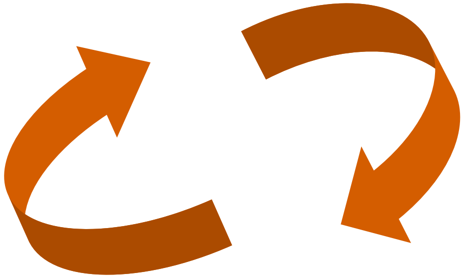
OPTUM™

Closing the Door to Inpatient Readmission

High Quality Care in the SNF

The Hospital - SNF Cycle



- Incomplete discharge summary
- Problem focused vs. patient focused care
- Medication reconciliation
- Unnecessary procedures
- Inattention to chronic care needs
- Premature discharge
- Psychosis
- Poor family communication
- Multiple consultants
- Hospitalist vs. primary care provider
- Nosocomial infections/complications
- Medical Errors

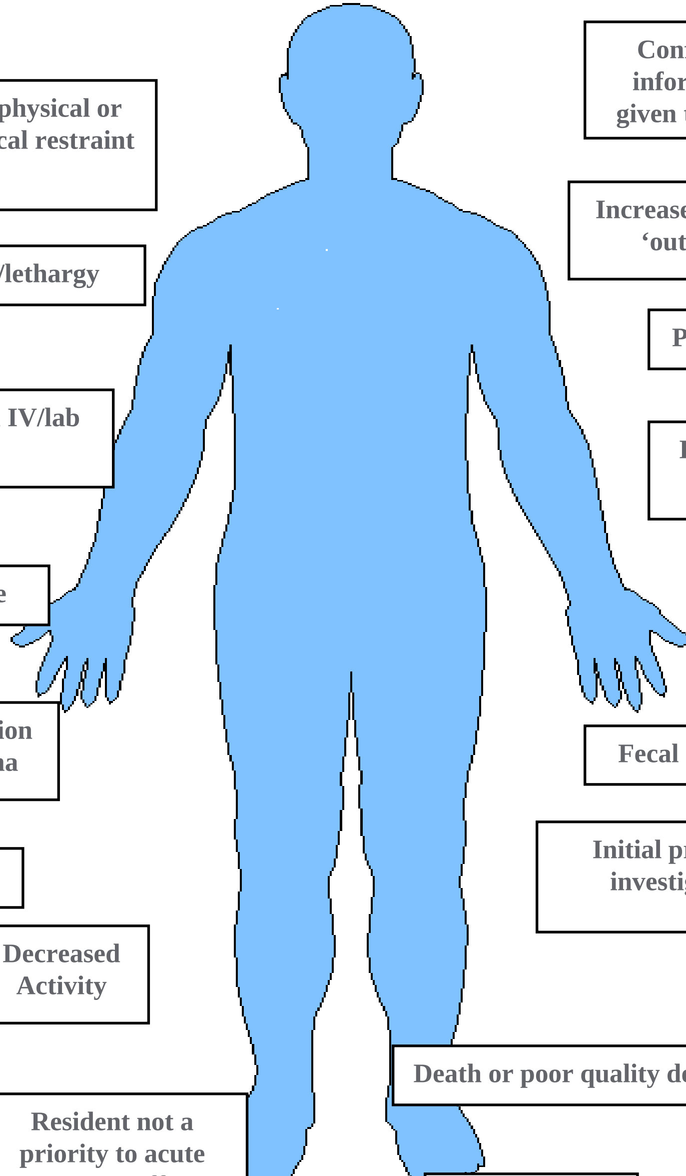
- Advance care planning
- Acute change in condition: Recognition and assessment
- Poor communication
- Interdisciplinary team collaboration
- Appropriate plan of care/monitoring
- Stakeholder alignment
- Lack of contingency planning
- Execution/implementation of plan
- Ambulatory care sensitive conditions
- 911 reflex
- Regulatory concerns
- “When in doubt…”
- Inadequate clinical professional engagement
- Medication reconciliation

Scope of problem

- >20% of all Medicare beneficiaries rehospitalized within 30 days
- 90% unplanned
- Cost to Medicare $17.4 B
- 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 B
- High proportion are avoidable
  - Considerable geographic variation
  - High prevalence of preventable conditions
- Correlated with negative health outcomes, e.g. delirium, functional decline

Mor et. al. The Revolving Door of Re-hospitalization from Skilled Nursing Facilities Health Affairs 29, No 1, 2010: 57-64

What can happen to your residents as a result of hospitalization



- Poor oral care/teeth problems
- New physical or chemical restraint
- Altered functional status/weakness
- Over sedation/lethargy
- Skin Breakdown: Pressure sores & Skin tears
- Eccymosis from IV/lab sticks
- Relocation Trauma
- Incontinence
- MRSA and or VRE
- Weight loss/ Loss of appetite
- Relocation Trauma
- Advance Directives NOT followed
- Lost equipment: (splints/braces)
- Decreased Activity
- Lack of discharge summary and info related to hospitalization
- Resident not a priority to acute care staff
- Conflicting information given to family
- Outpatient (clinic) visits get scheduled when not necessary or appropriate
- Increased confusion- 'out of sorts'
- Psychiatric exacerbation
- Lost teeth, hearing aids and glasses
- Decline in ADL's
- Physically unkempt
- UTI's secondary to catheter
- Fecal Impaction
- Broken bones from falls in hospital
- Initial problem not fully investigated/resolved
- Phlebitis
- Death or poor quality death
- Heel ulcers

§Increased anxiety/agitation
§Confusion from the hospitalization that can take a long time to clear
§Bad memories/waiting in ER for up to 18 hours

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Case #1

- 89 year old female with dementia, hypertension, CKD, eats independently but requires assistance with all other ADLs. Hospitalized 9 days ago with acute cardiac ischemia, change in level of consciousness, and suspected aspiration pneumonia. After 7 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 2am developed tachypnea and O2 sat 87% on 2L/min. Staff concerned regarding recurrent cardiac event. Covering physician unfamiliar with case ordered nurse to call 911. Patient re-hospitalized with suspected aspiration pneumonia, given supportive care.

