Reducing Rehospitalizations – Part 1

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Presentation Outline

• Articulate 5 criteria hospitals and other partners consider when choosing a post-acute provider with whom to contract.
• Learn effective change management strategies to achieve transition to a staffing model that employs an empowered, engaged workforce capable of reducing hospitalization.
• State how to properly assess for patient change in condition, use triage protocols and collaborate with medical practitioners to implement appropriate treatment regimen.
Why is this topic important to you?

Because Hospitals are Looking at YOU

Advice to Hospitals

Given:

- the implementation of federal- and state-operated health insurance exchanges,
- ACO’s,
- penalties for readmissions,
- payment reform initiatives

You must have a post-acute strategy

or suffer significant quality, financial performance, and patient experience consequences.

This is what they are saying

It is no longer possible to ignore the role of a post-acute strategy without suffering significant quality, financial performance and patient experience consequences.

- BoardRoom Press

Criterion to Evaluate the Post-Acute Partner Candidate

Compare yourself to other SNFs on these TEN Criterion
1. Performance on Quality

- Track record in Quality
  - Clinical competency
  - Outcomes
- Cost
- Patient experience
  - Ambiance of the care delivery site
  - Responsiveness of staff to patient/caregiver needs
  - Satisfaction
- The partner has the ability to track and benchmark data that demonstrate performance

2. Readmission Rate and other indicators

- The track record for readmission rates to acute care facilities
- Length-of-stay relative to benchmarks specific to a particular clinical condition
- Other clinical indicators

Six Measure Cohorts

- Acute myocardial infarction (AMI),
- Heart failure (HF),
- Pneumonia,
- Chronic obstructive pulmonary disease (COPD),
- Coronary artery bypass graft (CABG) surgeries, and
- Elective primary total hip and/or total knee arthroplasty (THA/TKA),

Hospital Readmission Reduction Program

- CMS measures hospital performance in the HRRP by calculating excess readmission ratios (ERRs) for each of the six program measures
- A payment adjustment factor is used to calculate the size of the payment reduction
- Payments were capped at
  - 1% in 2013
  - 2% in 2014
  - 3% in 2015 and forward
**Hospital Readmission Reduction Program**

- In 2019, hospital performance in the HRRP is assessed relative to the performance of hospitals within the same peer group.
- Hospitals will be stratified into five peer groups, or quintiles, based on the proportion of dual-eligible stays.
- The payment reduction is capped at 3%.

**New Research from MN and CA**

- Researchers studied six hospital systems that have formed preferred provider networks with SNFs between 2013 and 2016 as part of Medicare ACOs.
- They found that preferred SNFs were:
  - In urban areas,
  - More likely to be nonprofit,
  - Housed more Medicare-certified beds,
  - Delivered care to a lower proportion of Medicaid enrollees, compared to non-preferred SNFs.

**New Research from MN and CA**

- Preferred facilities:
  - More likely to receive five stars on each of the composite quality measures from Nursing Home Compare.
  - More likely to provide seasonal flu vaccines,
  - Less likely to initiate antipsychotic medications.
- Preferred SNFs across the sample size also exhibited:
  - Shorter lengths of stay,
  - Lower Medicare spending per post-discharge episode ($20,900 for preferred SNFs, versus $22,900 for non-preferred facilities),
  - Lower readmission rates,
  - Just to name a few.

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The amount of money collected in penalties has also increased since 2013:

- 2013: $290 million in total penalties
- 2014: $227 million in total penalties
- 2015: $428 million in total penalties
- 2016: $420 million in total penalties

In 2017, CMS estimates that the number of penalty dollars will jump up to $528 million.
Where Does NE Stand?

- Nationwide, 2,592 hospitals will lose a combined $420 million, according to a Kaiser Health News analysis of Medicare records.
- file:///C:/Users/mtellisnayak/Downloads/Nebraska_readmission_rates_for_HF.pdf - Check out the hospitals near you.

