Across the Great Divide: Care Transitions Between Healthcare Settings

Jennifer Wieckowski, MSG
Program Director, Care Transitions, Health Services Advisory Group of California, Inc. (HSAG-California)

Omkar Kulkarni, MPH, Supervisor,
Performance Improvement, Cedars-Sinai Health System

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Objectives

- Describe effective interventions to smooth transitions across settings for hospitals, nursing homes, and home health agencies.
- Learn from the successful steps that have been taken by Cedars-Sinai Health System to reduce readmissions.

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HSAG-California
Your Partner in Healthcare Quality

- HSAG-California is the Medicare Quality Improvement Organization (QIO) for California.
- The QIO Program is the largest federal program dedicated to improving health quality at the community level.

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HSAG-California
Your Partner in Healthcare Quality
(cont'd)

- QIOs are a major force and trustworthy partner for improvement.
- QIOs in every state and territory are united in a network administered by the Centers for Medicare & Medicaid Services (CMS).
- Current QIO initiatives run August 2011–July 2014.

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Hospital Readmission Penalties

- Effective October 1, 2012, 197 California hospitals will be penalized for having excess readmissions in congestive heart failure, acute myocardial infarction, or pneumonia.
- Up to 1 percent payment penalty will be applied to a hospital's base operating DRG amount for all discharges in FY 2013.

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Hospital Readmission Penalties *(cont'd)*

- Penalties are based on July 2008 to June 2011 data.
- Penalties will increase in FYs 2014 and 2015.
- Example: If a hospital's base operating DRG amount is $1,000 and the payment penalty is 1 percent, then the amount reduced by the penalty is $10 and the payment made to the hospital is $990.

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Medicare FFS Readmission Data April 2011 to March 2012

California All-Cause 30-Day Readmission Rates

Setting Discharged To	Number of Discharges	Number of Discharges Readmitted within 30 Days	30-Day Readmit Rate	% of 30-Day Readmits to another hospital
Home	392,005	67,985	17.3%	26.1%
Skilled Nursing Facility	176,345	40,139	22.8%	26.4%
Home Health Agency	123,903	25,553	20.6%	21.8%
Hospice	15,771	582	3.7%	35.9%
Other	53,076	10,897	20.5%	41.0%
All	**761,100**	**145,156**	**19.1%**	**26.6%**

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Medicare FFS Readmission Data April 2011 to March 2012

Number of Days from Discharge to Readmission

Setting Discharged To	Number of Readmissions	1–7 Days	8–14 Days	15–21 Days	22–30 Days
Home	67,985	36.1%	24.7%	19.4%	19.8%
Skilled Nursing Facility	40,139	32.5%	26.2%	20.5%	20.9%
Home Health	25,553	36.0%	26.2%	19.4%	18.5%
Hospice	582	43.0%	23.7%	17.2%	16.2%
Other	10,897	38.6%	22.1%	17.9%	21.4%
All	**145,156**	**35.3%**	**25.2%**	**19.6%**	**20.0%**

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Interventions

- Hospital Interventions:
  - Better Outcomes for Older Adults through Safe Transitions (BOOST)
  - Project Re-Engineered Discharge (Project RED)
  - Care Transitions Intervention (CTI)
- Nursing Home Intervention:
  - Interventions to Reduce Acute Care Transfers (INTERACT)
- Home Health Intervention:
  - Reducing Acute Care Hospitalizations Best Practice Implementation Package (BPIP)

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Components of Project RED

- Teach a written discharge plan the patient can understand.
- Assess the degree of the patient's understanding of the discharge plan (teach-back).
- Make appointments for follow-up medical appointments and post-discharge tests/labs.
- Identify the correct medicines and a plan for the patient to obtain and take them.
- Call the patient within three days of discharge to reinforce the discharge plan and help with problem-solving.

