SNF Readmission Reduction Collaborative

Presented by:

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Wyckoff Heights Medical Center

- Located on the border of Brooklyn (Bushwick section) & Queens (Ridgewood section)
- Teaching Hospital, 324 certified beds
- Service area over one million persons
- Diversity: age, race, ethnicity, culture, language
- Brooklyn's largest Hispanic community
- 92,000 Emergency Department visits
- 14,000 annual discharges
- 170,000 annual clinic visits

Background

- The Medicare Payment Advisory Commission (MedPAC) reported that within 30 days of discharge from the hospital, about three-quarters of patient readmissions were potentially preventable. This leads to a projected $12 billion in cost to Medicare (James, 2013).
- Over 20 percent of all Medicare beneficiaries are discharged to a skilled nursing facility (SNF; MedPAC 2015),
- Re-hospitalizations of patients discharged to SNFs are higher than that associated with other discharge destinations (Mor et al. 2010).
- Almost one quarter of Medicare Beneficiaries discharged to SNF are readmitted within 30 days.

Background

- The median hospital sends about 32% of its discharges to the most frequently used SNFs
- Under the Affordable Care Act (ACA), CMS (2016) implemented the Hospital Readmissions Reduction Program (HRRP) in 2012 to reduce payments to hospitals with an excess amount of readmissions within 30 days of discharge on certain measured conditions, including HF, MI, PN etc…

Significance

- The Centers for Medicare and Medicaid services' (CMS, 2015b) 30-day All-Cause Hospital Readmission measure includes data on Medicare patients who had an unplanned acute care hospitalization for any cause within 30-days of discharge from an acute care hospital.
- All cause readmission rates at Wyckoff were above the national average and 19 % of the readmissions were from SNFs.

Why Focus on Readmissions?

- CMS: Condition of participation on Discharge Planning (42CFR 482.43)

  Tracking readmissions to measure the effectiveness of discharge planning.

- CMS/National Quality strategy

  Our mission is quality driven and reducing readmission is a quality of care issue

- Quadruple Aim

  Optimize: Health, Cost, Patient experience & Provider wellbeing

- High Readmissions Rate
- *Financial incentives for reducing readmissions*
- CMS Penalty
- *Avoiding Medicare readmission penalty*

Baseline Readmission Data 2014

Facility Percentage of discharges to SNF overall is 20% (455 discharges)

SNF readmission within 30 days is 33% (153 discharges)

Source: Paid Medicare Claims from CMS

Wyckoff's Readmission Rates

Huge……

Unattainable……

Challenging…..

NYS Partnership for Patients

HOSPITAL and SNF Collaborative

Improving care transitions between the acute care setting and skilled nursing facilities (SNFs)

Objectives: To assist New York State hospitals in reducing their readmission rates by improving the transitions of care between acute care providers and SNFs

Goal: CMS goal of reducing readmissions by 12% from a 2014 baseline

SNF Collaborators

Selection of 2 SNFs with high volume and readmission rates

SNF #1

254 discharges in 2014

SNF #2

96 discharges in 2014

Work Group

Wyckoff

AVP, Social Work/Care Coordination

AVP, Transitional Care

Dir, Case Management

CNO

Chair, Dept of Medicine

Chair, Dept of Emergency Medicine

Patient Care Managers

SNF #1

Administrator

Director Admissions

Director of Nursing

Nurse Practitioner

SNF # 2

Administrator

Director Admissions

Director of Nursing

AIM Statement

- Improve Transitions between Hospital & SNFs
- Reduce SNF readmissions by 12%, from 2014 baseline
- Project Date: June, 2017 to August, 2018

Implementation

Process Mapping:

- Individual component of process.
- Streamline & revise process.
- Test the revised process.
- Review information shared between care settings.

Implementation

Internal Barriers

- Another meeting!!! No time…..
- Readmissions are difficult to solve… we are not the only Hospital.
- SNFs drive readmissions, not the Hospital….
- We can't control how the SNFs do business….
- Leadership Support .. buy-in…..??

Monthly meetings:

- Work group meeting times were conducive for everyone
- One case review in each meeting.
- Review of previous month readmission data.