Why do admissions/readmissions occur?

- Fundamental system issues related to transitions in care
- “White space”
- 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

Who's At Risk?

- Age/demographics
- Medical Conditions
  - CHF, Pneumonia, COPD, Psychosis, GI problems
- 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

Highest Rates of Rehospitalization and Most Frequent Reasons for Rehospitalization, According to Condition at Index Discharge

Table 2. Highest Rates of Rehospitalization and Most Frequent Reasons for Rehospitalization, According to Condition at Index Discharge.*

Condition at Index Discharge	30-Day Rehospitalization Rate	Proportion of All Rehospitalizations	Reason for Rehospitalization					
			Most Frequent	2nd Most Frequent	3rd Most Frequent	4th Most Frequent	5th to 10th Most Frequent	Less Frequent
	percent		*percent of all rehospitalizations within 30 days after index discharge*					
Medical								
All	21.0	77.6	Heart failure (8.6)	Pneumonia (7.3)	Psychoses (4.3)	COPD (3.9)	GI problems, nutrition-related or metabolic issues, septicemia, GI bleeding, renal failure, urinary tract infection (17.0)	All other (58.9)
Heart failure	26.9	7.6	Heart failure (37.0)	Pneumonia (5.1)	Renal failure (3.9)	Nutrition-related or metabolic issues (3.1)	Acute myocardial infarction, COPD, arrhythmias, circulatory disorders, GI bleeding, GI problems (14.0)	All other (36.9)
Pneumonia	20.1	6.3	Pneumonia (29.1)	Heart failure (7.4)	COPD (6.1)	Septicemia (3.6)	Nutrition-related or metabolic issues, GI problems, respiratory or ventilation problems, pulmonary edema, GI bleeding, urinary tract infection (14.9)	All other (38.9)
COPD	22.6	4.0	COPD (36.2)	Pneumonia (11.4)	Heart failure (5.7)	Pulmonary edema (3.9)	Respiratory or ventilation problems, GI problems, nutrition-related or metabolic issues, arrhythmias, GI bleeding, acute myocardial infarction (12.5)	All other (30.3)
Psychoses	24.6	3.5	Psychoses (67.3)	Drug toxicity (1.9)	Drug or alcohol misuse (1.6)	Pneumonia (1.6)	Chest pain, nutrition-related or metabolic issues, depression, GI problems, COPD, organic mental conditions (7.0)	All other (20.6)
GI problems	19.2	3.1	GI problems (21.1)	Nutrition-related or metabolic issues (4.9)	Pneumonia (4.3)	Heart failure (4.2)	Major bowel surgery, urinary tract infection, septicemia, GI bleeding, COPD, chest pain (13.4)	All other (52.1)
Surgical								
All	15.6	22.4	Heart failure (6.0)	Pneumonia (4.5)	GI problems (3.3)	Septicemia (2.9)	Nutrition-related or metabolic issues, postoperative infection, placement of cardiac stent, GI bleeding, operation for infection (14.6)	All other (68.7)
Cardiac stent placement	14.5	1.6	Cardiac stent (19.7)	Circulatory diagnoses (8.5)	Chest pain (6.1)	Heart failure (5.7)	Atherosclerosis, acute myocardial infarction, GI bleeding, GI problems, arrhythmias, other vascular surgery (19.4)	All other (40.6)
Major hip or knee surgery	9.9	1.5	Aftercare (10.3)	Major hip or knee problems (6.0)	Pneumonia (4.2)	Postoperative infection (3.1)	GI problems, GI bleeding, heart failure, operation for infection, rehabilitation, nutrition-related or metabolic issues (15.8)	All other (60.6)
Other vascular surgery	23.9	1.4	Other vascular surgery (14.8)	Amputation (5.8)	Heart failure (5.0)	Other circulatory problems (4.4)	Postoperative infection, other circulatory procedures, operation for infection, peripheral vascular disorders, pneumonia, septicemia (19.0)	All other (51.0)
Major bowel surgery	16.6	1.0	GI problems (15.9)	Postoperative infection (6.4)	Nutrition-related or metabolic issues (5.6)	GI Obstruction (4.3)	Pneumonia, major bowel surgery, renal failure, septicemia, operation for infection, GI bleeding (15.4)	All other (52.4)
Other hip or femur surgery	17.9	0.8	Pneumonia (9.7)	Heart failure (4.8)	Septicemia (4.7)	GI bleeding (4.0)	Urinary tract infection, fracture of hip or pelvis, other hip or femur surgery, aftercare, nutrition-related or metabolic issues, major hip or knee problems (20.7)	All other (56.1)

* Index conditions listed within medical and surgical groups are in order of decreasing total number of rehospitalizations within 30 days after discharge. The diagnosis-related group (DRG) numbers for the conditions listed are as follows: acute myocardial infarction: 121, 122, 123, 516, 526; arrhythmias: 138, 139; amputation: 113; cardiac stent: 517, 527; chest pain: 143; circulatory disorders: 124; COPD: 088; depression: 429; drug toxicity: 449; drug or alcohol misuse: 521; fracture of hip or pelvis: 236; gastrointestinal bleeding: 592; gastrointestinal problems: 182, 183, 184; heart failure: 127; major bowel surgery: 148, 149; major hip or knee problems: 209; nutrition-related or metabolic issues: 296, 297, 298; operation for infection: 415; organic mental conditions: 429; other hip or femur surgery: 210; other circulatory diagnoses: 144; other vascular surgery: 478, 479; pneumonia: 79, 80, 81, 89, 90, 91; postoperative infection: 418; psychoses: 430; pulmonary edema: 087; rehabilitation: 462; renal failure: 316; respiratory or ventilation issues: 475; septicemia: 416, 417; and urinary tract infection: 320, 321, 322. COPD denotes chronic obstructive pulmonary disease, and GI gastrointestinal.

