The ABC’s of Admission Management to Avoid Unnecessary Rehospitalizations

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Today’s Speakers

Robin Bleier
RB Health Partners, Inc.

Robin Allen
Consulate Health Care

Peggy Norris
Signature HealthCARE, LLC

The ABC’s of Admission Management to Avoid Unnecessary Rehospitalization
Objectives:
During this brief webinar we will include:
1. Articulate the role of the Facility Assessment related to the admission process
2. Brief on the value of the pre-admission process
3. Consider four elements of key clinical management

Facility Assessment Purpose
The purpose of the assessment is to determine what resources are necessary to care for residents competently during both the day-to-day operations and emergencies.

The assessment may be used to make decisions about your capabilities to provide services to the residents in your facility.

Facility Assessment Requirement
The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies.
Facility Assessment Flexibility

CMS has documented that they believe that each facility needs to have the flexibility to decide the best way to conduct their individual facility assessment as long as it addresses or includes the specified factors or items as set forth in our next slide.

Facility Assessment Key Components

There are three key components of the Facility Assessment:

- Section 483.70(e)(1), the facility's resident population
- Section 483.70(e)(2), the facility's resources
- Section 483.70(e)(3), a facility-based and community-based risk assessment utilizing an all-hazards approach

Competency-Based Approach

Using a competency-based approach focuses on ensuring that each resident is provided care that allows the resident to maintain or attain their highest practicable physical, mental, and psychosocial well-being.
Application Related to the Admission Process

The facility assessment is to support that the facility uses a process to evaluate its resident population and identify the resources needed to provide the necessary person-centered care and services the residents require.

Generalities Facility Assessment Tools

This is broken into three pieces for easy review:

The first part is the resident profile.

This includes numbers, diseases/conditions, physical and cognitive disabilities, acuity, and ethnic/cultural/religious factors that impact care.

Facility Assessment Tool Generalities

The second part of most facility assessment tools focuses on services and care offered based on resident needs.

Thus you would anticipate it includes types of care your resident population requires. The focus is not to include individual level care plans in the facility assessment.
Facility Assessment Tool Generalities

Typically the third part of such tools includes the facility resources needed to provide competent care for residents.

This would normally include items such as: numbers of staff, staffing plan, staff competencies, education and training, physical environment and building needs, and other resources, including agreements with third parties, health information technology resources and systems, a facility-based and community-based risk assessment, and any other information that you may choose to include.

Proactive Approach …

The facility assessment considerations is best applied as a proactive approach completed during the pre-admission process unless there is an unforeseen change in status there should be few resident status surprises with a pre-admission process in place.

Robin Allen
Pre-Admission Preparation

Important Considerations:

• Who is reviewing the potential admission?
• How is the potential admission screened for admission?
• Who makes the final decision and based on what information?

Pre-Admission Preparation

Review of Hospital Records:

I. Ensure all records for the Patient are provided (H&P; Labs; Psych Evaluations; Discharge Summaries, etc.)

II. What is the Patient's hospital length of stay; what is the readmission pattern; are there noted previous and recent SNF stays?

Pre-Admission Considerations

Interview

Family Member or Patient if 'Own Decision Maker'

Trauma Informed Care

Durable Medical Equipment

Advanced Directives

Begin 'Realistic Expectation Setting' Process

• Smoking
• Grievance Process
• Meds at bedside

LOA

Physician visitation

Discharge goals
Pre-Admission Considerations

Prior Living Arrangement

• LIVED ALONE (Self neglect)
• ILF (Independent Living Facility [with select services])
• ALF (Memory Care Unit)
• SNF (Why not returning?)
• Homeless

Pre-Admission Considerations

Social History

• ETOH/IV Drugs/Opioid Use
• Quibbling Siblings/Family Matters
• Legal Concerns/Sexual Predator, etc.

Pre-Admission Considerations

Risk History

• Violence
• Suicide/Homicide
• Wandering/Elopement
• Falls/Wounds/Other Key Clinical Concerns
• Involuntary Mental Health Admission / Baker Act
Pre-Admission Assessment Considerations

Demographics
Basic Medical History (Hospice)
Insurances / Finances / Payment
Medicaid Level of Care Assessment
Resident Representative / Health Care Decision Maker
Family and Support System
Language and Communication Ability
Medication List and Pharmacy Cost Estimate
Durable Medical Equipment
MDS Info

History of Falls
Skin Condition
Cognitive Functioning
Level of Dementia Care Required
Emotional and Psychiatric Needs
Behavior Concerns
Substance Abuse
Prior Living Arrangements
Discharge Plans
Physical Assistance Needs

Value of the Pre-admission Process

As we know, once we accept an admission, we are obligated unless the resident meets one of the approved rationales for discharge with an appropriate receiving facility to keep the resident unless an emergency discharge is indicated.

