FHCA 2019 Annual Conference & Trade Show

CE Session #38 – Best Practices to Reduce Return to Hospital for the Skilled Center

Wednesday, August 7 – 10:30 to 11:30 a.m.

Celebration 3-4 – Clinical/Care Practices

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

- This session will involve an overview of Return to Hospital challenges for skilled nursing centers while admitting much higher acuity of care residents and guests
- Attendees will identify and discuss systems used in their centers and current status of those systems
- Several protocols and processes will be provided for implementation by attendees for use in their centers to reduce Return to Hospital

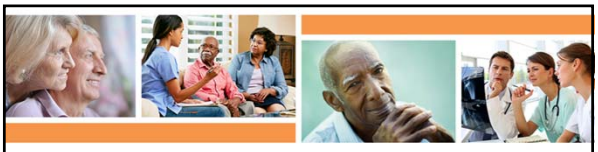
Seminar Description:

Hear from a provider who has tried and proven best practices to reduce return to hospital rates. Resources will be provided by the Health Services Advisory Group, along with tips on how hospitals and skilled centers can work together.

Presenter Bio(s):

Sara Busacca, RN, BSN, MBA, LNA, RAC-CT has a total of 30 years of health care experience with eight years as a Director of Nursing and 20 plus years as a Nursing Home Administrator. 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 and reduce both preventable hospital readmission and adverse drug events.

Holly Musselwhite joined AdventHealth Care Centers in 2015 and serves as Director of Specialty Programs. She has 20 years of health care experience, fueled by a passion for clinical excellence - in acute care, clinical leadership & education, staffing, and most recently in SNF/LTC. Holly loves to travel and learn about how health care works throughout the world. She holds a Master's in Business from Southern Adventist University and a Bachelor's in Nursing.



Best Practices to Reduce Return to Hospital For The Skilled Nursing Center

Sara Busacca, RN, BSN, MBA, LNHA, RAC-CT
Quality Improvement Specialists
Health Services Advisory Group (HSAG)

August 5, 2019

Keys to Communication

HSAG- Partnership

- Community coalitions should:
  - Review readmission data for post-acute utilization.
  - Analyze diagnosis-related group (DRG) data.
  - Organize community work-groups.
- Post-acute meetings encourage collaboration between acute hospitals and post-acute providers.
- Individual facility meetings provide an opportunity to address:
  - High volume, high readmission rate centers.
  - Facility-level readmission reports and RCA reviews.

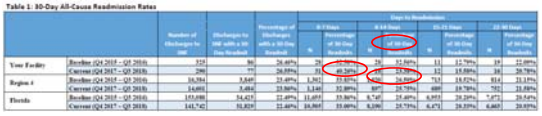
HSAG and the Facility level collaboration

- Facility reports
- Resources
- RCA
- QAPI tools
- Support
- MDS support
- Education to Acute Care on SNF regulatory changes

Utilize the Individual Facility Reports

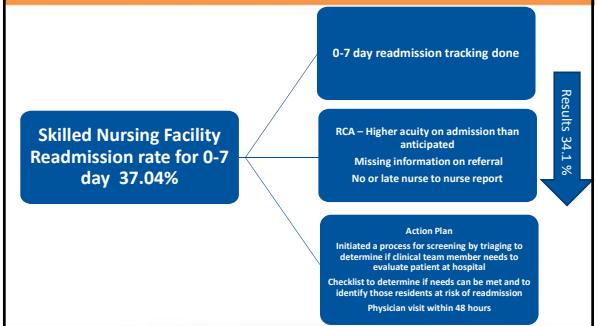
- Q3 2017–Q2 2018

- Q4 2017–Q3 2018



The CSAT data file (Part A claims for FFS beneficiaries) was used for this analysis for the time periods of 10/01/2017 – 03/30/18 and 12/01/17–9/30/18.

Case - Facility level collaboration



Promising Practices

- Measure nurse competency for disease management and physician communication.
- Use of at-risk for re-hospitalization revie tools.
- Use of readmission tracking tools.
- Completing root cause analysis (RCA)/ Quality Assurance and Performance Improvement (QAPI).
- Utilize available resource tools such as Zone Tools and Teach Back.
- Participate in post-acute provider networking and meeting opportunities.

Partnership Roles

Hospital/PAC	HSAG
Participate in a patient-centered approach to coordinate care in your community to reduce readmissions by 20% by 2019	Recognize your organization as an HSAG Medicare quality improvement community
Work with coalition members in a non-competitive environment	Assist in establishing a community collaborative
Designate a team leader and actively participate in meetings	Designate a resource consultant to serve as contact for your community and aid in the facilitation of community meetings
Develop and implement an action plan and utilize standard methodologies to measure improvement rates	Create community specific readmissions reports to identify the magnitude of local care transition issues

HSAG and Hospital Combined Post-Acute Meetings

Hillsborough Hospital – Post Acute Meeting

Education – CHF disease management education for patients and SNF.

