

LeadingAge

Team Collaboration to Support Optimal Transitions

What if

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What if

Today's Objectives

- Understand the Impact Of-
 - Safe Transitions
 - Unplanned Hospital Readmissions
- Strategies to Reduce Unplanned Readmissions
 - Palliative Care & Advance Directives
 - Addressing Functional Impairment
 - Health Literacy
 - Patient/Caregiver Engagement
 - Follow Up Care
- Practical Take Aways

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What if

Safe Transitions Result In:

- Improved patient experience
- Improved patient engagement and adherence to treatment plan
- Improved adherence to treatment plan
- Prevention of unplanned hospital readmissions
- Shorter LOS
- Decreased overall cost of care

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What if 

'Transfer Trauma'

This term was coined in the early 1960s when gerontologists first became concerned that *involuntary relocation* of the elderly—either from private residences to institutions or from one institution to another resulted in poor outcomes such as

- Relocation Stress
- Anger
- Depression
- Decline in cognitive and physical function
- Social and Psychological effects that can hasten death

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What if 

Readmissions: Impact on quality and revenue

The Protecting Access to Medicare Act of 2014 (PAMA) impacted changes to the SNF reimbursement rate

- began in October, 2018


SNFs receive a quarterly performance score based on

- individual performance
- achievement/comparison to other SNFs in the country






SNFs will either receive a payment incentive or a reduction - based on their performance

- SNFs with the highest rankings receive the highest incentive payments
- SNFs with a zero or low ranking will receive the lowest incentive payments

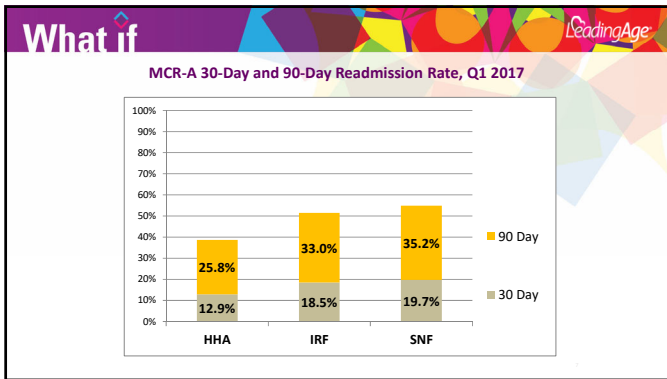
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What if 

The Numbers

-  CMS is withholding 2% of Medicare payments to SNFs and will redistribute 50-70% of the withhold back into to SNFs via the incentive payments.
-  CMS will keep the balance - 30-50% savings to Medicare!
-  The vast majority of skilled nursing facilities will face a penalty on their Medicare payments for fiscal year 2019 for poor 30-day readmission rates (the bottom 40% performers)
-  Of the 14,959 skilled nursing facilities subject to CMS' Skilled Nursing Facility Value-based Purchasing Program, 73% received a penalty and 27% received a bonus payment (2015-2017 data comparison)
-  The Patient Driven Payment Model (PDPM) which goes into effect fiscal year 2020 replaces the FFS model and will decrease reimbursement even more over the course of the patient's stay depending on their reason for admission

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What if

Planned Readmissions

- Bone marrow, kidney, or other transplants
- Maintenance chemotherapy
- Rehabilitation
- Pregnancy diagnoses and procedures such as normal pregnancy, Cesarean section, forceps delivery, vacuum, and breech
- Readmissions to psychiatric hospitals or units
- CMS' Table of potential planned readmissions

The principal diagnosis and all of the procedure codes from a readmission are used to identify planned readmissions- if an acute diagnosis is present, even for a planned procedure, the readmission is considered unplanned

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What if

30 Day Window

The 30-day readmission rate is the 30-day window after a patient is discharged from a hospital and admitted to a SNF. The SNF is still on the hook for a readmission penalty even if the patient is discharged before the 30 days are over

➔

Be proactive to get your patient back quickly!

➔

Optimal transitions matter!

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What if LeadingAge

Strategies to Reduce Unplanned Readmissions and Improve Transitions of Care

WE SPEND A LOT OF TIME
DESIGNING THE BRIDGE,
BUT NOT ENOUGH TIME
THINKING ABOUT THE PEOPLE
WHO ARE CROSSING IT.

