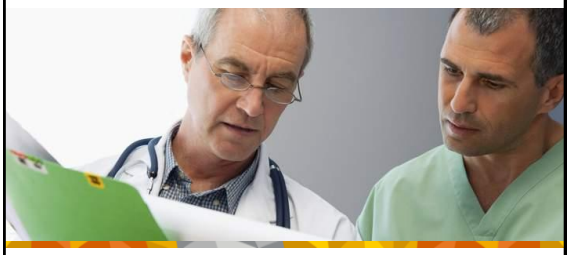
OPTUM



Closing the Door to Inpatient Readmission

High quality care in the SNF

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The hospital: Skilled Nursing Facilities (SNF) Cycle

The hospital: SNF Cycle (continued)

- Incomplete discharge summary
- Problem focused vs. patient focused care
- Medication reconciliation
- Unnecessary procedures
- Inattention to chronic care needs
- Premature discharge
- Psychosis
- Poor family communication
- Advance care planning
- Acute change in condition: Recognition and assessment
- Poor communication
- Interdisciplinary team collaboration
- Appropriate plan of care/monitoring
- Stakeholder alignment
- Lack of contingency planning
- Execution/implementation of plan
- Multiple consultants
- Hospitalist vs. primary care provider
- Nosocomial infections/complications
- Medical Errors
- Ambulatory care sensitive conditions
- 911 reflex
- Regulatory concerns
- "When in doubt…"
- Inadequate clinical professional engagement

OPTUM

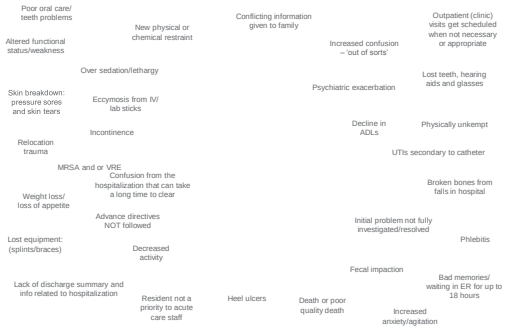
Scope of the problem

- More than 20% of all Medicare beneficiaries re-hospitalized within 30 days
- 90% unplanned
- Cost to Medicare = $17.4 billion
- 40% of Medicare beneficiaries discharged to receive post acute care (SNF, IRH, home health)
- Half of the above enter a nursing home
- 23.5% re-hospitalization rate from SNFs
- Even higher (26%) for those who previously resided in nursing home
- Medicare costs $4.34 billion
- High proportion are avoidable
  - Considerable geographic variation
  - High prevalence of preventable conditions
- Correlated with negative health outcomes, e.g., delirium, functional decline

OPTUM

Mor et. al. "The Revolving Door of Re-hospitalization from Skilled Nursing Facilities". Health Affairs. 28, No 1, 2010: 57-64.

What can happen to your hospitalized residents



OPTUM

EverCare 1998

Case #1

- 89-year-old female with dementia, HTN, CKD, eats independently but requires assistance with all other ADLs.
- Hospitalized nine days ago with acute cardiac ischemia, change in level of consciousness, and suspected aspiration pneumonia.
- After seven days in acute care returned to SNF with significant functional decline and increased confusion. Family was informed of sequence of events. Patients was DNR/DNI.
- 48 hours later at 2 a.m., she developed tachypnea and O2 sat 87% on 2L/min. Staff concerned about recurrent cardiac event. Covering physician unfamiliar with case ordered nurse to call 911.
- Patient re-hospitalized with suspected aspiration pneumonia, given supportive care.

OPTUM

Why do admissions/readmissions occur?

- Fundamental system issues related to transitions
- Physician presence in SNFs and coverage issues
- SNF technical capabilities
- ACP/Family dynamics
- Staffing
- Education/training in SNFs
- Regulatory environment
- Patient mix
- Fragmentation in system/information systems

OPTUM

Who's at risk?