SNF site visits:

- PFP staff & Hospital discharge planning staff made visits
  - Visualize the locations.
  - Better understanding of the environment.
  - Meet frontline staff who may be instrumental in hand-off.
  - “Wish list” for Hospital staff.

SNF Wish List

- Most recent Nursing/Doctor notes
- Labs
- Psych Notes if applicable
- Family/Guardian contact information
- Antibiotic administration & duration
- Immunization record/Hx
- Contact precaution (site & organism)
- MOLST/Advanced Directives, treatment goals
- Allergies
- Patient's baseline status

Wyckoff Wish List

- **Admission:**
- Use of Red Phone:
  - SNFs to call before sending the patient.
- MD/NP to MD hand-off
- **Discharge:**
- Preliminary PRI
- Nursing hand-off script prepared & implemented.
- Nursing Home capability list
- Review & Revise SNF transfer form to include missing items expressed in “SNF Wish List”

Nursing Verbal Hand Off

- Focus – med Rec, goals of care
- Purpose – standardized information sharing and communication process.
- Done at the time of transfer, Nurse to Nurse
- Hand off check list used as reference
- Shift to Shift Handoff : Day to Night Nursing Staff

Challenges

- Great idea, but easy to forget
- Time Constraints, Nurses busy with patient care
- Operational issues – Residents completes the discharge summary at the end.
- Hardwiring the process

- ☐ Overview of patient's hospital course: _____
- ☐ Vital Signs: _____
- ☐ Medication list (date and time the last dose was given; date and time the next dose is due; high-risk medications; medication allergies):
  _____
  _____
  _____
- ☐ Advance Directive (s) and Goals of Care (i.e., Full Code, DNR, DNI, Do not Hospitalize, MOLST):
  _____
- ☐ Treatment Plans: _____
  _____
- ☐ High-Risk Conditions: _____
- ☐ Relevant Lab and Diagnostic Testing results, pending or outstanding tests:
  _____
  _____
- ☐ Communication(s) between patient, family members and caregivers:
  _____
- ☐ Behavioral Issues: _____
- ☐ Follow up appointments that have been or need to be made:
  _____
- ☐ Special Care needs (e.g., wound care, diet, catheters, infection control issues, skin integrity, fall risk, specialized equipment): _____
  _____
- ☐ Hospital follow-up contact information (e.g., PCP or hospitalist name and phone number, specialist name and phone number): _____
  _____

