tools
    - INTERACT
    - Others recommended by AMDA
    - Innovative Tele-health and Information Technologies to connect to information exchange

Tackling Readmission Nursing Home Value-Based Purchasing Demonstration Project

- CMS initiative to improve Quality and Efficiency of care to Medicare beneficiaries
- Financial incentives to nursing homes that meet certain conditions providing high quality of care
- Demonstration includes three states: Arizona, New York, and Wisconsin
Tackling Readmission
Nursing Home Value-Based Purchasing Demonstration Project

- Quality Performance Based on Four Domains:
  - Staffing
  - Appropriate Hospitalizations
  - Minimum Data Set (MDS) Outcomes
  - Survey Deficiencies
- CMS will award points based on performance with each measure within the domain
- Points will summed for an overall quality score

For each state
- Nursing home scores in the top 20%
- Homes in the top 20% of improvement in their scores
- Eligible for a share of the State’s savings pool

Anticipate that potentially avoidable Hospitalizations may be reduced as a result of improvement of quality of care
Reduction in hospitalizations and subsequent skilled nursing stays result in Medicare savings
The saving will fund the payment awards
Tackling Readmission
Healthcare Policy Priority Reducing Readmissions

- CMS Launched Pilot Program (August)
  - 380 Participating Hospitals
  - Re-bill Medicare for Observation services if claims for inpatient care are rejected
  - Hope to reduce rates of classified observation stays

What Can Hospital leaders do to Tackle Readmissions?
Reducing hospital readmissions is an opportunity to improve quality and reduce costs in the health care system

What Can Clinical Leaders Do to Tackle Readmissions?
- Improve existing processes of Transition out of the Hospital
- Improve the “reception” of the patient into the new setting of care
- Enhance services at times of transition for patients at high risk of recurrent Rehospitalization
- Engage patients/families as active participants in their care and facilitating patient self-management and/or remote monitoring
What Can **Hospital Leaders** do to Tackle Readmissions?

- Examine Hospital's current rate of readmissions
- Assess and prioritize your improvement opportunities
- Develop an Action Plan of strategies to implement
- Monitor your hospital's progress

What Can **SNF Leaders** do to Tackle Readmissions?

- Work collaboratively with hospital and community healthcare providers
- Examine SNFs current rate of readmissions
- Track & Trend Data
- Assess and prioritize your improvement opportunities
- Develop an action plan of strategies to implement
- Monitor progress

**Tackling Hospital Readmission**

**Strategies/Practices:**

- Improved discharge planning (Transition)
- Targeting initiatives toward high risk population
- Initiatives to improve systemic failures
Tackling the Hospital-SNF 30-Day Readmission Rate

“Success in reducing readmissions lies in effectively partnering to not only achieve better outcomes but also to reduce the fragmentation and lack of support that so often comes with transitions between providers and care settings.”

Amy Berman, Program Officer
The John A. Hartford Foundation

References & Resources

- Healthcare Leader Action Guide to reduce Avoidable Readmissions, 2010 Health Research & Educational Trust

- Institute For healthcare Improvement: Effective Interventions to reduce Rehospitalizations, March, 2009.
Have you considered a customized complimentary HARMONY (HHI) MEDICARE PROGRAM EVALUATION or CASE MIX ANALYSIS for your facility? Perhaps your facility has potential for additional revenue. Benchmark your facility against key indicators and national norms. Email us at RUGS@harmony-healthcare.com for more information. Analysis is cost & obligation free.