Simplifying the Readmission Puzzle

Presented by
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MEDICAL DIRECTOR, POST-ACUTE CARE
NORTHEAST GEORGIA HEALTH SYSTEM

Dr. Swati Gaur is the medical director of New Horizons Nursing Facilities with the Northeast Georgia Health System. She is also the CEO of Care Advances Through Technology, a technology innovation company. In addition, she is on the EMR transition and implementation team for the health system, providing direction to EMR entity adapt to the LTC environment. She has also consulted with post-acute long-term care companies to optimize medical services in PALTC facilities, integrate medical directors and clinicians into the QAPI framework and create frameworks of interdisciplinary work in the organization. She established the palliative care service line at the Northeast Georgia Health System. She also is an attending physician in several nursing facilities. Prior to that, Dr. Gaur was a medical director at the LTC in Carl Vinson VA Medical Center and a member of the G&EC for VISN 7.

Danyce Seney, RN, BSN, IP, RAC-CTA, CPHQ

QUALITY IMPROVEMENT SPECIALIST

Danyce Seney is a quality improvement specialist and registered nurse with certifications in Lean, Infection Control Preventionist and Educator for Adult Learners.

Danyce supports skilled nursing facilities in utilizing a quality improvement framework to implement evidence-based interventions and strategies to improve patient safety, immunization rates and reduce avoidable readmissions.

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Amy Daly, MA, NHA, CPHQ

SENIOR QUALITY IMPROVEMENT SPECIALIST

Amy Daly is a licensed nursing home administrator with over 20 years of leadership and long-term care management experience. In addition to her work as a vice president of long-term care and facility administrator, Amy has served on the boards of the Genesee Health Facilities Association (as treasurer and education committee member) and the Genesee Health Facilities Foundation. Amy serves as a New York State Department of Health Informal Dispute Resolution (IDR) panel member and has been an adjunct clinical instructor of dental hygiene at Monroe Community College. Amy has a master's degree in health promotion and a bachelor's degree in health sciences.

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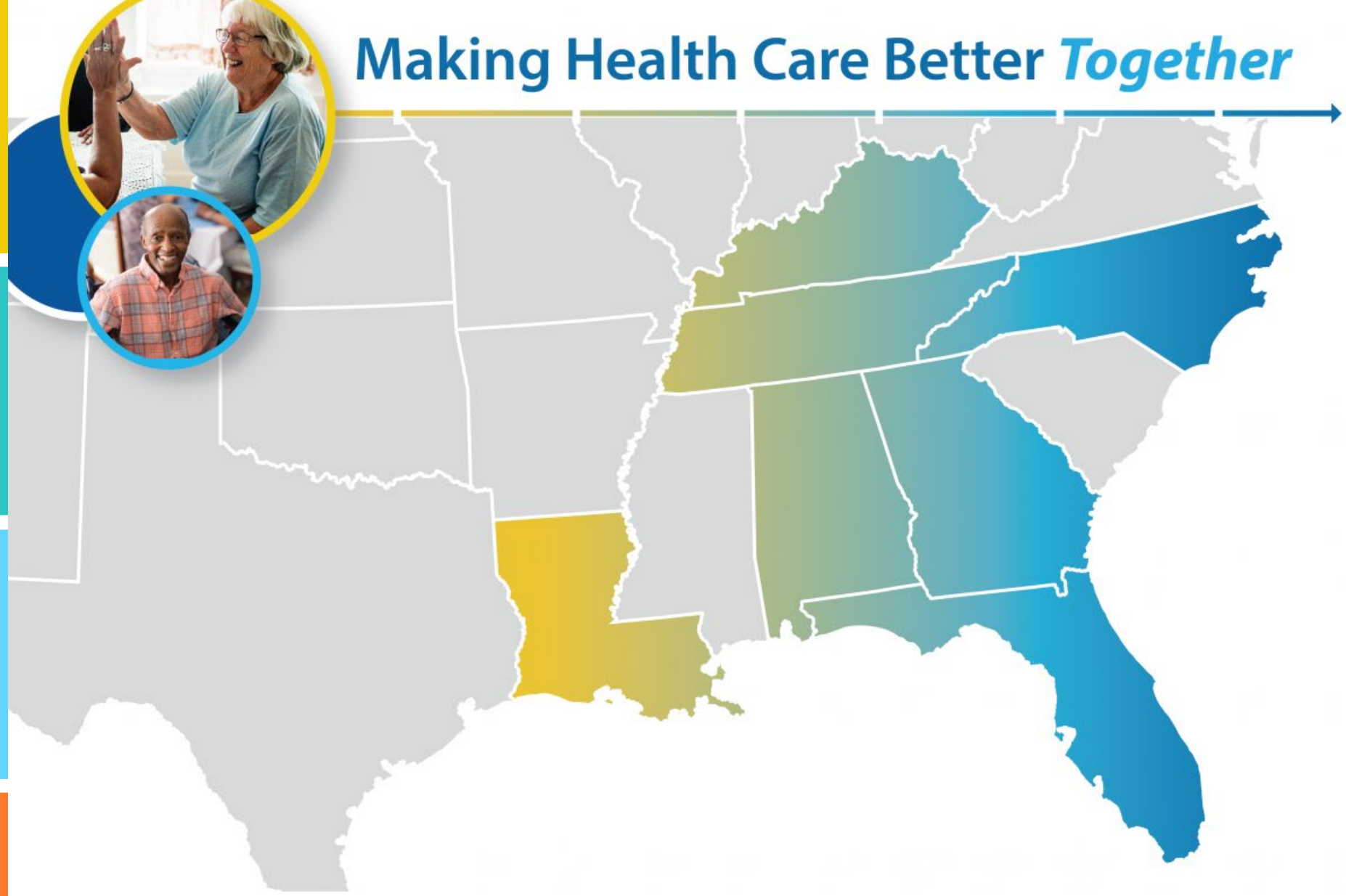