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Patient activation trumps all

Slide courtesy of Dr. J. Brock

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Home Health Resources

- Reducing Acute Care Hospitalizations BPIP
  - Call Me First Posters
  - Hospital Risk Assessment
  - Emergency Care Plan
  - Readmission Data

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INTERACT II

INTERACT™

- Designed to manage the acute changes in a nursing home resident
- Goal is to improve care quality, <u>not</u> to prevent all hospital transfers
- INTERACT II Web site http://interact2.net/

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INTERACT II Tools

- Communication Tools
- Decision Support Tools
- Advance Care Planning Tools
- Quality Improvement Tools

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Early Warning Tool
"Stop and Watch"

- Early warning tool for CNAs to alert license nurse of change
- Goal:
  - Improve CNA observation skills of subtle changes
  - Improve CNA to LVN/RN communication to initiate action BEFORE hospital transfer is unavoidable

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Early Warning Tool
"Stop and Watch" (cont'd)

INTERACT™

If you have identified an important change while caring for a resident today, please circle the change and discuss it with the charge nurse before the end of your shift.

S eems different than usual
T alks or communicates less than usual
O verall needs more help than usual
P articipated in activities less than usual

A te less than usual (Not because of dislike of food)
N
D rank less than usual

W eight change
A gitated or nervous more than usual
T ired, weak, confused, or drowsy
C hange in skin color or condition
H elp with walking, transferring, toileting more than usual

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SBAR
Physician/NP/PA Communication and Progress Note for New Symptoms, Signs, and Other Changes in Condition

Before Calling MD/NP/PA:
- ☐ **Evaluate the resident** and complete the SBAR form (use "N/A" for not applicable)
- ☐ **Check VS:** BP, pulse, respiratory rate, temperature, pulse ox, and/or finger stick glucose if indicated
- ☐ **Review chart:** recent progress notes, labs, orders
- ☐ **Review relevant *INTERACT II Care Path or Acute Change in Status File Card***
- ☐ **Have relevant information available when reporting** (i.e. resident chart, vital signs, advanced directives such as DNR and other care limiting orders, allergies, medication list)

S SITUATION
The symptom/sign/change I'm calling about is _____
_____
This started_____
This has gotten (circle one) worse/better/stayed the same since it started
Things that make the condition worse are _____
Things that make the condition better are _____
Other things that have occurred with this change are _____

B BACKGROUND
Primary diagnosis and/or reason resident is at the nursing home _____
Pertinent history (e.g. recent falls,fever, decreased intake, pain, SOB, other) _____
_____
Vital signs BP_____/_____ HR _____ RR _____ Temp _____
Pulse Oximetry _____% On RA_____on O2 at _____L/min via_____ (NC,
Change in function or mobility _____
Medication changes or new orders in the last two weeks

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SBAR *(cont'd)*

Physician/NP/PA Communication and Progress Note for New Symptoms, Signs, and Other Changes in Condition

A ASSESSMENT (RN) OR APPEARANCE (LPN)

(For RNs): What do you think is going on with the resident? (e.g. cardiac, infection, respiratory, urinary, dehydration, mental status change?) I think that the problem may be _____ *-OR*
I am not sure of what the problem is, but there had been an acute change in condition.
(For LPNs): The resident appears (e.g. SOB, in pain, more confused) _____

R REQUEST

I suggest or request **(check all that apply)**:

- ☐ Provider visit (MD/NP/PA)
- ☐ Lab work, x-rays, EKG, other tests
- ☐ IV or SC fluids
- ☐ Other (specify) _____
- ☐ Monitor vital signs and observe
- ☐ Change in current orders _____
- ☐ New orders _____
- ☐ Transfer to the hospital

Staff name _____ **RN/LPN**

Reported to: Name _____ **(MD/NP/PA) Date**____/____/____ **Time**_____**a.m./p.m.**

If to MD/NP/PA, communicated by: ☐ Phone ☐ In person

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Quality Improvement Tool

- Reviews transfers to identify opportunities to improve the identification, evaluation, and management of changes in resident condition and other situations that commonly result in transfers.
- Lists reasons why the resident was hospitalized.