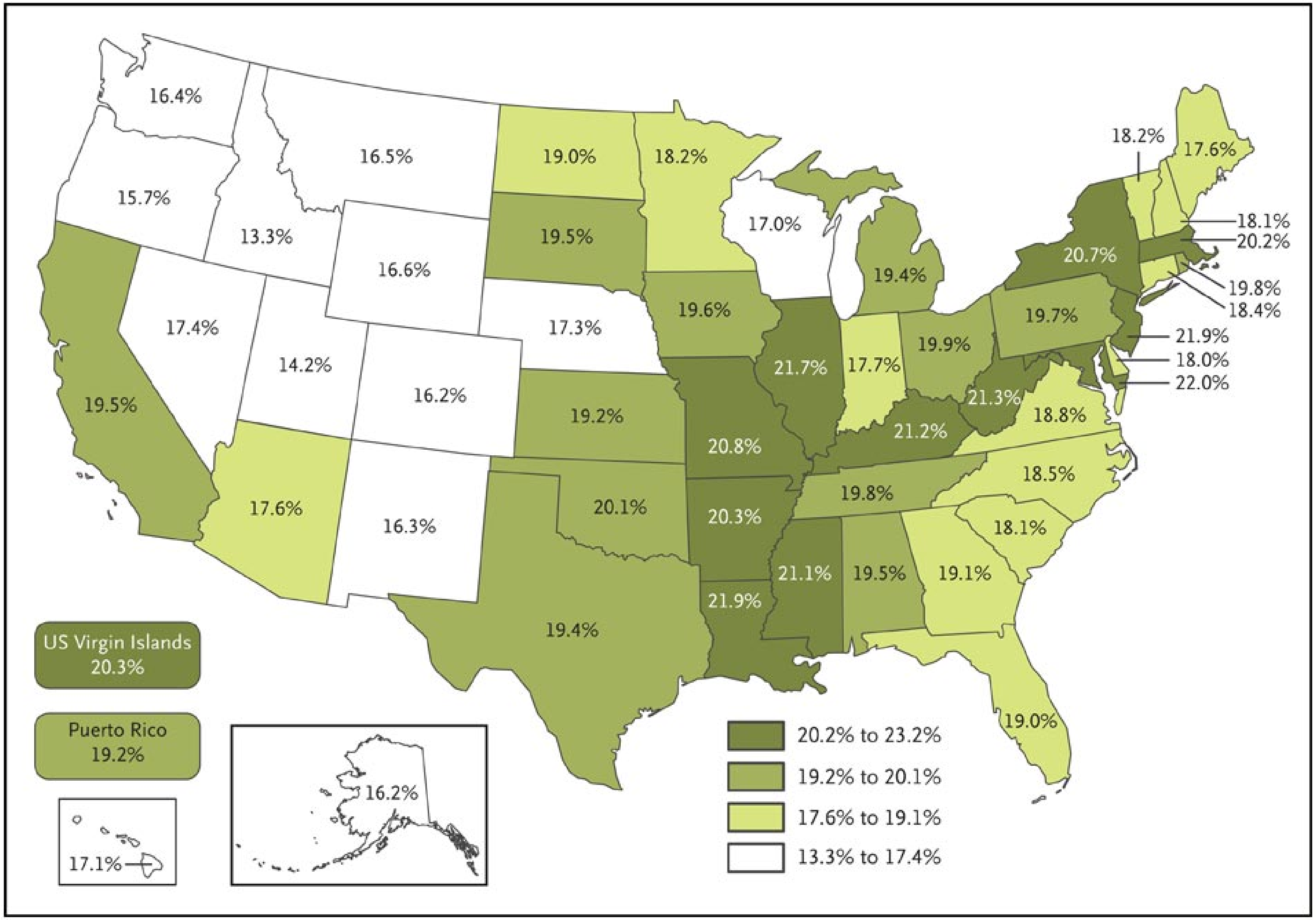
Jencks SF et al. N Engl J Med 2009;360:1418-1428

The NEW ENGLAND JOURNAL of MEDICINE

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 Re-hospitalization within 30 Days after Hospital Discharge



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SNF Hospital Readmission Levers

- Higher rate
  - Lack of Medication reconciliation
  - Clinical instability
  - Depression
- Lower rate
  - Geriatric 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 Readmissions**
- 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

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 bedhold 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

Mor, Intrator, Feng, Grabowski The Revolving Door of Re-hospitalization from Skilled Nursing Facilities Health Affairs 29, No 1, 2010: 57-64

Case #2

- 78 year old male hospitalized 2 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.

Why should we care?

