Florida Health Care Association
2013 Annual Conference

The Westin Diplomat Resort & Spa

Session #53 – Assess and Educate to Prevent Rehospitalizations

Thursday, August 8 – 10:00 to 11:30 a.m.
Regency 1

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

- identify two reasons why returns to the hospital are not desirable;
- identify four strategies for front line staff that help reduce or avoid rehospitalization; and
- describe two strategies to make transitions to other care areas successful and smooth.

Seminar Description:

In today's climate of penalties to hospitals for unnecessary rehospitalizations, your ability to keep residents in your facility will not only provide better care for your residents, but develop good relationships with your local hospitals. This session will help attendees improve processes to keep residents where they belong – in their home.

Presenter Bio(s):

Jennifer Moore, RN, Content Developer for Relias Learning, has worked in long term care for 12 years. She has held positions including Director of Nursing, Medicare Nurse Coordinator, Nurse Consultant, Area Manager and Director of Quality Assurance. Additionally, she was responsible for maintaining an effective compliance program under a Corporate Integrity Agreement with the Office of Inspector General for a period of five years. Jennifer was responsible for establishing a zero-house-acquired pressure ulcer program, as well as participating in her company’s community restraint-free initiative.
Assess and Educate to Prevent Re-Hospitalizations

Session Objectives

- Describe two reasons why returns to the hospital are not desirable
- Describe four strategies for clinical staff that help reduce or avoid re-hospitalizations
- Identify two strategies to make transitions to other care areas successful

The Problem — Part 1

- Beneficiaries in LTC facilities account for only 3% of the Medicare dollars spent but 5% of total Medicare spending
- Medicare spending for each LTC beneficiary in 2006 was $14,538 – twice the average Medicare spending for all beneficiaries
- 39% of the $14,538 was spent on inpatient hospital stays
The Problem — Part 2

- 51% of beneficiaries living in a long term care facility had at least one ER visit during the year and 26% of those had two or more
- 27% of beneficiaries living in a long term care facility had a skilled stay during the year, averaging 40 covered SNF days
- Of the 27% that had a skilled stay, 36% of those had another SNF admission before the end of the year

Why Should We Care?

- Reducing hospitalizations by 25%, an estimated $2.1 billion could be saved.
- Relationships with hospitals
- Better care for our residents

Most Frequent Re-Hospitalizations

According to a study in the American Geriatric Society Publication in May 2012, 78% of avoidable hospitalizations were due to:
- Pneumonia
- CHF
- UTI
- Dehydration
- COPD
Determine the extent to which hospitalizations were a result of manageable or preventable conditions
May indicate quality of care problems
2007 OIG review – 35% of hospitalizations caused by poor quality or unnecessary fragmentation of services

approximately 68% of residents have some degree of impaired cognition
Of all residents 23% have moderate impairment
Your facility is a familiar surrounding – their home
Reduced anxiety
Staff is familiar with the resident

30-day readmissions dropped to 17.8 percent from 18.5% in the fourth quarter of 2012 and from 19.5 percent during the past five years per the Centers for Medicare & Medicaid Services.

What does this mean?
70,000 fewer readmissions in 2012.

…but we need more
Factors to Consider - Diagnosis

- Co-Morbidity or Underlying Disease
- Physician confidence in ability to manage resident's condition
- Presence of Complications
- Risk of Complications
- Clinical Stability
- Level of Function

Factors to Consider – Resident and Family Comfort with Facility

- Risk vs Benefit of Hospital Transfer
- Lack of understanding and review of advanced directives
- Personal Preferences
- Provision of Palliative Care
- Provision or use of Hospice
- Confidence in Facility

Let's Start From the Beginning
Facility or Hospital?

- Statistics show that acute infections managed in the facility have a better outcome and have fewer complications
  - Their home
  - Reduced risk of increased confusion due to dislocation
  - Staff familiar with the resident and can deviation from their normal quicker

Hot Spots

- Admission Process
- At Risk Population
- Nurses’ knowledge
- Medication Management
- Communicating with on-call physicians
- Consistent Assignments
- Nurse Practitioner presence

Admission Process

- Thorough admission assessment
  - All body systems
  - What is baseline for this person
  - Identify Risk
    - Put a plan in place
  - Communicate the plan

- Falls
  - Many falls indicative of sub-acute process getting worse
  - Lack of being able to identify changes in conditions may lead to falls
**Identify At Risk Population**