- Hospital Education Coordinator provided on-site education for SNF facilities for CHF
- Utilized and promoted Teach-Back methodology for patient teaching.
- Communicated to SNF the progress of education and packet for continued education.
- Streamlined Materials so that education materials are consistent throughout providers.

Results – Reduced HF readmission rates by 3.4% to SNF and Home

HSAG and Hospital Combined Post-Acute Meetings

Jacksonville Medical Center – Work Groups

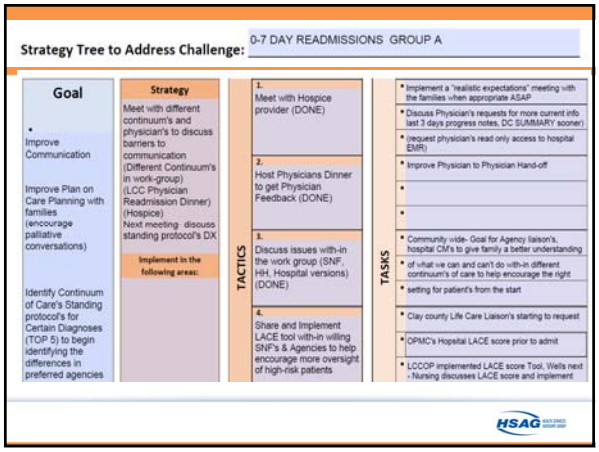
Group 1 - 0-7 Day Readmissions

- Chart audit on every 0-7 day readmission
- Case manager call with 0-7 day readmission to discuss cause/gap
- Identify trends for next steps
- Strategy tree completed

Group 2 - Improve Communication

- 3008 sample laminated and used for education of hospital staff
- Dedicated phone for nurse to nurse report piloted
- Contact list from hospital and SNF
- SNF Check-list for equipment needs

Results – Reduced Readmissions by 3%



HSAG and Hospital Combined Post-Acute Meetings

Miami Hospital Readmission Challenge

3 Skilled Nursing Facilities and 2 Home Health agree to be in pilot to review readmission charts and determine drivers

- End of Life discussions
- Medication / Prescription
- Discharge Instructions & Summary
- Elected post acute level of care (Incorrect level of care)
- Transitions of care after post acute care
- Patient / Family preparation and education

Based on the results – action plans were developed with referring SNF at the post-acute meetings and community meetings.

The project in on going but the a reduction of readmission was noted in the first quarter of the initiation of consistent best practices.

HSAG and Community Efforts to Reduce Readmissions

Jacksonville

Northeast Florida Coalition for Coordinated Care for Seniors(NEFL CCCS)

- Transition of Care Symposium in April – 6 Physicians included as guest speakers discussing improving transitions of care
- Over 150 attended representing all levels of care

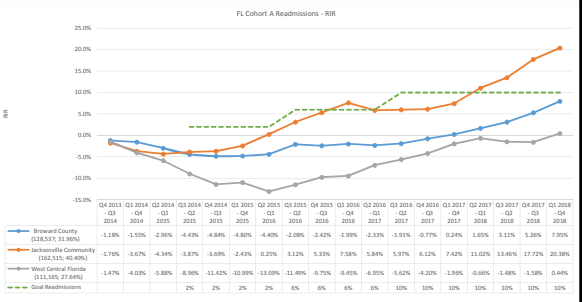
Orlando Coalition

- Developed the SNF to Emergency Department Transfer form that is being utilized in several other communities.

Miami Coalition

- High Risk Medication pilot – Use of screening tools to identify discrepancies.
- Medication Reconciliation