_____ / _____ _____

WHMC RN PRINT Name **SIGN** **Date and Time**

_____

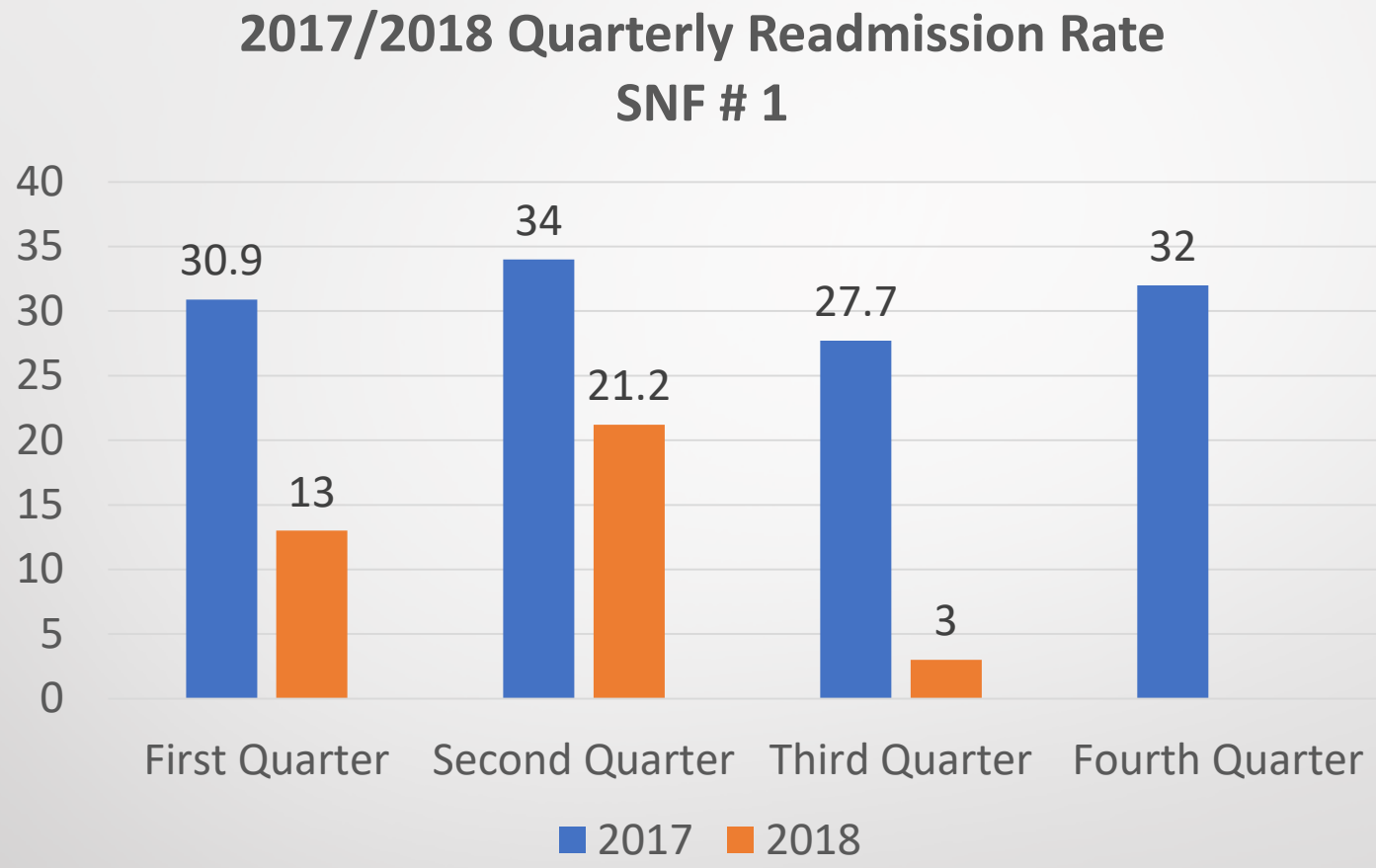
Receiving Facility

