

# Care Transitions in the Long-Term & Skilled Nursing Facility Setting

James E. Lett, II, MD, CMD  
November 20, 2014



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## Speaker Disclosures

Dr. Lett:

- Boehringer-Ingelheim Pharmaceuticals: Speakers Bureau for Care Transitions: Unbranded
- Sanofi Pharmaceuticals: Speakers Bureau for Diabetes Care in LTC



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## Learning Objectives

By the end of the session, participants will:

- Objective 1: Review the trends which have contributed to issues causing readmissions in the health care system.
- Objective 2: Understand programs currently in place to reduce readmissions in the long term care continuum.
- Objective 3: Learn to initiate actions to reduce hospital readmissions which will increase patient/resident satisfaction and augment patient-centered care.

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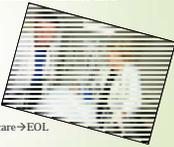
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### Defining "Transitions of Care"

- **The movement of patients** from one health care practitioner or setting to another as their condition and care needs change
- **Occurs at multiple levels**
  - **Within Settings**
  - **Between Settings**
  - **Across Health States**
    - Healthy → Curative care → Palliative care → EOL
  - **Across cultures and continents**



Coleman E. <http://www.caretransitions.org/definitions.asp>

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### Qualitative Studies Have Shown

- Patients and their caregivers are unprepared for their roles in the next setting of care.
- They:
  - Do not understand essential steps in management of their care
  - Cannot contact appropriate health practitioners for guidance
  - Are frustrated by being forced to perform tasks healthcare professionals left undone Coleman



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### Re-hospitalizations – Medicare Fee-For-Service

- Analysis of Medicare Claims data from 2003-2004
- 11,855,702 Medicare beneficiaries discharged from the hospital
  - 19.6% (nearly 1/5) were re-hospitalized within 30 days
  - 34% were re-hospitalized within 90 days
  - 50.2% of those re-hospitalized within 30 days after a medical discharge there was no bill for a visit to a physician office

Jencks SF, et al. N Engl J Med 2009;360:1418-28

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### Re-hospitalizations Update:

- Medicare FFS hospital 30-day readmission rate based upon 2012 data has fallen to 18.4%  
Gerhardt, G. et al. Medicare readmission rates showed meaningful decline in 2012. *Medicare and Medicaid Research Review*. March 2, 2013.
- Annual cost of readmissions to Medicare is \$17.5 billion  
Armour S. Hospital readmissions for U.S. medicare patients decline. *Bloomberg*. Feb 28, 2013.
- Appears to be no "right" 30-day readmission rate, but pressure to reduce the rate will continue

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### Geographic Variation of Care

- Variation in Medicare beneficiary spending reveals no evidence that those in high spending areas have better health outcomes than in low spending areas.\*
- If there were no variation in post-acute care services (e.g., HHA, SNF, rehab facilities) Medicare spending would decline by an estimated 73%

\*10/11 March 2013. *Interim Report Of The Committee On Geographic Variation In Health Care Spending And Promotion Of High Value Care: Preliminary Committee Observations*  
[http://books.nap.edu/openbook.php?record\\_id=18308](http://books.nap.edu/openbook.php?record_id=18308)



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### Hospital Discharge Concerns



- Upon hospital discharge 30% of patients have at least one medication discrepancy Wong JD, et al. *Ann Pharmacother* 2008;42:1373-9
- 14.3% with discrepancies readmitted within 30 days versus 6.1% in those with none  
Coleman EA, Smith JD, Raha D, Min SJ. Posthospital medication discrepancies: prevalence and contributing factors. *Arch Intern Med*. 2009;169:1842-7
- Hospital to Nursing Home Adverse drug events (ADEs) attributable to medication changes occurred in 20% of bi-directional transfers
  - 50% of ADEs were caused by discontinuation of medications during hospital stay  
Boockvar K, et al. *Arch Intern Med* 2004;164:545-50

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### The Discharge Disconnect

- 49% of patients experienced at least 1 medical error in the hospital to home transition
  - Those with a "work-up" error were 6 times more likely to be re-hospitalized within 3 months (Moore C, et al. J Gen Intern Med 2003;18:548-51)
- 41% of hospital discharged patients have test results returned after discharge. Up to 11% of patients were felt to have actionable abnormal test results - some requiring urgent action - that were **still pending** at discharge; however, PCPs were often unaware of the abnormal results.
  - Roy, Poon et al. Patient safety concerns arising from test results that return after hospital discharge. Ann Intern Med 2005; 143:121-128




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### Evidence Hospitalizations Can Be Avoided

- Studies have estimated that 30% to 67% of hospitalizations among nursing facility residents could be prevented with well-targeted interventions (Jacobson, et al., 2010).
- 45% of hospital admissions among Medicare-Medicare enrollees receiving Medicare skilled nursing or Medicaid nursing facility services could have been avoided (Walsh et al., 2010).
  - 314,000 potentially avoidable hospitalizations
  - \$2.6 billion in Medicare expenditures in 2005
- Interventions have proven effective:
  - Evercare reduced hospital admissions by 47% and emergency department use by 49% (Kane, et al., 2004).
  - Nursing facility-employed staff provider model in NY reduced Medicare costs by 16.3% (Moore & Martelle, 1996).
  - INTERACT II reduced hospital admissions by 17% (Ostlander, et al., 2011).