About Alliant Health Solutions

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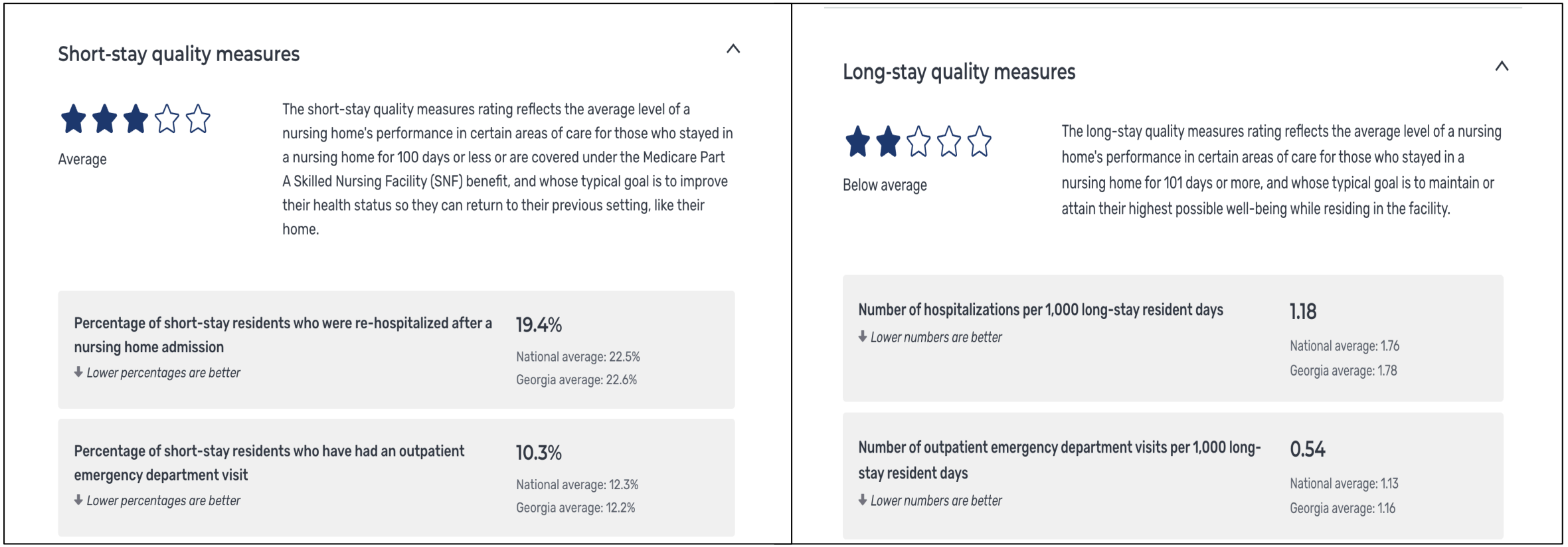
Learning Objectives

- ✓ Understand facility admission and readmission data.
- ✓ Analyze readmission data to prioritize interventions.
- ✓ Learn how to operationalize improvement.

Understand Facility Admission and Readmission Data



Short-stay quality measures

Average

The short-stay quality measures rating reflects the average level of a nursing home's performance in certain areas of care for those who stayed in a nursing home for 100 days or less or are covered under the Medicare Part A Skilled Nursing Facility (SNF) benefit, and whose typical goal is to improve their health status so they can return to their previous setting, like their home.

Percentage of short-stay residents who were re-hospitalized after a nursing home admission
Lower percentages are better
19.4%
National average: 22.5%
Georgia average: 22.6%

Percentage of short-stay residents who have had an outpatient emergency department visit
Lower percentages are better
10.3%
National average: 12.3%
Georgia average: 12.2%

Long-stay quality measures

Below average

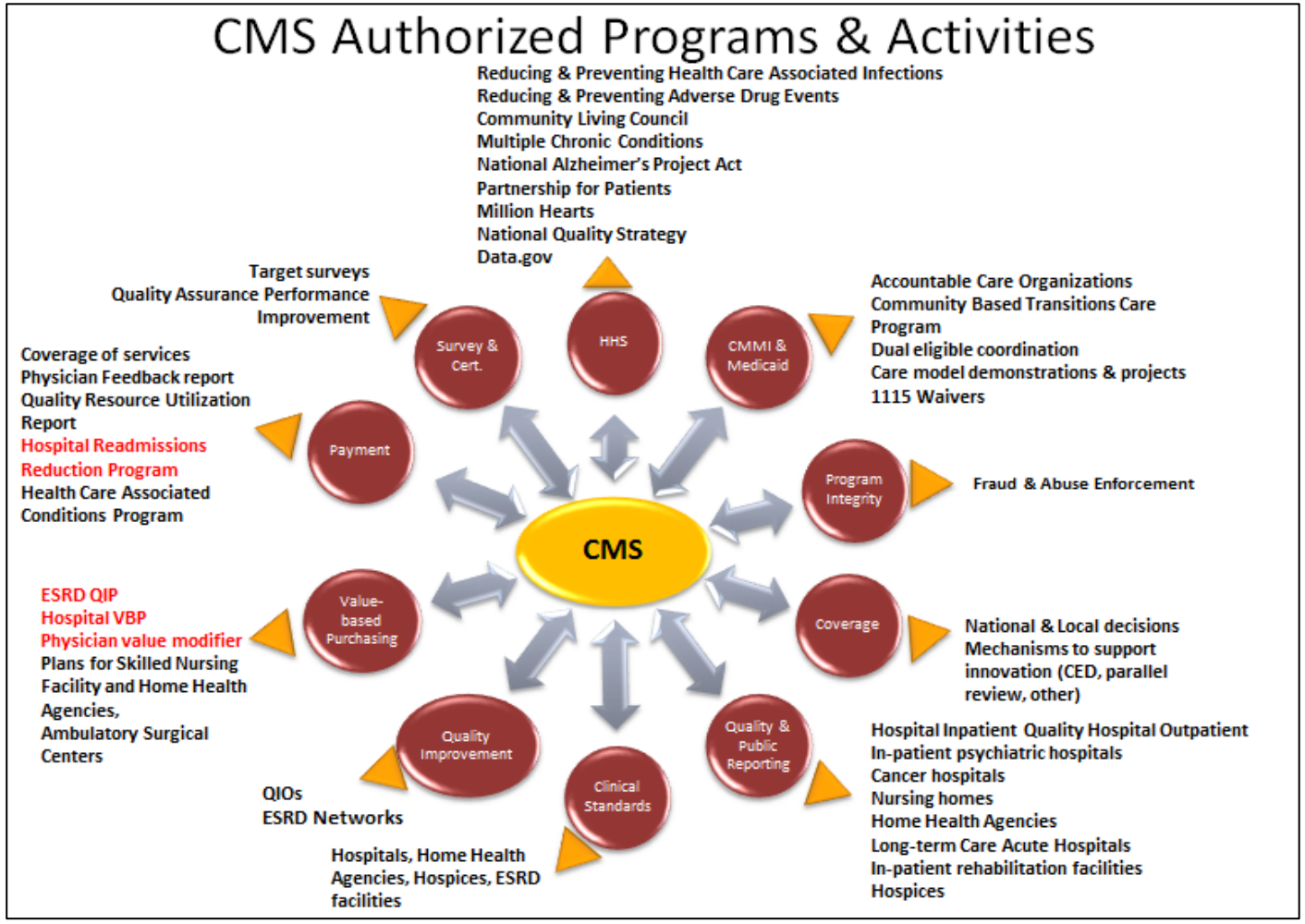
The long-stay quality measures rating reflects the average level of a nursing home's performance in certain areas of care for those who stayed in a nursing home for 101 days or more, and whose typical goal is to maintain or attain their highest possible well-being while residing in the facility.

