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

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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

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.
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

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

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

Re-hospitalizations Update:

- Medicare FFS hospital 30-day readmission rate based upon 2012 data has fallen to 18.4%
- Annual cost of readmissions to Medicare is $17.5 billion
- Appears to be no “right” 30-day readmission rate, but pressure to reduce the rate will continue

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%


Hospital Discharge Concerns

- Upon hospital discharge 30% of patients have at least one medication discrepancy
- 14.3% with discrepancies readmitted within 30 days versus 6.1% in those with none
- 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
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;18:646-51).
- 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).

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 48% (Rowe 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% (Ouslander, et. al., 2011).

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

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


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% w/ hospitalization
- 7.2% w/ visit w/o hospitalization
- Greater likelihood: male, dual eligible, > Charlson score, certain dx (neoplasm, respiratory dz), for profit SNF or fewer LPN hours per pt/day

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**

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

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

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 days were identified by any claim submitted for a Medicare-enrolled individual in observation status. Composite percent change: 0.7% [panel A] and 1.1% [panel B].)


Focus is shifting to integration of services, population-based accountabilities and new models of payment. And new payment models are forcing change.
Patients will move from being revenue centers to being cost centers.

Brendan Thompson, M.D.

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)

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.
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

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

- Penalty 2% in FY 2014
  - Projected to affect 2,225 hospitals and result in $127 million in penalties
  
  Kaiser Health News; Rau J

- Increasing to 3% in FY 2015 (Oct 2014)

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 SNPs to be reported on NH Compare by 2015
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.

Bundling Payment Demo Models for Post-Acute Care

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

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

Community Based Care Transitions Program (CCTP)

- 5-year demonstration created by Section 3026 of the ACA, initiated in 2011 & administered through the CMMI. 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.
Current Transition Models: A Sampling

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 (Ouslander, 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).

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.1

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 share 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.

2. Seven steps to safer transitions in the LTCC
3. Both planned & unplanned transitions
4. 99 pages, 16 tables & 14 appendices
5. Products, Resources, References & Bibliography
6. Access and use is free of charge

**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.
Hospital Guide to Reducing Medicaid Readmissions

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- 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
- Hospital Item to the Trick
- Hospital Readmission Risk Tool
- Hospital Inventory Tool
- Hospital Readmission Impact and Financial Analysis Tool
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Avoidance of Unnecessary ED Transfers

- Communication between caregivers

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

George Bernard Shaw

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-Bykovskyi et al. JAGS 61:1095-1102, 2013
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

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

Advance Care Planning Tools
<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Notes</th>
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<tr>
<td>03/19/2015</td>
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</table>
This approach to recognition, assessment, treatment, and monitoring of ACOCs enables staff to evaluate and manage a patient at the facility and avoid the transfer to a hospital or emergency room (ER).

http://www.amda.com/tools/guidelines.cfm#acoc

Know-It-All Series – Tools to Reduce Unnecessary Transitions to Hospitals:

Know-It-All Before You Call©
• A series of data collection cards intended to help nursing staff physically evaluate patients and collect relevant medical history and related medical record data before notifying a practitioner about a resident’s change in condition. This allows the practitioner to receive more complete, clinically important information about the resident’s condition in a way that facilitates accurate and effective clinical decision making.

Know-It-All When You’re Called©
• 200-plus page guide on change of conditions for attending practitioners. Content is organized alphabetically by condition and includes the specific data they should be receiving from the nurse, suggested geriatric diagnoses related to the information given, what the follow-up should be for various time points, how to make the “stay or go” decision and much more in an easy-to-use pocket format.

http://www.amda.com/tools/kia.cfm#KNOW
AMDA Transitions Support Tools (cont.)

- Resident/Family Checklist to the Community from the Nursing Facility
- Sample SNF to Community Checklist Policy
- Sample Planned Patient Transfer to the Community Checklist
- Against Medical Advice Discharge Checklist
  - http://www.amda.com/tools/clinical/Against_Medical_Advice_Checklist.pdf

Avoidance of Unnecessary ED Transfers

- Medication management

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
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

Medication Reconciliation: Simplified

- Know what medications are taken.
  - Prescription
  - Non-prescription (O/T C)
  - 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.

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)
  - Diabetic toxicity
  - Insulin — hypoglycemia (Cooper, South Med J 1999;92:485)
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, Dusetzina, 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

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


Incidence Rate of Adverse and Temporary Ham Events (cont.)

<table>
<thead>
<tr>
<th>Patient Harm by Category of Harm</th>
<th>Adverse Events</th>
<th>Temporary Harm Events</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication</td>
<td>37%</td>
<td>43%</td>
</tr>
<tr>
<td>Resident Care</td>
<td>37%</td>
<td>40%</td>
</tr>
<tr>
<td>Infections</td>
<td>26%</td>
<td>17%</td>
</tr>
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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

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

End-of-Life/Palliative Care

- [Image of a document labeled "Last Will and Testament"]

- [Image of a document labeled "Will"]
Of all deaths in the United States in 1993, 20% occurred in US nursing homes, and the proportion of deaths occurring in nursing homes is expected to increase to 40% by 2020.


POLST

Not a “Yes-No” Scenario

- Clarify Advance Directives, not “DNR: Yes/No” upon admission & each readmission... & document it
- Does the patient want:
  - Chest compression/Intubation
  - IV antibiotics
  - Tube feeding
  - Re-hospitalization, etc...
- Facility policy to designate a site in the chart where the Advance Directives are located
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).

Conclusions: 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.

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

Creating the Transfer Process

- Create a Policy and Procedure for Transfers
**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

**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:  
  - facilitate transport to the receiving facility  
  - gather all necessary documents and information for communication with the receiving facility (include the list here)  
  - communicate directly with the receiving facility about the resident being transferred  
  - communicate with the resident’s primary care physician  
  - communicate with the resident’s family or legally authorized representative  
  - 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.

**Creating the Transfer Process**  

- Determine the Critical Information to be Sent in the Discharge Packet
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; Stier et al., *Ann Emer Med* 2001

**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)

**TABLE 5: 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 manager)
  - 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.
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

Creating the Transfer Process

- Provide the tools for Safe Transfers

AMDA: Universal Transfer Form
The Devil is in the Details

- Clearly assigned roles and accountability
  - Who copies critical information when the ward clerk is away
  - Is the FAX/copy machine locked in the DON or Administrator office after hours… who unlocks
- Up-to-date, accurate list of family members & phone numbers – in the order to be called
  - Do all know where it is in the chart
  - Who calls
  - Who updates

Cautions

- Forms alone don’t change process
- Do not confuse paperwork with communication
- Garbage in… Garbage out
Creating the Transfer Process

Monitor & Measure Your Process

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

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
Care Coordination Measures Are Rapidly Developing

- AHRQ – Comparative Effectiveness Research for Case Management
- NQF – Performance Measures for Care Coordination
- CMS – 10th SDW 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

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

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
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^*


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

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

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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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-.../FAQ-tcms.pdf
- www.aafp.org/dam/AAFP/documents/.../payment/TCMFAQ.pdf

Transitional Care Codes

National Average $142.96
- 99495: Transitional Care Management Services with the following required elements:
  - Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
  - Medical decision making of at least moderate complexity during the service period
  - Face-to-face visit, within 14 calendar days of discharge.

National Average $231.11
- 99496: Transitional Care Management Services with the following required elements:
  - Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
  - Medical decision making of at least high complexity during the service period
  - Face-to-face visit, within 7 calendar days of discharge.

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.
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
- Proposes to pay $41.92 for a new G-code