a. **Check *all* that apply:**

CHANGE IN:	NEW CONDITION:	NEW SYMPTOM(S)/SIGNS OF:	OTHER CHANGE:
☐ Appetite/intake	☐ Bleeding	☐ Altered mental status	☐ Abnormal lab value(s)
☐ Behavior	☐ Breathing difficulty or SOB	☐ Congestive heart failure	☐ Abnormal vital signs
☐ Function	☐ Constipation	☐ Dehydration	☐ Family concern
☐ Skin or a wound	☐ Diarrhea	☐ Fever	☐ Other (specify)
	☐ Fall	☐ Lower respiratory infection	_____
	☐ Pain (new or worsened)	☐ Urinary tract infection	
	☐ Other (specify)		

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Advancing Excellence *Campaign:*
Safely Reduce Hospitalizations Tracking Tool

Welcome

Safely Reduce Hospitalizations Tracking Tool v1.2
December 4, 2012

This easy-to-use tool helps you track transfers of residents to the hospital along with information needed for your quality improvement project and root cause analysis. This tool also produces monthly summaries for you to enter on the Advancing Excellence in America's Nursing Homes website where you will be able to access trend graphs of your progress over time:
http://www.NHQualityCampaign.org

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Advancing Excellence *Campaign:*
Safely Reduce Hospitalizations Tracking Tool

- 30-day readmission rate
- Admissions by day of week
- Transfers by doctor
  - Five doctors who order the most transfers
- Transfers by outcome
  - ED visit only, admitted inpatient or observation
- Transfers by reason
- Transfers by time of day

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Advancing Excellence *Campaign:*
Safely Reduce Hospitalizations Tracking Tool

- Percent of Admissions from Hospital to Your Nursing Home for which a Structured Transfer Tool was Used
- Percent of Admissions from Hospital for which Information from the Hospital was Adequate to Care for the Resident
- Percent of All Transfers for which a Structured Communication Tool was Used to Receive Information from Hospital when Resident was Last Admitted to Nursing Home
- Percent of All Transfers for which Resident had a Documented Advance Care Planning Discussion in the Past Quarter
- Percent of All Transfers in which Resident's Advance Care Plan was Reviewed at Time of Transfer
- Percent of All Transfers in which a Structured Communication Tool was Used at Nursing Home to Evaluate Acute Condition
- Percent of All Transfers for which a Root Cause Analysis was Completed

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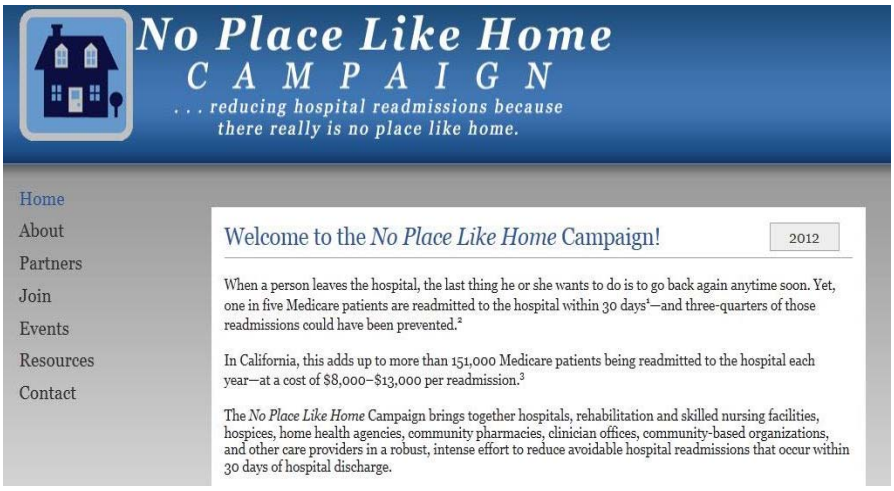
No Place Like Home *Campaign*
www.noplacelikehomeca.com