Number of hospitalizations per 1,000 long-stay resident days
Lower numbers are better
1.18
National average: 1.76
Georgia average: 1.78

Number of outpatient emergency department visits per 1,000 long-stay resident days
Lower numbers are better
0.54
National average: 1.13
Georgia average: 1.16

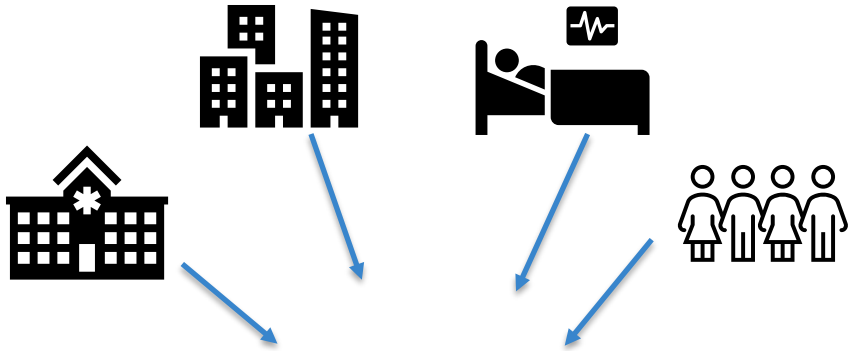
[Find Healthcare Providers: Compare Care Near You | Medicare]

Quality Initiatives



CMS Authorized Programs and Activities

Why Should We Care?



Quality Care

QRP measure

Care Compare

Census

VBP measure

Bonus/ Penalties

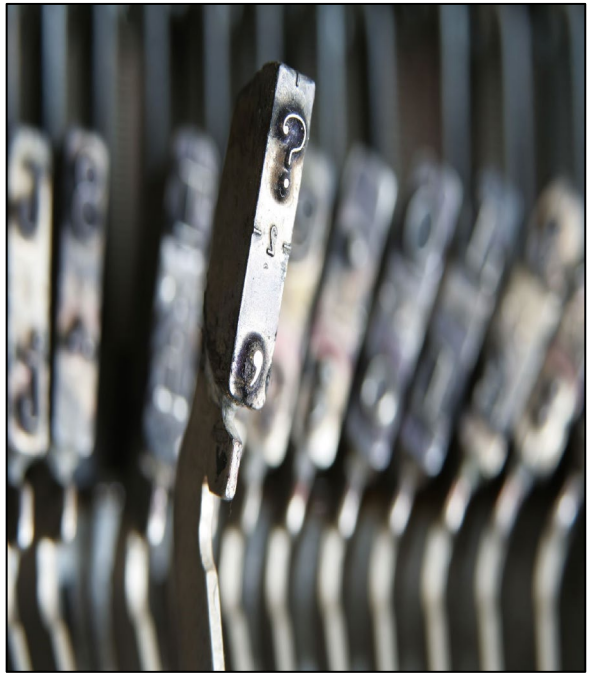
Financial Stability

The SNF VBP Program Hospital Readmission Measure

Program Year	Baseline Period	Performance Period
FY 2019*	CY 2015 (1/1/2015-12/31/2015)	CY 2017 (1/1/2017-12/31/2017)
FY 2020	FY 2016 (10/1/2015-9/30/2016)	FY 2018 (10/1/2017-9/30/2018)
FY 2021	FY 2017 (10/1/2016-9/30/2017)	FY 2019 (10/1/2018-9/30/2019)
FY 2022	FY 2018 (10/1/2017-9/30/2018)	4/1/2019-12/1/2019**
FY 2023	FY 2019 (10/1/2018-9/30/2019)	FY 2021 (10/1/2020-9/30/2021)
FY 2024***	FY 2019 (10/1/2018-9/30/2019)	FY 2022 (10/1/2021-9/30/2022)
FY 2025***	FY 2019 (10/1/2018-9/30/2019)	FY 2023 (10/1/2022-9/30/2023)
FY 2026	FY 2022 (10/1/2021-9/30/2022)	FY 2024 (10/1/2023-9/30/2024)
FY 2027	FY 2023 (10/1/2022-9/30/2023)	FY 2025 (10/1/2024-9/30/2025)

SNF VBP Program Hospital Readmission

Measure and Link to Technical Report	FY 2024 Program Year	FY 2025 Program Year	FY 2026 Program Year	FY 2027 Program Year	FY 2028 Program Year
SNFRM	Yes	Yes	Yes	Yes	-
Skilled Nursing Facility Healthcare-Associated Infections (SNF HAI) Requiring Hospitalization	-	-	Yes	Yes	Yes
Total Nurse Staffing Hours per Resident Day (including Registered Nurse [RN], Licensed Practical Nurse	-	-	Yes	Yes	Yes
[LPN], and Nurse Aide hours)					
Discharge to Community — Post-Acute Care (DTC-PAC) Measure for SNFs	-	-	-	Yes	Yes
Percent of Residents Experiencing One or More Falls with Major Injury (Long-Stay)	-	-	-	Yes	Yes
Discharge Function Score for SNFs	-	-	-	Yes	Yes
Number of Hospitalizations per 1,000 Long Stay Resident Days	-	-	-	Yes	Yes
Skilled Nursing Facility Within-Stay Potentially Preventable Readmission (SNF WS PPR) Measure	-	-	-	-	Yes

