Clinical Considerations for Improving Rehospitalizations and ER Visits in LTC

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WELCOME AND THANK-YOU!

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1. Trends
2. Case Studies & Critical Thinking
3. Smart Nursing Home Admissions
4. Q & A

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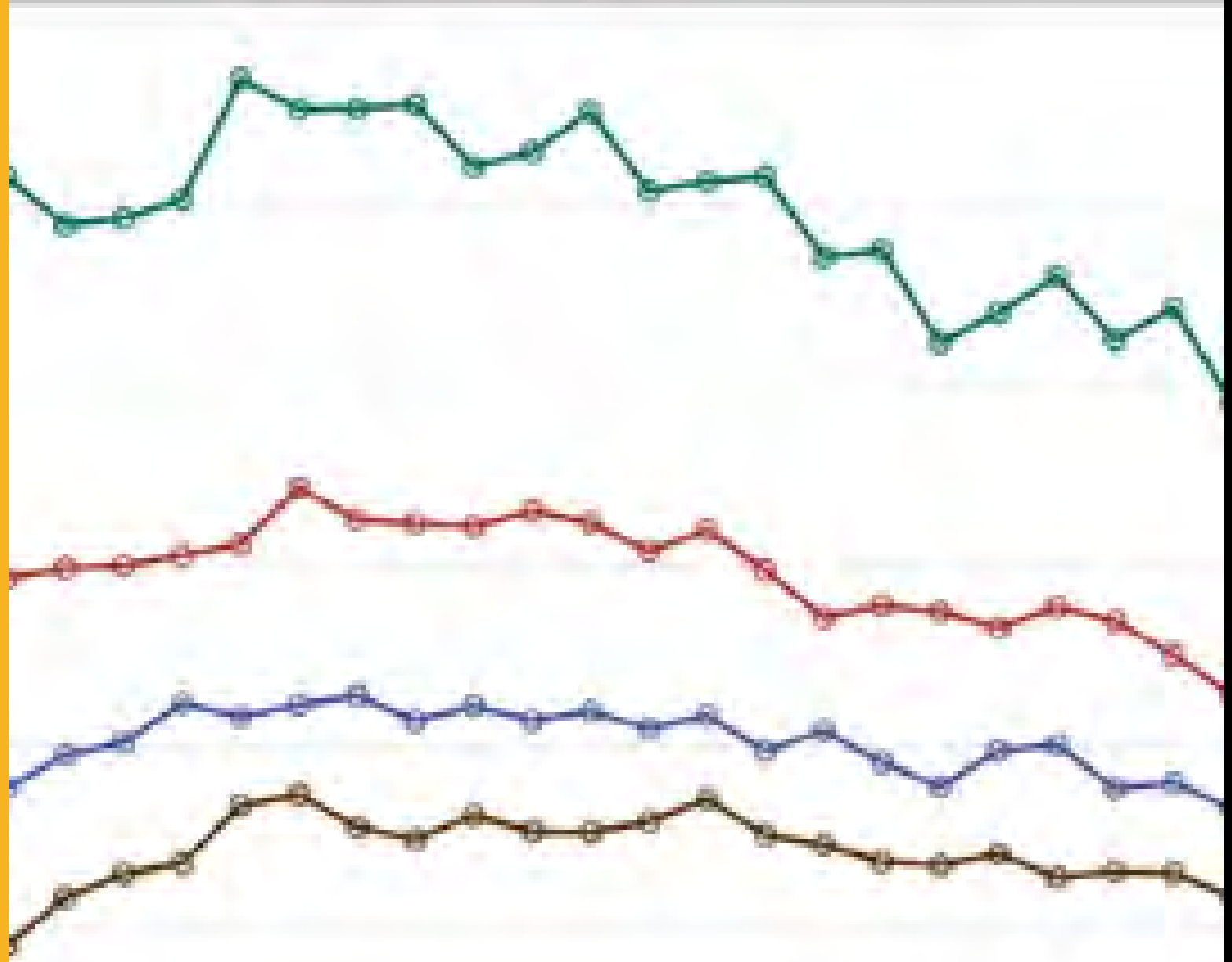

Trends

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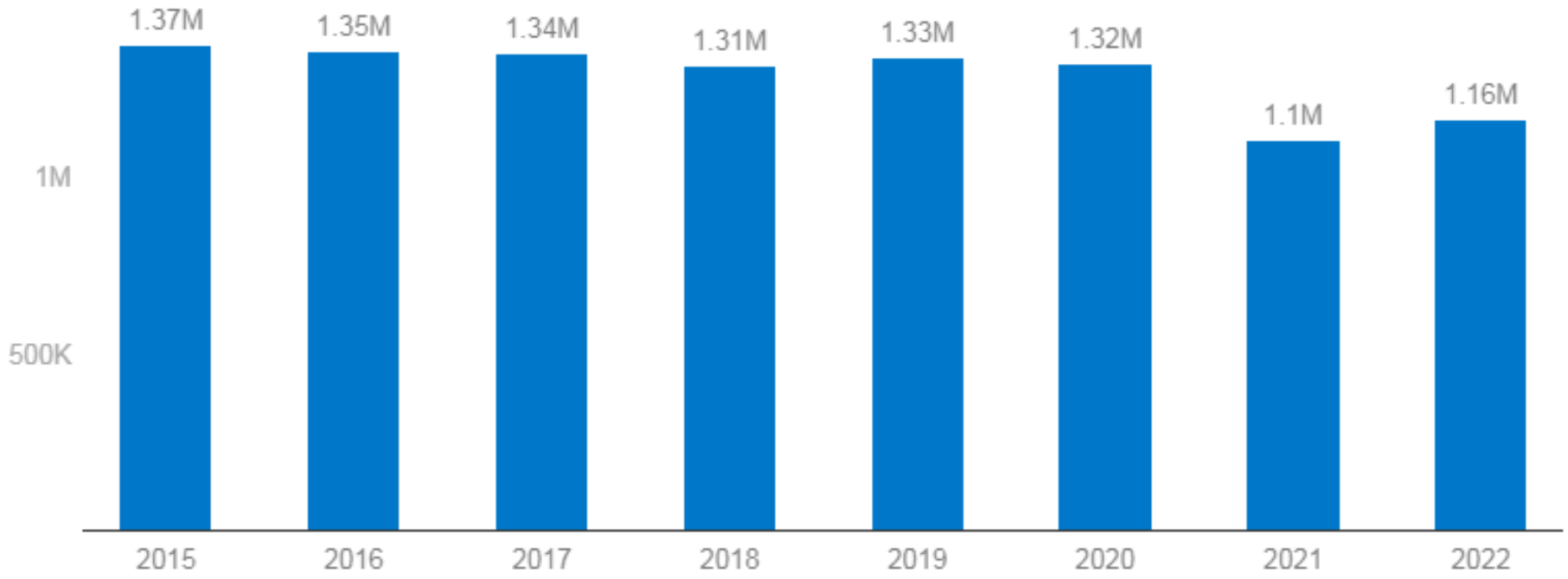
Nursing Home Trends

