Simplifying the Readmission Puzzle

Presented by
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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 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.

Email: adaly@ipro.org
About Alliant Health Solutions
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**

- 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.

<table>
<thead>
<tr>
<th>Percentage of short-stay residents who were re-hospitalized after a nursing home admission</th>
<th>19.4%</th>
</tr>
</thead>
<tbody>
<tr>
<td>National average: 22.5%</td>
<td></td>
</tr>
<tr>
<td>Georgia average: 22.6%</td>
<td></td>
</tr>
<tr>
<td>Lower percentages are better</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Percentage of short-stay residents who have had an outpatient emergency department visit</th>
<th>10.3%</th>
</tr>
</thead>
<tbody>
<tr>
<td>National average: 12.3%</td>
<td></td>
</tr>
<tr>
<td>Georgia average: 12.2%</td>
<td></td>
</tr>
<tr>
<td>Lower percentages are better</td>
<td></td>
</tr>
</tbody>
</table>

**Long-stay quality measures**

- 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.

<table>
<thead>
<tr>
<th>Number of hospitalizations per 1,000 long-stay resident days</th>
<th>1.18</th>
</tr>
</thead>
<tbody>
<tr>
<td>National average: 1.76</td>
<td></td>
</tr>
<tr>
<td>Georgia average: 1.78</td>
<td></td>
</tr>
<tr>
<td>Lower numbers are better</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of outpatient emergency department visits per 1,000 long-stay resident days</th>
<th>0.54</th>
</tr>
</thead>
<tbody>
<tr>
<td>National average: 1.13</td>
<td></td>
</tr>
<tr>
<td>Georgia average: 1.16</td>
<td></td>
</tr>
<tr>
<td>Lower numbers are better</td>
<td></td>
</tr>
</tbody>
</table>

Find Healthcare Providers: Compare Care Near You | Medicare
Quality Initiatives

CMS Authorized Programs & Activities

- Reducing & Preventing Health Care Associated Infections
- Reducing & Preventing Adverse Drug Events
- Community Living Council
- Multiple Chronic Conditions
- National Alzheimer’s Project Act
- Partnership for Patients
- Million Hearts
- National Quality Strategy

- Accountable Care Organizations
- Community Based Transitions Care Program
- Dual eligible coordination
- Care model demonstrations & projects
- 1115 Waivers

Target survey
Quality Assurance
Performance Improvement

Coverage of services
Physician Feedback Report
Quality Resource Utilization Report
Hospital Readmissions Reduction Program
Health Care Associated Conditions Program

ESRD QIP
Hospital VBP
Physician value modifier
Plans for Skilled Nursing Facility and Home Health Agencies
Ambulatory Surgical Centers

QIOs, ESRD Networks
Hospitals, Home Health Agencies, Hospices, ESRD facilities

Alliant Health Solutions

CMS

Quality Improvement
Clinical Standards
Quality & Public Reporting

Payment
Survey & OAS

Program Integrity
Fraud & Abuse Enforcement

National & Local decisions
Mechanisms to support innovation (CED, parallel review, other)

Hospital Inpatient Quality Hospital Outpatient Inpatient Psychiatric Hospitals
Cancer Hospitals
Nursing Homes
Home Health Agencies
Long-term Care Facilities
Inpatient Rehabilitation Facilities
Hospices
Why Should We Care?

- QRP measure
- Care Compare
- Census
- VBP measure
- Bonus/Penalties
- Financial Stability

Quality Care

Care

Census

Financial Stability

Quality Care

Why Should We Care?
## The SNF VBP Program Hospital Readmission Measure

<table>
<thead>
<tr>
<th>Program Year</th>
<th>Baseline Period</th>
<th>Performance Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 2019*</td>
<td>CY 2015 (1/1/2015-12/31/2015)</td>
<td>CY 2017 (1/1/2017-12/31/2017)</td>
</tr>
<tr>
<td>FY 2020</td>
<td>FY 2016 (10/1/2015-9/30/2016)</td>
<td>FY 2018 (10/1/2017-9/30/2018)</td>
</tr>
<tr>
<td>FY 2022</td>
<td>FY 2018 (10/1/2017-9/30/2018)</td>
<td>4/1/2019-12/1/2019**</td>
</tr>
<tr>
<td>FY 2024***</td>
<td>FY 2019 (10/1/2018-9/30/2019)</td>
<td>FY 2022 (10/1/2021-9/30/2022)</td>
</tr>
<tr>
<td>FY 2026</td>
<td>FY 2022 (10/1/2021-9/30/2022)</td>
<td>FY 2024 (10/1/2023-9/30/2024)</td>
</tr>
<tr>
<td>FY 2027</td>
<td>FY 2023 (10/1/2022-9/30/2023)</td>
<td>FY 2025 (10/1/2024-9/30/2025)</td>
</tr>
<tr>
<td>Measure and Link to Technical Report</td>
<td>FY 2024 Program Year</td>
<td>FY 2025 Program Year</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>----------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>SNFRM</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Skilled Nursing Facility Healthcare-Associated Infections (SNF HAI) Requiring Hospitalization</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total Nurse Staffing Hours per Resident Day (including Registered Nurse [RN], Licensed Practical Nurse [LPN], and Nurse Aide hours)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Discharge to Community — Post-Acute Care (DTC-PAC) Measure for SNFs</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Percent of Residents Experiencing One or More Falls with Major Injury (Long-Stay)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Discharge Function Score for SNFs</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Number of Hospitalizations per 1,000 Long Stay Resident Days</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Skilled Nursing Facility Within-Stay Potentially Preventable Readmission (SNF WS PPR) Measure</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
Decision Points

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

Internal data:
1. Tracker
2. Readmission Risk Assessments

HER-generated reports

Care Compare

Payer mix

- Medicaid
- Medicare
- Managed care
- Private pay
Medicare admission vs. All admissions

Hospital vs. Emergency Department Admissions

Data fidelity

From 19 to ? in XXX months.
Readmission Team: Leadership Triad

**Administrator**
- Data reconciliation
- Goal alignment
- Buy in/leadership

**DON**
- Case Vignettes
- Intervention implementation
- Buy in/leadership

**Medical Director**
- Clinical rationale
- Clinician education
- Buy in/leadership
All residents sent out

ED Admissions

Discuss whys?

Hospital readmissions

<48 hours from admit

>48 hour to 30 days from admit
Medicare admission vs. All admissions

Hospital vs. Emergency Department admissions

Data fidelity

From 19 to ? in XXX months.

0 non-procedure ED admissions

Programmatic evaluation
Clinical evaluation

Change in how we measure data

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
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
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

Making Health Care Better *Together*

Program Directors

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