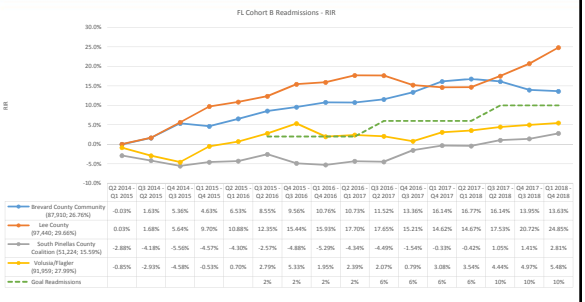
Florida Cohort A: Readmissions



	Q4 2013 - Q3 2014	Q1 2014 - Q4 2014	Q2 2014 - Q1 2015	Q3 2014 - Q2 2015	Q4 2014 - Q3 2015	Q1 2015 - Q4 2015	Q2 2015 - Q1 2016	Q3 2015 - Q2 2016	Q4 2015 - Q3 2016	Q1 2016 - Q4 2016	Q2 2016 - Q1 2017	Q3 2016 - Q2 2017	Q4 2016 - Q3 2017	Q1 2017 - Q4 2017	Q2 2017 - Q1 2018	Q3 2017 - Q2 2018	Q4 2017 - Q3 2018	Q1 2018 - Q4 2018
Broward County (128,537; 31.96%)	-1.18%	-1.55%	-2.96%	-4.43%	-4.84%	-4.80%	-4.40%	-2.08%	-2.42%	-1.99%	-2.33%	-1.91%	-0.77%	0.24%	1.65%	3.11%	5.26%	7.95%
Jacksonville Community (162,515; 40.40%)	-1.76%	-3.67%	-4.34%	-3.87%	-3.69%	-2.43%	0.25%	3.12%	5.33%	7.58%	5.84%	5.97%	6.12%	7.42%	11.02%	13.46%	17.72%	20.38%
West Central Florida (111,165; 27.64%)	-1.47%	-4.03%	-5.88%	-8.96%	-11.42%	-10.99%	-13.09%	-11.49%	-9.75%	-9.45%	-6.95%	-5.62%	-4.20%	-1.98%	-0.66%	-1.48%	-1.58%	0.44%
Goal Readmissions				2%	2%	2%	2%	6%	6%	6%	6%	10%	10%	10%	10%	10%	10%	10%

The number of beneficiaries for each community and the percentage of beneficiaries within the cohort are displayed next to the community name. The data source for the beneficiary counts is the NCC Scorecard.

Florida Cohort B: Readmissions



	Q2 2014 - Q1 2015	Q3 2014 - Q2 2015	Q4 2014 - Q3 2015	Q1 2015 - Q4 2015	Q2 2015 - Q1 2016	Q3 2015 - Q2 2016	Q4 2015 - Q3 2016	Q1 2016 - Q4 2016	Q2 2016 - Q1 2017	Q3 2016 - Q2 2017	Q4 2016 - Q3 2017	Q1 2017 - Q4 2017	Q2 2017 - Q1 2018	Q3 2017 - Q2 2018	Q4 2017 - Q3 2018	Q1 2018 - Q4 2018
Brevard County Community (87,910; 26.76%)	-0.03%	1.63%	5.36%	4.63%	6.53%	8.55%	9.56%	10.76%	10.73%	11.52%	13.36%	16.14%	16.77%	16.14%	13.95%	13.63%
Lee County (97,440; 29.66%)	0.03%	1.68%	5.64%	9.70%	10.88%	12.35%	15.44%	15.93%	17.70%	17.65%	15.21%	14.62%	14.67%	17.53%	20.72%	24.85%
South Pinellas County Coalition (51,224; 15.59%)	-2.88%	-4.18%	-5.56%	-4.57%	-4.30%	-2.57%	-4.88%	-5.29%	-4.34%	-4.49%	-1.54%	-0.33%	-0.42%	1.05%	1.41%	2.81%
Volusia/Flagler (91,959; 27.99%)	-0.85%	-2.93%	-4.58%	-0.53%	0.70%	2.79%	5.33%	1.95%	2.39%	2.07%	0.79%	3.08%	3.54%	4.44%	4.97%	5.48%
Goal Readmissions						2%	2%	2%	2%	6%	6%	6%	6%	10%	10%	10%

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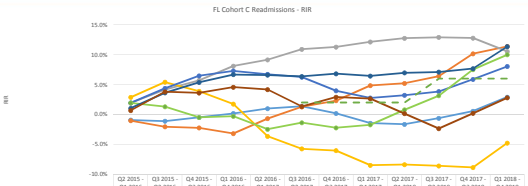
Florida Cohort C: Readmissions