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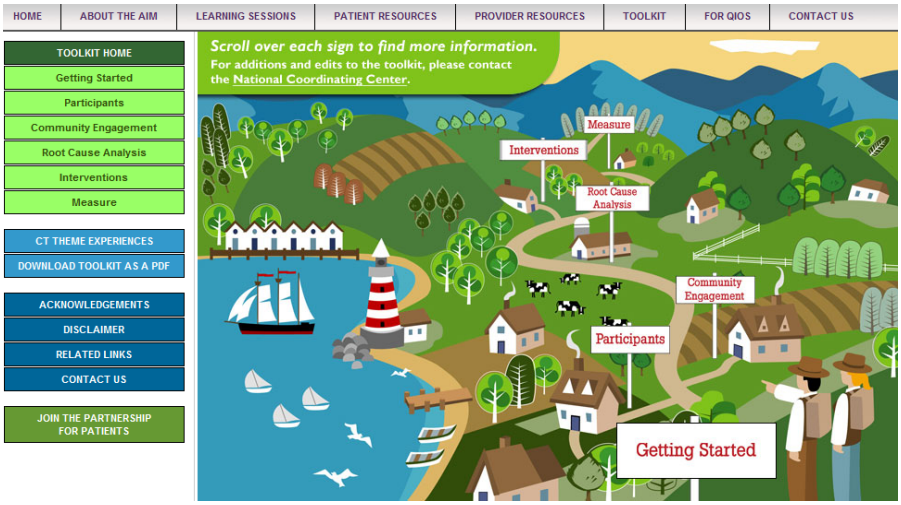
Care Transitions QIO Support Center

http://www.cfmc.org/integratingcare/toolkit.htm



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Thank You!

Jennifer Wieckowski, MSG
Program Director, Care Transitions
HSAG-California
700 North Brand Blvd., Suite 370
Glendale, CA 91203
818-265-4650
jwieckowski@hsag.com

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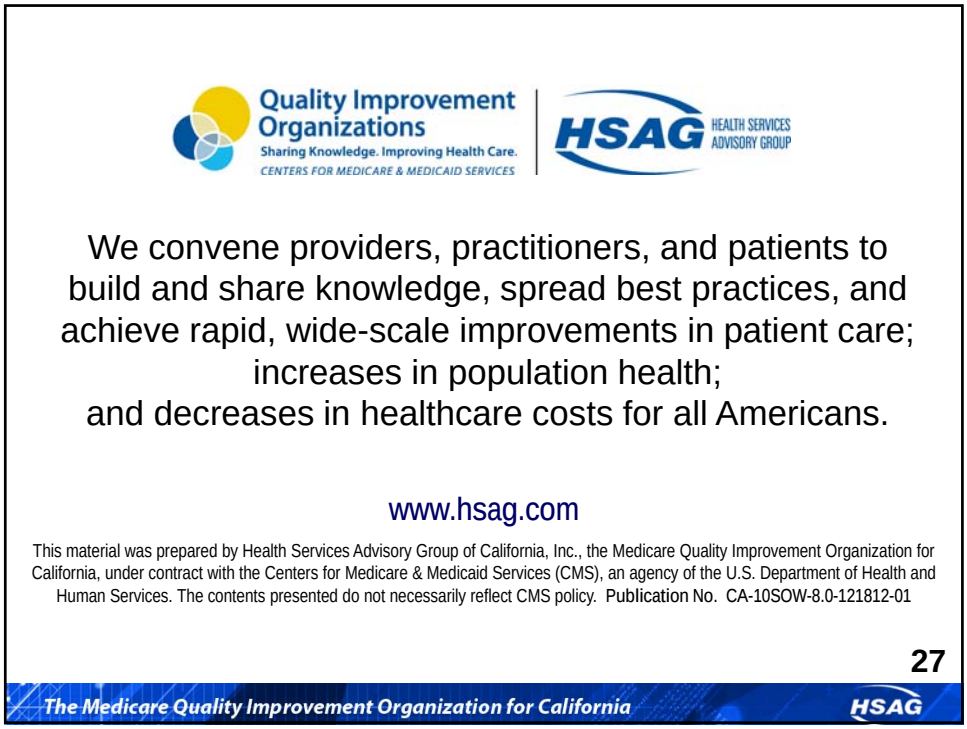
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