FHCA 2019 Annual Conference & Trade Show

CE Session #16 – S'more on Hospital Readmissions: A Case Study

Monday, August 5 – 12:30 to 1:30 p.m.

Celebration 7-8 – Operations/Quality Improvement

Upon completion of this presentation, the learner will be able to:

- Utilizing Health Services Advisory Group Medicare Readmission reports for center Root Cause Analysis
- Understanding the correlation between readmission rates, perceptions of care delivery and publicly reported data
- Implementing a Quality Assurance Performance Improvement project to effectively reduce potentially preventable hospital readmission's based on available data

Seminar Description:

This session will review Stoney Camp Health and Rehabilitation's Medicare readmission rate which is well above the state and region readmission averages. Speakers will review the impact this has on the center's quality, survey, hospital partnerships and revenue. There will be "S'more" discussion of how root cause analysis, acute and post-acute partnerships and community resources can be utilized with QAPI to put the camp fire out.

Presenter Bio(s):

Sara Busacca, RN, BSN, MBA, LNA, RAC-CT, has a total of 30 years of health care experience, eight years as a Director of Nursing and 20 plus years as Nursing Home Administrator and was instrumental in improving quality for those centers she worked with by promoting a strong quality improvement program. She currently works as a quality improvement specialist for Florida's QIO-QIN, Health Services Advisory Group. Sara works with skilled nursing centers both at a corporate and individual level to improve care coordination, reduce both preventable hospital readmission, and adverse drug events. Sara also has provided several public speaking opportunities to educate and promote best practices in improving coordination of care across the health care continuum.

Danny Davis is a Nursing Home Administrator working with Health Services Advisory Group (HSAG) as a Quality Improvement Specialist. Part of HSAG's Care Coordination Team, Danny visits with skilled nursing centers and Corporations to provide resources and support focused on reducing rehospitalizations from the post-acute setting.

S'more on Readmissions

Sara Busacca, RN, BSN, MBA, LNHA, RAC-CT
Danny M. Davis, NHA, MS-HCA
Quality Improvement Specialists
Health Services Advisory Group (HSAG)

August 5, 2019

Acronyms

- Centers for Medicare and Medicaid Services (CMS)
- Chronic Obstructive Pulmonary Disease (COPD)
- Diagnosis (DX)
- Health Services Advisory Group (HSAG)
- High-Risk Medications (HRM)
- Home Health Agency (HH or HHA)
- Interventions to Reduce Acute Care Transfers (INTERACT®)
- Minimum Data Set (MDS) 3.0
- Quality Assurance and Performance Improvement (QAPI)
- Quality Improvement Organization (QIO)
- Root Cause Analysis (RCA)
- Situation Background Assessment Recommendation (SBAR)
- Skilled Nursing Facility (SNF)
- Skilled Nursing Facility Readmission Measure (SNFRM)
- Value Based Purchasing (VBP)

Objectives

- Understand the correlation between readmission rates, perceptions of care delivery, and publicly reported data.
- Use HSAG Medicare Readmission reports as part of the facility RCA.
- Examine how asking patient-centered questions during RCA could uncover opportunities for successful transitions of care.
- Discuss the overall impact of successful partnerships with facility stakeholders.

Stoney Camp Health & Rehabilitation Center: Overview

- History
  - 120-bed SNF in a rural community
  - Nursing Home Compare overall rating 4-Star
  - Preferred provider with local hospital system
  - Highly regarded in the community
  - Average occupancy rate 95%

★★★★

Stoney Camp Health & Rehabilitation "This IS NOT a 2-Star Center!"

- Current Status
  - Nursing Home Compare overall rating 2-Star
  - Removed from local hospital-system preferred-provider status
  - Publicly reported data is challenging community reputation
  - Average occupancy rate 86%

Stoney Camp Health & Rehabilitation
"Where do we even begin?"

- Nursing Home Compare
- QIES/CASPER*
- Payroll-Based Journal
- Confidential Feedback Reports
- QIO resources

*Quality Improvement and Evaluation Service (QIES) / Certification And Survey Provider Enhanced Reports (CASPER)

Stoney Camp Health & Rehabilitation
Nursing Home Compare: Staffing

Staffing rating	★★★★★ Below Average		
Average number of residents per day	162.8	106.3	85.6
Total number of licensed nurse staff hours per resident per day	1 hour and 32 minutes	1 hour and 38 minutes	1 hour and 33 minutes
RN hours per resident per day	30 minutes	43 minutes	41 minutes
LPN/LVN hours per resident per day	1 hour and 2 minutes	55 minutes	53 minutes
Nurse aide hours per resident per day	2 hours and 16 minutes	2 hours and 42 minutes	2 hours and 19 minutes
Physical therapist staff hours per resident per day	14 minutes	6 minutes	5 minutes

- Average census reported as 162.8 at a facility that only has capacity for 120 residents...
- Who is responsible for validating the Payroll-based Journal reporting prior to final submission?
- Who is responsible for monitoring that discharge assessments have been completed and submitted timely?

