Finalizing Room Preparations
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Webinar Series
Reduce Your Hospital Readmissions Through a Resident-Centered Approach
June 15, 2018

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Today's Speaker

Diane Sanders-Cepeda, DO CMD
Geriatrician and Certified Medical Director
Geriatric & Family Care Center of South Florida, PA

Bob Murphy
Administrator
Whispering Oaks
REDUCING READMISSIONS & AVOIDING HOSPITALIZATIONS

A Resident-Centered Approach to Reducing Readmissions & Avoiding Hospitalizations in Post-Acute/Long Term Care Facilities

Diane Sanders-Cepeda, DO CMD
Senior Medical Director
United Retiree Solutions
Geriatric Medicine, Board Certified
Family Medicine, Board Certified
Certified Medical Director

Guide to avoiding the Hospital Merry Go Round
Objectives & Goals

• Review CMS initiatives targeting readmissions and potentially avoidable hospitalizations
• Discuss Challenges and approaches to resident-centered reduction in readmissions and hospitalizations
• Discuss Best Practices and strategies to incorporate the facility's Medical Director in driving resident-centered approaches

THE IMPACT OF REDUCING AVOIDABLE ADMISSIONS ON U.S. HOSPITALS

- Potentially avoidable admissions are 24% of all admissions for most hospitals.
- These avoidable admissions cost $16.5 million annually, with a median cost of $23,555 per admission.

Important Dates and Timeline

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
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<tbody>
<tr>
<td>Jan 2016 - Dec 2015</td>
<td>Initial implementation of CMS VBP program</td>
</tr>
<tr>
<td>Oct 2016</td>
<td>SNF VBP reporting and payment participation</td>
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<tr>
<td>Feb 2017</td>
<td>SNF VBP reporting and payment participation</td>
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<tr>
<td>Nov 2017</td>
<td>SNF VBP reporting and payment participation</td>
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<tr>
<td>Aug 2018</td>
<td>MDS 3.0 specifications</td>
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<tr>
<td>Oct 2017</td>
<td>SNF VBP reporting and payment participation</td>
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Oct 1, 2018
Medicare cuts go into effect

ACHA/NACL 2018
CMS identified that potentially avoidable hospitalizations were higher in the most vulnerable population.

Most Vulnerable population identified as dually eligible Medicare and Medicaid beneficiaries living in long term care facilities also known as LTC Duals.

CMS Potentially Avoidable Conditions:
- Bacterial Pneumonia
- UTI
- CHF
- Dehydration
- COPD
- Skin Ulcers
In 2010, PAH rate was at 227 per 1000 beneficiaries.
In 2015, PAH rate was at 157 per 1000.
Reduced rate of potentially avoidable hospitalization over five years means that 133,000 hospitalizations were avoided.

Potentially Avoidable Hospitalization Rates for Dual-Eligible Beneficiaries Living in Long-Term Care Facilities, by State
CMS Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents 2012

- Collaboration between the CMS Innovation Center and CMS Medicare-Medicaid Coordination office

- CMS partnered with Enhanced Care and Coordination organizations in 7 states
  - ECCPs partnered with LTC facilities
  - First phase – demonstrated improved care, lowered cost, and reduced avoidable hospitalization

How do we achieve Resident-Centered Care in the Nursing Facility?
Resident-Centered Care is Individualized Care

Best Practice Opportunity

Quality vs. Quantity
What is the Patient’s Journey through your Nursing Facility?

Points of Impact in Care Planning

BEST PRACTICE OPPORTUNITY

Impacting and Individualizing Care – where are our opportunities?

- Chronic disease management
  - Disease Trajectory
  - Contingency Planning
  - Palliative Care

- Advance Care Planning
  - Goals of Care
  - Identify Patient Preferences
  - Advance Directives, POLST discussions

- Transitions of Care
  - Initial Admission
  - Discharge Planning
  - Transitions to Home
The goal is to anticipate what the resident will need in case of changes or declines in condition.

Plan should be clearly documented with intention to execute an official order if and when patient’s condition changes.
Palliative Care Interventions

Palliative care interventions should begin with the onset of disease.

Advance Care Planning

- Goals of Care discussions
- Patient Preference Identification
- Advance Directives, POLST discussions

Transitions of Care

Initial Admission
- Complete Medication Review, Reconciliation and Evaluation is needed with each transition

Discharge Planning
- Needs to be proactive
- Prep for Patient’s medications, DME, and additional rehab needs

Transitioning to Home –
- If patient is being discharged from the facility
- What is the patient’s social structure?
- Is their environment safe?
- Can they afford to pick up their medications?
Working with your Medical Director to achieve best outcomes

Clinical Case Review

In Conclusion
Hospitalization Prevention Program

The Journey of Whispering Oaks

Bob Murphy, NHA
Administrator
AHCA/NCAL Quality Award Senior Examiner

Whispering Oaks

- Located in urban area of Tampa, FL
- Located close to local hospitals
- Stand-alone, non-profit facility
- Worked with HSMC to avoid unnecessary rehospitalizations
- AHCA/NCAL National Quality Award Silver recipient
The Journey

- We started to track hospitalizations in 2012 by patient, hospital, date, physician, and diagnosis
- Physicians are notified when patients were returned within 72 hours
- Educating nurses that it is easier to treat patients in house rather than discharge/readmit from the hospital and that we take all of our residents back
- Educating physicians that the nursing staff can effectively treat patients in house
- Pushing direct care RN nurse hours to 50% of daily nurse staffing
- Communicate daily with the hospital post-acute managers to manage care in the acute setting

The Journey

- More follow up is required after SNF discharge to home, phone calls at 3/2/20 days
- Most of our physicians now have 5 day/week visits/coverage
- Full review and assessment of patient needs upon admission, especially medications
- We use consistent assignments for both nursing and housekeeping to recognize changes quicker
- We introduce our palliative care program to all residents and families upon admission
- Patient Ping looks like it will be a good tool for post-acute/SNF management

Systematic Processes in Place

- Daily nursing meeting to review prior days 24-hour reports
- Weekly Medicare meeting to review the status of all post-acute patients
- Weekly Standards of Care/At Risk meeting to review potential complications and implement appropriate interventions to prevent hospital admits and readmits
**Systematic Processes in Place**

In-House Protocols (excluding 911 conditions):
- Charge nurse assesses resident using SBAR
- Charge nurse calls the RN house supervisor to discuss the assessment
- House super has the option of calling the nurse administrator on call and most times they do
- Utilize eSNF (Telemed Program) or attending physician consultation
- Family notification

**Applying Baldrige Framework of Performance Excellence**

- **Leadership**: make sure your team is following facility policies and protocols
- Review strategic plan monthly to better manage hospital admits and readmits
- Talk to your patients and families to determine advanced directive criteria and keep them engaged in the post-hospital process
- Measure and monitor post-acute discharges and compare your data to your competitors
- Keep your staff educated and keep your turnover to a minimum
- Talk to your staff to improve your work processes through learning circles or staff meetings

**Questions**

If we are unable to get to everyone’s questions this morning, we’ll compile a Q&A document that will be on FHCA’s Website.

Thank you for attending today’s webinar.