Figure 1

Number of Certified Nursing Facility Residents, 2015-2022



SOURCE: KFF analysis of Nursing Home Compare, 2015-2022 • PNG

KFF

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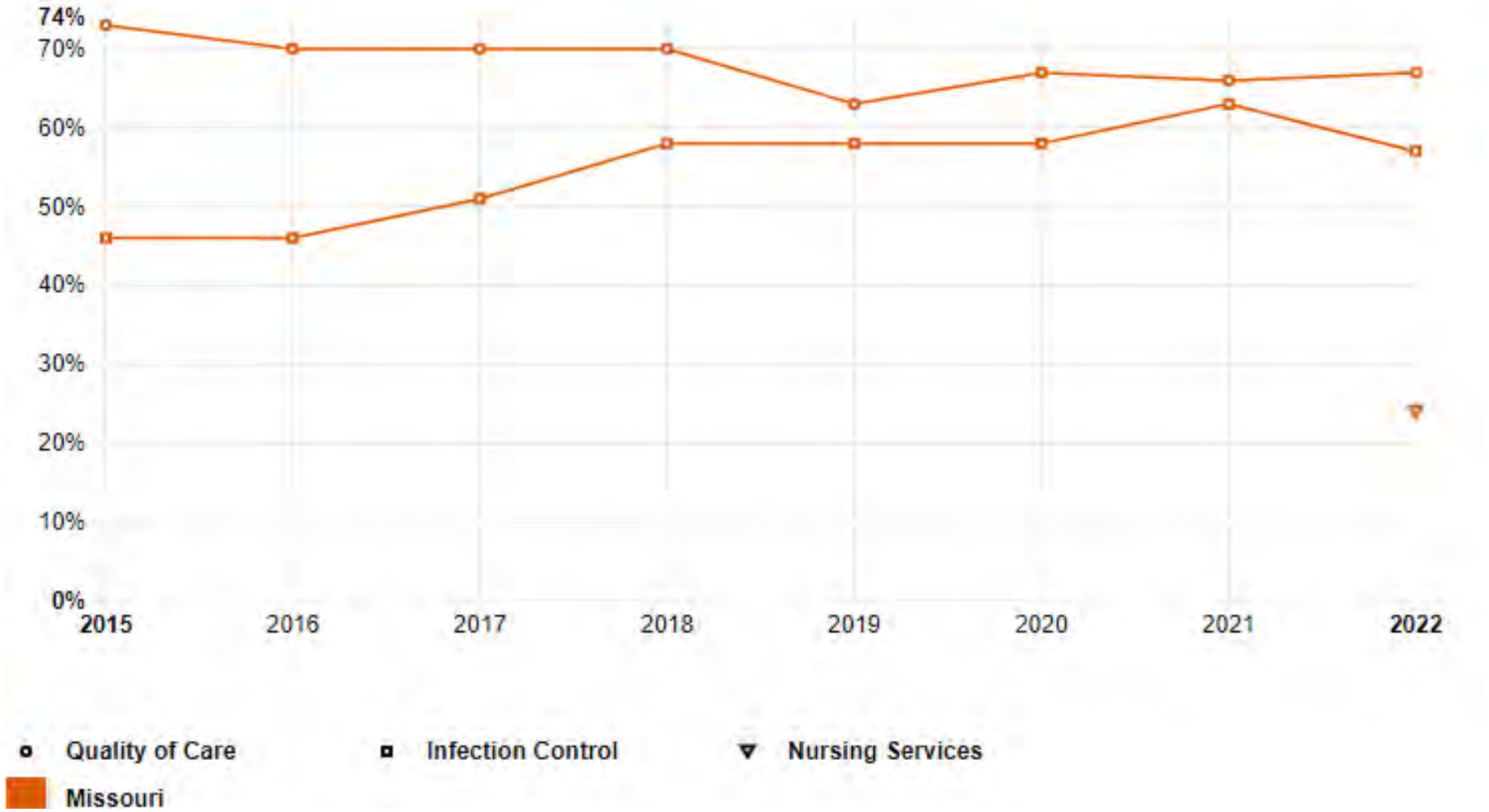
Quality Care Trends in LTC



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Rehospitalizations and Value-Based Purchasing

"One in 5 Medicare beneficiaries discharged from the hospital receives post-acute care in a skilled nursing facility (SNF) **at a cost of more than $28 billion annually.**[1] Nearly one-quarter of those admitted to SNFs are readmitted to the hospital within 30 days,[2] and *readmission is associated with a quadrupled mortality rate within 6 months*.[3]"

Source: https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2789442

Influence of Hospital and Nursing Home Quality on Hospital Readmissions

According to a study performed by *The American Journal of Managed Care…*

As of October 2012, Medicare began financially penalizing hospitals for "excess" readmissions as part of the ACA. Specifically, hospitals are penalized for all-cause 30-day rehospitalization in excess of the "expected" risk-adjusted rate for individuals initially admitted with congestive heart failure (CHF), heart attack, or pneumonia.