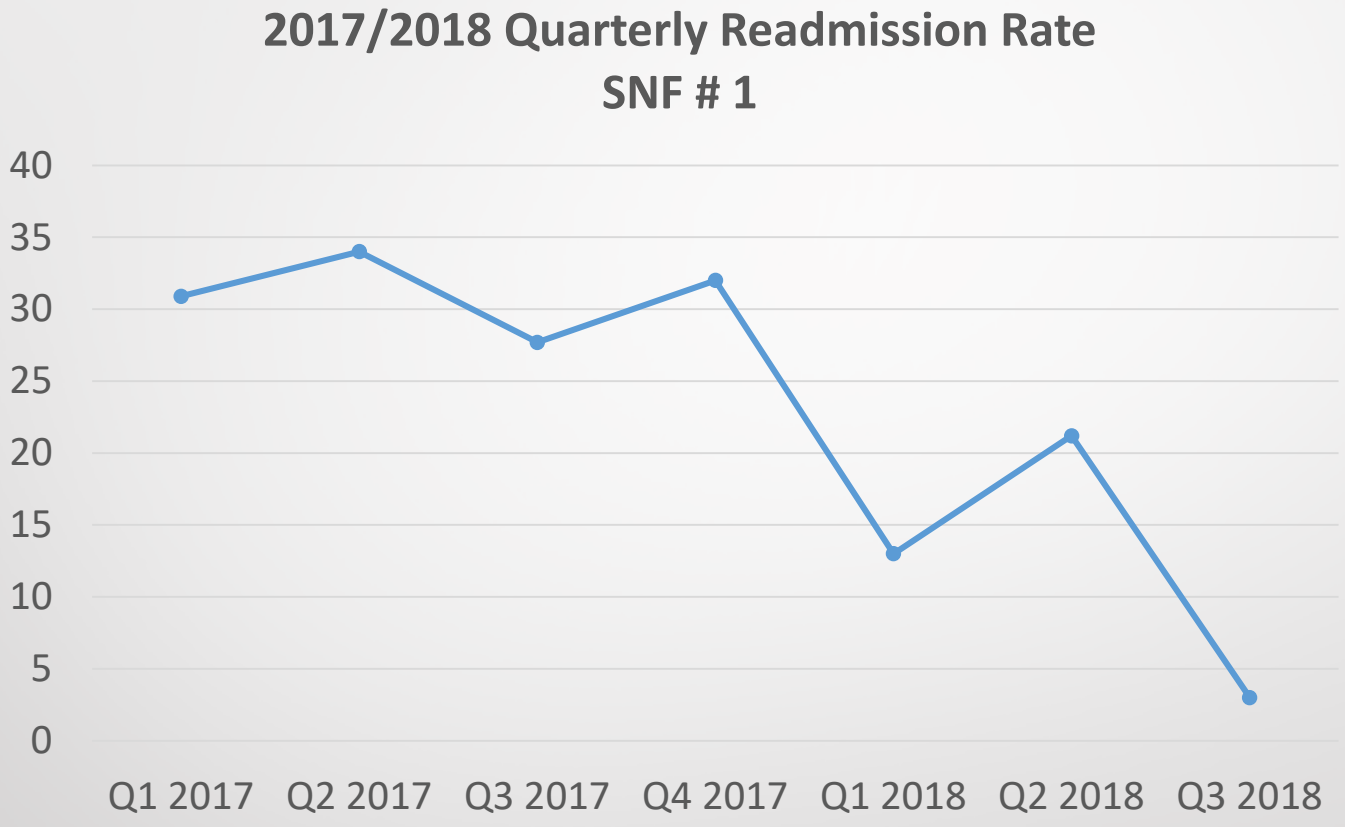
_____ _____

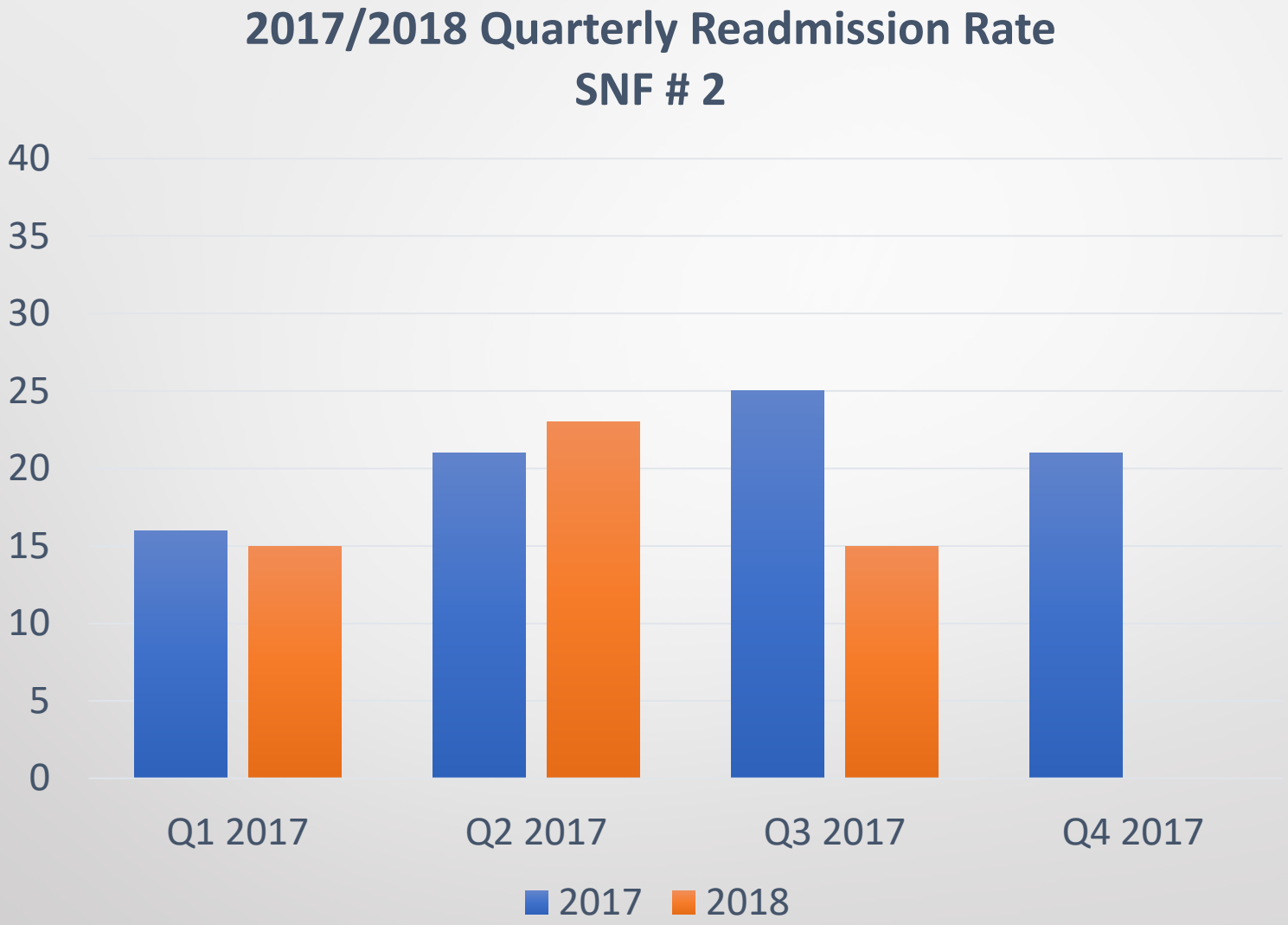
Name of Person Spoken to at Facility **Title of Person spoken with**