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

Hospitalcompare.hhs.gov website

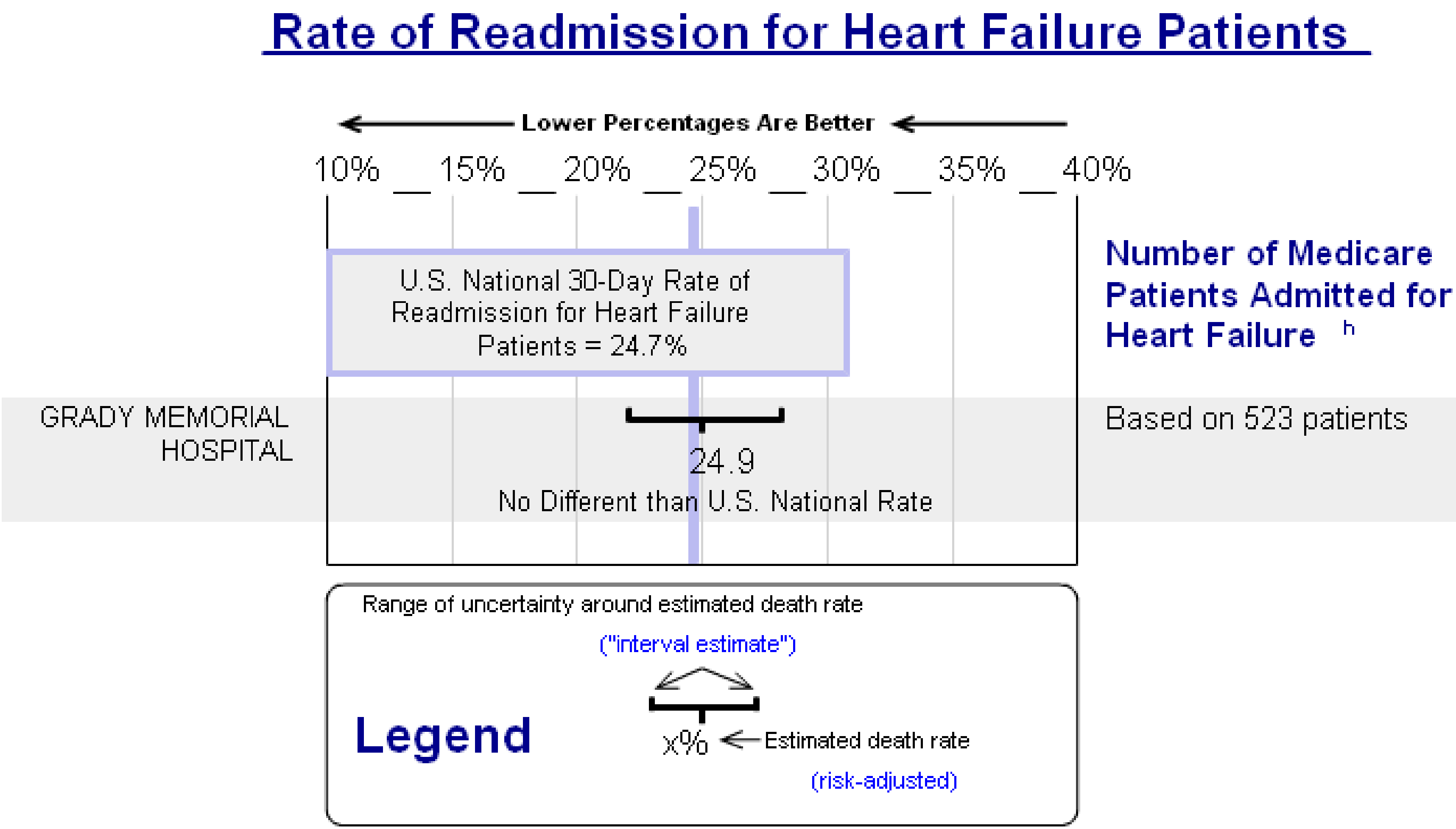
- **Hospital Readmissions Measures**

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

- "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 & Medicaid integrated service and financing reform

Some Elements of Care Common to Most of the 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

Shoring up SNF capabilities

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

HSL RSU Trial

- Physician history & physical template
  - Care guidelines for common geriatric syndromes
  - Med rec template
  - Goals of care/advance directives
  - Number of hospitalization past 6 mos.
- Palliative Care Consults (3 or more hosp)
- 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 hospital

