Reducing Readmissions
Operational and Clinical Strategies for Success!

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Pathway Health

Objectives

Review
Review leadership strategies to prepare your organization to reduce unnecessary hospital readmissions, including organizational readiness, clinical readiness, clinical competency and quality monitoring

Identify
Identify 3 key resources available to utilize for program development and staff education

Discuss
Discuss the importance of the need for strategic partnerships within the care continuum
CMS Objective

- Passive – FFS
- Active – VBP
- Quality
CMS Goal

Focus on Readmissions
EXAMPLE REPORT
The Skilled Nursing Facility Value-Based Purchasing Program
Quarterly Confidential Feedback Report

Facility:
CCN:
City, State:

Your SNF’s Performance on the Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM) in [YEAR]

<table>
<thead>
<tr>
<th>Measure</th>
<th>Your SNF’s Number of Eligible Stays</th>
<th>Your SNF’s Number of Readmissions*</th>
<th>Your SNF’s Risk-Standardized Readmission Rate**</th>
<th>National Average Readmission Rate***</th>
</tr>
</thead>
<tbody>
<tr>
<td>SNFRM</td>
<td></td>
<td></td>
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</tbody>
</table>

Source: Medicare claims and eligibility data from [YEAR].

* The number of stays at your SNF that were followed by an unplanned hospital readmission within 30 days of discharge from a prior proximal hospitalization.

** The risk-standardized readmission rate is your SNF’s risk-adjusted rate of unplanned readmissions.

*** The national average readmission rate is the unadjusted average readmission rate for all eligible SNF stays nationally.

Key Facility Leadership Strategies
Successful Planning
F726 Nursing Services (Competency)

Facilities may adopt certain tools to aid staff with these competencies, as these tools have proven to be effective. For example, the Agency for Healthcare Research and Quality (AHRQ) has training modules for detecting and communicating resident changes in condition https://www.ahrq.gov/professionals/systems/long-term-care/resources/facilities/ptsafety/ltcmodule1.html. Also, Interventions to Reduce Acute Care Transfers (INTERACT) is a program with several resources aimed at improving staff competencies in this area https://interact2.net/tools_v4.html. Staff may inform surveyors of the tools they use to help show evidence of the required competencies. However, merely stating or referencing the tools is not enough on its own to verify compliance. Staff must also demonstrate that they possess the competency to use the tools in a manner that accomplishes their purpose, of aiding to effectively identify and address resident changes in condition.


INTERACT Website has changed:
http://www.pathway-interact.com/

The INTERACT™ Quality Improvement Program

- Designed to improve the quality of nursing home care
- Provides tools, resources to staff to reduce avoidable acute care transfers
- Supported by Centers for Medicare and Medicaid Services
- Early identification of change in resident status
- Improved documentation
- Enhances communication
- Guides nursing home staff when there is a change in the resident status
- Provides an opportunity to improve quality of care
- Advanced care planning

http://www.pathway-interact.com/
Care Transition Management

AMDA Transitions of Care CPG


Hospitalizations Goal:
https://www.nhqualitycampaign.org/goalDetail.aspx?g=hosp

National Nursing Home Quality Improvement Campaign
Discuss with IDT the key reasons to focus on care transition system:

- Can lead to adverse events
- Higher readmission rates
- Higher costs
- Miscommunication
- Can occur from any setting
- Patient satisfaction

Importance of Care Transitions

- Injuries
- Medication Errors
- Complications
- Infections
- Fall risk
- Cognition
- Clinical Outcomes
Key Components of Care Transitions

- Communication methods – standardized and agreed upon between providers
- Understanding competencies and capabilities
- Comprehensive discharge planning
- Medication Reconciliation
- Patient/Caregiver education
- Follow up post-discharge
- Open communication between providers

QAPI Project: Hospital Readmissions
Assess Organizational Readiness

Assess Organization Systems

- Corporate Programs and Outcomes
- Facility specific protocols
- Assess need to change
- Benchmark internal systems for review
  - Current status
  - Industry standards
  - Best practice approach
- Identify opportunities

Topic #1:
What are the top 2 obstacles I have encountered with reducing hospital readmissions?
Weekends are a Concern with Readmissions

What are strategies to overcome this challenge?