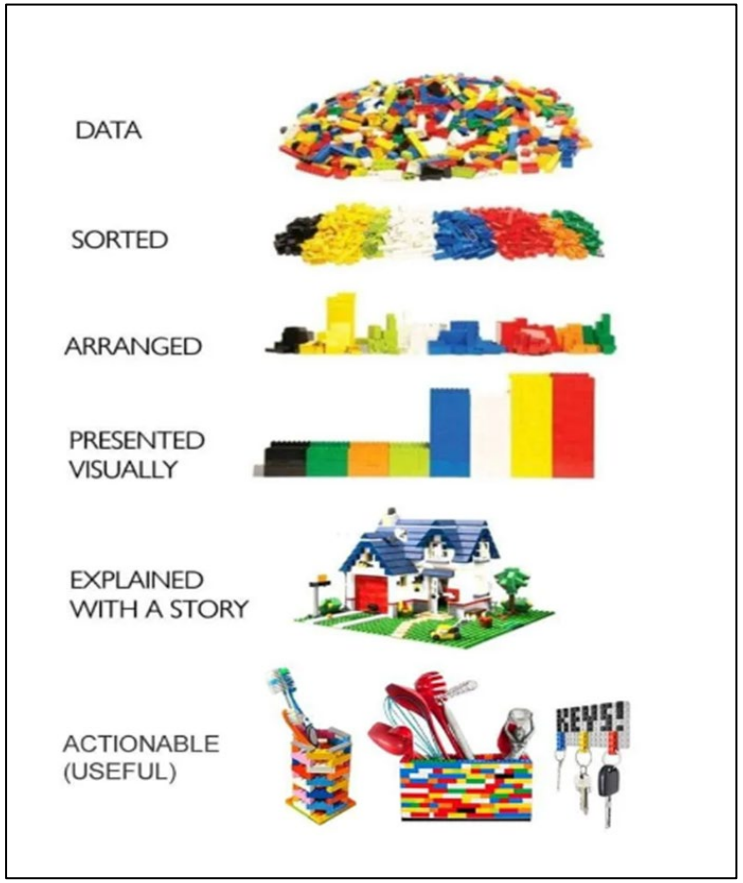


Future Expansion of the SNF VBP Program

SNF VBP Program

Decision Points

- What data to collect?
- Who collects the data?
- How often will you observe data?
- How do you make sense of data?

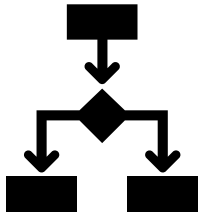


[Stanford University Lego Data Story]

What Is Your Data Telling You and Where Do You Start?

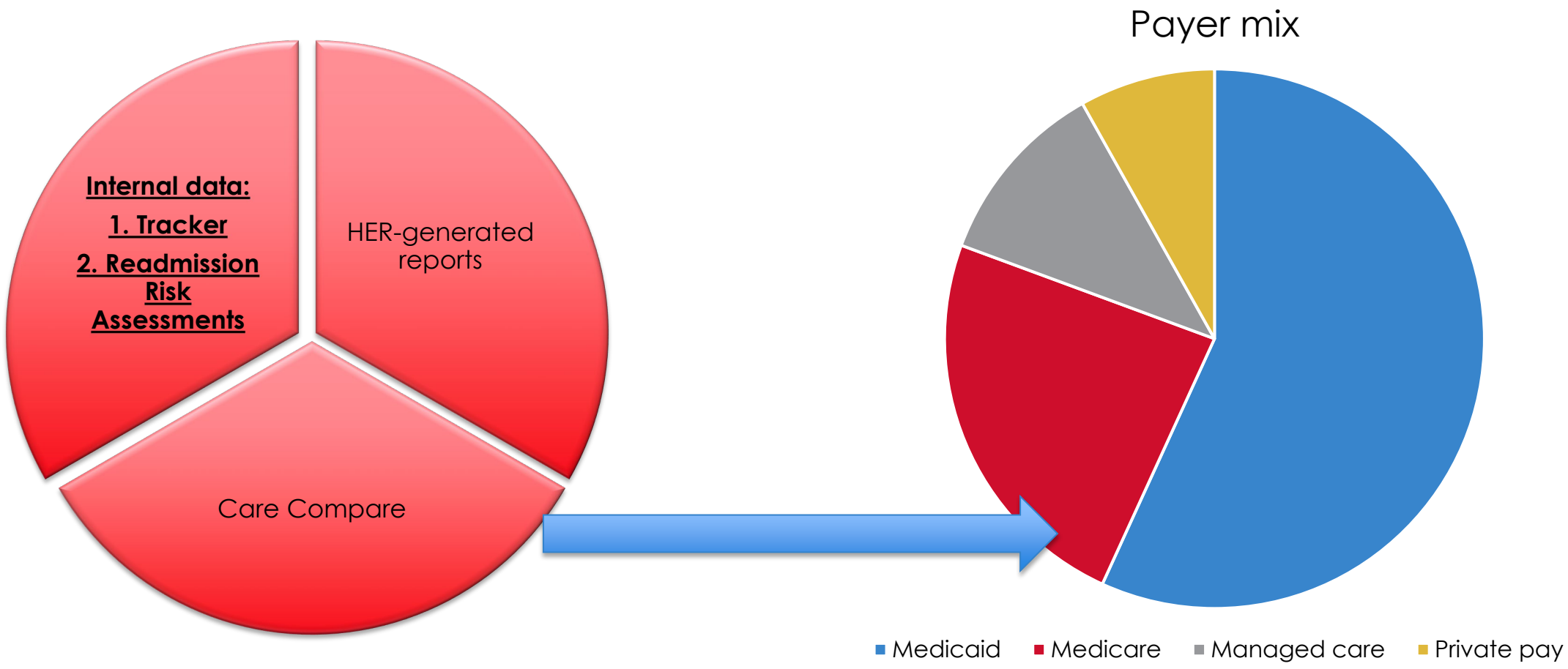
- People and process approach:

- Who will meet?
- Who will get the data?
- Who will get the background for the case discussion?
- Who will determine priority interventions?
- Who will implement?



- How often will they meet?
- What data?
- How will they do RCA?
- How will we determine priority?
- What protocols to implement?