- Age/demographics
- Medical conditions: CHF, pneumonia, COPD, psychosis, GI issues
- Surgical procedures: Cardiac stent placement, hip/knee surgery, vascular surgery, bowel surgery
- Dialysis
- Previous re-hospitalization
- Longer index hospitalization
- SNF discharge: compare to community or IRF

OPTUM

Rehospitalization

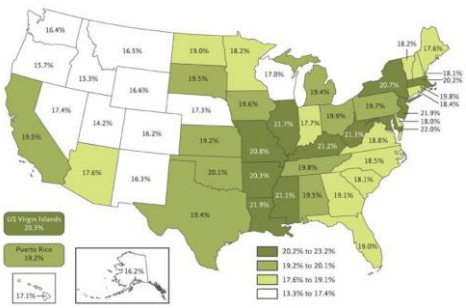
Highest rates of rehospitalization and most frequent reasons for rehospitalization, according to condition at index discharge

Jencks SF, et al. N Engl J Med 2009;360:1418-1428

Where do they live?

- Pre-hospital living situation
  - Impact of nursing home vs. community setting prior to the post hospital SNF admission
  - Rate higher for those previously in NH
- Differences between short term rehab or medically complex and permanent NH residents
- Readmit rates?
  - What is scope of problem
- Financial implications for health system

Rates of rehospitalization within 30 days after hospital DC



Jencks SF, et al. N Engl J Med 2009;360:1418-1428

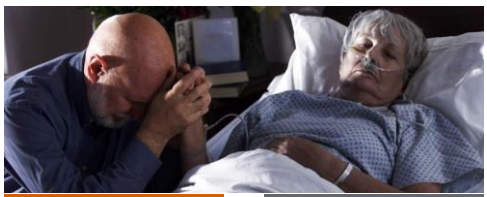
SNF hospital readmission levers

HIGHER RATE
- Lack of medication reconciliation
- Clinical instability
- Depression

LOWER RATE
- Genetic assessment
- NP involvement
- Facility factors

Berkowitz, Jones, Rieder, et. al. Improving Disposition Outcomes for Patients in a Geriatric Skilled Nursing Facility, J Am Geriatric Soc 59: 1130-1136, 2011

All readmissions not created equal



Expected readmission
- Planned; unrelated
- Planned; related

Unanticipated readmissions
- Unplanned; unrelated
- Unplanned; related (preventable vs. all-cause readmissions)

Stephen F. Jencks, M.D., M.P.H., "Re-hospitalization: Understanding the Challenge," Presentation at the National Medicare Readmissions Summit, Washington, DC, June 1, 2009.

Potentially preventable readmissions (PPR)

- Same Medicare payment diagnostic category
- Medical vs. surgical readmission (MedPAC)
- Condition specific
  (78% — can be managed in SNF)
  - CHF
  - Respiratory infection
  - UTI
  - Sepsis
  - Electrolyte imbalance
- Evercare TAP criteria
  - Later slides

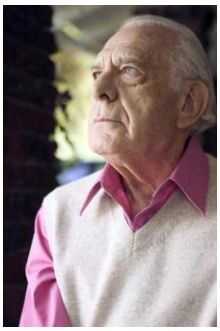
Other factors that drive readmissions

- System drivers, e.g. SNFs lack incentive to coordinate care
- Medicaid is typically the primary payer so SNFs have incentive to shift costs to Medicare or Medicaid payment policies may be driving care process failures (Medicaid payment levels and bed-hold rates are factors)
- Transformation of nursing homes from long term to post acute
- Consider LOS in SNF — the longer one stays the more the SNF is accountable
- Provider practice patterns, willingness to use hospice
- FFS rewards more care rather than coordination and quality

OPTUM

Case #2

- 78-year-old male, hospitalized two weeks earlier with COPD exacerbation, was discovered to have urinary retention and BPH. Had indwelling urinary catheter x 4 days, treated with IV steroids, nebs, and Abx. Started on alpha blocker and returned to SNF.
- Experienced weakness, fatigue, decreased appetite. C/o not feeling well, temp 99.8 other VS WNL. Several days ago was unable to participate in activities; stayed in bed.
- Physician called and discontinued alpha blocker, slowed steroid taper. Yesterday patient had temp 100.3.
- This morning developed hypotension, HR 119, unable to obtain O2 sat.
- Sent to ER where found to have pyuria, sepsis, and dehydration. Admitted to ICU for further care.