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### SNF Readmissions to Hospital

- In 2006 there were 1.70 million SNF episodes, of which 419,669 (23.5%) re-hospitalized within 30 days
- From 2000-2006 the re-hospitalization rate increased by 29% - from 18.2% to 23.5%

Total Medicare reimbursements associated with these re-hospitalizations - \$4.34 billion

Mor, Intrator, et al. Health Affairs, Jan 2010




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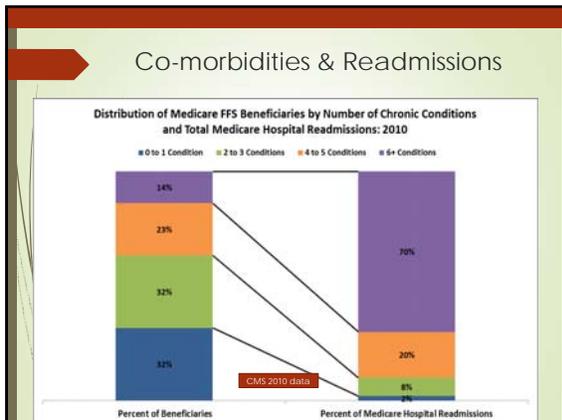
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More than 25% of hospital readmissions within 30-days of discharge are for conditions not identified in the initial hospital admission.

Sommers & Cunningham. Research Brief No. 6. National Institute for Health Care Reform. 2011. [www.nihcz.org/Reducing\\_Readmissions.html](http://www.nihcz.org/Reducing_Readmissions.html)

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### Acute Care Utilization After SNF Discharge

- 55,980 Medicare beneficiaries >65 who were hospitalized → SNF → discharged home
  - January 2010 thru August 2011
- Acute care utilization within 30 days of SNF discharge was 22.1% (37.5% w/in 90 days)
  - 14.8% re-hospitalization
  - 7.2% ED visit w/o hospitalization
- Greater likelihood: male, dual eligible, > Charlson score, certain dx (neoplasm, respiratory d2), for profit SNF or fewer LPN hours per pt. day

Toles, Anderson et al. Restarting the cycle: Incidence and predictions of first acute care use after nursing home discharge. JAGS 2014;62:79-85.

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## Observation Stays (OBS)

- Short term treatments provided to outpatients to determine whether beneficiaries require inpatient treatment or can be discharged. US Dept of HHS
- OBS vs. Inpatient Stays:
  - Three key differences in coverage
    1. Part B has a 20% co-pay
    2. Part B does not cover the same services as Part A
    3. OBS stay days do not contribute toward a Medicare covered SNF stay

Daughtridge, Archibald, Coway. JAMA. March 12, 2014

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## Quality Improvement of Care Transitions and the Trend of Composite Hospital Care

**A** National rates of hospitalizations and observation stays per 1000 FFS Medicare beneficiaries

Period	Composite rates	Hospitalizations	Observation stays
July 2009 - June 2010	~155	~110	~40
July 2010 - June 2011	~150	~105	~40
July 2011 - June 2012	~140	~100	~40
July 2012 - June 2013	~130	~95	~40

**B** National rates of rehospitalizations and observation stays within 30 days of hospital discharge per 1000 FFS Medicare beneficiaries

Period	Composite rates	Rehospitalizations	Observation stays
July 2009 - June 2010	~62	~58	~4
July 2010 - June 2011	~60	~56	~4
July 2011 - June 2012	~58	~54	~4
July 2012 - June 2013	~55	~52	~4

Hospitalizations and Observation Days, Rehospitalizations and Observation Days Within 30 Days of Discharge, and Composite Rates for Both, per 1000 Medicare Fee-for-Service (FFS) Beneficiaries, Between July 2009 and June 2013. Observation stays were identified by any claim submitted for a Medicare patient treated in observation status. Composite percent change: 5.7% (panel A) and 11.1% (panel B). Data from Medicare Part A Claims. JAMA. 2014;311(10):1013-1014. doi:10.1001/jama.2014.509 - Accessed 4/29/14

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Focus is shifting to integration of services, population-based accountabilities and new models of payment. And new payment models are forcing change

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*Patients will move from being revenue centers to being cost centers.*



Brendan Thompson, M.D.