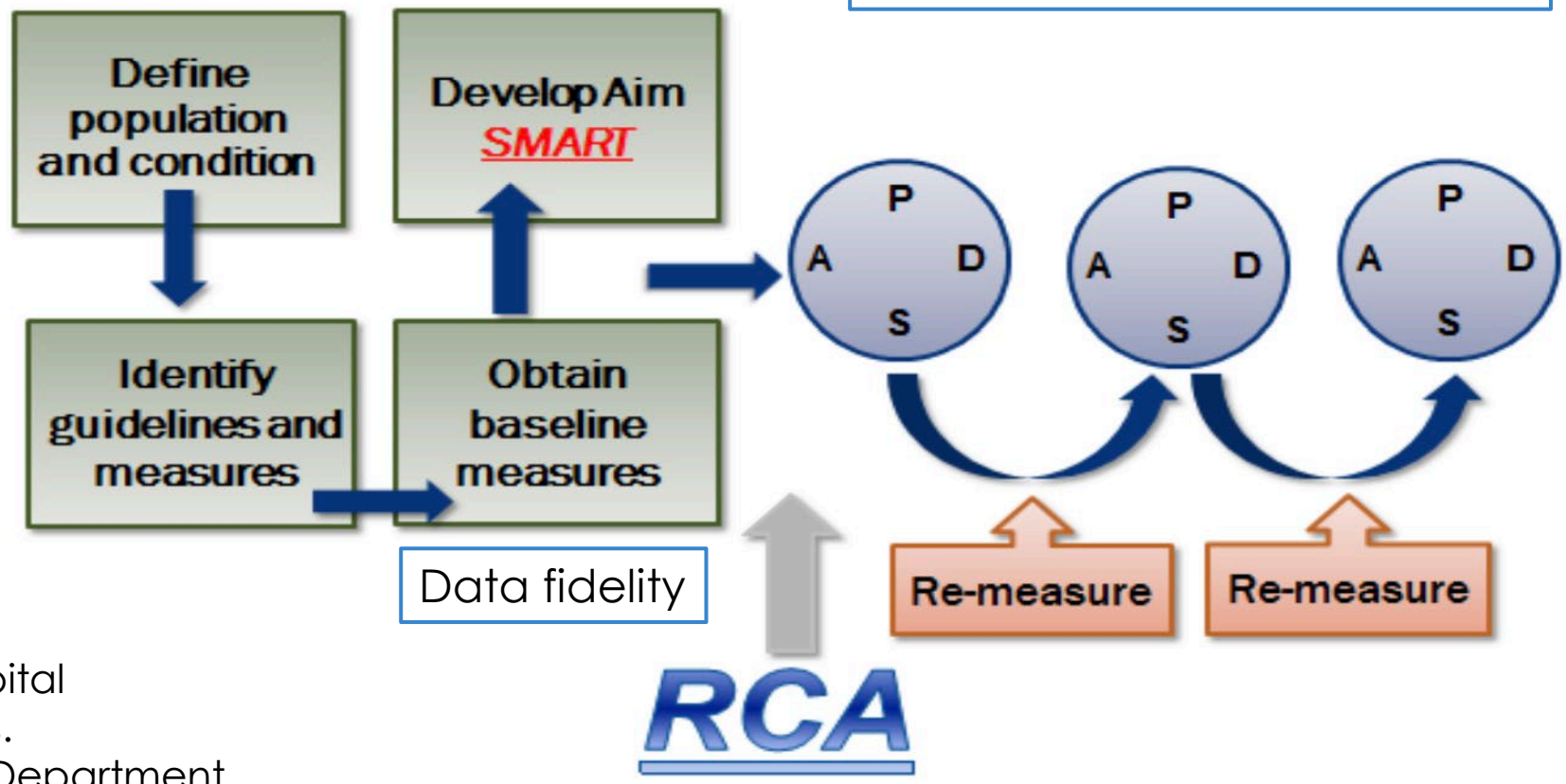
Data Sources and Dashboards: What's in Your Toolkit?



Project Flow

Medicare admission
vs.
All admissions

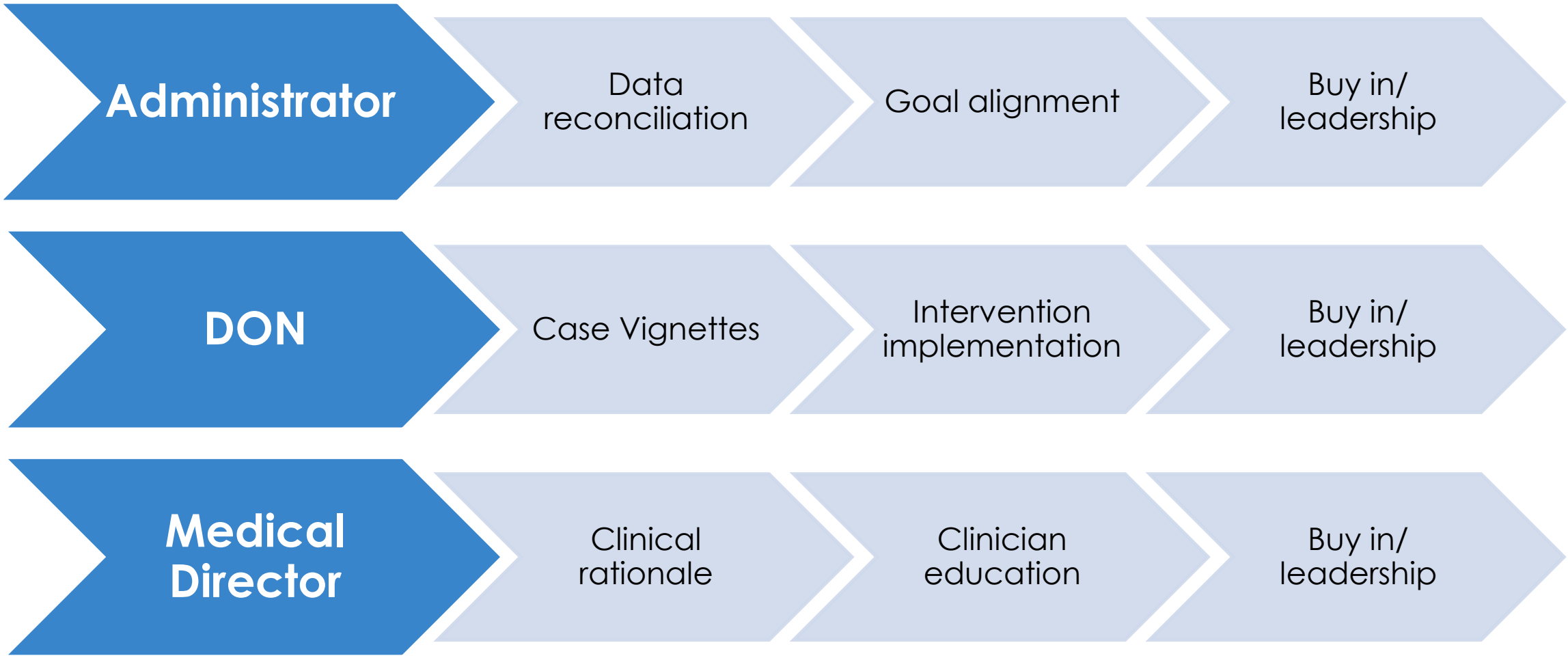
From 19 to ? in XXX months.