Some patient advocates say the Medicare penalties are pressuring hospitals to avoid admitting or readmitting patients in order to keep their numbers acceptably low. Instead, hospitals will take patients "under observation," a designation that often results in the patient — including poor and elderly — getting a huge bill for hospital services and for rehabilitation later.
3. Healthcare reform readiness

- A coordinated, formal care management process (led by on-site hospitalists, SNFists etc)
- Processes supporting performance improvement
- Use of Evidence-based care protocols
- IT infrastructure
  - Connectivity between acute and post-acute providers specific to EMR
  - Computerized physician order entry
- These factors reveal how much the hospital will have to augment the post-acute care entity’s infrastructure and care management processes.

Being a Preferred Provider

- With the advent of bundled payment programs and accountable care organizations, hospitals are forming tighter bonds with skilled nursing facilities across the country. But are these “preferred providers” of hospitals actually providing higher quality care than their “non-preferred” peers?
- Researchers found that hospitals are choosing to work more closely with SNFs with
  - lower use of resources,
  - shorter lengths of stay, and
- perform better on quality measures.

Care Transition Strategies

- Research shows a strong link between care transitions and lower readmission rates
- When patients move from the hospital to the next site of care, they benefit from
  - A clear treatment plan
  - Providers who are aware of and able to carry out the treatment plan
  - Access to the proper support services

4. Clinical Skills

- Registered Nurses vsLicensed Practical/Vocational Nurses
- Registered therapists vs techs.
5. The FIT with your organization’s service line

- Culture
- Mission, Vision, Values
- Integrity
- Focus on patient-centered care
- Safety
- The ability of the post-acute entity to make a positive contribution to the value of the service line brand of the acute-care organization

University of PA Study – SNF Takeaways

- Payment really matters. Hospitals have been “really conscientiously and in a very collective manner reorganizing the way that they are thinking about post-acute care, and specifically trying to save costs, along those lines.” The payment structure is having a distinct effect on hospitals’ behavior.
- Some of the things hospitals are doing have “enormous implications” for skilled nursing facilities.
  - Hospitals are trying to move away from SNF use,
  - Particularly for joint replacement patients..
- There’s uncertainty over what the ultimate implications are for SNFs. There is a question of what sorts of pressures SNFs will face, given these hospital practices
- SNFs are facing downward referral pressures as hospitals try to send their patients, more and more frequently, home.

6. Partner’s Leadership

- The stability of the post-acute care organization’s leadership team
- Can the post-acute leaders (administrative and clinical) implement a shared plan of action with the acute care hospital to achieve staff accountability
  - Adjusting role descriptions
  - Performance evaluation mechanisms
  - Incentive mechanisms

7. Synergy

- Does the breadth of services offered by the post-acute provider satisfy service line operational, financial, and/or strategic gaps?
- Does the breadth of services support the hospitals critical success factors?
- Do the services appeal to referring physicians, payers and patients?
8. Long-term viability

- Operating and cash-flow position
- Debt capacity
- Ownership structure
- Regulatory status (licensure and accreditation)
- Stability of clinical staff
- Condition of physical plant/resources

9. Accessibility

- The ability to admit/transfer patients to post-acute care 24 hours a day, seven days a week
- Limited/no wait time to achieve patient transfer from the acute to the post-acute setting
- Proximity of the location
- Ease of street access and parking
- Lack of barriers to entry based on payer contracts

10. Ease of forming the partnership

- Level of interest on the part of the post-acute provider
- Track record for prior affiliations, alliances and partnerships
- The time needed to complete due diligence
- The extent of the barriers, if any

Post-acute Care Provider Strategic Partner Evaluation Tool™

<table>
<thead>
<tr>
<th>Criterion to Evaluate Partner Candidate</th>
<th>Evaluation (circle one)</th>
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<tbody>
<tr>
<td>Performance quality: competency, outcomes</td>
<td>Lower</td>
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<tr>
<td>Performance on cost</td>
<td></td>
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<tr>
<td>Performance on patient experience (satisfaction)</td>
<td></td>
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<tr>
<td>Readmissions rate and other clinical indicators</td>
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<tr>
<td>Healthcare reform readiness</td>
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<tr>
<td>Clinical skills</td>
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<tr>
<td>&quot;Fit&quot; with your organization’s service line</td>
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<tr>
<td>Partner’s leadership: execute, manage integration</td>
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<tr>
<td>Synergy</td>
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<td>Long-term viability</td>
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<td>Accessibility (location)</td>
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<td>Accessibility (scheduling)</td>
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Why is this important?