The pre-admission period is key to appropriate evaluate a referred individual to see if the facility can meet their needs in accordance to the Facility Assessment.

Peggy Norris
4 ELEMENTS OF KEY CLINICAL MANAGEMENT

- ADMISSION ASSESSMENT PROCESS
- IDENTIFICATION OF HIGH RISK
- COMMUNICATION & IDT REVIEW
- IMPLEMENTATION OF A QUALITY IMPROVEMENT FRAMEWORK

Reducing readmissions in skilled nursing facilities (SNFs) is a top priority for the Centers for Medicare & Medicaid Services (CMS). Research shows that more than 20 percent of Medicare beneficiaries discharged from a hospital to a SNF will return to a hospital within 30 days, costing Medicare more than $4 billion per year. These returns are often due to potentially preventable conditions, such as dehydration, infections, medication errors, and unaddressed social needs.

Nationally, readmissions cost Medicare $26 billion dollars annually, of which $17 billion are potentially avoidable.

https://www.hsag.com/care-coord-tools
SKILLED NURSING FACULTY CARE COORDINATION TOOLKIT www.hsg.com/care-coord-tools

- An overview of care coordination best practices to avert hospital readmissions
- Measures & practices aimed at preventing readmissions. Readmissions play a vital role in quality measures.
- Are you doing quality ranking for at least the first 7 days? Is upper management involved? Are nurses proficient in clinical assessment skills? How do you educate your staff members? Are you using SBAR (situation, background, assessment, recommendations)? SBAR is available in the Internal Tools, are you using SBAR or equivalent system to ensure proper/informed communication? This change of condition notification is essential to regulatory compliance.
- The SNFRM is the measure used to evaluate SNFs in the SNF VBP Program. The program ties portions of SNF payments to their performance on this measure, which is calculated by assessing the risk-standardized rate of all-cause, unplanned hospital readmissions for Medicare fee-for-service SNF patients within 30 days of discharge from a prior hospitalization. Below are the top 10 things you should know about the SNFRM.

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- The SNFRM includes all unplanned readmissions. Unplanned admissions are identified using a modified version of the OASIS History Readmissions Algorithm. Additional information on the measure's calculations may be found on the SNF VBP Program's website at https://www.cms.gov/Medicare/Quality-Programs/SNFRM/downloads/PIPCharterWkshtdebedits.pdf.
- Provides a summary of the unique circumstances that are excluded from SNF RM criteria. Understanding the exclusion criteria will improve the accuracy of your internal data tracking and help determine the financial impact of the SNF RM.
- Step-by-step instructions on how to access your CASPER report. This report provides data that may affect your facility's standing regarding value-based purchasing. Tracking and trending these data will help ensure there are no surprises when the penalties are determined.

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- Reducing Readmissions Preparation Program Nursing Home Readmission Assessment (Pre-Pub)
- An assessment tool to evaluate what prevention elements your organization has or does not have in place to help reduce readmissions. An assessment provides a measure of your organization's current performance and provides direction toward processes that can be leveraged for improvement.
- QAPI Worksheet to Create a Performance Improvement Project (PIP) Sample
- A completed sample PIP related to improving accuracy of assessment of patient acuity at admissions to reduce readmissions. Knowing where to get started with improvement projects can feel overwhelming. This sample PIP is available for adoption or to help guide your efforts as you complete your own PIP.
- Strategy Tree to Address Challenges
- The strategy tree sample outlines possible tactics and tools to be implemented to successfully complete the PIP related to improving accuracy of assessment of patient acuity. Often, the strength of an intervention is determined by how well it is executed. This tool helps ensure strong strategic development and implementation of interventions.

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FOR POTENTIALLY AVOIDABLE RETURN TO HOSPITAL (RTH)

- Maintain thorough documented assessment of resident with clinical & interdisciplinary team review to establish a 48hr baseline care plan and further develop a comprehensive care plan to meet the individual needs of the resident and provide person centered care.
- Provide accurate reconciliation of medications for home meds - hospital & discharge admission/readmission with physician.
- Establish consistent early identification of change in condition with notification of physician for evaluation and treatment utilizing facility resources before critical decline requiring transfer.
- Staff education and facility focus for early identification & management of "early sepsis".
- Improvement of advance care planning process to include palliative or hospice care to avoid futile hospital care at the end of life.
- Utilizing clinical practice guidelines, decision support tools such as: the intervention to reduce acute care transfers (INTERACT) program (over 25 quality improvement, communication, decision support and advance care planning tools available and free for use in clinical practice and education).
- Implementation of a quality improvement framework and QAPI process to proactively manage acute changes in condition, tracking root cause for RTH, identifying trends & measures to avoid return to hospital.

United by Medicare's

The Infections—including

TAKEAWAYS

- Sepsis is one of the most deadly conditions in the United States, with about 250,000 fatalities annually.
- The estimated annual cost of sepsis readmissions is more than $3.5 billion, recent research indicates.
- Infections—including sepsis—are the leading cause of sepsis readmissions, the researchers found.