Source: Centers for Medicare and Medicaid Services (CMS) Nursing Home Compare (https://www.medicare.gov/NursingHomeCompare) Staffing calculations as updated April 24, 2019.

Stoney Camp Health & Rehabilitation
Nursing Home Compare: Quality

	STONEY CAMP HEALTH & REHAB	FLORIDA AVERAGE	NATIONAL AVERAGE
Short-stay quality of resident care			
Measures used to calculate the star rating - Short-stay residents			
Percentage of short-stay residents who were re-hospitalized after a nursing home admission. *Lower percentages are better.*	28.1%	24.6%	22.6%
Percentage of short-stay residents who have had an outpatient emergency department visit. *Lower percentages are better.*	7.5%	8.7%	10.7%

- Facility percentage of re-hospitalizations is above the Florida and national averages.
- Stakeholders may be using this data for Preferred Provider/Partnership decisions.
- Perspective patients and families may be using this data to help make placement decisions.

Source: Centers for Medicare and Medicaid Services (CMS) Nursing Home Compare (https://www.medicare.gov/NursingHomeCompare) Quality of Resident Care Short-stay residents as updated April 24, 2019.

Stoney Camp Health & Rehabilitation Readmission Measures

- Provider Rating Report
  - Observed Rate
  - Expected Rate
  - Risk-Adjusted Rate
- Nursing Home Compare
- SNFRM
- SNF VBP readmission measure

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HSAG: HELP!

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The Partnership with HSAG

- Community coalitions:
  - Review readmission data for post-acute utilization
  - Review data for top admission and readmission diagnosis-related group (DRG)
  - Organize community work-groups
- Post-acute meetings:
  - Encourage collaboration between acute hospitals and post-acute providers to hold hospital-specific readmission meetings
- Individual facility meetings:
  - Provide an opportunity to address:
    - High-volume, high-readmission rate centers
    - Facility-level readmission reports and RCA reviews

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Stoney Camp Individual Facility Report

- Q4 2017–Q3 2018

Table 1: 30-Day All-Cause Readmission Rates

		Number of Discharges to SNF	Discharges to SNF with a 30-Day Readmit	Percentage of Discharges with a 30-Day Readmit	Days to Readmission							
					0-7 Days		8-14 Days		15-21 Days		22-30 Days	
					N	Percentage of 30-Day Readmits	N	Percentage of 30-Day Readmits	N	Percentage of 30-Day Readmits	N	Percentage of 30-Day Readmits
Your Facility	Baseline (Q4 2015 – Q3 2016)	317	102	32.18%	41	40.20%	29	28.43%	17	16.67%	15	14.71%
	Current (Q4 2017 – Q3 2018)	358	77	22.79%	24	31.17%	19	24.68%	19	24.68%	15	19.48%
Region 4	Baseline (Q4 2015 – Q3 2016)	16,284	3,849	27.49%	1,302	33.83%	1,020	26.50%	713	18.52%	814	21.15%
	Current (Q4 2017 – Q3 2018)	14,691	3,454	23.86%	1,146	33.18%	897	25.75%	689	19.78%	752	21.58%
Florida	Baseline (Q4 2015 – Q3 2016)	153,088	34,425	22.49%	11,655	33.86%	8,745	25.40%	6,953	20.20%	7,072	20.54%
	Current (Q4 2017 – Q3 2018)	141,742	31,829	22.46%	10,505	33.00%	8,190	25.73%	6,471	20.33%	6,663	20.93%

- Q1 2018–Q4 2018

Table 1: 30-Day All-Cause Readmission Rates

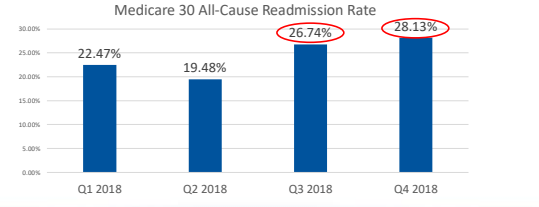
		Number of Discharges to SNF	Discharges to SNF with a 30-Day Readmit	Percentage of Discharges with a 30-Day Readmit	Days to Readmission							
					0-7 Days		8-14 Days		15-21 Days		22-30 Days	
					N	Percentage of 30-Day Readmits	N	Percentage of 30-Day Readmits	N	Percentage of 30-Day Readmits	N	Percentage of 30-Day Readmits
Your Facility	Baseline (Q4 2015 – Q3 2016)	317	102	32.18%	41	40.20%	29	28.43%	17	16.67%	15	14.71%
	Current (Q1 2018 – Q4 2018)	348	85	24.43%	32	37.65%	25	29.41%	9	10.59%	19	22.35%
Region 4	Baseline (Q4 2015 – Q3 2016)	16,284	3,849	27.49%	1,302	33.83%	1,020	26.50%	713	18.52%	814	21.15%
	Current (Q1 2018 – Q4 2018)	14,480	3,493	24.12%	1,153	33.01%	914	26.17%	688	19.70%	738	21.13%
Florida	Baseline (Q4 2015 – Q3 2016)	153,088	34,425	22.49%	11,655	33.86%	8,745	25.40%	6,953	20.20%	7,072	20.54%
	Current (Q1 2018 – Q4 2018)	139,729	31,133	22.28%	10,326	33.17%	8,003	25.71%	6,295	20.22%	6,509	20.91%