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### The Affordable Care Act (ACA)

- Enacted in 2010 with evolving programs through 2020
- In its 906 pp a number of programs are influential in, & influenced by Care Transitions. Some prominent ones include:
  - Accountable Care Organizations
  - Hospital Readmissions Reduction Program
  - Bundled Payments for Care Improvement
  - Community Based Care Transitions Program (CCTP)



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### Accountable Care Organizations (ACOs)

- Voluntary program initiated in 2012.
- Entity headed by a hospital, physician group or "convener" which receives the CMS reimbursement & distributes payments to all providers.
- Must have an adequate panel of hospitals, clinicians & sites of care to provide quality clinical services.
- Agrees to serve at least 5,000 Medicare FFS recipients for at least 3 yrs.

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### Accountable Care Organizations (ACOs)- cont.

- Performance is based upon:
  - prior financial benchmarks (what the cost of care was for patients prior to the ACO)
  - 33 quality measures
  - Recently proposed that one quality measure be 30-day readmission rates



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### Hospital Readmission Reduction Program (HRRP)

- Initiated October 2012 (FY 2013) for "excessive" 30 day hospital readmissions in AMI, CHF & Pneumonia
  - Penalty is for ALL Medicare diagnoses when initiated
  - 1% penalty affected >2000 hospitals & resulted in >\$280 million in penalties in FY 2013
- Kaiser Health News: Rau J  
<http://www.kaiserhealthnews.org/Stories/2012/August/13/medicare-hospitals-readmissions-penalties.aspx>
- Penalty 2% in FY 2014
  - Projected to affect 2,225 hospitals and & result in \$227 million in penalties
- Kaiser Health News: Rau J  
<http://www.kaiserhealthnews.com/Stories/2013/August/02/readmissions-penalties-medicare-hospitals-year-two.aspx>
- Increasing to 3% in FY 2015 (Oct 2014)



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### HRRP (cont.)

- Expands to include diagnoses of COPD, hip & knee joint replacement surgery in FY 2015
- Proposed to add CABG to this list in 2017
- Structured so that about half of all hospitals will always be penalized
- Thus far, hospitals serving low income patients are far more likely to be penalized
- The "Doc Fix" bill of April 2014 directs CMS to develop an all-cause readmission measure for SNFs to be reported on NH Compare by 2015



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### Bundled Payments

- Initiated 2013 with 4 distinct models
- Voluntary
- Sets payment for an "episode of care" based on historical costs & readmission rates
- If the entity can deliver *quality* care below the "bundle price," eligible to participate in the savings.
- Depending on which model chosen can select from 48 episodes of care, for 30-60-90 days as prospective or retrospective reimbursement.



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### Bundling Payment Demo Models for Post-Acute Care

Model 2	Model 3
Selected MS-DRGs, plus post acute	Post acute only for selected MS-DRGs
All services (hospital, physician, LTC, HHA, SNF, DME, Part B meds, etc.) and readmissions	Post acute services, physician, HHA, SNF, DME, Part B meds, etc., and readmissions
Payment is traditional FFS - reconciliation with target pricing (retrospective)	Payment is traditional FFS - reconciliation with target pricing (retrospective)



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### Community Based Care Transitions Program (CCTP)

- 5-year demonstration created by Section 3026 of the ACA initiated in 2011 & administered through the CMML. It provides funding to local community based organizations (CBOs) as the payee and critical partner.
- CBOs are contracted to provide services across the continuum of care and must have formal agreements with a suitable array of partners, including hospitals.
- CBOs partner with acute care hospitals to test models of improved care transitions for high-risk Medicare patients moving to other care settings. There must also be sufficient representation of multiple health care stakeholders, including consumers, on the board.
- Initial award is for 2 years, with annual renewal based upon performance. 102 sites are participating across the country providing care transition services to nearly 700,000 Medicare beneficiaries in 40 states.
- Initially, \$500 million was authorized to be distributed over 5 years to eligible CBOs. In March 2013, the Senate stripped \$200 million from the appropriation.

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## Current Transition Models: A Sampling

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### INTERACT

- INTERACT (Interventions to Reduce Acute Care Transfers) is a set of tools and strategies designed to assist NH staff in early identification, assessment, communication, and documentation about changes in resident status.
- INTERACT II was evaluated in 25 NHs in three states in a 6-month quality improvement initiative that provided the tools, on-site education, and every two-week teleconferences facilitated by an experienced nurse practitioner. There was a 17% reduction in self-reported hospital admissions in these 25 NHs compared to the same 6-month period in the previous year. The group of 17 NHs rated as engaged in the initiative had a 24% reduction, compared to 6% in the group of 8 NHs rated as not engaged, and 3% in a comparison group of 11 NHs. The average cost of the 6-month implementation was \$7,700 per NH. The projected savings to Medicare in a 100-bed NH were approximately \$125,000 per year (Oustander, JG, Lamb, G, Tappen, R, et al. Interventions to Reduce Hospitalizations from Nursing Homes: Evaluation of the INTERACT II Collaborative Quality Improvement Project. *J Amer Geriatr Soc* 59:745-753, 2011).