- Care delivery is being redesigned in the hospital – what next?
- Future Partners will look at your data

The Care Delivery Redesign

- At the core is payment reform where more profitability meant more services
- Providers are looking to reduce the cost of care as reimbursement pressures rise.
- CMS is no longer providing payments for unnecessary readmissions.
- BUT, did you also know…….

Provider payments are also tied to…..

8 HCAHPS measures for Medicare patients
- Communication with nurses
- Communication with doctors
- Responsiveness of hospital staff
- Pain management
- Communication about medicines
- Hospital cleanliness and quiet
- Discharge information
- Overall rating of a hospital

What Does All This Mean to ME?

- Investigate your local hospitals’ readmissions rate and approach them with plans for lowering it.
- Hospitals are doing more follow-ups after patients are discharged from the emergency department
- The more you can help a hospital reduce rehospitalizations, the more valuable a partner you become.
Key Strategies in Reduction of Unnecessary Hospitalization and Development of Acute Care Collaborations

Quality in Caring

Ellen Rychlik, RN, BSN
Director of Outpatient Oncology
UPMC Hillman Cancer Center

Make An Impact
“The effect you have on others is the most valuable currency there is.”

A Historical Overview

- Recognizing the unacceptable rate of nursing staff turnover (citing burnout, low job satisfaction, staff complaints with regard to floating all the time) multiple patient/resident satisfaction issues evidenced by numerous complaints filed, and multiple unnecessary hospitalizations – change was inevitable.
- Recognizing the incoming complexity and coinciding needs of the patient population, achieving a stable clinical environment in which the management of the clinically acute could be safely and effectively accomplished was the utmost priority.
- Strategic clinical programs were ONLY THEN successfully developed and implemented.
- In 2008, while leading the team as the Director of Nursing and Clinical Services (for the past 8 years), we were recognized by the American Health Care Association as the first facility in New York State to have achieved the Gold Level of Quality in patient care and services, utilizing the Malcolm Baldrige Performance Excellence Criteria (the highest level of recognition) making us the fourth in the US to have achieved this honor.
- Securement of Collaboration with Acute Care Centers of Excellence

The Beginning – Big Dreamer
“Mountain tops inspire leaders, but valleys mature them.” – Winston Churchill

The population we serve has changed
- Average age of our clientele has increased for both post acute and long term care
- Older adults are often frailer and have multiple co-morbidities
- Alternative levels of care results in increased care needs upon admission to SNF
- Age related functional and physical changes, and family, social, and behavioral issues needed to be considered

Providers of post acute care and skilled nursing must respond to this population shift in order to remain viable.

Stabilization of care providers allow for Early Identification of Deviation and Predictability of Outcomes (opportunity)
- Stability in staffing, clinical capability of providers, and approach to care were variables (opportunity)
Acute care is governed by specific, evidenced based care regimens making deviation close to impossible (opportunity)
- In the Post acute industry, care regimens has not yet been standardized (opportunity)
Recognizing the moral and ethical dilemma, with a push to secure Advanced directive tools (MOLST, Palliation parameters, etc.) in an environment of MCO’s and capitation of services, it was evident that advanced directives were being utilized, not as intended, i.e. basis for care direction based on patient choice, but rather as a means to reduce hospitalizations.

(Moral Responsibility)
According to the AHCA, there are more than 100,000 vacant FT positions in the US with an average turnover rate of 70%.