13 The CSAT data file (Part A claims for FFS beneficiaries) was used for this analysis for the time periods of 10/01/2017–09/30/18 and 01/01/18–12/31/18.

Stoney Camp Individual Facility Report

Table 2: Facility Readmission Rate

Q2 2016	Q3 2016	Q4 2016	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018
31.43%	27.69%	30.23%	30.61%	32.94%	20.00%	27.27%	22.47%	19.48%	26.74%	28.13%



14 The CSAT data file (Part A claims for FFS beneficiaries) was used for this analysis for the time period and 01/01/18–12/31/18.

Stoney Camp: The Initial Review

Facility Trends

- 30-Day All-Cause Medicare readmission rate increased over the last 2 quarters.
- 0–7-day is the highest Medicare readmission rate and increased from the last reporting period.
- 22–30-day Medicare readmission rate increase from last reporting period.
- Overall, the facility is above the state and region 30-day Medicare readmission rates and did not receive the 2% incentive CMS payment.

Stoney Camp - Audit Drill Down

- Four patients with multiple readmissions; 1 patient had 3 within 4 weeks of admission
- The highest day of readmission occurred on day 4
- Highest readmission DX: Sepsis
- Second-highest readmission DX: COPD
- 85% of readmissions occurred from one hospital
- 8% of readmissions occurred after patient was discharged home with HH
- Significant number of readmissions occurred on the weekends

Stoney Camp Health & Rehab Readmission Case Study

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Mr. Smore: MR #4569878

- The Client
- The Beneficiary
- The Resident
- The Patient
- The Guest
- The Cancer Patient

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First Readmission: Day 4
Bowel Obstruction

Potential pro-active interventions:

- Identification of readmission risk on admission
- Transfer information clarification
  - Hospital to SNF
    - Nurse-to-nurse report
    - 3008 completeness
  - SNF to Hospital
    - SNF to ED hand-off communication
    - Post re-admission discussion with nursing officer or risk
- Education to patient regarding opioid use and side effects
- Nurse education and competency

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Second Readmission: Day 14
Pneumonia

Potential pro-active interventions:

- INTERACT®
  - SBAR
  - STOP & WATCH
  - Clinical Pathway – Respiratory
- Disease management (Zone tool)
- Respiratory Services
- Interdisciplinary team meetings (morning meetings/ huddles)
- Pharmacy involvement for HRM

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Third Readmission: Day 8
Heart Failure

Potential pro-active interventions:

- Discussing advance directives
  - Hospice vs. palliative care
  - Honoring patient wishes
- Physician services on the weekend
- Emergency room communication and what treatment the facility is capable of providing
- Telehealth offered
- Nurse competency for new hires and periodic checks based on skills testing

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Mr. Smore: the person

- Spouse
- Father
- Brother
- Best friend
- Employee
- Uncle
- The life of the party

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Lessons Learned!

- Patient goals need to be addressed
- Incorrect level of care, skilled nursing care was not discussed with patient.
- Teach-back to start as soon as possible at hospital: J tube, diet medication (opioid use)
- Home health to visit patient while in the hospital
- Better coordination of equipment delivery/dressing for J-tube/nutrition (the HH had to borrow equipment/feeding for Saturday from local hospital because equipment wouldn't arrive until Monday to the home)
- Medication reconciliation to have pharmacy involvement and education to the patient
- No palliative care provided, pain/chronic disease management
- No primary care provider involvement
- Multiple physicians involved: No cross communication between providers
- Local oncologist appointment scheduled in three weeks

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QAPI

Improve the Transitions of Care

- Be engaged in community efforts and meetings to reduce avoidable readmissions.
- Complete a review on each readmission to determine the root cause and identify communication gaps.
- Work together as a healthcare community to develop action plans to improve quality and safe transitions for the patient.

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Thank you!

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Quality Improvement Organizations | HSAG

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