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### Project RED

The Re-Engineered Discharge (RED) program was developed at Boston University Medical Center (BUMC) to improve hospital discharge planning.

**IMPLEMENTATION**

A "discharge advocate," or specially trained nurse, educates patients about their diagnoses throughout the hospital stay, organizes post-discharge health-care services, verifies the medication plan, follows evidence-based guidelines, provides a written discharge plan and tests patient understanding of it, ensures the discharge summary gets to outpatient providers, and calls to reinforce the plan 2-3 days later. A toolkit and technical assistance is available to hospitals that use Project RED.

**IMPACT**

Project RED significantly reduced hospital utilization and was especially effective for patients with higher rates of hospital utilization the previous six months.<sup>1</sup>

1. <http://www.lafayettegeneral.com/Images/Interior/pdf-documents/reengineered%20discg%20plan.pdf>

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**project BOOST**  
Better Outcomes for Older adults through Safe Transitions

### Project BOOST

The intervention was created by the Society of Hospital Medicine in Philadelphia. BOOST (Better Outcomes for Older adults through Safe Transitions) seeks to reduce 30-day readmission rates, with a focus on older adults; improve discharge patient satisfaction and HCAHPS scores; improve communication between hospital and outpatient physicians and providers; identify high-risk patients and target specific interventions to minimize adverse events; and improve patient and family discharge preparation.

**IMPLEMENTATION**  
The program includes step-by-step project management tools such as a TeachBack training. It offers in-person training, followed by a year of mentoring and coaching. The mentoring program provides a train-the-trainer DVD and curriculum for nurses and case managers on using the process, and webinars targeting the educational needs of other team members including administrators, data analysts, physicians, and nurses. BOOST also has a listserv, community website, and quarterly webinars and teleconferences. The BOOST Data Center allows clients to store and benchmark data against others and generates reports.

**IMPACT**  
At six BOOST sites, 30-day readmission rates were reduced from 14.2 percent to 11.2 percent.  
1. <http://www.hospitalmedicine.org/AM/Template.cfm?Section=Home&TEMPLATE=/CM/HTMLDisplay.cfm&CONTENTID=27543>

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### Transitions of Care in the Long-Term Care Continuum (TOC CPG): AMDA

- <http://www.amda.com/tools/clinical/toccp.pdf>
- Seven steps to safer transitions in the LTCC
- Both planned & unplanned transitions
- 99 pages, 16 tables & 14 appendices
- Products, Resources, References & Bibliography
- Access and use is free of charge



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### Key Elements of the AMDA CPG in Safe Transitions



1. IDT members communicate with each other
2. Communication with the receiving entity is performed.
3. End-of-life/Palliative care instead of unnecessary transfers is provided based upon resident wishes.
4. Verify the patient/resident has arrived at the receiving entity & appropriate information is received.
5. Accountability & responsibility is assigned for each step of a transition.
6. Monitor performance by specific measures with feedback & continuous quality improvement.

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### Hospital Guide to Reducing Medicaid Readmissions

Hospital Guide to Reducing Medicaid Readmissions. August 2014. Agency for Healthcare Research and Quality, Rockville, MD.  
<http://www.ahrq.gov/professionals/systems/hospital/medicaidreadmitguide/index.html>  
Publication # 14-0050-EF



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### Hospital Guide to Reducing Medicaid Readmissions

- Contents
  - Acknowledgments
  - About the Principal Investigators
  - Introduction
  - Why Focus on Medicaid Readmissions?
  - How to Use This Guide
  - Overview of Guide Content
  - Roadmap of Tools
  - Section 1: Know Your Data
  - Section 2: Inventory Readmission Reduction Efforts
  - Section 3: Develop a Portfolio of Strategies
  - Section 4: Improve Hospital-Based Transitional Care Processes for Medicaid Patients
  - Section 5: Collaborate With Cross-Setting Partners
  - Section 6: Provide Enhanced Services for High-Risk Patients
  - References
- Tools
  - Introduction to the Tools
  - Tool 1: Data Analysis Tool
  - Tool 2: Readmission Review Tool
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  - Tool 5: Cross-Continuum Team Inventory Tool
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  - Tool 7: Portfolio Design Tool
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  - Tool 9: Readmission Risk Tool
  - Tool 10: Whole-Person Assessment Tool
  - Tool 11: Discharge Information Checklist
  - Tool 12: Cross-Continuum Team How-to Tool
  - Tool 13: Community Resource Guide Tool