Study

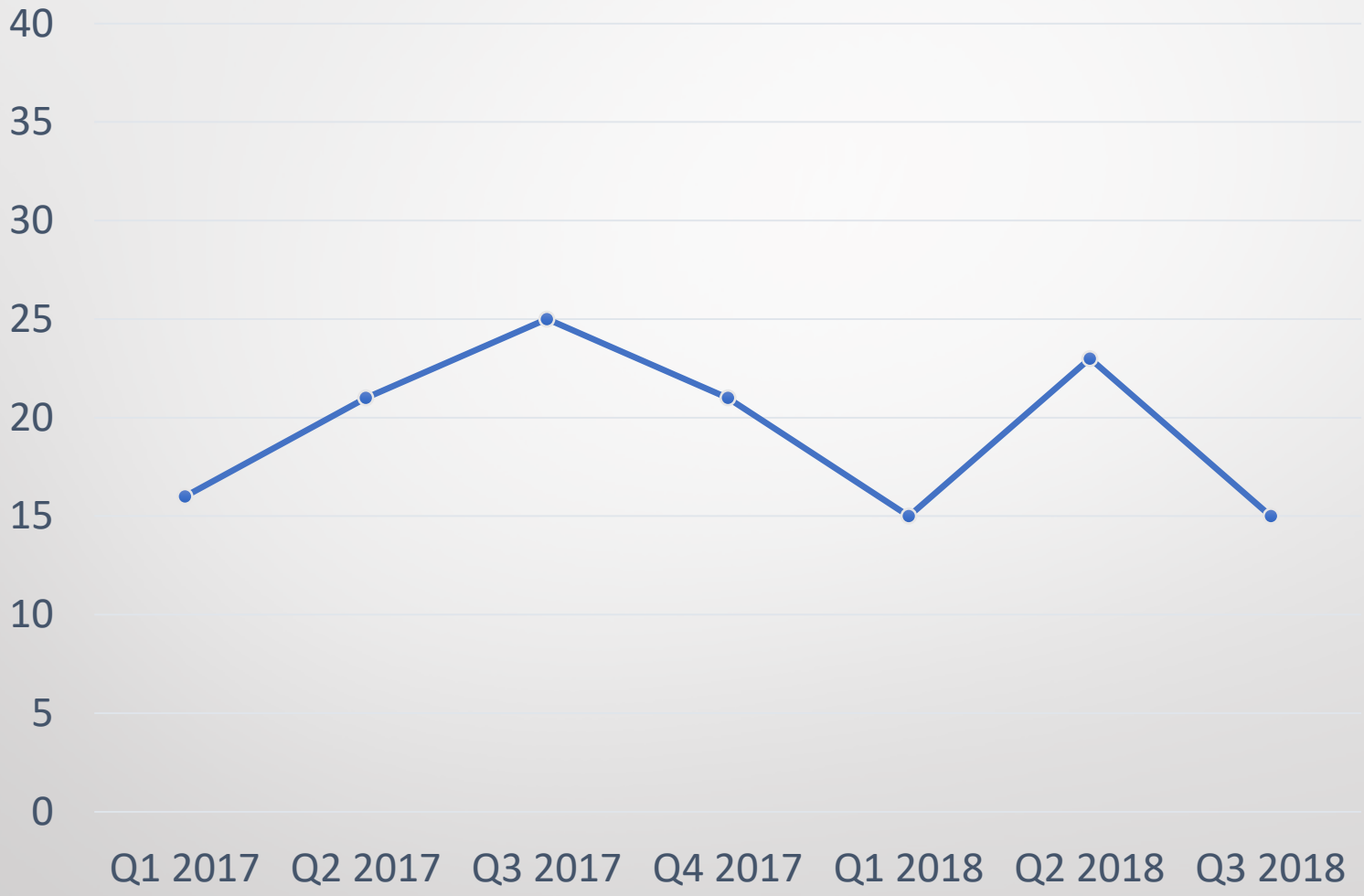
- Readmission data was reviewed with SNFs before the project started for use as a baseline.
- House Physician looked at readmissions from clinical perspective, during the project.