Topic #2

What Impressions do physicians, families and acute care partners have of our capabilities?

How can we proactively manage impressions?

Topic #3 Impressions
Root Cause Analysis

Investigation and Correction
1. “Needs Assessment” of clinical team
2. Engage Key Players
3. Identify Resources

**Clinical Capacity**

- Assess clinical capacity
- Safely manage acute conditions
- Disease state programs
- Episodic Management
- Rapid turnaround for admissions
- All hours
- Engage Medical Director and Physicians
- Partnership and Collaboration
A Few Questions......

• Are we confident in our preadmission process?
• Is our admission assessment and management process solid?
• Do our nurses have excellent head-to-toe assessment skills?
• Do our nurses understand disease processes?
• Do our nurses understand pharmacology related to disease processes and management?
• What is our process for comprehensive discharge care planning upon admission?
• What systems do we have in place to ensure good assessment, communication and follow through for early identification of changes in condition?

Clinical Competency
Clinical Readiness, Capacity and Competency

• Strategies for Competency:
  • Education
  • Post-Test
• Competency Skills Checklist:
  • Heart Sounds
  • Lung Sounds
  • Vital Signs
  • Temperature
  • Pulse
  • Respiration
  • Blood Pressure
  • Oxygen Saturation
Policies and Procedures

- Regulatory Compliance
- Best Practice Guidelines
- Scope of Practice (licensing board)
- Monitoring
- Documentation directions
- Notifications (clinician and resident representative)

Teamwork and Collaboration

- Medical Director to assist with training
- Facility review of Interact clinical pathways
- Pharmacy management and training on high risk medications
- Additional education provided by Lab, therapy, or physician extenders
- The complexity of services provided and the skill level of nursing
Implementation

• Take the opportunity to have one of the facility leaders/managers or readmissions team member to participate in daily report and shift to shift report for at least 7 days on all shifts
• Review the 24-hour report
• Complete walking rounds with the nursing assistants
• Develop an interdisciplinary team of nurses from all shifts to review the current gaps in communication and systems
F660 Discharge Planning Process

“The facility must develop and implement an effective discharge planning process that focuses on the resident’s discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions.”

• Documentation of referrals
• Documentation of response to referrals

• If discharge not feasible, documentation – who and why

Procedures

Gather information on:
• Prior living setting
• Plans for discharge
• Assistance needs and availability
Discharge Plan

Interdisciplinary Team + Resident + Resident Representative

Destination

- Identify destination
- Is the destination safe?
- Discuss/document risks/benefit discussion
- Address options to meet safety needs
- Determine if a referral to Adult Protective Services will be necessary
Discharge to Another Facility

“Assisting the resident means the facility must compile available data on other appropriate post-acute care options to present to the resident.”

Considerations

• Resident Cognition
• Function
• Motivation
• Endurance
• Available Support

Plan-Medication Teaching

• Name
• Dose
• Time
• Route
• Special instructions
• Side effects or special considerations
# Practice and Repetition

![Image of two people practicing a task]

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## DISCHARGE CHECK LIST

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharge orders received from physician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resident will be self-medicating</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication Teaching Completed with return demonstration</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication Supply ready for discharge</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Condition Teaching Completed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment Teaching Completed with return demonstration</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nutritional Teaching Completed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Necessary Equipment and Supplies ordered and ready for discharge (list)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lab or Radiology appointments made and transportation scheduled and communicated</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Apointments scheduled and transportation scheduled and communicated</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services Arranged and contact confirmed with report for discharge</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Discharge Transportation and Support arranged for transfer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Needs for Discharge (list)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharge paperwork reviewed with resident/resident representative</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharge Summary Completed</td>
<td></td>
<td></td>
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</tbody>
</table>

(Discharge Coordinator) ___________________________  (Date) __________________

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Post-Discharge Follow-Up

Notes: ____________________________

Discharge date: __________________________

Principal discharge diagnosis: __________________________

Interpreter needed? ☐ Y ☐ N Language/Dialect __________

Prior to phone call:

Review:

- Health history
- Medicine lists for consistency
- Medicine list for appropriate dosing, drug-drug and drug-food interactions, and major side effects
- Contact sheet
- Discharge planner notes
- Discharge summary

Call Completed: ☐ Y ☐ N

With whom (patient, caregiver, both): __________________________

Number of hours between discharge and phone call: __________________________

Consultations (if any) made prior to phone call:

☐ None
☐ Called MD
☐ Called DE
☐ Other __________________________

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https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html
Follow Up Is Essential

- Ensure that the individual has connected with their primary care provider and/or specialist
- Ask about symptoms, concerns, and medications - coaching approach
- Is the plan working?
- Are they accessing the necessary community resources?
- Is their caregiver showing up?
- Do they feel safe?
- Does the caregiver have questions?

F661 Discharge Summary
F661: Final Summary of Resident status

Identification and demographics
Customary Routine
Cognitive Patterns
Communication
Vision
Mood and Behavior Patterns
Psychosocial Well-being
Physical functioning and structural problems
Continence
Disease diagnoses and health conditions

- Dental and nutritional status
- Skin Condition
- Activity Pursuit
- Medications
- Special Treatments and Procedures
- Discharge Planning
- Documentation of Summary Information
- Documentation of Participation in Assessment

The discharge summary contains necessary medical information that the facility must furnish at the time the resident leaves the facility, to the receiving provider assuming responsibility for the resident’s care after discharge.

Timing of Discharge Summary

Employee Education

- Policy and Procedures
- Assessment Process
- Discharge Care Plan Process
- Consistent implementation of interventions
- Resident/resident representative teaching with return demonstration
- Documentation
- Follow up

Resources for Staff Education
4 Key Resources for Education

The INTERACT™ Quality Improvement Program
- www.pathway-interact.com

AMDA: Transitions of Care Clinical Practice Guideline

Centers for Medicare & Medicaid (CMS) State Operations Manual, Appendix PP, Guidance to Surveyors for Long Term Care Facilities (Rev. 173, 11-22-17)

National Nursing Home Quality Improvement Campaign. Hospitalizations Goal
- https://www.nhqualitycampaign.org/goalDetail.aspx?g=hosp

Agency for Healthcare Research and Quality: Chartbook on Care Coordination. Transitions of Care:
https://www.ahrq.gov/research/findings/nhqrdr/chartbooks/carecoordination/measure1.html

Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User’s Manual, Version 1.16. October 2018:

CMS Critical Element - LTC Survey Pathways (Download):

Additional Resources
Additional Educational Resources

- American Heart Association: [https://www.heart.org/en](https://www.heart.org/en)
- American Lung Association: [https://www.lung.org/](https://www.lung.org/)
- Centers for Disease Control and Prevention: [https://www.cdc.gov/](https://www.cdc.gov/)
- Nursing Practice Manuals
- And more!
Partnership Positives

- Can identify systems in place for quality and reduction of unnecessary hospital readmissions
- Have good communication systems
- Are proactive and participate in collaborative efforts
- Are confident in clinical competency
- Can show good data on positive outcomes
- Identify opportunities for improvement quickly and correct any concerns
- Provide all facility staff with ongoing quality development education

Payment Model Expectations

- Performance based pay
- Data, Data, Data
  - Quality metrics
  - New-Performance Measures
  - Standardization of data
- Risk Arrangements
- Publicly Reported Data
PAC Leadership and Success

Consulting | Talent | Training | Resources

Realign and Redesign
Strategic Relationships
Organization Data Strategy
Readiness for Change
Operations and Clinical
Leading Through Change

- Understand
- Vision
- Communication
- Collaboration
- Outcomes
In Summary:

- Prepare ALL staff now
- Look at your data
- Develop an Action Plan
- Consider a QAPI, PIP
- Involve the ENTIRE team
- Ongoing re-evaluation
- Monitor Data
- Ongoing Communication
- Always Follow up
- Position Yourself Successfully for the Future

Questions
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