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### Avoidance of Unnecessary ED Transfers

- ❖ Communication between caregivers
- ❖ Medication management
- ❖ Advance directives/End of life clarity

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Avoidance of Unnecessary ED Transfers

- ❖ Communication between caregivers

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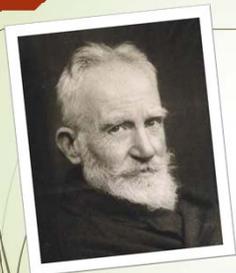
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"The biggest problem with communication is the illusion that it has been accomplished"

*George Bernard Shaw*

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The Consequences of Poor Communication During Transitions from Hospital to SNF: A Qualitative Study

- 27 nurses from 5 Wisconsin SNF's
- "Nurses note multiple deficiencies in hospital to SNF transitions, with **poor quality discharge communication** being identified as the major barrier to safe and effective transitions."

King, Gilmore-Bykovskiy et al. JAGS 61:1095-1102, 2013

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## Interventions to Reduce Acute Care Transfers (INTERACT)

- Quality Improvement Tools
  - Tracking Hospitalization Rates
  - Quality Improvement Reviews - Root Cause Analyses
- Communication Tools
  - For Communication Within the Nursing Home
  - For Communication Between the Nursing Home and Hospital
- Decision Support Tools: Change in Condition File Cards and Care Paths
  - Acute Change in Condition File Cards
  - Care Paths
- Advance Care Planning Tools
  - <http://interact.fau.edu>

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### Decision Support Tools: Change in Condition File Cards and Care Paths

**Acute Change in Condition File Cards**

- [Acute Change in Condition File Cards](#)

**Care Paths**

- [Acute Mental Status Change](#)
- [Change in Behavior, New or Worsening Behavioral Symptoms](#)
- [Dehydration](#)
- [Fever](#)
- [GI Symptoms - nausea, vomiting, diarrhea](#)
- [Shortness of Breath](#)
- [Symptoms of CHE](#)
- [Symptoms of Lower Respiratory Illness](#)
- [Symptoms of VTI](#)

**Advance Care Planning Tools**

- [Advance Care Planning Tracking Tool](#)
- [Advance Care Planning Communication Guide](#)
- [Identifying Residents Who May be Appropriate for Hospice or Palliative/Comfort Care Orders](#)
- [Comfort Care Order Set](#)
- [Deciding About Going to the Hospital](#)
- [Education on CPR](#)
- [Education on Tube Feeding](#)

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### AMDA Transitions Support Tools (cont.)

- Resident/Family Checklist to the Community from the Nursing Facility
  - <http://www.amda.com/tools/clinical/transitions-of-care.cfm>
- Sample SNF to Community Checklist Policy
  - [http://www.amda.com/tools/clinical/PP-SNF\\_to\\_Community\\_Checklist.pdf](http://www.amda.com/tools/clinical/PP-SNF_to_Community_Checklist.pdf)
- Sample Planned Patient Transfer to the Community Checklist
  - [http://www.amda.com/tools/clinical/SNF-community\\_Checklist.pdf](http://www.amda.com/tools/clinical/SNF-community_Checklist.pdf)
- Against Medical Advice Discharge Checklist
  - [http://www.amda.com/tools/clinical/Against\\_Medical\\_Advice\\_Checklist.pdf](http://www.amda.com/tools/clinical/Against_Medical_Advice_Checklist.pdf)

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### Avoidance of Unnecessary ED Transfers

#### ❖ Medication management



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*If the whole materia medica, as now used, could be sunk to the bottom of the sea, it would be all the better for mankind, and all the worse for the fishes."*  
- Oliver Wendell Holmes, Sr., MD, 1861



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### Medication Reconciliation

- **Medication Reconciliation:** "A process for obtaining and documenting a complete and accurate list of a patient's current medications upon admission or discharge and comparing this list to the physician's admission, transfer, and/or discharge orders to identify and resolve discrepancies."

USP Patient Safety CAPSLink Oct 2000 AHRQ

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### Medication Reconciliation: *Simplified*

- Know what medications are taken.
  - Prescription
  - Non-prescription (OTC)
  - The neighbor's
  - The dog's
- Know why they are taken.
- Ensure the need for each medication.
- Determine a good reason not to stop each medication.
- Ensure a final, correct, legible, and understandable, "take only these" list of medications to the next level of care and the patient/caregiver.