2017/2018 Quarterly Readmission Rate
SNF # 1
40
35
30
25
20
15
10
5
0
30.9
13
34
21.2
27.7
3
32
First Quarter
Second Quarter
Third Quarter
Fourth Quarter
2017
2018


2017/2018 Quarterly Readmission Rate
SNF # 1
40
35
30
25
20
15
10
5
0
Q1 2017
Q2 2017
Q3 2017
Q4 2017
Q1 2018
Q2 2018
Q3 2018


2017/2018 Quarterly Readmission Rate
SNF # 2
40
35
30
25
20
15
10
5
0
Q1 2017
Q2 2017
Q3 2017
Q4 2017
2017
2018

2017/2018 Quarterly Readmission Rate
SNF # 2



Lessons Learned

- Advance Care Planning
  - Discussion on goals of care can influence decisions about readmission.
  - Need for improvement in End of Life conversations with patient/family.
  - Advance Care Planning tools provided to SNF Partners.
  - http:/interact2.net/home_health.aspx.
- Physician affiliation & SNF can play important role if committed to reducing readmissions.
- Medical, Nursing and ED support is critical.

Lessons Learned

Together we can make a Difference

- Case reviews are an important component of a robust ongoing process improvement.
- Identified specifics in communication breakdown

  Circle back is important to identify missing information during transitions

  - Missing information between PRI sent & transfer summary : change in meds, isolation, dementia, radiation therapy schedule etc.
- Convenient location is critical to families.
- Safety of the patient can be assured through a trusting relationship

Holding the Gain

- Share the gains across the board
- Ongoing process
- Much still needs to be done
- Sustainability:
  - Continue meetings
  - Review readmissions
    - In real time
    - Clinical & non-clinical aspects.
- Include other SNF partners in the project
- Two partners added, January 2019
  - High volume
  - High readmission rates

Future Steps

- Improving Advance Care Planning across the settings.
  - Learning 8-Step MOLST protocol
  - Improving comfort level with end-of-life conversations
  - Review & evaluate our process to address Advance Care Planning/MOLST
  - Include SNFs Partners in MOLST training
- Accuracy/Validation of SNF Readmission data.

Future Steps

- Categorize issues for better solutions:
  - Clinically complex/multiple chronic disease
  - Financial & Psychosocial barriers
  - Med. Rec.
  - Functional
  - Mental Health History
  - Substance Abuse History
  - Unclear of goals of care
- 90 day readmissions after post acute stay – collaboration with SNF and Homecare.