OPTUM

Why should we care?

- PPACA
- HCERA
- Public reporting for hospitals
- Demonstrations and pilots
- Quality of Care
- Patient outcomes
- Payment system reform
  - Denials for 30 day same diagnosis
  - Med-PAC recommends that Medicare reduce payment to hospitals with relatively high risk-adjusted readmission rates for select conditions.
  - RHQDAPU Program
  - Bundled payments

OPTUM

Hospital readmissions measures

www.hospitalcompare.hhs.gov

What are the outcome-of-care measures that show risk-adjusted hospital readmissions?

Hospital readmissions measures (continued)

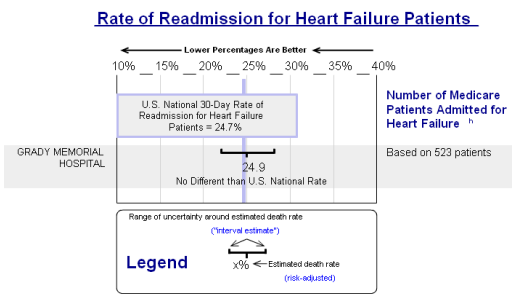
Readmission is when patients who have had a recent stay in the hospital go back into a hospital again. The information on this website shows how often patients are readmitted within 30 days of discharge from a previous hospital stay for heart attack, heart failure, or pneumonia. Patients may have been readmitted back to the same hospital or to a different hospital or acute care facility. They may have been readmitted for the same condition as their recent hospital stay, or for a different reason.

This website shows how different hospitals' rates of readmission for heart attack, heart failure, and pneumonia patients compared to the U.S. National Rate.

You can see whether the 30-day risk-adjusted opens in a new window rate of readmission for a hospital is lower (better) than the national rate, no different than the national rate, or higher (worse) than the national rate, given how sick patients were when they were admitted to the hospital.

For some hospitals, the number of cases is too small (fewer than 25) to reliably tell how well the hospital is performing, so no comparison to the national rate is shown.

Hospital compare



Readmission reduction strategies

- Service delivery reform
- Financing reform
- Medicare and Medicaid integrated service and financing reform

OPTUM

Some elements of care common to most transitions models

- Medication management/reconciliation
- Assessing patient's understanding/ ability to follow care plan
- Discharge support
- Coaching for primary care physician visit
- Use of home visits
- Screening for cognitive ability
- Use of centralized health record
- Involving family and other caregivers
- Arranging community-based support services

OPTUM

Shoring up SNF capabilities

- IV fluids
- Hypodermoclysis
- Labs/diagnostics
- Pharmacy
- Palliative care and hospice availability

OPTUM

Health and safety laboratory (HSL) trial

- Physician history and physical template
  - Care guidelines for common geriatric syndromes
  - Med reconciliation template
  - Goals of care
  - Advance directives
  - Number of hospitalizations in the past six months
- Palliative Care Consults: three or more hospitalizations total
- TIPS conferences
- Readmission to acute care declined from 16.5% to 13.3% (20% decline)
- Patients more likely than baseline to die on unit in accordance with wishes vs. transfer to the hospital

Evercare approach

- Toolkit
  - ACP
  - Getting the discharge summary
  - Med records (HEDIS requirement)
  - Timely initial visit
- Transfer envelope
- Discussion guide
- Out patient consultation form
- Nurse practitioner expectations for emergency department and post-hospital
- TAP