Study consisted of 1,382,477 individual hospitalizations discharged to 15,356 NHs from 3683 hospitals with the following results:

- 20% of sample rehospitalized within 30 days
- average resident 80 years old, average hospital stay of 9 days, white, female, generally cognitively intact, and had moderate ADL impairment
- Patients discharged to NHs with lower RN staffing levels, low occupancy levels, and a higher weighted deficiency score were at an increased risk of rehospitalization
- Patients who were discharged to freestanding, for-profit NHs with a higher proportion of Medicaid residents and a higher number of admissions per bed were associated with an increased likelihood of rehospitalization.

Source: https://www.ajmc.com/view/influence-of-hospital-and-nursing-home-quality-on-hospital-readmissions

Quality Measures in Missouri

Sample size:

- 50 homes from all 7 DHSS Regions
- 1-2 overall star rating *randomly selected based on overall star rating*

1 & 2 star homes were higher than both the MO average and National average for these 2 factors

	Sample average	MO average	National average
Rehospitalizations	25.75	23.9	22.1
Outpatient ER visit	14.02	12.1	11

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What Do YOU Send People Out For??

Polling question

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Rehospitalization
Sample Statistics Per Region

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Outpatient ER Visits Sample Statistics Per Region

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Most Common Transfer Diagnosis

Chart from: https://innovation.cms.gov/innovation-models/rahnfr-phase-two

Condition	Percentage
Pneumonia	32.8%
Dehydration	10.3%
Congestive Heart Failure (CHF)	11.6%
Urinary Tract Infection (UTI)	14.2%
Skin ulcers, cellulitis	4.9%
COPD, asthma	6.5%
Total	80.3%

>40% of these are "unnecessary"

Most Common Reasons For ER Visits

Wang, H.E., et. Al (2012)."Emergency Department Visits by Nursing Home Residents in the United States" Journal of American Geriatric Society, 59(10). doi: 10.1111/j.1532-541 5.2011.03587.x

Condition	Percentage
Sepsis	23.7%
Circulatory Diseases	20.9%
Injury	18.0%
Respiratory Diseases (pneumonia, aspiration pneumonitis and other pulmonary infections)	15.5%
Genitourinary diseases (pyelonephritis, kidney and UTI)	14.9%

- **Nursing home residents were >6x more likely to present with sepsis**
- **Nursing home residents were >2x as likely to die in the hospital**

Costs of "avoidable" Transfers

- Monetary Costs to Facility
  - Potential Revenue Recapture (PRR)
    - Money is LOST for each non-billable days due to hospitalization
    - MOQI example- "PRR of total short and long stay non-billable days during hospitalizations ranged from $590,000 to over $5 million per facility for six years (2014-2019)"
- Nurse Workflow
  - Less disruption of routine saves time
    - Consider increased workload of transfer/readmission. "Change in condition orders are a lot less work than prepping to send residents out."
- Health Costs to Residents
  - Physical, mental and overall functional decline of residents
  - Relocation trauma
  - Information "lost in translation" (i.e., hospital "telephone")

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CASE STUDIES & CRITICAL THINKING

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Critical Thinking

- **Yes**, we can do IVs
- **Yes**, we can get portable x-rays, dopplars, EKGs
- **Yes**, we can do urinalysis via dipsticks
- **Yes**, we can monitor I/Os, blood pressures, orthostatics, labs
- **Yes**, we can give LMW heparin, use incentive spirometers, use inflatable compression pads, and wound vacs.
- **Yes**, we can handle ostomies, stomas, surgical wounds, surgical drains, peritoneal dialysis.
- **Yes**, we can remove PICC lines, butterflies, and clean ports.
- **YES—we CAN do a lot!!**

If you want to change the numbers, you have to change the practices!

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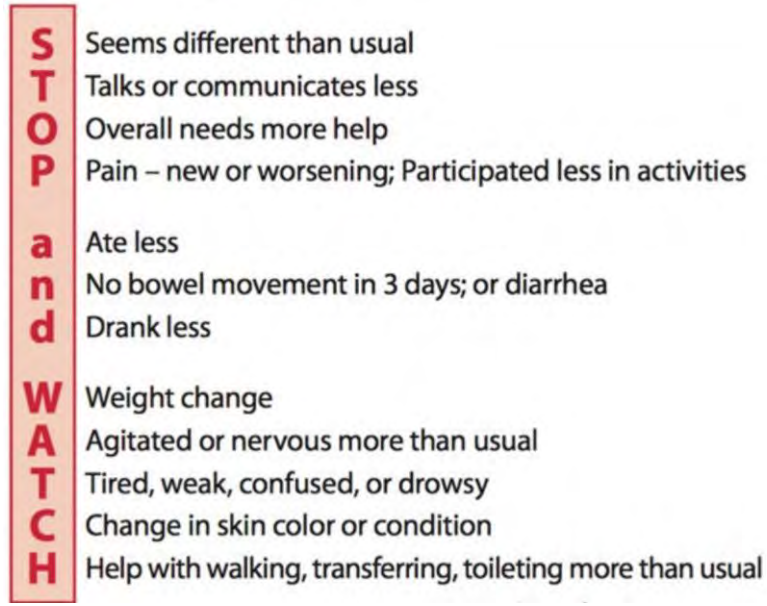
Which would you prefer?