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### High-Risk Medications

- Institute for Healthcare Improvement (IHI) list of high-alert medication categories
  - Anticoagulants
  - Narcotics
  - Insulin
  - Sedatives
- Most common Adverse Drug Reactions (ADR):
  - NSAIDs-related
  - Psychotropic-related (fall with fracture)
  - Digoxin toxicity
  - Insulin – hypoglycemia Cooper, South Med J 1999;92:485



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### High-Risk Medication Use: Pre- & Post-Hospitalization

- Study population of 52,559 dual-eligible NH residents 65 & older who are hospitalized, then readmitted to the same NH in 2008
- Defined high-risk medications using the Beers criteria for potentially inappropriate med use.
- Results:**
  - Around 1 in 5 (21%) hospitalized nursing home residents used at least 1 high-risk medication the day before hospitalization.
  - Among individuals with high-risk medication use at hospitalization, the proportion using these medications dropped to 45% after nursing home readmission but increased thereafter, to 59% by the end of the 30-day period.

Stevenson, Duzatira, O'Malley et al. High-risk medication use by nursing home residents before and after hospitalization. *Medical Care*. Prepublication on-line (accessed 9/12/14)




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### Incidence Rate of Harm Events (stays < 35 days)

- 22 percent of Medicare SNF residents experienced adverse events during their SNF stays
  - 21,777 post-acute Medicare SNF residents experienced at least 1 adverse event
- An additional 11 percent of residents experienced temporary harm events
- Preventability**
  - Preventable—Harm could have been avoided through improved assessment or alternative actions: 59%
    - 13% Clearly preventable
    - 46% Likely preventable

Source: OIG, Adverse Events in Skilled Nursing Facilities, OEI-06-11-00370, February 2014.




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### Incidence Rate of Adverse and Temporary Harm Events (cont.)

#### Patient Harm by Category of Harm

Category of Harm	Infections	Resident Care	Medication
Adverse Events	26%	37%	37%
Temporary Harm Events	17%	40%	43%

Source: OIG, Adverse Events in Skilled Nursing Facilities, OEI-06-11-00370, February 2014.

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### Costs to Medicare

- 59% of those who experienced events went to a hospital for care
- 19% percent hospitalization rate among observed population
- Projected Medicare reimbursements for inpatient stays and ED visits because of adverse events in SNFs:
  - \$208 million - Estimated reimbursements monthly
  - \$136 million - Estimated reimbursements monthly for preventable events
- \$2.8 billion - Extrapolated reimbursements for FY 2011



Source: OIG, Adverse Events in Skilled Nursing Facilities, OEI-06-11-00370, February 2014

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### Utilize the Medical Director & Consultant Pharmacist

- Screen for high-risk medications & evaluate usage
- Screen for high-risk combinations (i.e., multiple anti-coagulants)
- Link the drug to need, not a convenient diagnosis
- Medication review for unplanned discharges
- Chart review for residents with 9 (?) or more medications



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### End-of-Life/Palliative Care



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### Let Me Decide Program

- Educated staff in hospitals and nursing homes, residents, and families about advance directives
- offered competent residents or next-of-kin of mentally incompetent residents an advance directive that provided a range of health care choices for life-threatening illness, cardiac arrest, and nutrition.
- 6 nursing homes were pair-matched on key characteristics, and 1 home per pair was randomized to take part in the program. Control nursing homes continued with prior policies.
- Satisfaction was not significantly different in intervention and control nursing homes. Intervention nursing homes reported fewer hospitalizations per resident (mean, 0.27 vs 0.48;  $P = .001$ ) and less resource use (average total cost per patient, Can \$3490 vs Can \$5239;  $P = .01$ ) than control nursing homes. Proportion of deaths in intervention (24%) and control (28%) nursing homes were similar ( $P = .20$ ).
- **Conclusion** Our data suggest that systematic implementation of a program to increase use of advance directives reduces health care services utilization without affecting satisfaction or mortality.

Molloy, Guyatt, Russo et al. JAMA March 15, 2000; vol. 283, No. 11.

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### Improve the Transfers That Are Necessary

- Develop a transfer process to:
  - ❖ Create a Policy & Procedure for transfers
  - ❖ Determine the information to be sent
  - ❖ Provide the tools/forms for safe transfers
  - ❖ Monitor & Measure your process

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### Creating the Transfer Process

❖ *Create a Policy and Procedure for Transfers*



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**Sample Policy for Transition of a NH Resident to ED/Hospital**

*Title: Appropriate and patient-centered transfer*

**Purpose:**

- To make clear the appropriate information that should be included with a resident who is transferred
- To set responsibility among the professional staff and support services with respect to transfers
- To maintain patient-centered care by involving the resident and his/her family member(s) or legally authorized representative

AMDA CPG: Appendix 6, p. 57

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**Sample Policy for Transition of a NH Resident to ED/Hospital (cont.)**

**Procedure:**

- One key individual involved in the care of the patient (e.g., the unit nurse) will be responsible for coordinating the transfer process. This individual will ensure that all necessary action has been taken to:
  - a) facilitate transport to the receiving facility
  - b) gather all necessary documents and information for communication with the receiving facility (include the list here)
  - c) communicate directly with the receiving facility about the resident being transferred
  - d) communicate with the resident's primary care physician
  - e) communicate with the resident's family or legally authorized representative
  - f) document all communication and activities in the resident's medical chart
- Use the approved checklist to document that all of the above procedures have been carried out.