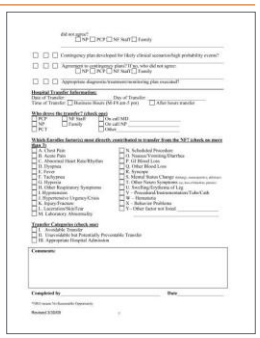
Retrospective data collection tool/TAP


TAP Retrospective Data Collection Tool

Enrollee Demographic Information:

Baseline Data:

Evaluation of Change in Condition (CIC):


Hospital Transfer Information:

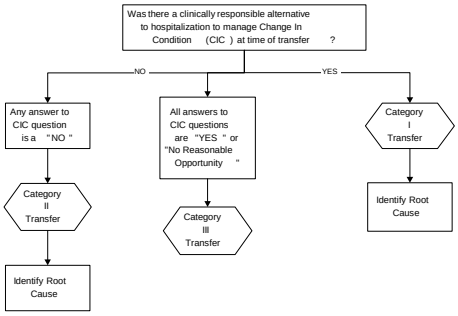
Who drove the transfer? (check one)

Which Enrollee factor(s) most directly contributed to transfer from the NF? (check no more than 3)

Transfer Categories (check one)

Comments:

Process flow to determine hospital transfer category



TAP categories

I **Avoidable Hospital Transfer**	II **Unavoidable But Potentially Preventable Hospital Transfer**	III **Appropriate Hospital Admission**
Clinically responsible alternative to hospitalization exists at time of transfer Transferred against member/ family/representative wishes and/or expressed goals of care as documented in the medical record Services needed to evaluate and safely treat the medical condition are available in the NF at the time the problem was recognized Elective Outpatient Procedure	Clinically responsible alternative to hospitalization may not exist at the time of transfer, however, evaluation/management of change in condition (CIC) may be incomplete. Important elements of evaluation/management ofchange in condition include: • NF staff recognition, assessment, and monitoring of CIC • Prompt notification of primary and/or on-call NP/PA • Appropriate assessment by NP/PA between identification of CIC and transfer • NP/PA/PA contact with CSM prior to transfer • NP/PCP collaboration and discussion of options • Development of appropriate diagnostic/treatment/monitoring plan by PCT • Family/RP contact by NP/PA • Review of ACP/goals of care • Agreement of all stakeholders (NP/PA/PCP/NF staff/Family) to diagnostic/treatment/monitoring plan and proposed f/u • Development of contingency plan for likely clinical scenarios/high probability events • Agreement of all stakeholders (NP/PA/PCP/NF staff/Family) to contingency plan • Execution of appropriate diagnostic/treatment/monitoring plan	Clinically responsible alternative to hospitalization does not exist at the time of transfer, and all elements of evaluation/management of change in condition are either complete or there was no reasonable opportunity (NRO) or ability to effectively complete them. Inpatient care is consistent with the member/family/representative wishes and/or expressed goals of care as documented in the medical record. Inpatient based treatment was needed to: • Preserve or increase function • Optimize pain control • Provide surgery • Inpatient diagnostics

Reduction in unnecessary hospitalizations

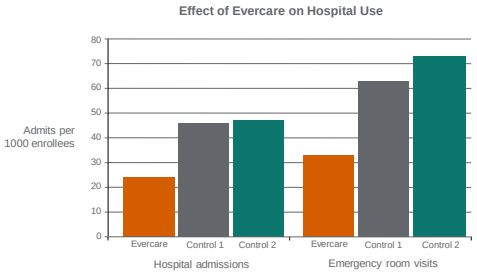
The University of Minnesota School of Public Health found that the incidence of hospitalizations among nursing home populations was twice as high in control residents as in Evercare residents.

Evercare®

Members in the control group were also twice as likely to go to the emergency room than Evercare members.