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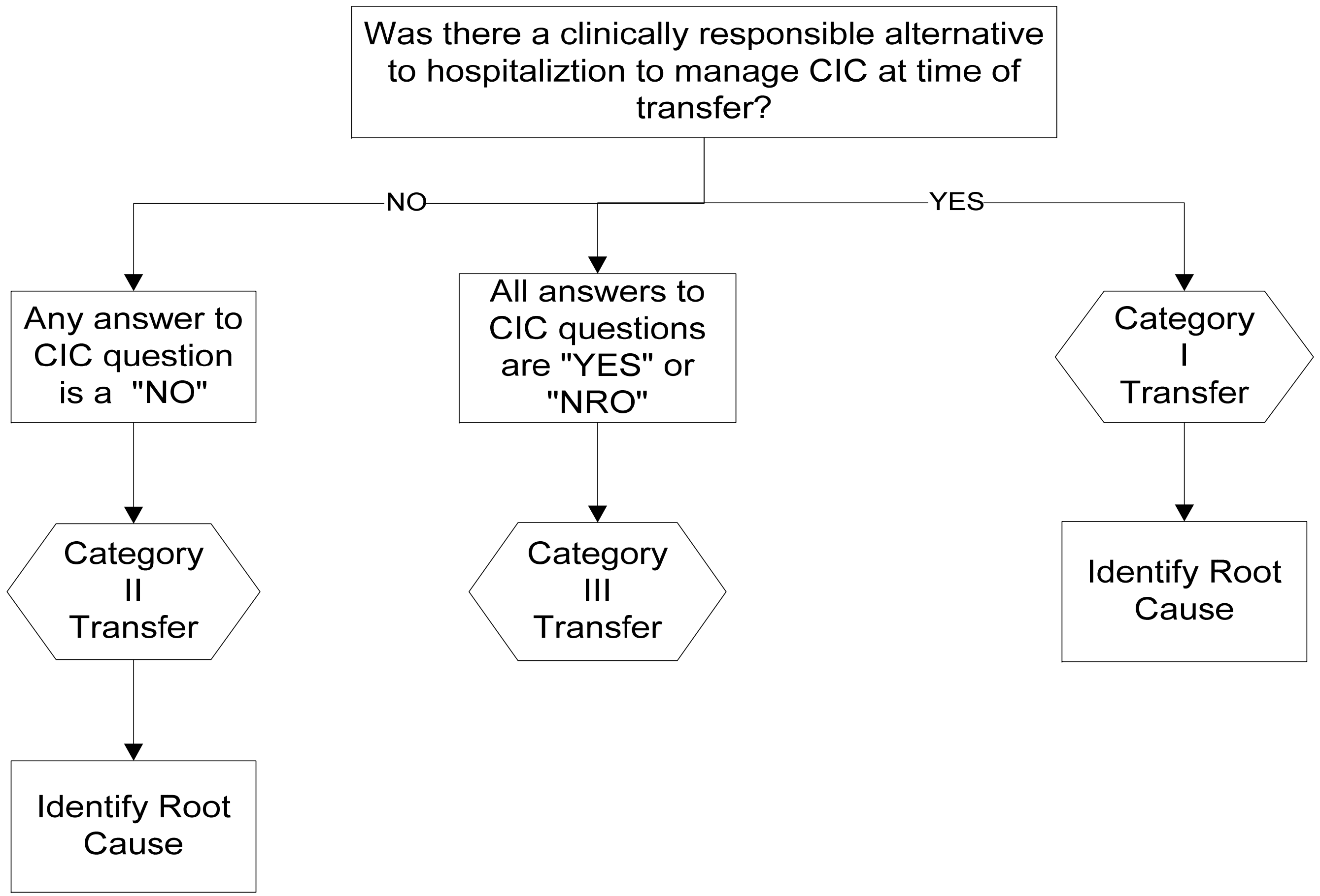
Evercare approach

- Toolkit
  - ACP
  - Getting disch summary
  - Med rec (HEDIS requirement)
  - Timely initial visit
- Transfer envelope
- Discussion Guide
- OP Consultation Form
- NP expectations for ED & post-hospital
- TAP