- Identify residents at risk at time of admission
  - Ensure care plan to address these in the interim until formal care plan is developed
    - Why are they here?
  - Communicate to nursing assistants who needs additional monitoring, why and what to look for
    - Follow up frequently during the shift
- Highest potential include
  - History of repeat hospital admissions
  - Dementia
  - Recent hospital discharges
  - Multiple co-morbidities

**At Risk - Social**

- Elderly (65 or over)
- Male
- African American
- Cognitive Impairment
- Rural or low income area
- Residents new to facility
- Non-English speaking

**At Risk - Clinical**

<table>
<thead>
<tr>
<th>Acute Conditions</th>
<th>Chronic Conditions</th>
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</thead>
<tbody>
<tr>
<td>Dehydration</td>
<td>Diabetes</td>
</tr>
<tr>
<td>UTI</td>
<td>Respiratory conditions</td>
</tr>
<tr>
<td>Bacterial Pneumonia</td>
<td>Circulatory conditions</td>
</tr>
<tr>
<td></td>
<td>Dementia and behavior problems</td>
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</tbody>
</table>
Do You Look at These?

- Quality Measures
- Incident Reports
- Survey outcomes
- Family or staff complaints

Find the Connections

- History of CHF
- Admitted with pneumonia

What to do?
- Front line staff trained to observe for subtle changes in condition
- Cardiac and pulmonary assessment skills need to be sharp
- Edema assessment
Find the Connections

- History of CHF
- Admitted with pneumonia

- DEMENTIA

INTERACTION

Find the Connections

- Dementia Resident
- Admitted with Dehydration and UTI
- Requires supervision of 1 for toileting

What to do?
- What is your hydration protocol
- Is it being followed
- Are they on thickened liquids?
- Is supervision really happening?

Find the Connections

- Dementia Resident
- Admitted with Dehydration and UTI
Find the Connections

- Dementia Resident
- Admitted with Dehydration and UTI
- A-FIB

Find the Connections

- History of Diabetes
- Admitted with peripheral artery disease (PAD)

What to do?
- Monitor blood sugars
- Skin checks, especially on lower extremities
- Preventative measures
- Podiatry visits scheduled

Find the Connections

- History of Diabetes
- Admitted with peripheral artery disease (PAD) treated with Pletal (cilostazol)
- GERD

INTERACTION
How Do You Know What Your Nurses Know?

- Are they up for the challenge?
- How do your nurses keep their skills sharp
  - How do you perform skills testing to be sure?
- Do they know the pathophysiology of the disease?
- How well do they know the residents?
- What type of ongoing education do they get regarding those disease processes that are prevalent in our industry?

Communication with the Doc

- Unfamiliar with the resident
  - Weekend admission (less than 72 hours)
  - Reluctant to write orders
- Nursing staff are unable to provide skilled services needed
- Nurses themselves inexperience or insecurity may prefer resident to be sent to hospital

About the On Call Doc...

- Nurse: "Hi Doctor, I am calling about Mrs. Jones. Her behavior has been just terrible today! She won't eat, she tried to hit another resident, and she started throwing things around her room."
- Doctor: Is this her usual behavior?
- Nurse: "I am not sure because I only work once a month and not always on this wing. Nurse shouts out to nursing assistant: "Hey, is this Mrs. Jones' regular behavior?" Staff member answers back "No"
- Doctor: Does she have Alzheimer's or dementia?
- Nurse: "Hold on, let me look at her chart...Yes, she does and the staff said this is not normal for her."
- Well, send her to the ER since I am covering for her regular doctor and I don’t really know her.

...and the nurse.
Communicate using SBAR

- Situation – What is the situation you are talking about?
- Background – what is the clinical background information that is pertinent to the situation?
- Assessment – share results of your clinical assessment
- Recommendation – what do you want to happen and by when?

Staff to Staff Communication

- Acute charting
- 24 hour report
- Walking rounds between nurses
- Walking rounds between nurses and aides
- When aides report something what is done?
  - Do nurses look into it?
  - Do they follow up with the aide?

Consistent Assignments

- When staff know resident, they know recognize when things aren’t right
  - Subtle changes in mental, physical or psychosocial ability
- Good communication between nursing assistants and nurses
- Follow through when told
- Focus on excellence
- Staff to acuity
Nurse Practitioner

- Do you use Nurse Practitioners?
  - Increased presence leads to shorter times to get treatment ordered or resident seen
  - Regular presence makes it easier to order tests and begin treatment earlier without sending them out.
  - Better quality of care

Re-Hospitalization Rates

- Do you know your re-hospitalization rates?
  