Step 1: Detection/Proactive

- Monthly nursing assessments. Full body—head-to-toe, ***literally***.
  - *Excellent resource available for this! Just ask Wendy or your QIPMO nurse!*
- Daily (or at least weekly) rounding with CNAs.
  - Ask *intentional* questions about the residents
- Admin observations.
- Use (and train!) evidence-based communication tools.
  - INTERACT® (Interventions to Reduce Acute Care Transfers) https://pathway-interact.com/
  - Stop and Watch
  - SBAR
  - Care Cards
- QA trends with an RCA (root cause analysis) with shared information.



(https://efaidnbmnnnibpcajpcglclefindmkaj/https://www.in.gov/health/files/INTERACT_Stop_and_Watch_Early_Warning_Tool.pdf)

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Step 2: Re-evaluation/Proactive

STATEMENT: My staff always just call the doctor and send them out, without consulting with me or even trying to handle it in-house. What's behind that? What are we paying for RNs for??

"Staff don't see the benefit of keeping a resident with a condition change in the building."

Step 2: Re-evaluation/Proactive

A. What do you do when there is a condition change? Break down the steps to the very first action.
B. Do you use an SBAR, Stop-Watch, or Care Cards?
C. Is there a practicing time-line before initiating transfer to the hospital or ER?
D. Is there a back-up RN to help make the decision?
E. What is the follow-up and who handles it? *This should include contacting family members and/or POA (and PCP if necessary).*
F. Is anyone keeping score of the wins??

WINS	LOSSES
IIII	II

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Step 3: Education/Proactive

=

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Step 3: Education/Proactive

Percentage of short-stay residents who were re-hospitalized after a nursing home admission (lower percentages are better)

41.9%

National Average 22.1%

Missouri Average 23.9%

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Step 4: Investigation/Reactive

1. Perform a nursing assessment: Observation, Inspection, Auscultation, Palpation. Are your nurses doing AND documenting these elements of the issue?
2. Use critical thinking. Are your nurses empowered to take the findings and determine next course of action through ***clinical judgment*****??**
3. Make decisions based on best-practices. What resources do they have? How often do you utilize professionals in the field to learn the latest best practices?

   Example: Changing Foley catheters every 30 days. CDC no longer recommendations routine changes of catheters.
4. Contact the physician with a game plan. (Including your primary care docs and medical directors on your goals to reduce rehospitalizations and ER visits will help them think in terms of prevention versus reaction.)

   Remember the R" in SBAR stands for Recommendation.

ARE YOUR NURSES USING NURSING JUDGMENT?

- Critical Thinking
  - "a way of imposing intellectual standards' in the approach to any subject, content, or problem based on evidence and science rather than "assumptions and/or conjectures"
- Clinical Reasoning
  - "cognitive process used by healthcare practitioners to address patient issues"
- Clinical JUDGMENT
  - "an interpretation or conclusion about a patient's needs, concerns, or health problems, and/or the decision to take action (or not), use or modify standard approaches, or improvise new ones as deemed appropriate by the patient's response"
    - More influenced by what nurses "**bring to the situation**" than the objective data at hand
    - Sound clinical judgment rests on **knowing the patient** and his/her typical pattern!!
    - Influenced by the **context** in which the situation occurs

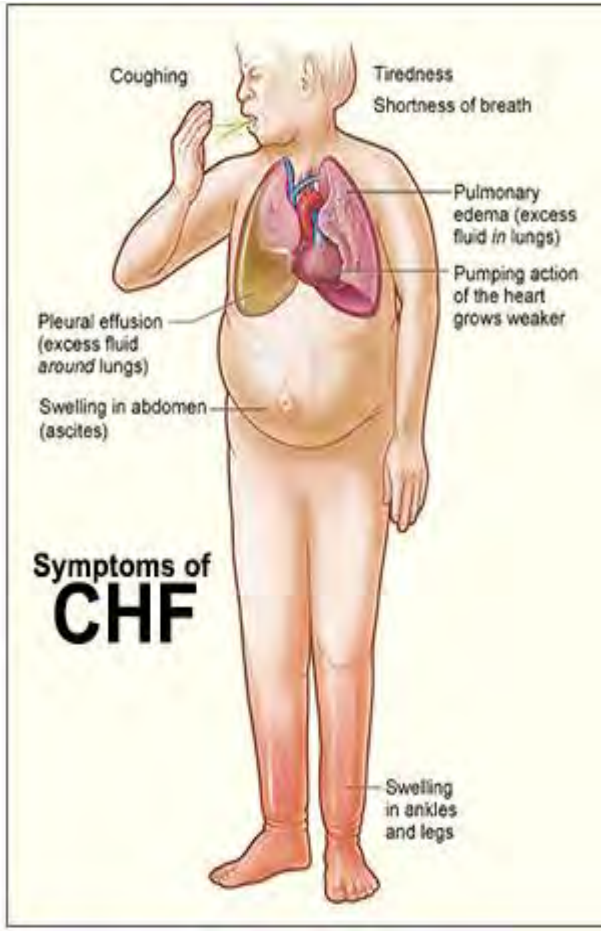
Case Study #1—CHF

Resident was admitted from SE Hospital, July 15, 2022 due to an exacerbation of CHF.
Ht: 67 inches
Wt: 256 lbs.