AMDA CPG: Appendix 6, p. 57

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**Creating the Transfer Process**

❖ *Determine the Critical Information to be Sent in the Discharge Packet*



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■ Perhaps as many as two-thirds of NH residents cared for in the ED are cognitively impaired. Gillick & Steel, JAGS 1983

■ 10% of NH residents transported to ED without documentation & essential data usually missing in the other 90%. Jones et al. Acad Emer Med 1997; Slier et al. Ann Emer Med 2001



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### Issues & Concerns When Caring for a NH Patient

■ Survey of Emergency Room Nursing Personnel: Top Five Issues:

- No advance notification of resident's arrival
- Ambulance driver unable to answer questions about the resident's history, change in mental status, etc
- Forms from the NH have no address
- No NH phone numbers are listed to call in a report
- NH's do not send resident's hearing aids & residents become combative due to fear

Davis et al. Annals of Long-Term Care, 2005

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### TABLE 5: (p. 23) Essential Information That Should Accompany Every Transitioning Patient

- Patient name
- Primary diagnosis for admission to sending facility
- Accurate medication list with prescription and non-prescription drugs, with doses and frequency\*
- Allergies and medication intolerances
- Vital signs
- Copies of advance directives including AND/DNR status
- Name and specific contact information for:
- Sending facility (including phone number of facility/wing of facility and nurse name)
- Responsible practitioner at sending and receiving sites of care
- Responsible family member/decision-maker
- Barriers to communication
- English comprehension is poor: provide primary language spoken by the patient
- Vision: requires glasses to appropriately see, blind, etc.

AMA 100: CPG

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**TABLE 5 (cont.):  
Essential Information That Should Accompany Every  
Transitioning Patient**

- Hearing impairment
- Cognitive issues that impair decision-making; who should be contacted for decision-making
- Health literacy or cultural issues that may inhibit communication
- Reason for transfer (i.e., the acute change in condition or problem precipitating the transfer) along with any acute changes from baseline associated with this transfer (e.g., confusion, unable to walk, unresponsive)
- Medical devices, lines (e.g., central line, dialysis site, pacemaker) or wounds
- Patient's ability to feed self, special dietary needs (e.g., pureed foods, low-salt diet)
- Significant test results
- Tests with results pending, consults or procedures ordered but not yet performed
- Prognosis and goals of care

AMDA TOC CPG

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**Creating the Transfer Process**

❖ *Provide the tools for Safe Transfers*




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**AMDA: Universal Transfer Form**




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Creating the Transfer Process

**Monitor & Measure Your Process**



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Table 16 (p. 39): Sample Performance Measurement Indicators

**Process indicators**

- Facility has adopted and implemented policies and procedures to guide care transitions to the hospital, emergency department, community home, and other LTCC facilities
- Appropriately trained staff members are designated as responsible for managing care transitions
- Facility provides appropriate in-service training and education programs for health care professionals at all levels on the management of care transitions
- Facility utilizes a standard form to provide essential patient information to receiving entities in care transitions
- Documentation of DNR/AND status is routinely sent with any patient who is transferred to an emergency department
- Patients' wishes concerning end-of-life care are documented and advance directives are revisited at regular intervals as health status and care goals change
- Designated staff members follow up as a matter of course to ensure that a transferred patient has successfully transitioned to the new setting or level of care

AMDA TOC CPG

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Table 16 (cont.): Sample Performance Measurement Indicators

**Decreases in:**

- Avoidable care transitions
- Readmissions resulting from avoidable post-discharge complications and adverse events
- Costs associated with readmissions
- Duplicative use of diagnostic services
- Medication-related adverse events
- Patient harm resulting from errors in the transition process

**Increases in:**

- Patient safety
- Quality of life for patients with complex health care needs
- Patient and family satisfaction with care

AMDA TOC CPG

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### Care Coordination Measures Are Rapidly Developing

- AHRO – Comparative Effectiveness Research for Case Management
- NQF – Performance Measures for Care Coordination
- CMS – 10th SOW for QIOs supports Care Transitions
- TJC – Patient Safety Standard #8 Medication Reconciliation
- URAC – Incorporated Transition of Care in revised CM Standards
- NCQA – Complex Case Management Standards
- AMA – PCPI Transitions of Care
- ANA – Care Coordination Quality Measures



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### Information Technology Issues

- Access to hospital EMR &/or HIT exchanges
- SKYPE/ Facetime/ Facebook
- Telemedicine
- Interoperability
  - Physician office & Hospital
  - Laboratory/Radiology results
- Email or texting access
- Facility EMR: coding, billing & templates for notes