Retrospective Data Collection Tool

Retro Data
Collection Tool

Process Flow to Determine Hospital Transfer Category

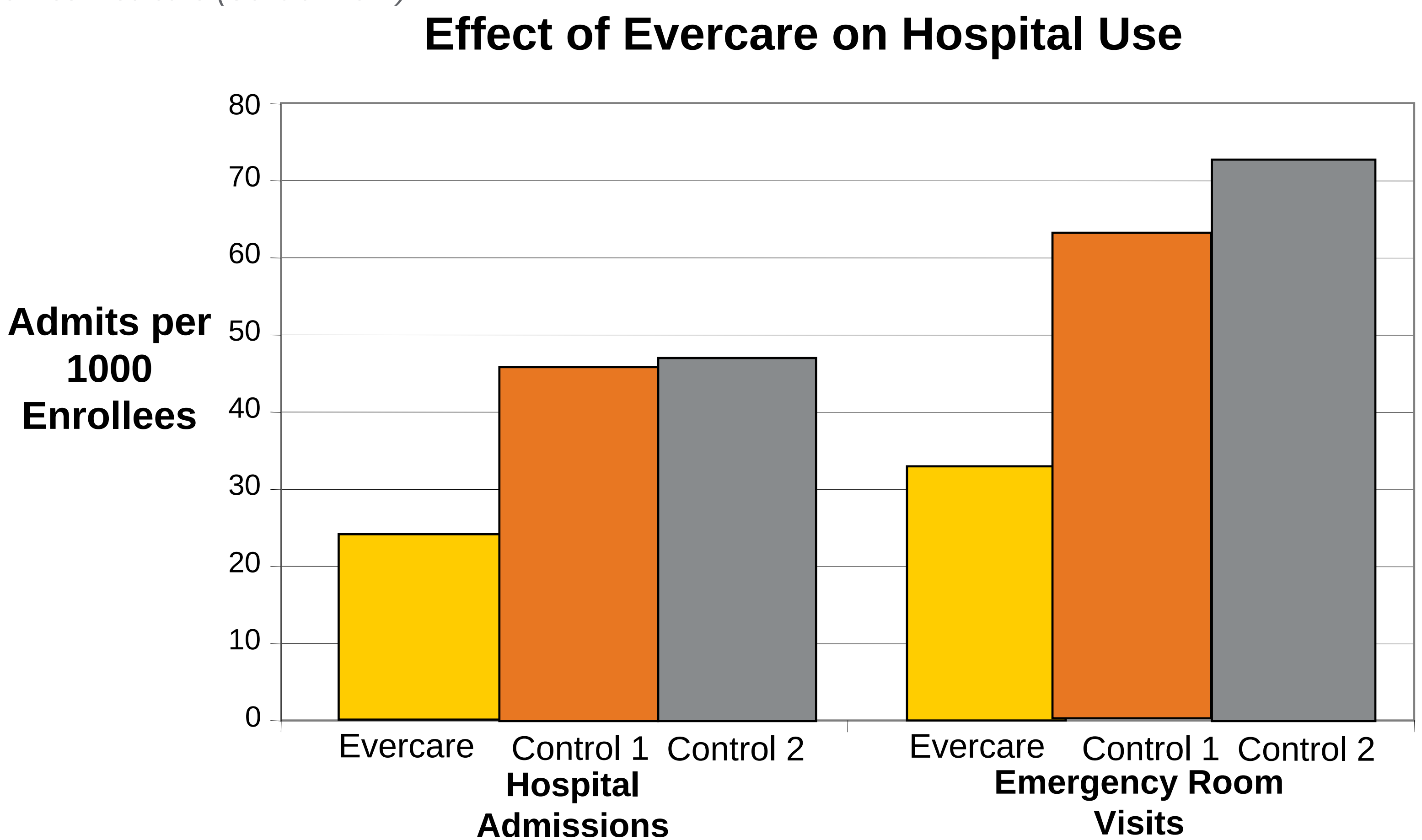


TAP Categories

I	II	III
Avoidable Hospital Transfer	**Unavoidable But Potentially Preventable Hospital Transfer**	**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 of change 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

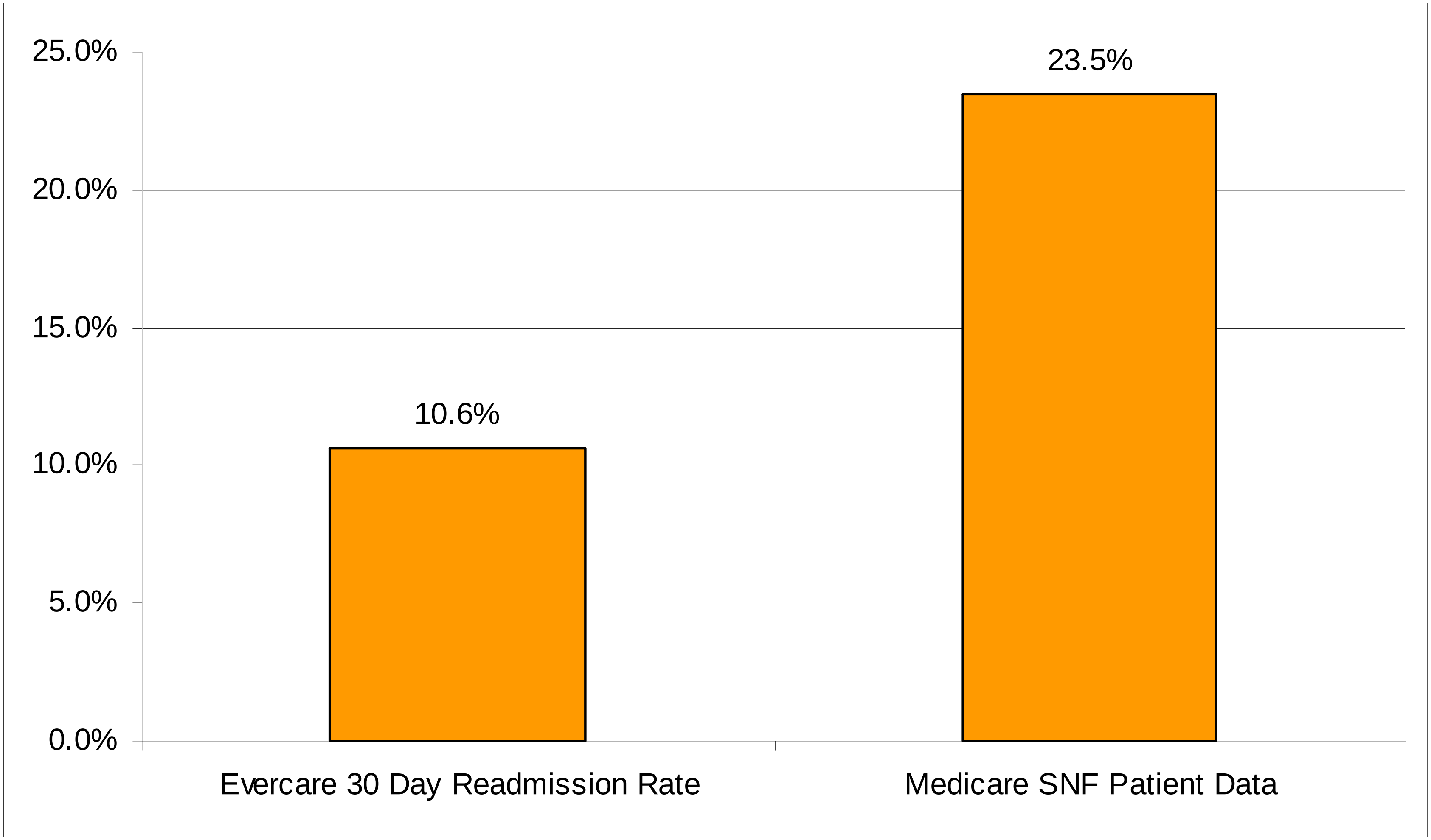
Reduction In Unnecessary Hospitalizations

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. Members in the control group were also twice as likely to go to the Emergency Room than Evercare members. Evercare had ½ the hospitalizations compared to fee-for-service Medicare (Control 1 & 2).