Meds:
40mg Lasix twice a day
40meQ of potassium daily
Torsemide 20mg daily

Was able to transfer on admission, slowly and with assist x1, used walker for balance, and walked in a hunched position.

Physician asked for daily weight x 2 weeks with a call if weight increased 2-3 lbs/day or 5 lbs/week.



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Case Study #1: CHF

5 months later

Resident began complaining of her shoes hurting her feet. After about 2 weeks a nurse overheard a CNA telling another CNA that she was having a hard time getting Mrs. Smith's shoes on. The nurse asked if her feet were swollen. "Not too bad, they're just old shoes." So the nurse advised the aid to get a shoe horn and let her know if there was any swelling issues.

5 days later

As the nurse was passing meds, she noted that Mrs. Smith looked like she had gained weight. She also noted Mrs. Smith had more difficulty in positioning herself in her Lazy-Boy in order to take her medications. She also complained of back pain. When the nurse asked why, Mrs. Smith stated she'd been resting easier in her chair than the bed. Knowing this was not uncommon, the nurse offered some Tylenol and went on.

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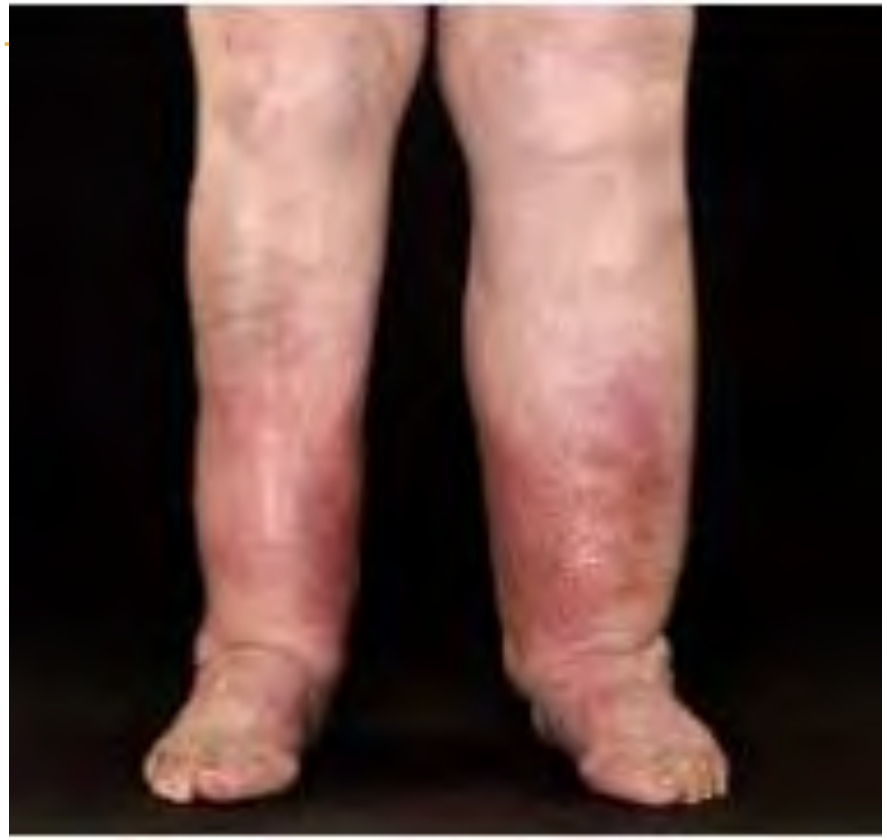
Case Study #1: CHF

2 days later

Mrs. Smith was complaining of shortness of breath. When the nurse assessed her, she had 4+ pitting edema, weeping on the right leg, significant ascites, and oxygen had been placed in her nose at 2 L/NC. No abnormal bowel or lungs were noted. However, the nurse reported to her supervisor that she'd had a hard time hearing the heartbeat.

QUESTION
What can Nurse Sally do at this point?



Case Study #1: CHF

Nurse Sally called the doctor and gave a clinical update. Mrs. Smith was having trouble keeping her oxygen saturation above 90% even with 2L of oxygen.

The doctor told Nurse Sally to send Mrs. Smith to the ER for evaluation.

Mrs. Smith spent 23 hours in the hospital under observation receiving heavy diuretics via IV. She returned to the nursing home and subsequently was sent out again the next night for "heart" problems. Due to the quick and heavy diuresis, Mrs. Smith's heart went into atrial flutter and then severe A-fib.

Mrs. Smith returned from the hospital 6 days later on 4 more heart medications and on compassionate care. She passed away 2 weeks later after filling with fluid and in acute renal failure.

Case Study #1

At what timepoints could the nurse have been PROACTIVE?

What tools could have been used?

What are the potential costs to this care scenario?

- Monetary?
- Workflow?
- Resident health outcomes?

Case Study #2:

- "Carl" admitted to nursing home, due to need for assistance w ADLs 2nd Parkinson's Dx.
- Age 72
- Ht: 69 inches
- Wt: 125 lbs.

- Meds:
  - Sinemet (carbidopa/ levodopa) 25mg/100mg
- Independent walking with cane, slow, hunched shuffle.
- Resting tremor bilateral upper extremity, worse on L side, mainly at rest.
- Able to eat and drink on own.
- Had DBS removed 6 months prior due to infection.

Case Study #2

2 months later

"Carl" has not been showing up to as many activities as he normally does. When the CNA asked him why he hadn't been coming to game night Carl said he was having more trouble with moving game pieces and holding cards lately. "Carl" also complained that his tremor was just keeping him from doing what he wanted to which was "why I'm in this damn place!!" The CNA reported this to the nurse saying "Carl" seems more sad lately and wouldn't take his medications and wasn't eating as much as usual- have you noticed he isn't participating as much. The nurse communicated this to the provider, a depression screen was conducted and an SNRI was added to his medication profile for "situational depression".