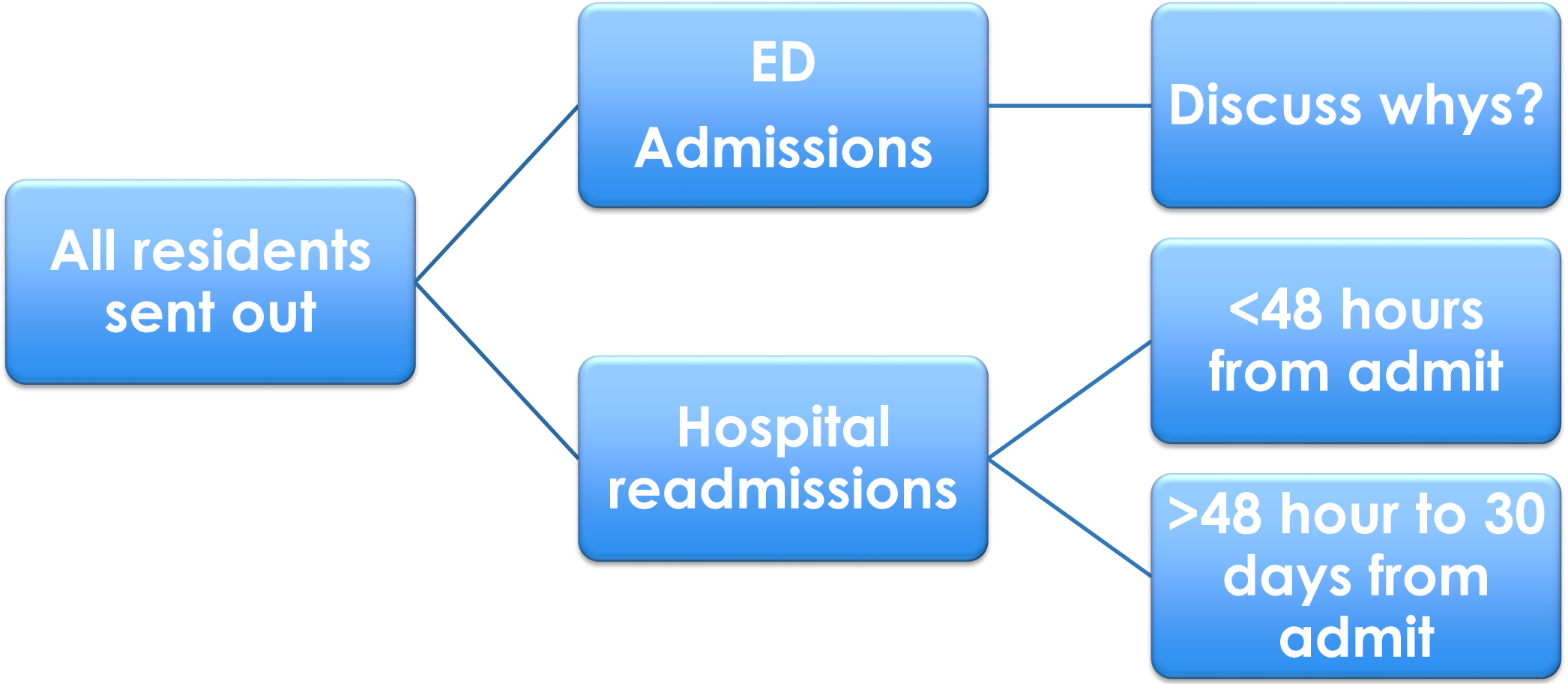


Hospital
vs.
Emergency Department
Admissions

https://quality.allianthealth.org/wp-content/uploads/2020/02/QI-Workbook-Final-Version_2.pdf