The annual estimated cost of sepsis readmissions is about half the annual cost of all four of the conditions in Medicare's Hospital Readmissions Reduction Program, recent research shows.

"In our study, the estimated annual cost of sepsis readmissions amounted to more than $3.5 billion within the United States. When compared to $7.2 billion for the four conditions (AMI, CHF, COPD and pneumonia) targeted by the Hospital Readmissions Reduction Program (HRRP), this accounts for a significant under-recognized burden on the U.S. healthcare system," the researchers wrote in the journal CHEST.

A NOTE ON SEPSIS & HOSPITAL READMISSIONS

At national level, the annual cost of index admissions for sepsis are estimated at more than $23.3 billion.

Key Takeaways

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HIGH RISK IDENTIFIED

Interdisciplinary team review during daily clinical review & at-risk reviews to develop comprehensive care plan with goals & approaches for the high risk resident and reduce potential for return to hospital.

- History of falls or high risk for falls.
- High co-morbidities of cardiac and/or pulmonary disease or history of pulmonary.
- Psychiatric or psychotropic medication.
- Nutritional compromise, dehydration, pressure wounds or other wounds.
- History of presence of NPOs or C-POE.
- History of behaviors or presence of unstable behavior @ admission.
- DKA or potential for abnormal or critical labs.
- History of Q-Bled.
COMMUNICATION & IDT TEAM

- INTERDISCIPLINARY TEAM SHOULD CONSIST OF CEO & DIRECTOR OF NURSING, ADMINISTRATIVE NURSES, THERAPISTS, DIETARY MANAGER, DIETICIAN, ACTIVITY DIRECTOR, SOCIAL SERVICES, MSW COORDINATORS, NURSE PRACTITIONERS (ifa/available)
- PHYSICIAN REVIEW OF ALL ORDERS & MEDICATIONS (HOME, HOSPITAL, ADMISSION/READMISSION)
- PHARMACY REVIEW OF NEW MEDICATIONS, ADDRESSING UNNECESSARY MEDICATIONS, AND POTENTIAL FOR ADVERSE MEDICATION CONCERNS; REVIEW OF MEDICATIONS POST FALL OR CHANGE OF CONDITION AS INDICATED
- PSYCHIATRIC TEAM, PSYCHIATRIST, PSYCHIATRIC NURSE PRACTITIONER OR PSYCHOLOGIST AS NEEDED
- TELEHEALTH SERVICES
- WOUND MANAGEMENT (IF FACILITY WOUND PHYSICIAN OR WOUND CLINIC)
- CARE & SERVICES PROVIDED OR RECOMMENDED BY THESE SERVICES SHOULD BE ADDRESSED IN THE RESIDENT CARE PLAN WITH REVIEW AND UPDATES AS REQUIRED
- HISTORY & PHYSICAL AND HOSPITAL DISCHARGE SUMMARY AND HOSPITAL CONSULT REPORTS SHOULD BE AVAILABLE & REVIEWED BY TEAM
- ALL ALLERGIES IDENTIFIED & DOCUMENTED FROM MEDICAL REVIEW AND AS NOTED BY RESIDENT/FAMILY
- FAMILY & RESIDENT INVOLVEMENT IN CARE PROCESS AT TIME OF ADMISSION, ESTABLISHING ADVANCE DIRECTIVES AND DISCHARGE PLANNING

OTHER RESOURCES - LINKS

- Skilled Nursing Facility Care Coordination Toolkit - HIAA
  Components of a Nursing Home Pre-Admission Assessment: Why Evaluating Potential Residents Is So Important: June 26, 2019
  https://www.mhiaa.org/patient-centred-care/nursing-home-pre-admission-assessment

- COST OF Sepsis Readmissions Estimated At More Than $11 Billion Per Patient: March 18, 2019

- Skilled Nursing Facility Sepsis Care Kit

- Strategies to Reduce Potentially Avoidable Hospitalizations Among Long-Term Care Facility Residents May 24, 2019
  https://www.tripdatabase.com/article/161553-

- The Joint Commission Journal on Quality and Patient Safety 2017; 43:565–572
  Care Transitions Between Hospitals and Skilled Nursing Facilities: Perspectives of Sending and Receiving Providers
  https://journals.lww.com/jqps

- DAV Value Based Payment FAQs - 1st Quarter 2018

- CMS Value-Based Program: Other VBP Resources
  https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBP/Other-VBP-Resources

- Centers for Medicare & Medicaid Services (CMS): Hospital readmissions reduction program

- INTERACT Tools - INTERACT Tool - Interventions to Reduce Acute Care Transfers
  https://www.interact.org

Florida Risk & Compliance Resources
www.fhca.org

Questions?
Email Kim Broom
kbroom@fhca.org

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Thank you for joining us today!

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