eQuipping for Quality: Steps to Measure Up!

The AHCA/NCAL Quality Initiative

Why is this Important?

Hospital readmissions impacts elderly individuals physically, emotionally, and psychologically by placing them at an increased risk for medical complications, infection, and reduced physical functioning. Hospital readmission puts skilled nursing center residents at risk for iatrogenic problems such as functional decline, falls, delirium, polypharmacy, pressure ulcers, hospital-acquired infections, and others. According to Medicare Payment Advisory Commission (MedPAC) data, nursing home residents with diagnoses such as CHF, respiratory infections, urinary tract infections, and sepsis and electrolyte imbalances account for more than 70% of potentially avoidable 30-day readmissions.

Hospital readmission within 30 days of discharge cost Medicare over eighteen billion dollars[1] for preventable care that could be realized thru improvements in hospital and post-acute care services. Based on US National Health Expenditure projections, if not addressed, unaltered 30-day readmission spending will grow to an excess of $28 billion annually.

Research has shown that many readmissions can be avoided by improving coordination of care during the transition from one health care setting to another, especially during this time when elderly individuals may be more vulnerable to post-acute care complications. Improvement in readmission rates results in better provider-patient and provider-provider communication, strengthened services for high risk elderly, enhanced engagement of staff in their daily care giving, more timely coordination of follow-up care, increased customer satisfaction with the experience of care, and positively impacts the centers revenue stream.

Best Practices:

- Incorporate the INTERACT III system into daily operations to reduce hospital readmissions. This easy to implement system is designed to focus on early identification of acute and sub-acute changes in medical condition(s) of residents and implementation of interventions in the LTC center to prevent unnecessary readmission. INTERACT III is available at no cost and includes tools, instructions for use, and educational materials.
- Conduct a 72-hour post admission care conference with each new resident and family to introduce the patient to the care delivery team and set goals for a successful discharge to build trust and acceptance. During their stay, conduct weekly “bed side care conferences” to deliver progress reports towards discharge goals.
- Educate staff about resident-level and system-level factors that contribute to 30-day readmissions.

$18 billion represents 2.0% of hospital and 11.9% of nursing home spending in 2012

- Resident-level factors can include multiple comorbidities, decline in physical and cognitive function, and health behaviors that are incongruent with the prescribed regimen.
- System-level factors can include ineffective communication and lack of care coordination between health care professionals as an individual transitions from one health care setting to another.

- Train staff to identify disease processes and corresponding symptoms. Leadership should identify those diagnoses, or medical conditions that are the primary cause for readmissions, and design specific education for direct care givers that focuses on early detection of clinical changes and rapid intervention.
- Adopt disease-specific or generic intervention programs that may result in high readmission rates (e.g. CHF, Heart Failure, COPD) for early detection of exacerbations and steps to prevent readmission based on the resident population and institutional/provider factors.
- Identify your largest referral and readmission source and collaborate with them to determine reasons for readmission and identify joint quality improvement steps to address those issues. Creating open communication lines and developing a close working relationship with acute care providers provides important information and feedback to incorporate into quality improvement projects.
- Have pharmacies and providers jointly review all orders before delivery to the SNF.
- Provide patient education on primary and co-morbid conditions with a special focus on medication administration post-discharge. Conduct post discharge follow up calls with residents, making sure to address medication administration during one of the calls.

Tools:

- AHCA Hospital Readmission Resource Website: Free member resources.
- INTERACT III: Free evidence-based program that includes a complete package of easily implemented clinical, educational, communication, and improvement tools specifically designed for nursing centers.
- Readmission Causes & Prevention Strategies Template

Measure Up/Follow Up:

- Task your QAPI team to conduct a monthly review of all readmissions to determine causes and identify avoidable readmissions. Findings should be used to identify opportunities, strengthen education, determine what processes worked best, and determine next steps or course of action.
- LTC Trend Tracker: Use of this web based system, free to AHCA members, allows individual centers to measure readmission data, track, and trend their performance on a customized dashboard and celebrate success!

- Meet with your largest referral source/readmission hospital(s) on a regularly scheduled basis to validate data outcomes and review readmissions and identify points of opportunity (discharge information, early detection of acute changes, and communication with physicians) and action plans to address opportunities.

More on the Topic:

- Contact your local QIO
- Project Boost (Better Outcomes by Optimizing Safe Transitions)
- Agency for Healthcare Research and Quality (AHRQ)
- Advancing Excellence Campaign

DISCLAIMER: The AHCA/NCAL quality programs' contents, including their goals and standards, represent some preferred practices, but do not represent minimum standards or expected norms for skilled nursing and/or assisted living providers. As always, the provider is responsible for making clinical decisions and providing care that is best for each individual person.