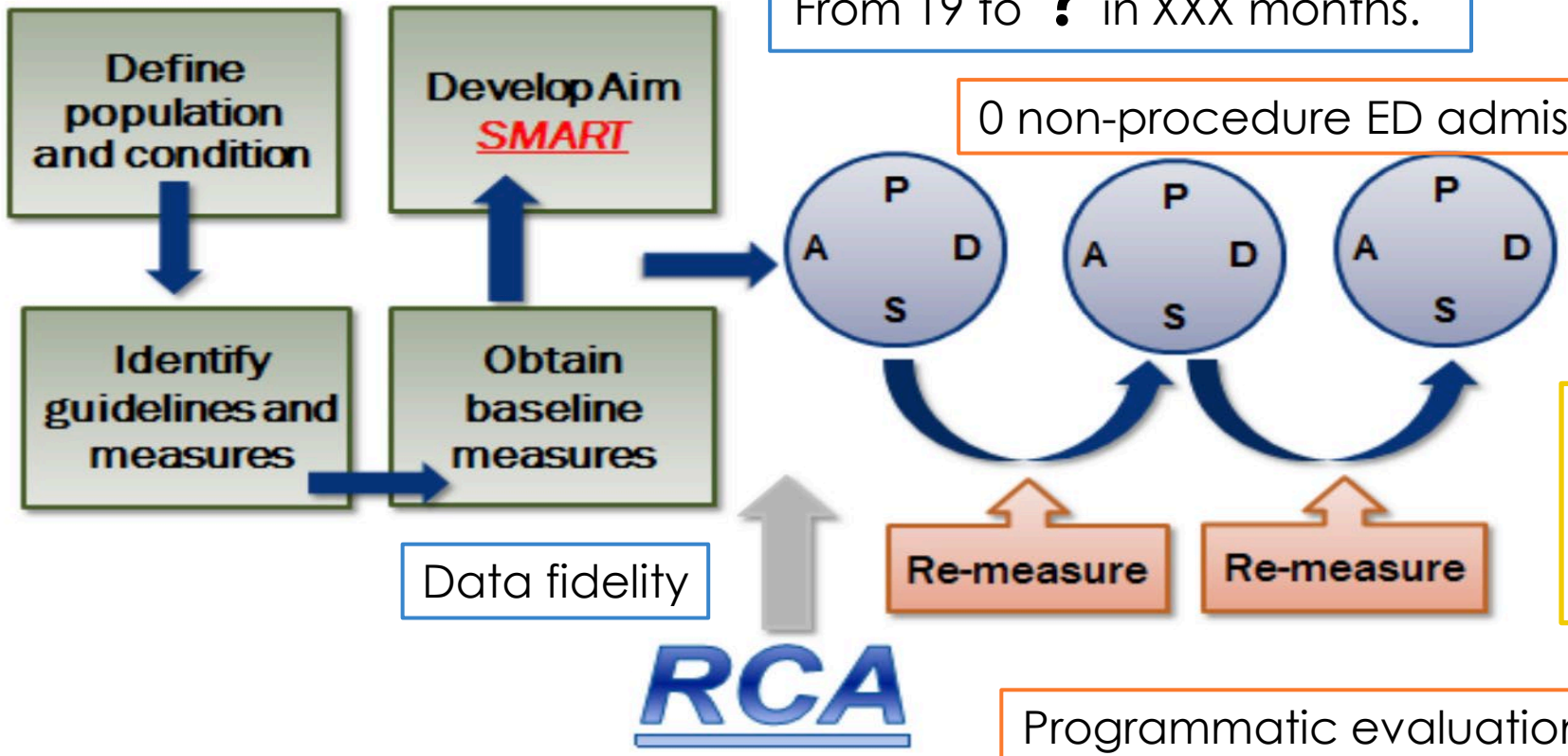
Readmission Team: Leadership Triad




All residents sent out
ED Admissions
Discuss whys?
Hospital readmissions
<48 hours from admit
>48 hour to 30 days from admit

Project Flow

Medicare admission vs. All admissions



From 19 to ? in XXX months.

0 non-procedure ED admissions

Change in how we measure data

Hospital vs. Emergency Department admissions

Data fidelity

Programmatic evaluation
Clinical evaluation

https://quality.allianthealth.org/wp-content/uploads/2020/02/QI-Workbook-Final-Version_2.pdf

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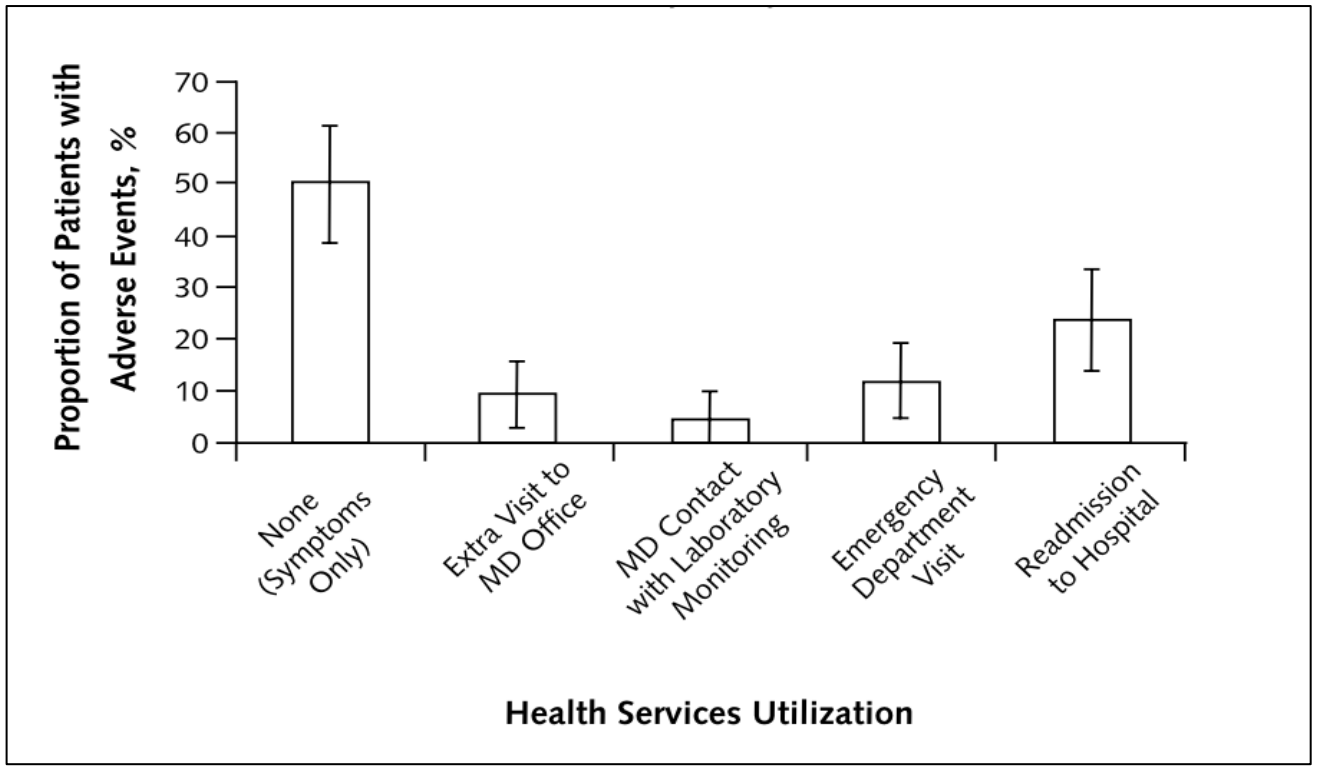
Annals of Internal Medicine

ARTICLE

The Incidence and Severity of Adverse Events Affecting Patients after Discharge from the Hospital

Alan J. Forster, MD, FRCPC, MSc; Harvey J. Murff, MD; Josh F. Peterson, MD; Tejal K. Gandhi, MD, MPH; and David W. Bates, MD, MSc



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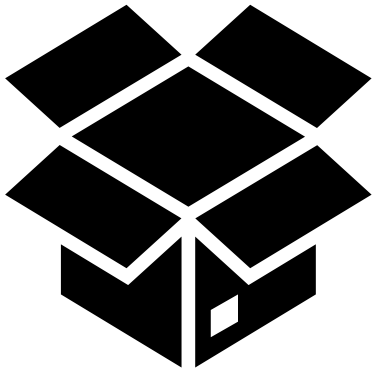
Emergency Department Admissions

- Timeliness of assessment
- Incomplete assessment
- Inter-shift handoff
- Early clinician outreach
- Communication style to family
- Capability of stat labs
- +/- Telehealth

The Root Cause

- Transition of Care
- Congestive Heart Failure
- Sepsis



Questions?