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

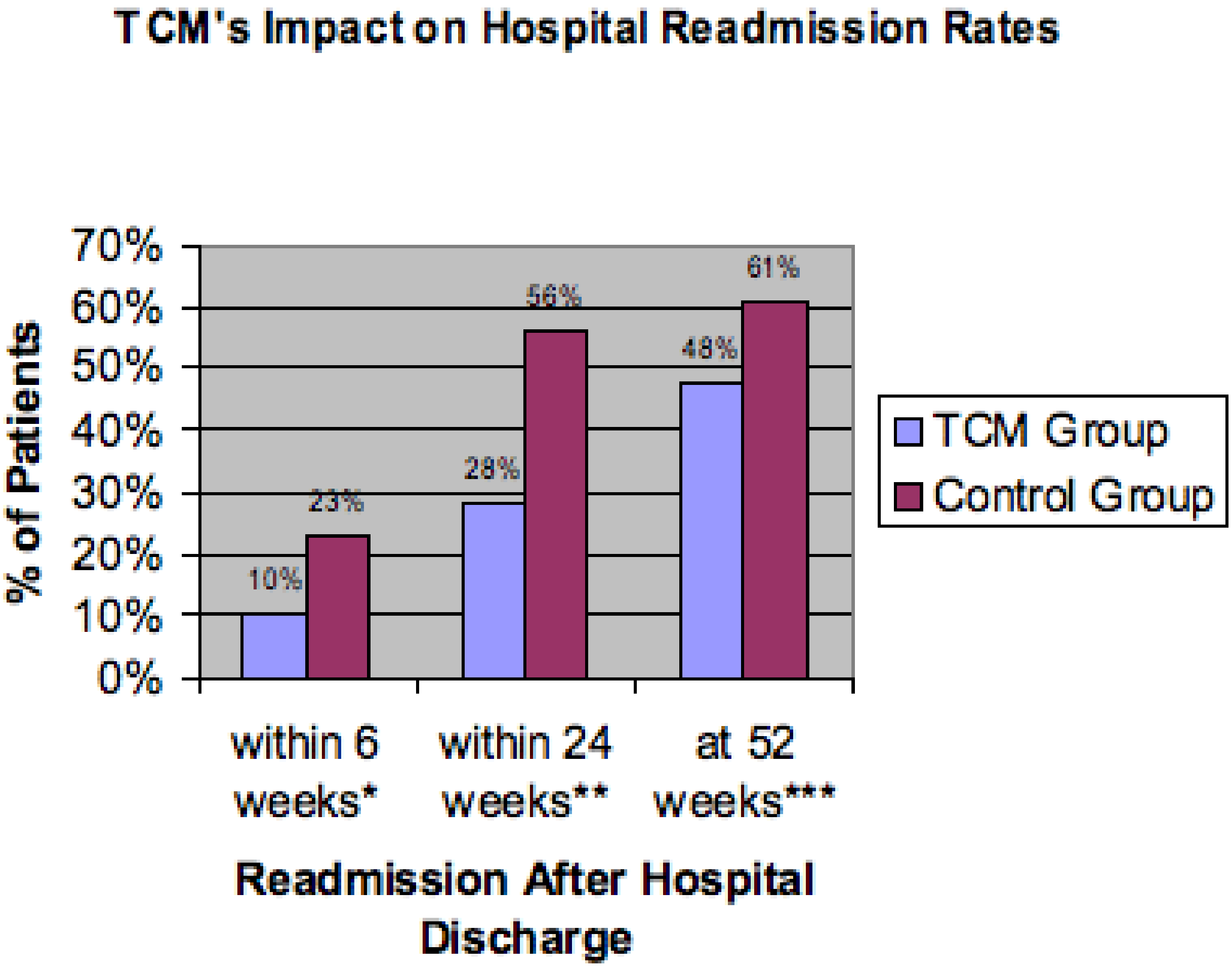
- Re-engineered discharge (RED)
- Discharge advocate to perform
  - Education re: disease and meds
  - Preparation and reinforcement of after hospital care plan
  - Review procedure for handling unanticipated problems
  - Transmission of written plan to care providers
- Nurse avatar used successfully as patient advocate alongside Discharge advocate
- Initial research shows 30% reduced likelihood of re-hospitalization within 30 days
- >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