5 days later

The CNA reported to the nurse that "Carl" was very confused after breakfast and was angry, even towards his favorite aide Carol. He was dizzy, unstable and required assistance to sit in a chair.

Case Study #2

The nurse performed a head-to-toe assessment.
Significantly worse tremor to upper extremities. Weak, thready pulses, confusion, A&Ox2, angry, confused, dizzy and unable to stand on his own and his tremor was significant at rest and with movement. No abnormal bowel or lungs were noted, HR rapid (110) but regular-S1 and S2 noted. T=98.6, BP=90/55

- What should the nurse do now?

Case Study #2

The nurse called the provider and reported the following- "Carl" is confused, combative, dizzy, weak, cool to the touch and his HR is rapid.

The provider recommended that Carl be transferred to the ER for evaluation.

- "Carl" entered the hospital where he received and IV and aggressive rehydration in the ER. His labs came back negative for infection and sepsis but with a critically low albumin level. He was discharged back to the nursing home on a thickened liquid diet and 1 on 1 eating assistance.
- "Carl" was readmitted to the hospital 7 days later with s/s of aspiration PNA. He became septic during this hospitalization and passed away in the ICU.

Case Study #2

At what timepoints could the nurse have been PROACTIVE?

What tools could have been used?

What are the potential costs to this care scenario?

- Monetary?
- Workflow?
- Resident health outcomes?

SMART NURSING HOME ADMISSIONS

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What's Your Vision?

Nursing homes are businesses. Every business has a vision, a mission statement, a plan.

-Who are you going to take? Local? Whoever needs you?

-What age group and clinical population are you going to take?

***Very different care needs, staffing needs, training, resources!

(EXAMPLE: young, mental health and substance abuse hx has MANY different needs than older dementia with falls and chronic health conditions).

Keeping in mind that the more acute clinical care required, the harder you're going to have to train your nurses to keep those rehospitalizations and ER visits down. (Think micro med-surg more than nursing home!)

-Where does your money come from? Med A vs Medicaid vs Medicare Advantage or maybe all 3!

-Med A (shorter term, higher $$, will fluctuate)

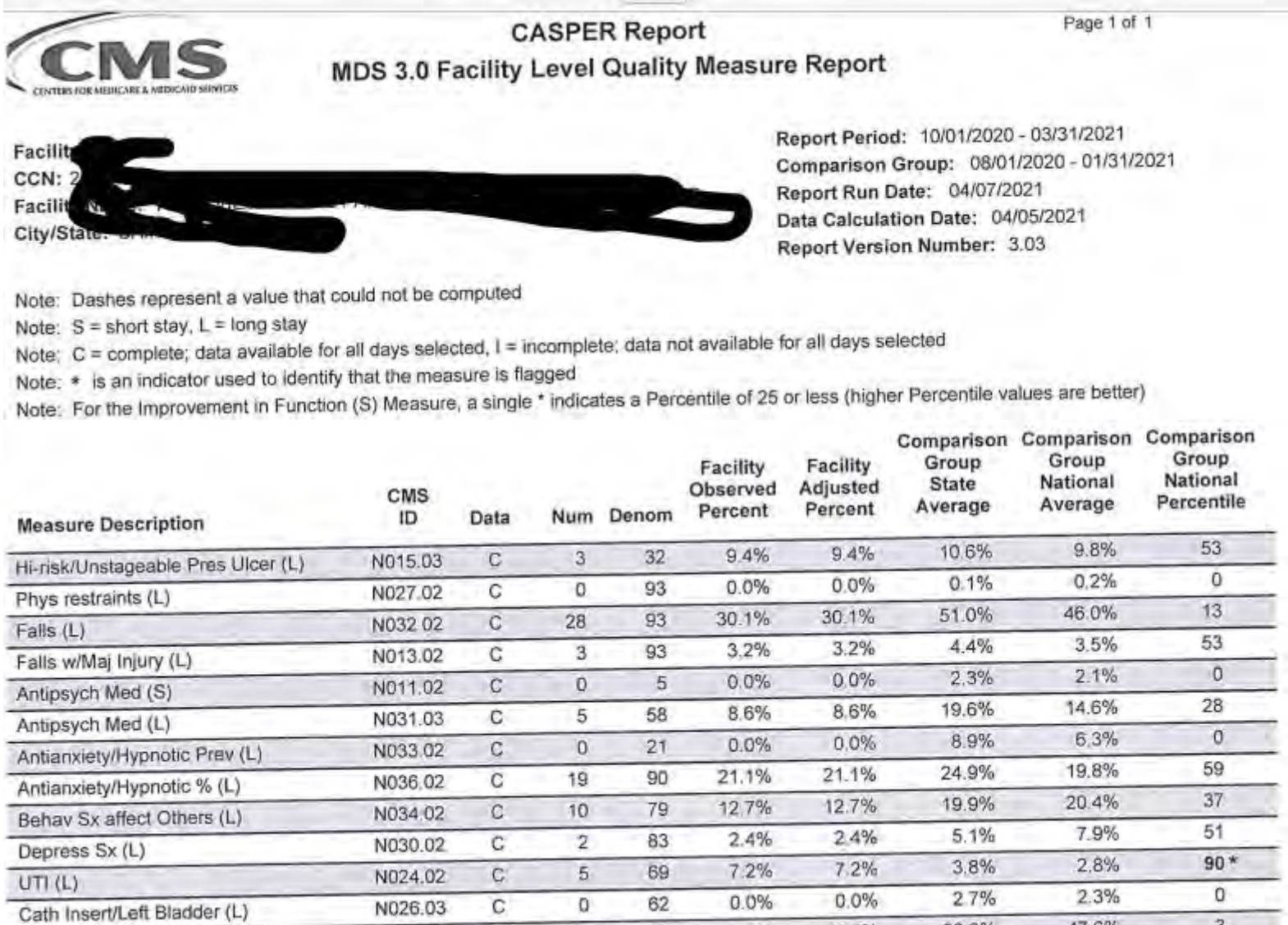
-Medicaid/Long-term care insurance (longer term, flat rates, less fluctuation, lower $)

-Medicare Advantage (fluctuates in $$ paid and time paid out, intermediate terms)

Sneak Peek

FYI:

Your CASPER Facility QM Report is a really good idea of who you take without even seeing the 672 demographics sheet.



CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

CASPER Report

MDS 3.0 Facility Level Quality Measure Report

Facilit
CCN: 2
Facilit
City/State:

Report Period: 10/01/2020 - 03/31/2021
Comparison Group: 08/01/2020 - 01/31/2021
Report Run Date: 04/07/2021
Data Calculation Date: 04/05/2021
Report Version Number: 3.03

Note: Dashes represent a value that could not be computed
Note: S = short stay, L = long stay
Note: C = complete; data available for all days selected, I = incomplete; data not available for all days selected
Note: * is an indicator used to identify that the measure is flagged
Note: For the Improvement in Function (S) Measure, a single * indicates a Percentile of 25 or less (higher Percentile values are better)

Measure Description	CMS ID	Data	Num	Denom	Facility Observed Percent	Facility Adjusted Percent	Comparison Group State Average	Comparison Group National Average	Comparison Group National Percentile
Hi-risk/Unstageable Pres Ulcer (L)	N015.03	C	3	32	9.4%	9.4%	10.6%	9.8%	53
Phys restraints (L)	N027.02	C	0	93	0.0%	0.0%	0.1%	0.2%	0
Falls (L)	N032.02	C	28	93	30.1%	30.1%	51.0%	46.0%	13
Falls w/Maj Injury (L)	N013.02	C	3	93	3.2%	3.2%	4.4%	3.5%	53
Antipsych Med (S)	N011.02	C	0	5	0.0%	0.0%	2.3%	2.1%	0
Antipsych Med (L)	N031.03	C	5	58	8.6%	8.6%	19.6%	14.6%	28
Antianxiety/Hypnotic Prev (L)	N033.02	C	0	21	0.0%	0.0%	8.9%	6.3%	0
Antianxiety/Hypnotic % (L)	N036.02	C	19	90	21.1%	21.1%	24.9%	19.8%	59
Behav Sx affect Others (L)	N034.02	C	10	79	12.7%	12.7%	19.9%	20.4%	37
Depress Sx (L)	N030.02	C	2	83	2.4%	2.4%	5.1%	7.9%	51
UTI (L)	N024.02	C	5	69	7.2%	7.2%	3.8%	2.8%	90 *
Cath Insert/Left Bladder (L)	N026.03	C	0	62	0.0%	0.0%	2.7%	2.3%	0

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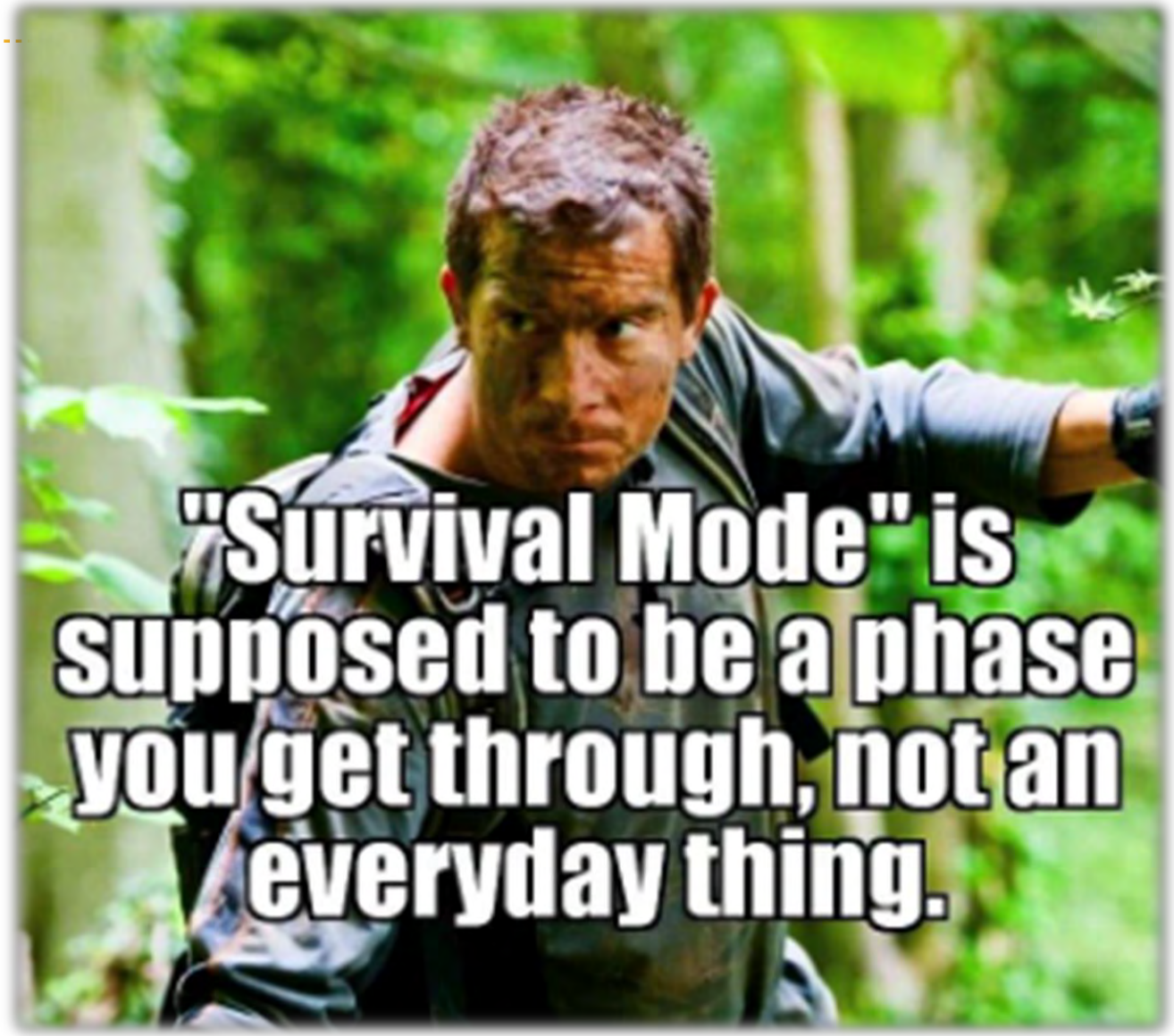
Tool Kit