DR. PRADEEPT SINGH

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Palliative Care

Curative care is directed at healing or curing a disease, like taking an antibiotic for a urinary tract infection.

Palliative care involves providing care that helps relieve symptoms, but does not cure or treat the cause of a disease.

Understanding this, helps us as nurses, communicate with our patients about disease management.

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Advance Directives

Examples: Living Will, Power of Attorney, POLST or MOLST enable the physician to include details about what treatments not to use, under what conditions certain treatments can be used, how long treatments may be used, and when treatments should be withdrawn. Issues covered in advance directives may include:

- Resuscitation
- Mechanical ventilation
- Tube feeding
- Use of antibiotics
- Requests not to transfer to an emergency room
- Requests not to be admitted to the hospital
- Pain management

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Impact of Functional Impairment

Functional impairment is associated with an increased risk of 30-day, all-cause hospital readmissions in aging individuals, especially those admitted for heart failure, myocardial infarction or pneumonia.

The most functionally-impaired patients were 42% more likely to be readmitted compared to those with no impairments

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National Transitions of Care Coalition 7 Essential Interventions

Medication Management Transition Planning Patient and Caregiver Education & Engagement Information Transfer Follow up Care Healthcare Provider Engagement Shared Accountability Across Providers and Organizations

<http://www.ntccc.org/Home/About/55/Default.aspx>

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Impact of the Physical Therapist

Readmission rates are 3 times higher if physical therapist discharge recommendations are replaced with less intensive interventions- only 55% of DC summaries include these recommendations

Few discharge planning processes include a therapy handoff

Only 19% of DC summaries include information about functional abilities

Older adults who discharge home with unmet needs for assistance with ADLs have a 66% higher readmission rate than those with the same functional level whose needs were addressed prior to discharge

Non-homebound patients must have information and access to community outpatient therapy if care plan goals not met

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Impact of the Occupational Therapist

- Address medication non-adherence through medication labs
- Identify problems with medication management; dexterity, vision, understanding of medication schedule, health literacy, etc.
- Bring insight into the patient's discharge needs and help prevent unsafe discharges related to inability to perform ADLs
- Coordinate training sessions with patient and caregiver prior to discharge
- Identify and address functional limitations and environmental hazards to prevent falls through a pre-discharge home assessment
- Encourage participation in activities to promote community reintegration

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Impact of the Speech Therapist

Studies have shown that LOS is > in patients who do not participate in goal setting	<ul style="list-style-type: none"> • related to impaired ability to communicate
Cognitive Impairment Identification	<ul style="list-style-type: none"> • Health Literacy, ability to understand and follow prescribed treatment plan & problem solve- must involve caregiver early in stay • Teach back-implications for the care team in transition planning and patient engagement
Speech/Aphasia/Language Barriers	<ul style="list-style-type: none"> • Methods for contacting emergency help • Teach alternative methods of communication aids to patient and caregiver. • Referrals to social supports to help prevent isolation • Assess & recommend need for interpretive services
Swallowing Defects and Potential Problems	<ul style="list-style-type: none"> • Prevent aspiration pneumonia • Provide education on proper swallowing techniques • Patient teaching to prevent dehydration due to fear of swallowing liquids

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Health Literacy

What does Health Literacy Mean to you?

Patient Experience
<http://www.ashd.edu/health/health-literacy/>

Assessment Tools

Documentation & Care Planning

Teach Back

Health literacy is the ability to obtain, read, understand, and use healthcare information in order to make appropriate health decisions and follow instructions for treatment.

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Recognizing Health Illiteracy

- Assessment Tools*; REALM, SAHL, etc.
- Frequently missed appointments
- Incomplete registration forms
- Non-adherence with medications
- Inability to name medications, explain purpose or dosing
- Identifies pills by looking at them, not reading label
- Unable to give coherent, sequential history
- Asks fewer questions
- Lack of follow-through on tests or referrals

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Short Assessment of Health Literacy*

This is a list of 18 words of varying difficulty that are used in the test. Patients are presented with the words in the order listed in the table below.