Nursing Home and Partnership for Community Health:
CMS 12th SOW GOALS

OPIOID UTILIZATION AND MISUSE

Promote opioid best practices

•

Reduce opioid adverse drug events in all settings

PATIENT SAFETY

Reduce hospitalizations due to c. diff

•

Reduce adverse drug events

•

Reduce facility acquired infections

CHRONIC DISEASE SELF-MANAGEMENT

Increase instances of adequately diagnosed and controlled hypertension

•

Increase use of cardiac rehabilitation programs

•

Reduce instances of uncontrolled diabetes

•

Identify patients at high-risk for kidney disease and improve outcomes

CARE COORDINATION

Convene community coalitions

•

Reduce avoidable readmissions, admissions to hospitals and preventable emergency department visits

•

Identify and promote optimal care for super utilizers

COVID-19

Support nursing homes by establishing a safe visitor policy and cohort plan

•

Provide virtual events to support infection control and prevention

•

Support nursing homes and community coalitions with emergency preparedness plans

IMMUNIZATION

Increase influenza, pneumococcal, and COVID-19 vaccination rates

TRAINING

Encourage completion of infection control and prevention trainings by front line clinical and management staff

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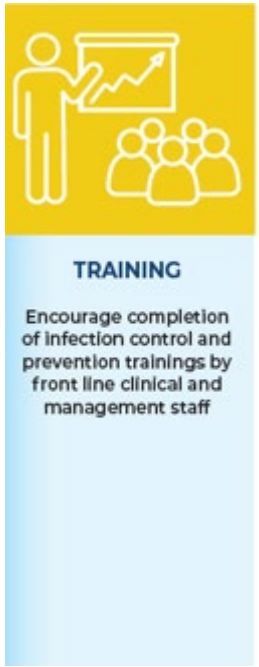
Scan the QR codes or Click the Links to Complete the Assessments!

CMS requested Alliant Health Solutions, your QIN-QIO, to work with select nursing homes to understand emerging healthcare needs in nursing homes. Alliant Health Solutions is engaging nursing home leadership in this key area to ensure plans are in place to achieve and maintain health quality and equity!

Please scan the QR code below and complete the assessment.



Nursing Home Infection Prevention (NHIP) Initiative Training Assessment

https://bit.ly/NHIPAssessment

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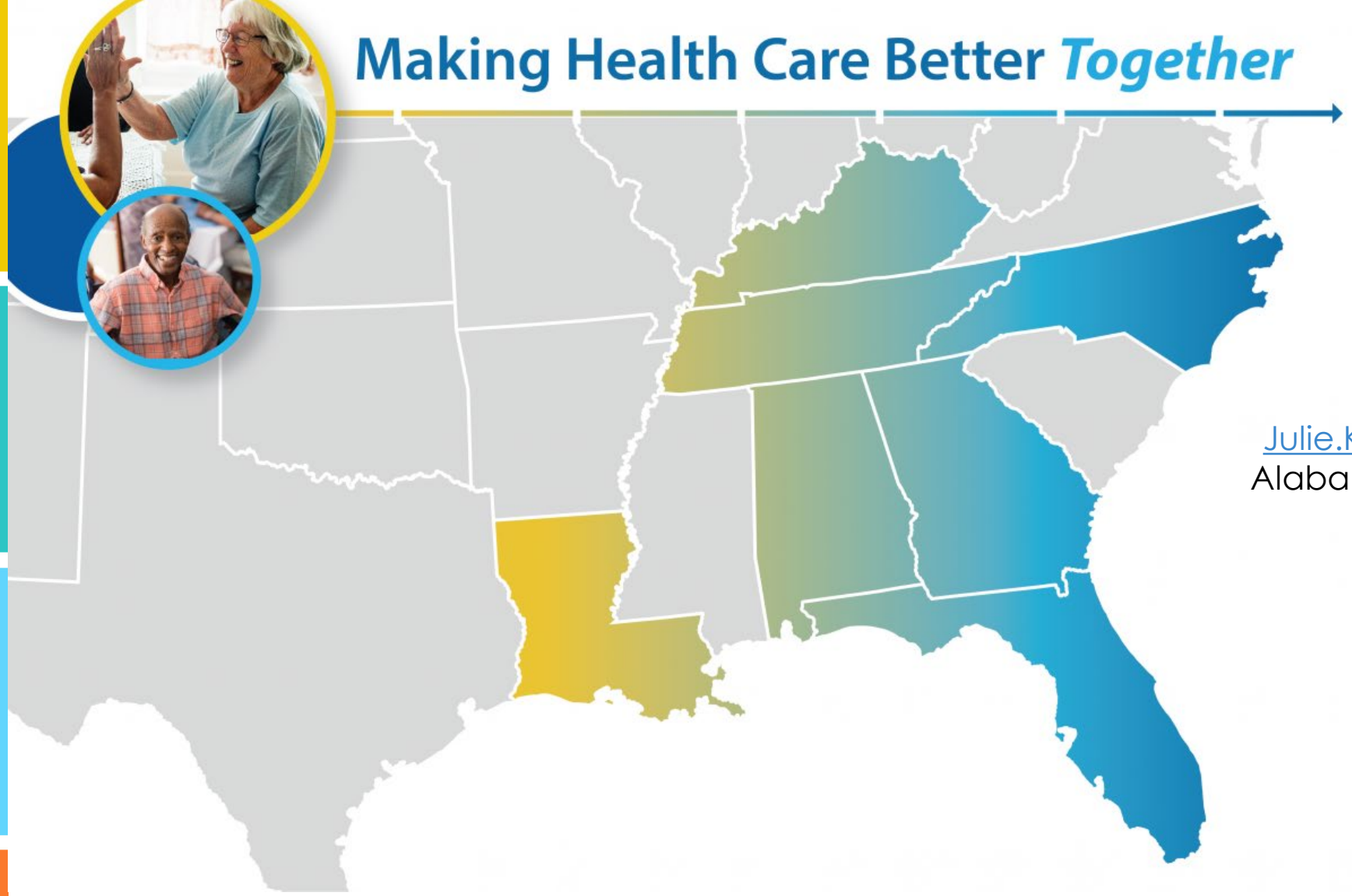

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