1. Check out your mission and vision statements. Talk to the owners or CEO. *Who do you THINK you're taking? These answers may be different depending on who you ask.*
2. Look at Nursing Home Compare. Where do you currently rank on rehospitalizations and outpatient ER visits?
3. Look at your QA reports for the last year (minimum). What are your admission vs. readmission vs. ER visit rates? Are you going up/down?
4. Do a root cause analysis study of those rehospitalizations and ER visits. (This is time intensive but can be done more quickly through the MDS, depending on how deep you go).
5. Identify trends—are you sending out for dehydration and uti's? pneumonia? Are you sending out within a general time spand (i.e., 2 days or 2 weeks) within receiving the patient? If so, this may expand into a conversation you need to have with the hospital case workers.

Tool Kit

6. Look at your nursing processes. First of all, can all of your nurses tell you what the process is as described in your policies and procedures? Do you even have policies and procedures on sending someone out??
7. Create a QAPI team to work on this OR just employ a little nurse empowerment and put one of the floor nurses in whom you see potential or who has excellent clinical skills in charge of creating a process or program that goes into the clinical side rather than just the paperwork side—learn and accept from peers better than administration.
8. Do reconnaissance. Meet your potential admissions at the hospital first. Work with the case manager and the hospital floor nurse in charge of that patient and ask critical questions.
9. Hit the ground running on clinical concerns as soon as they come in your building—don't wait 3 days to deal with incoming clinical issues!

Time to End "Survival Mode"



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RRAP!

Review—your past stats and your business plan

React/Root Cause—see trends/commonalities

Assess—1) assess those residents they come into your building 2) assess your staff to see if they have the clinical confidence and skills to care for who you want you in your building.

Practice—get those skills on the floor! Lead by demonstration. Ask questions during assessments and draw answers out of your staff so next time they can do it themselves.

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Apps for Clinical Guidelines

- Epocrates--https://www.epocrates.com/ (online library, some material free but good resource)
- Up-to-Date
- Johns Hopkins Medical University Library for Nurses https://browse.welch.jhmi.edu/nursing_resources/clinical-tools-and-apps
- Medscape
- Nursing Central https://nursing.unboundmedicine.com/nursingcentral
- Pocket Lab Values (App available)

Resources for Best Practices

- AHRQ, National Guideline Clearinghouse Search or browse for guidelines by topic or organization.
- CDC Stacks Guidelines and Recommendations Centers for Disease Control and Prevention public health publications.
- Registered Nurses' Association of Ontario (RNAO) Nursing Best Practice Guidelines Registered Nurses' Association of Ontario (RNAO) nursing guidelines.
- Systematic Evidence Reviews and Clinical Practice Guidelines By the NIH-National Heart, Lung, & Blood Institute
- National Center for Complementary and Alternative Medicine
- MedScape

Contact Us With Questions!

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TODAY'S WEBINAR HAS BEEN APPROVED FOR CEU HOUR(S)

IN ORDER FOR MO LNHAS TO GET CREDIT:

- It is REQUIRED that you complete a brief survey/evaluation via:
  - ✓ A pop-up at the end of the webinar, or
  - ✓ An automated email from GoToWebinar that will be sent to attendees
  - ✓ *You only need to complete it once (either via the pop-up or the email)*
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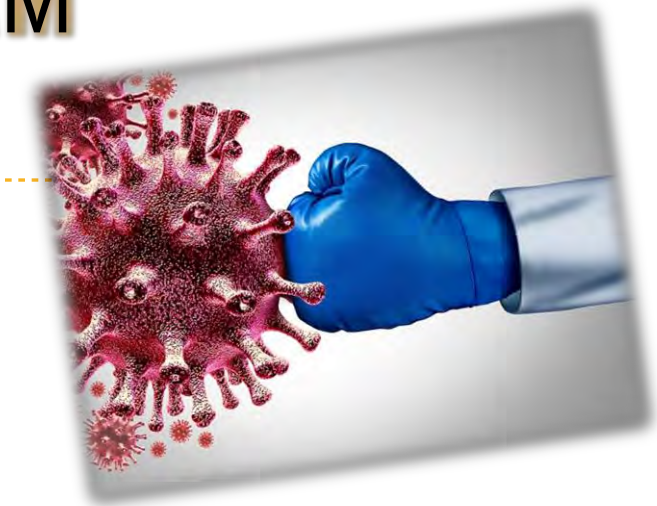

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