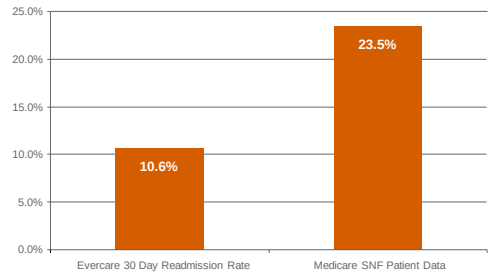
Evercare had half the hospitalizations compared to fee-for-service Medicare (Control 1 and 2).

Reduction in unnecessary hospitalizations (continued)



Source: Dr. Robert Kane et al, University of Minnesota, 2003

Evercare readmission rate



Case #3

- 89-year-old female with severe degenerative arthritis R hip h/o duodenal ulcer related to NSAID use now s/p R THR returned to SNF not anticoagulated due to recent GI bleed
- Developed acute onset dyspnea, hypoxia and tachycardia
- BP 84/60 HR 126 RR 28 T 100.6
- Staff called 911. Patient readmitted to hospital with acute PE

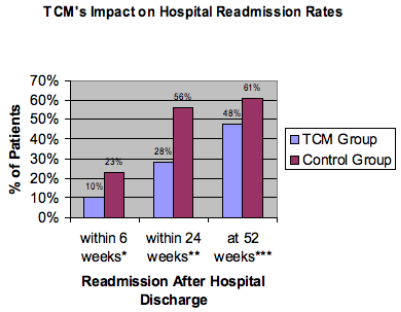
Project RED (re-engineered discharge)

- Discharge Advocate to perform:
  - Education regarding disease and meds
  - Preparation and reinforcement of after hospital care plan
  - Review procedure for handling unanticipated problems
  - Transmission of written plan to care providers
- Nurse avatar used successfully as patient advocate alongside Discharge Advocate
- Initial research shows 30% reduced likelihood of re-hospitalization within 30 days
- More than 50% of discharged patients had medication problem requiring corrective action post discharge
- 91% of receiving physicians had discharge summary within 24 hours of discharge
- Savings of $380 per patient (includes cost of nursing time)

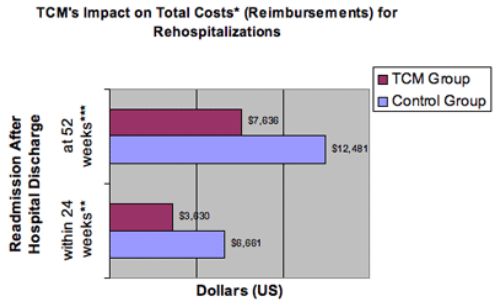
Transitional Care Model

- Advance Practice RNs: Transition Nurse managers
- Comprehensive discharge planning and home visits
- Active engagement/support of families and caregivers
- Collaboration with physicians

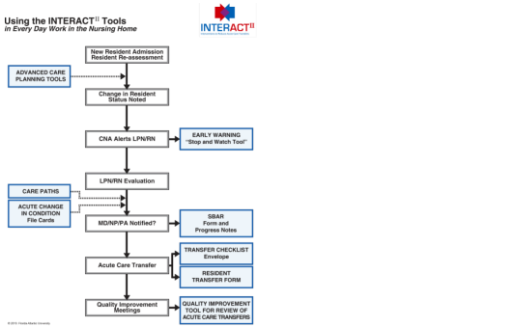
Transitional Care model



Transitional Care Model



Interact II



Other approaches

- POLST/MOLST
- Project BOOST
- Lean Healthcare
- Care Transitions Program
  - Self management model/transition coaching

Conclusions

- SNFs need to improve technical capabilities, staff training and education to prevent readmissions
- We need to continue to understand who is at highest risk for re-hospitalization
- Early recognition of decline/early intervention
- Contingency planning
- Family communication/involvement/support
- Advance Care Planning is critical
- Many tools/resources available
- No excuses!

Thank you.

Any questions?

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