References

MedPac. 2015. “A Data Book: Healthcare Spending and the Medicare Program.” Retrieved from:http// medpac.gov/-documents-/data-book

Mor, V., Intrator, Z. Feng, and D. C> Brabowski.2010. “The Revolving Door of Rehospitalzation from Skilled Nursing Facilities.” *Health Affairs (Millwood)29* (1): 57-64.

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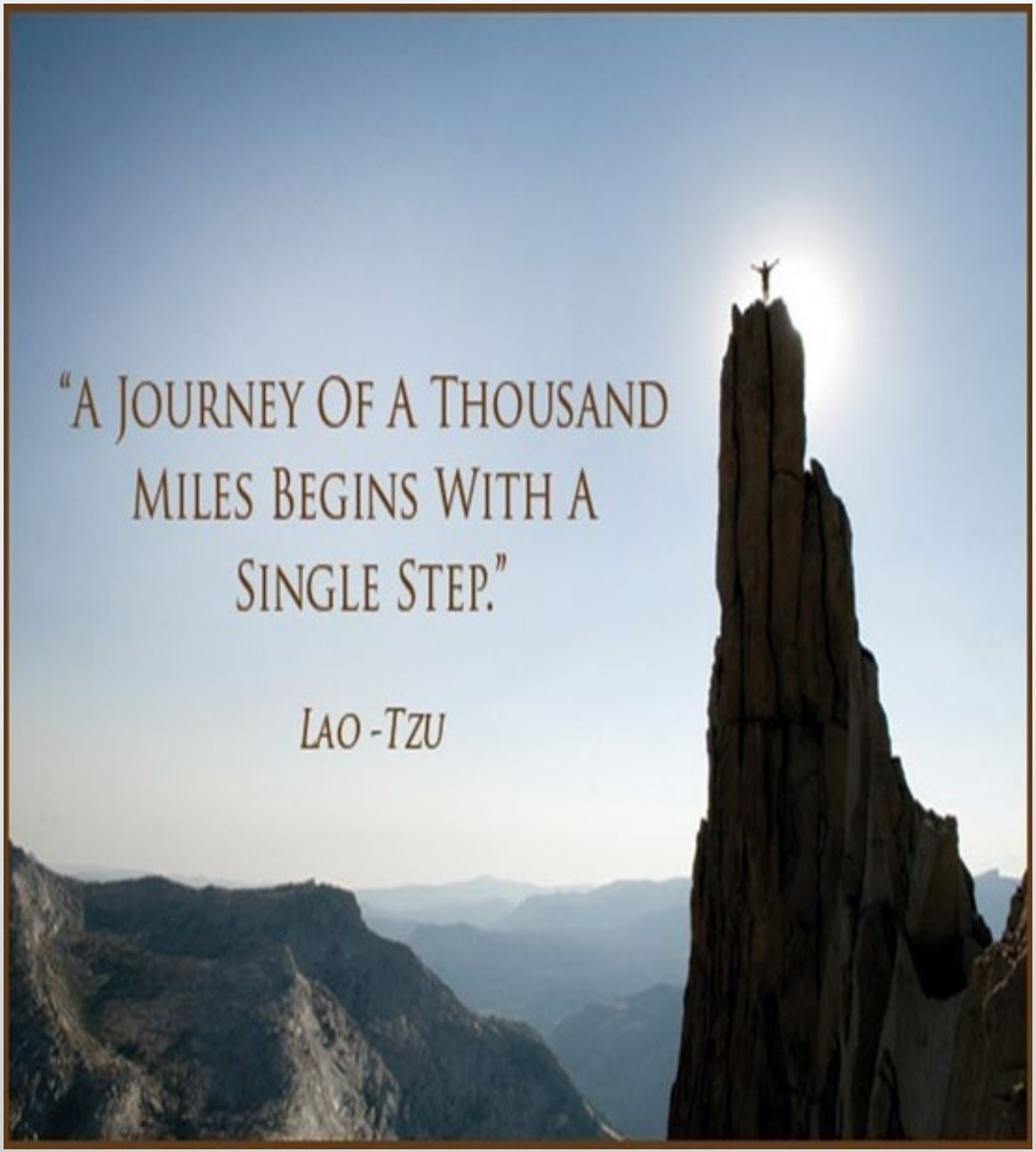
"A JOURNEY OF A THOUSAND
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LAO -TZU