<table>
<thead>
<tr>
<th>Readmitted Residents</th>
<th>Average Census</th>
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- Do you review charts on all (re-) hospitalizations?
- QAPI
Industry Impact

- 40% of Medicare patients are discharged to a setting such as a SNF, Home Care or Hospice
  - 50% of these are admitted for rehabilitation or long term care
- Total cost of hospital re-admissions with a direct relationship to LTC was $4.34 billion according a 2010 study

Senders and Receivers

- Expectations out of balance
- Sender – give critical information to receiver in a timely manner
- Disconnect between what the receiver actually receives versus what they actually need to provide care

Senders -vs- Receivers

**Senders say:**
- Too many delays
- Receiver did not call back
- Receiver too busy to take report

**Receivers say:**
- No handoff occurred
- Incomplete information
- No opportunity to discuss hand-off with sender
Senders -vs- Receivers

Senders say:
- Too many delays
- Receiver did not call back
- Receiver too busy to take report

Receive say:
- No handoff occurred
- Incomplete information
- No opportunity to discuss hand-off with sender

21% unsuccessful

Root Causes of Ineffective Transitions of Care

- Communication Breakdowns
- Patient Education Breakdowns
- Accountability Breakdowns

A Closer Look...

Communication Breakdowns
- Expectation differ between senders and receivers of patients
- Culture does not promote successful handoff (lack of teamwork and respect)
- Inadequate amount of time provided for successful hand-off
- Lack of standardized procedures in conducting a successful handoff (e.g., use of SBAR tool - Situation, background, assessment, recommendation)
A Closer Look...

**Patient Education Breakdowns**
- Patients/caregiver receive conflicting recommendations, confusing medication regimens, and unclear instructions regarding follow up care
- Patients/caregivers excluded from planning process
- Patients may lack an understanding of their medical condition or plan of care – lack of buy in

**Accountability Breakdowns**
- Clinical entity does not take responsibility to ensure the coordination happens
- Providers often fail to coordinate care or communicate (especially true with multiple hands in the pot)
- Steps are not taken to assure that sufficient knowledge and resources will be available

What to do?
- Why are they here? – main diagnosis
- What co-morbidities do they have
- Can the resident communicate with you?
  - Are there family that can help?
- Do you know their baseline prior to hospital admission?
**Make it smooth**

- Start discharge planning on admission
- Identify risk factors of readmission and re-hospitalization
  - What are their risk factors
  - If going home, what does the family need to know
  - If going to another facility - provide comprehensive documentation
- Communicate, Communicate, Communicate
- Home visits by therapy

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**If Not Done Well...**

- Can lead to re-admissions
- Increased health care costs
- Stressful for caregivers, families, and residents
- Compromise safety

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**Predictors of Poor Discharge Outcomes**

- Over 80 years old
- Multiple active medical problems
- Longer stay than expected
- Failed discharge teaching
- History of non-compliance
- Inadequate teaching or discharge preparations
- Difficulty coping with daily demands
Of most concern...

- Assistance with medication monitoring
- Comprehensive medical information records
- Lack of electronic medical record
- Poor understanding and/or compliance with discharge instructions
- Physician lack of familiarity with resident and/or their wishes
- Reluctance of nurses or family members to intervene with the physician makes a decision to hospitalize a resident

Medication Management

- Medication reconciliation upon admission or readmission
- Do you know the “hot” medications that cause interactions?
  - Warfarin – NSAIDS, sulfa drugs (Bactrim DS), macrolides (E-mycin), quinolones (Cipro), Dilantin
  - ACE inhibitors – Potassium supplements, NSAIDS
  - Digoxin – Nexium, Lipitor
  - Theophylline – Dilantin, Cognex, Cipro

Medication Management

- Do you do a reconciliation when a resident returns to your facility from the hospital? Returns home?
- Monitoring lab values
  - Critical values
Successful Transfers

SHARE
- STANDARDIZE critical content
- HARDWIRE within your system
- ALLOW opportunity to ask questions
- REINFORCE Quality and Measurement
- EDUCATE and Coach

Pulling it Together

- Assess
- Educate
- Evaluate

QAPI
Contact Information

Jennifer Moore, RN
Silverchair Learning Systems
111 Corning Road, Cary, NC 27518
jmoore@reliaslearning.com