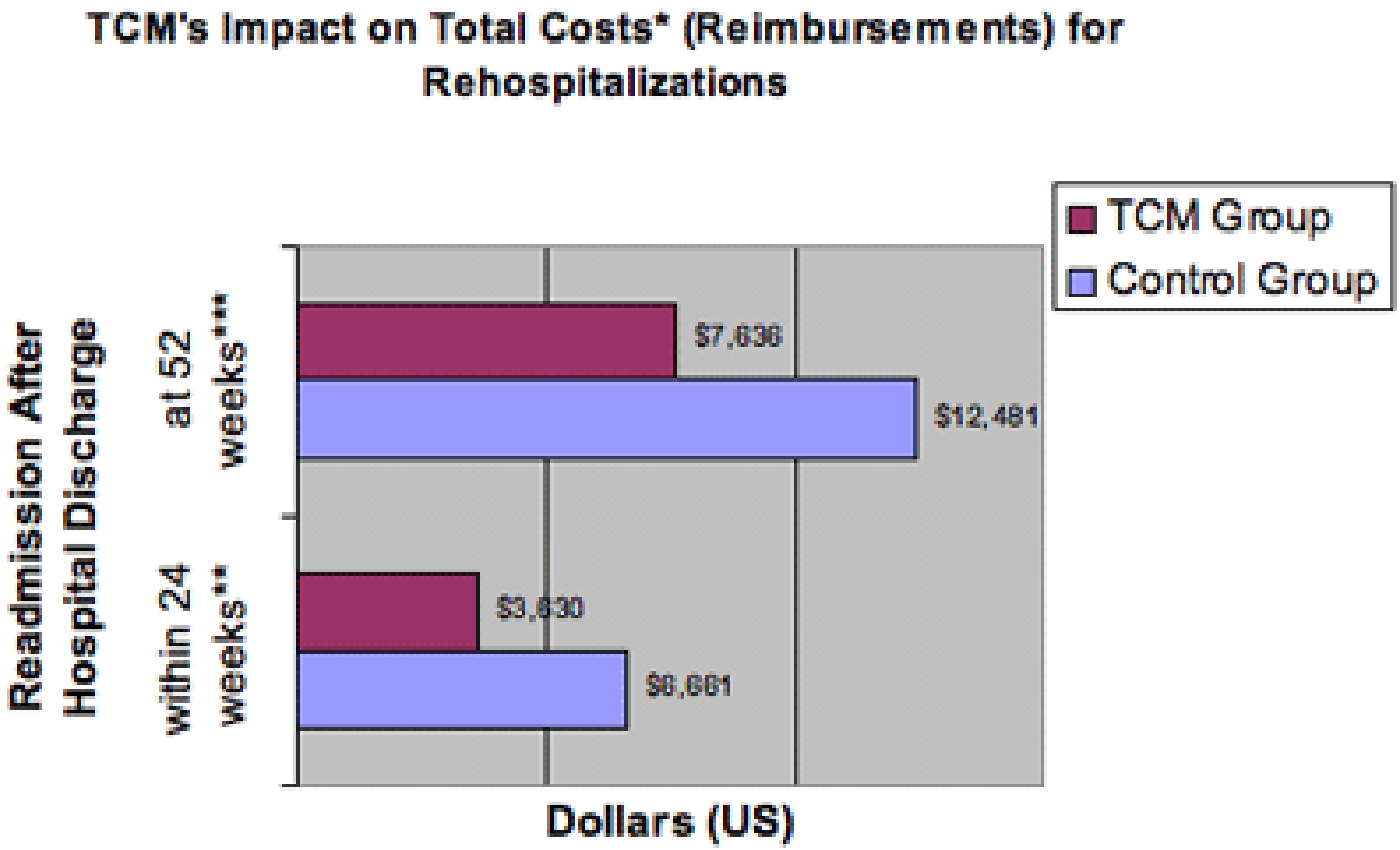
- Advance Practice RNs – Transition Nurse managers
- Comprehensive discharge planning and home visits
- Active engagement/support of families and caregivers
- Collaboration with physicians

Mary D. Naylor, PhD, RN, FAAN, Marian S. Ware Professor in Gerontology
Director, New Courtland Center for Transitions & Health
University of Pennsylvania School of Nursing

Transitional Care Model



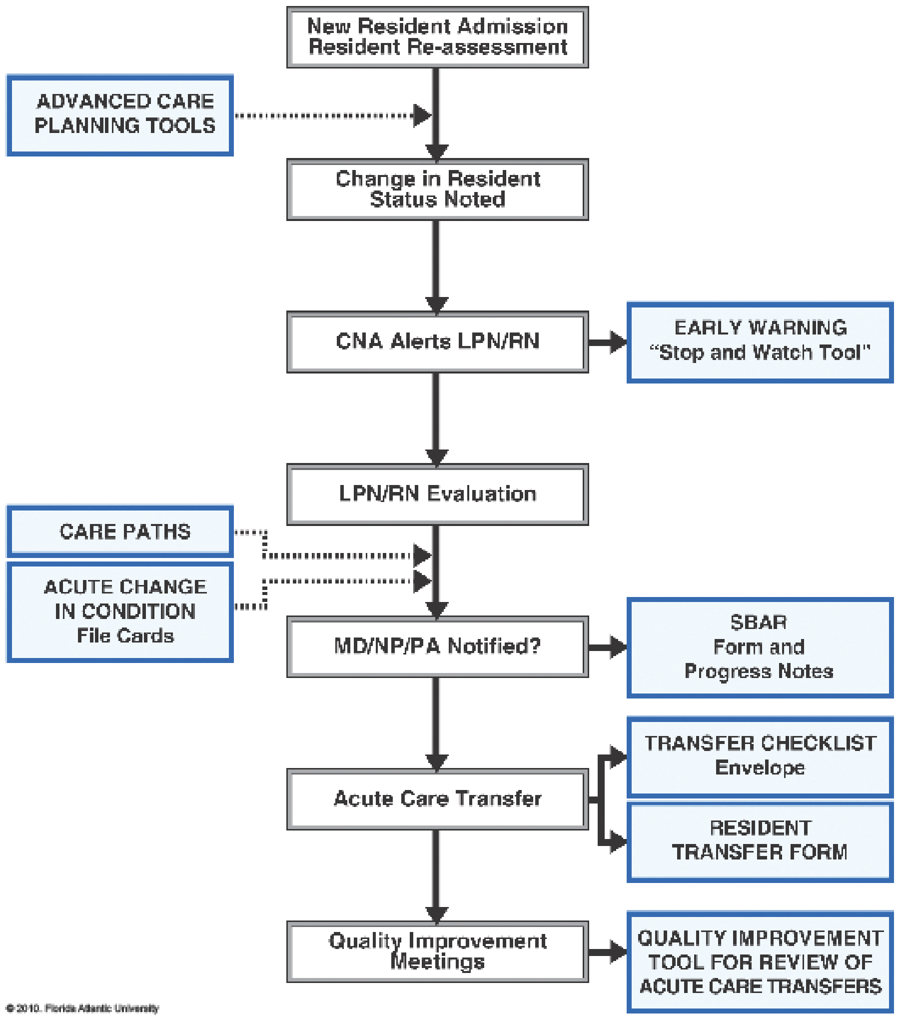
Transitional Care Model



Interact II

Using the INTERACT II Tools
in Every Day Work in the Nursing Home

INTERACT II



Other approaches

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

Conclusions

- SNFs need to step up, improve technical capabilities, staff training and education to prevent readmissions
- 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.

OptumHealth
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