Turnover leads to staff instability and vacant shifts, which, in turn, result in rushed, depersonalized care > poor quality outcomes > diminishing satisfaction ratings

90% of Nursing Facilities have policies that promote staff rotation

Nursing Home Industry Facts

Direction is so much more important than speed. Many are going nowhere fast. - Unknown

Developing a Strategy

SWOT Analysis on Care Delivery Model

* Strength – Dedicated workforce, supportive management who Lead with the Golden Rule

* Weakness – Staffing Model Instability

* Opportunity – Reduce Turnover> Increase Job Satisfaction > Improve Quality of Care> Increase Patient/Resident/Family Satisfaction> Secure Health Care Continuum Partnerships. (Needed Metrics)

* Threat – Nursing Home Culture/Philosophy

Recognized need for paradigm shift in staffing model and staffing capabilities which would in turn maintain/sustain staffing stability and empower critical/clinical thought.

Changing the Philosophy

The health care continuum is requiring the post acute care level to manage higher level acuity. Employing a 1980’s nursing home philosophy as it pertains to staffing models and staff skill will not prepare for this requirement and provide safe, effective/efficient, quality care to the patient and reduced hospitalizations.

If you put good people in bad systems you get bad results. You have to water the flowers you want to grow. - Stephen R. Covey
Recognizing the Need for Change

Forward-thinking health care leaders will recognize the long-term financial benefit that good nurse staffing and supportive working environments can offer by reducing nursing staff turnover, avoiding complications, improving quality performance, reducing hospital readmissions, improving staff, patient/resident/family satisfaction scores.

Permanent Assignment

1. It is the continuity/consistency in the relationship with patients/residents and families that must be preserved if a balance is to be struck between the cost and quality in health care.
2. The continuity of the care giver ensures predictability of routine allowing for the desired anticipation of individual patterns as they pertain to the activities of daily living and behavioral deviations. This in turn allows the staff to better meet the needs of the patient/resident population ensuring patient/resident safety and behavioral and physical well-being.
3. With Permanent Assignment, staff not only develop closer relationships with the patients for which they are caring, but with co-workers as well.
4. Rotating staff assignment continually severs relationships and inhibits the caregivers ability to recognize decline.

Effective Change Management

- People’s Reaction to Change:
  - Don’t resist change
  - Resist being changed
- Organizational Change
  - Normally involves some threat, real or perceived, of personal loss for those involved.
- Need to Clearly Define the Change
  - Reason for change
  - Empowerment of the employee in decision making
  - Personalize the change
- It is critical that people truly understand the vision/the reasoning behind the change for the change to be successful.

Effective Change Management

- Allows you to zero in on any obstacles and monopolize on your strengths. Too often systems fail from sabotage by people who like the “old ways” in which things were done. Managing the natural resistance to change by identifying and converting that resistance into commitment and enthusiasm must be a planned process.
- You must implement the system to do what it does best – structure repetitive work and let the people do what they do best – think, be creative, and solve problems.

Barbara Bowers, “Turnover Reinterpreted” – rotating staff made CNA’s feel less valued for their skill, experience, and knowledge.
Use Plan-Do-Study-Act (PDSA) cycles to test a change quickly on a small scale, see how it works, and refine the change as necessary before implementing it on a broader scale.

Permanent Assignment

Start Low and Move Slow

- Began on SA unit (Unit 1) and moved into LTC.
- Function and maintain as a closed unit.
- Floating between Units eliminated.
- Called separate meetings with each shift explaining the needed change, demonstrating current situation in quality metrics and satisfaction ratings from surveys of patients/residents/family, and staff. Educated staff on impending change based on national agenda(s).
- Explained how the change would personally affect/impact them as the CNA/Nurse.
- Promoted autonomy and the relationship with ownership.

Permanent Assignment

Start Low and Move Slow

2. Sought feedback on development of patient/resident assignment (balancing workload)
   - ADLs
   - Behaviors
   - Clinical Complexity
   - Utilized “coaching” as a means to promote confidence.
   - Assured of continual management support pulling on established historical practices.
Questions – Comments - Thoughts