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### Utilize Your Medical Director

- Leadership in patient-centered care
  - 25% of readmissions **not** related to index admission dx
  - Social issues often drive readmissions in elders
- Hospitals are looking for partners, not empty beds
  - Appropriate transition information to the hospital/ED
  - 73% of variation in Medicare costs are in the PAC realm
- Know your facility 30-day readmission data
  - Review unscheduled transfers out: ED & hospital admissions
- Focus on gaps where readmissions (and harm) occur
  - Dementia
  - End-of-life/Palliative Care: Urgency & accuracy in Advance Directives
  - Observation Stays



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### Utilize Your Medical Director-2

- Prepare the facility for measurements that will be utilized to allow participation in ACA programs, managed care...and survival
  - Patient and family satisfaction\*
  - CMS star rating\*
  - 7 and 30-day readmission rates\*
  - Average length of stay\*
  - Infection rates\*
  - Referral volumes^
  - Physician relationships^



\*Chase T. How are hospitals measuring their performance? Building an offensive strategy in the outcomes-driven world of healthcare. American HealthCare, 2012  
^Maly MB, et al. Prioritizing Patients Across the Continuum. J Am Med Dr Assoc Nov 2012; 1309: 811-6

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### Utilize Your Medical Director-3

- Access to the hospital EMR
- Meet regularly with the hospital
  - Share readmission data
  - Visit ED & Hospitalists staff meetings
- Reach out to the referring hospital
  - Exchange cell phone numbers & names
  - Reciprocal visits



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### Summary

- Improve the transfers you do make by creating a transfer process to include:
  - Policy & Procedure for transitions including accountabilities
  - Determine the information to be sent
  - Put in place the tools/forms for safe transfers
  - Monitor & Measure Your Process

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Summary.....continued

- Patient responsibility does not end when the patient enters the ambulance - it extends until the next caregiver assumes care.
- Phone call follow-up to the receiving facility to confirm patient and information is received and whether further information is needed...*and share the information*
- The gold standard for communication is clinician-to-clinician verbal interaction

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Other AMDA Resources

- AMDA White Paper: Improving Care Transitions From the Nursing Facility to a Community-Based Setting (2009)
- AMDA White Paper: Improving Care Transitions Between the Nursing Facility and the Acute Care Hospital Settings (2010)

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AMDA Long Term Care Medicine - 2014

**QA**

**QUESTIONS**

Contact Information James E. Lett, II, MD, CMD - [jlett2md@aol.com](mailto:jlett2md@aol.com)

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### Transitional Care Management Services (TCM) Reimbursement

Beginning January 1, 2013 payment for Transitional Care Management post-discharge from acute care facilities:

- www.cms.gov/Medicare/Medicare...Service-Payment/.../FAQ-tcms.pdf
- www.aafp.org/dam/AAFP/documents/.../payment/TCMFAQ.pdf

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### Transitional Care Codes

National Average \$142.96	National Average \$231.11
<ul style="list-style-type: none"><li>99495: Transitional Care Management Services with the following required elements:<ul style="list-style-type: none"><li>Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge</li><li>Medical decision making of at least moderate complexity during the service period</li><li>Face-to-face visit, within 14 calendar days of discharge.</li></ul></li></ul>	<ul style="list-style-type: none"><li>99496: Transitional Care Management Services with the following required elements:<ul style="list-style-type: none"><li>Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge</li><li>Medical decision making of at least high complexity during the service period</li><li>Face-to-face visit, within 7 calendar days of discharge.</li></ul></li></ul>

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### Complex Chronic Care Coordination Payment

- On July 8, the Centers for Medicare & Medicaid Services (CMS) included in its proposed rule on the 2014 Medicare physician fee schedule a plan for a separate payment for complex chronic care (CCC) management services, beginning in 2015.
- The patients would have to have multiple complex chronic conditions that are expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.
- CMS does not spell out a lot of specifics related to this proposal, saying that it intends, through separate rule making, "to develop standards for furnishing complex chronic care management services to ensure that the physicians who bill for these services have the capability to provide them."
- Proposed standards likely will include that the practice must use a certified electronic health record (EHR) for beneficiary care that meets the most recent standard for meaningful use.

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**Complex Chronic Care Coordination Payment**

- To bill requires physicians provide:
  - 24/7 access
  - Continuity of care
  - Care management including med reconciliation
  - Patient-centered care plan
  - Management of care transitions
  - Coordination with community-based services
- Rule location: [s3.amazonaws.com/public-inspection.federalregister.gov/2014-15948.pdf](https://s3.amazonaws.com/public-inspection.federalregister.gov/2014-15948.pdf)
- Proposes to pay \$41.92 for a new G-code

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