Word	Related	Distractor	Score
1. kidney	...renal	...knee	...10th
2. vaccination	...vaccine	...vaccination	...10th
3. medications	...medication	...medication	...10th
4. antibiotics	...antibiotic	...antibiotic	...10th
5. menstruation	...menstruate	...menstruate	...10th
6. infection	...infect	...infect	...10th
7. circulation	...circulate	...circulate	...10th
8. pronunciation	...pronounce	...pronounce	...10th
9. exercise	...exercise	...exercise	...10th
10. stool	...stool	...stool	...10th
11. behavior	...behavior	...behavior	...10th
12. anemia	...anemia	...anemia	...10th
13. jaundice	...jaundice	...jaundice	...10th
14. exercise	...exercise	...exercise	...10th
15. menstruation	...menstruate	...menstruate	...10th
16. infection	...infect	...infect	...10th
17. kidney	...renal	...knee	...10th
18. vaccination	...vaccine	...vaccination	...10th

Patients are presented with 18 test terms.

Each key word has both a related meaning and a distractor word unrelated in meaning to the test term.

This tests the patient's comprehension as well as pronunciation of common health-related terms. The test takes only 2-3 minutes and requires minimal training.

Patients are considered to have inadequate health literacy if they score < 14.

*This information is for illustrative purposes only; complete instructions for use and permission to use the assessment tool are required- available at: <https://www.ahrq.gov>

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REALM Assessment Tool*

Behavior
Menopause
Antibiotics
Jaundice

Exercise
Rectal
Anemia

The patient scores one point for each word they correctly read aloud.

A score < 7 indicates an 8th grade level or less ability to read and interpret health information and additional clinical interventions are indicated

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Patient & Caregiver Education and Engagement

Nursing

- Patient centered teaching techniques
- Assess readiness to learn
- Identify social determinants of health
- Provide disease management education
- Review Yellow & Red Zones
- Provide a written easy to understand discharge plan
- Provide a written easy to understand medication plan

Therapist

- Assess patient's health literacy
- Assess patient's understanding of home modifications
- Educate re: risks associated with functional decline
- Provide written illustrated home exercises
- Promote community integration
- Provide resources for communication disorders
- Ensure understanding of medication regime

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Long Wait to Continue Care

Primary Care Follow-Up Critical to Long-Term Patient Outcomes

3 Week Wait Time for Primary Care

20.3 Days National average wait time for a new patient primary care appointment

Relationship Between Physician Follow-Up, 90-Day Readmissions

Low-Risk Elder Adult Sample, Home Discharge
N = 325

Follow-up Status	Annual health expenditures per person \$10,000 greater
With Follow-up Visit	22%
Without Follow-up Visit	52%

The Advisory Board

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Follow Up Care

Nurse's Role

- Confirm patient is established with a PCP
- Confirmation of and/or schedule follow-up appointments
- Confirm patient's understanding of required follow up care
- Confirm HH Clinician available to see patient within 24 hrs. of discharge
- Ensure patient has access & means to obtain medications
- Ensure patient understands who to call when
- Teach self management
- Provide warm handoffs to the receiving provider
- Follow up call post discharge

Therapist's Role

- Utilize a standardized handoff tool-
- Promote patient engagement and self management
- Provide therapist provider continuity of care from hospital to home
- Confirm patient's understanding of required follow up care
- Early engagement of caregiver training to ensure support
- Provide information to patient on how to obtain rehabilitation therapy post discharge
- Confirm outpatient therapy scheduled if no HHS

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Take Aways to Reduce Readmissions

- Warm Handoffs, discipline specific
- Schedule follow up appointment(s)
- Post discharge follow up calls
- Post discharge availability
- Medication teaching, consider a discharge educator role
- Easy to read written/illustrative discharge instructions
- Consider Palliative Care referrals for patients with chronic non- curative illnesses
- Advance Directives; patients may prefer 'DNH'
- Readmission workgroup, physician led
- Mindset that all patients will likely benefit from home health services or outpatient therapy
- Approach all patients with universal precautions mindset re: Health Literacy
- Develop preferred provider networks for HHS, OP, etc.
- Readmit directly to the SNF
- Weekend discharges- ensure thorough clinical oversight
- If patient is rehospitalized while a patient at the SNF, take proactive measures to return patient quickly

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The word cloud features 'thank you' in multiple languages: English (thank you, thanks, thank), Spanish (gracias, gracias), German (danke, danke), Japanese (thank you), Indonesian (terima kasih), and others. The word 'thank you' is the largest and most prominent.

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