	Q2 2015 - Q1 2016	Q3 2015 - Q2 2016	Q4 2015 - Q3 2016	Q1 2016 - Q4 2016	Q2 2016 - Q1 2017	Q3 2016 - Q2 2017	Q4 2016 - Q3 2017	Q1 2017 - Q4 2017	Q2 2017 - Q1 2018	Q3 2017 - Q2 2018	Q4 2017 - Q3 2018	Q1 2018 - Q4 2018
Gainesville (76,351; 10.5%)	-0.93%	-1.11%	-0.49%	0.17%	0.98%	1.37%	0.19%	-1.45%	-1.63%	-0.62%	0.56%	2.91%
Miami-Dade (108,137; 14.9%)	-1.03%	-2.05%	-2.23%	-1.18%	-0.68%	1.28%	2.31%	4.83%	5.21%	6.39%	10.15%	11.36%
Orlando (147,577; 20.3%)	1.92%	4.14%	5.70%	8.09%	9.14%	10.90%	11.27%	12.12%	12.74%	12.89%	12.76%	10.52%
Osceola (25,316; 3.5%)	2.87%	5.40%	3.88%	1.74%	-3.64%	-5.74%	-6.03%	-8.47%	-8.37%	-8.58%	-8.85%	-4.76%
Palm Beach (193,459; 26.6%)	1.94%	4.37%	6.46%	7.27%	6.72%	6.25%	3.96%	2.76%	3.22%	3.83%	5.87%	8.03%
Pensacola (68,062; 9.4%)	1.94%	1.31%	-0.49%	-0.30%	-2.46%	-1.37%	-2.22%	-1.73%	0.79%	3.13%	7.50%	9.98%
Polk County (68,797; 9.5%)	1.04%	3.62%	5.36%	6.66%	6.58%	6.35%	6.81%	6.43%	6.96%	7.09%	7.67%	11.34%
Tallahassee (38,965; 5.4%)	0.66%	3.79%	3.60%	4.57%	4.17%	1.33%	2.91%	2.64%	0.15%	-2.36%	0.20%	2.79%
Goal Readmissions						2%	2%	2%	2%	6%	6%	6%

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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.

Thank you!

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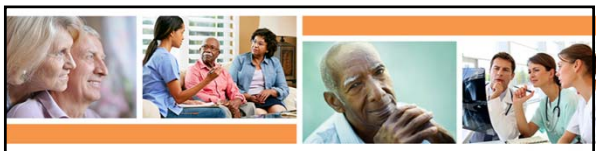

CMS Disclaimer

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Background

- AdventHealth Care Center Apopka North
- Closest SNF to the local hospital
- SNF Administrator attends monthly community meeting, DON attends on occasion.
  - Receives quarterly data from HSAG when attending these meetings.
  - Receives HSAG community readmission data quarterly
  - Participant in SNF-to-ED transfer tool deployment
  - Requested bene-level review of CMS claims data for readmissions from HSAG
- SNF team noted sharp rise in readmission Q4 2017-Q1 2018
- New hospital leadership
- New SNF facility DON & ADON

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Hospital leadership reached out to the facility requesting a meeting to discuss readmissions.

Data analyzed by SNF and hospital prior to meeting

- Current readmissions in the last 45 days
- Facility readmission patterns HSAG data reports

SNF and hospital leaders met to review readmission cases & trends

Plan to meet monthly at alternate sites, involve facility clinical leaders

New Dialogue Begins

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Data

- 74% of readmissions in a 6 month period occurred within 0-7 days of SNF admission
- Majority of readmission to hospital happened during 11p-7a
- Most common readmission diagnosis was infection; majority had infection diagnosis while in hospital initially
- Half of the readmissions had an index hospital stay longer than 7 days
- Cases reviewed showed many had refused palliative and hospice care during the index hospital stay, and remained full code status
  - Several who initially refused palliative/hospice - when readmitted to the hospital - were accepting of DNR orders and Palliative/Hospice care
  - Some cases expired within 6 months from SNF discharge

AdventHealth

SNF Opportunities

On-call after-hours providers more likely to send residents to the hospital.

Standardized process for Nurse Shift-to-shift handoff to 11-7

Physician collaboration

Hardwire SBAR

Pre-Admission Screening

Process/Timing for Advanced Care Planning

AdventHealth

Hospital Opportunities

3008 accuracy

- Staff nurse education, current and new-hire
- Supervisor education (<15% were accurate)

Nurse to Nurse hand-off

- Low number of completed hospital to SNF reports called

Hand-off to SNF regarding hospital work done on Advanced Care Planning

Hand-off to SNF regarding infection treatment plan and pending culture results

AdventHealth

Actions Taken

- Physician/Physician extender rounding schedule adapted to ensure new admits seen early in stay (no later than 72 hours)
- Meet with physicians with higher readmission rates, strategize and share concerns
- Nurses to speak with DON prior to transfer to hospital for non-911 cases
- Nurse-to-nurse shift hand-off standard format
- SBAR education with emphasis on preparation with S-B-A before call
- Training provided on Advanced Care Planning
- Initiate Pre-Admission Screening tool to ID risks and needs
- Meet with all providers to review readmission rates and rounding schedules
- Improve timeline/process for Advanced Care Planning

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Results

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Summary

Use data and tools from HSAG, facility, and hospital to examine the trends

Participate in community efforts, attending meetings and taking action

Identify problems and collaborate on efforts regularly

Share what is working, and what is not, with openness

Don't accept the status quo!

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