We MUST Reduce Rehospitalization Rates

Using the QAPI Process to Make the Right Decisions

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Session Objectives

- Review why and how rehospitalization is on the forefront of our industry’s consciousness
- Understand the 5 key elements and the relationship to the 12 Action Steps of Quality Assurance Performance Improvement (QAPI) in Nursing Homes
- Describe the initial steps to take to analyze rehospitalization rates within the SNF
- Describe three key steps needed to apply the QAPI process to develop a Performance Improvement Plan (PIP) to reduce unnecessary rehospitalizations

The Issue

- Cost of rehospitalization is around $17 billion for Medicare recipients
- Almost 20% of all Medicare hospital stays result in readmission within 30 days of discharge
  - According to The Agency for Healthcare Research and Quality (AHRQ), 90% of readmissions within 30 days are unplanned and likely the result of a break in the clinical process.
  - 20-40% of re-hospitalizations are avoidable
  - For the elderly, re-hospitalizations can be traumatizing
- Rehospitalization is a symptom of care fragmentation
- Current momentum for change, including legislation is in place
Hospital Readmission Reduction Program (HRRP) Penalizes Hospitals with High Readmission Rates

- The HRRP began October 1, 2012
  - Payment reduction determined by an adjustment factor based on an assessment of readmissions, with a maximum payment reduction of 1 percent in 2013, 2 percent in 2014, and 3 percent in 2015 and beyond
  - For each hospital, an excess readmissions ratio will be calculated based on measures of readmissions currently used in the hospital inpatient quality report (IQR) program
- The SO WHAT? What will hospitals do to decrease readmissions?
  - Ideally, correctly match the care needs of the patient to the SNF setting?
  - Or simply to those with the lowest rehospitalization rates...

Three Conditions are All the Rage!

<table>
<thead>
<tr>
<th>Condition at Hospital Discharge</th>
<th>30-Day Rehospitalization Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMI (Heart Attack)</td>
<td>19.9</td>
</tr>
<tr>
<td>Heart Failure (HF)</td>
<td>24.7</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>18.3</td>
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</tbody>
</table>

These three conditions made up approximately 10% of hospital discharges in 2009

U.S. Department of Health and Human Services, Quarter 2, 2012

2014 Hospital Inpatient Prospective Payment System ( IPPS)

- In October 2012, Medicare began encouraging to hospitals with excess 30-day readmissions to lower 30-day readmission rates for heart attack, heart failure, and pneumonia patients by reducing a portion of the hospital’s payments by up to one percent, depending on their performance on key readmissions measures
- The FY 2014 IPPS rule increases the maximum reduction of payments to up to two percent
  - It adds hip and knee surgery and chronic obstructive pulmonary disease to the list of conditions used to determine the reduction, effective in FY 2015
Drivers of Rehospitalization (IHI Study)

Failures in care coordination between the hospital and SNF that lead to rehospitalization within 30 days after discharge fall into two main categories:

• Care provided within the skilled nursing facility
  • Inappropriate end-of-life care
  • Lack of disease-specific protocols
  • Patient/family knowledge deficit
• Care provided during the transition from the hospital to the skilled nursing facility
  • Fragmentation of patient information
  • Medication issues
  • At-risk patients not properly identified at discharge

Note: Certain factors, such as the preferences of the resident regarding advance directives, influence care during the transition to and within the SNF

So, What Do You Do and How Do You Do It?

▪ You would like to reduce your Rehospitalization Rate
  • You know it’s a concern
  • You know it’s high
▪ Addressing the problem requires focus, structure and a systems approach that is data-driven
▪ The framework: QAPI

Improve your business by effectively measuring Health Care Reform metrics

▪ It all boils down to efficiency, satisfaction, and quality
▪ Efficiency in delivering services
  • length of stay
  • Rehospitalization
▪ Satisfaction
  • Patient/family/caregiver
  • Correlations to efficiency
▪ Quality
  • Population management
  • Outcomes but also process
▪ Regardless of who is the stakeholder these metrics are essential (and at your fingertips!)
QAPI AND REHOSPITALIZATION

The Five Elements

1. Governance and Leadership
   - Led by administration
   - Sufficient resources
   - Facility-wide QAPI training
   - Policies established
   - Priorities are set and expectations established
   - Staff are accountable for quality

2. Feedback, Data Systems and Monitoring
   - Installation of systems to monitor care and services
   - Draws data from multiple sources
   - Feedback system from residents and families
   - Performance indicators for a wide range of processes and outcomes
   - Established targets
   - Review performance against benchmarks and targets
   - Track and investigate adverse events

3. Performance Improvement Projects (PIPs)
   - Conduct PIPs
   - Identify priority areas that need attention for PIPs
   - Examine and improve care or services
   - Establish teams
   - PIP findings are reported to leadership for further action

4. Systematic Analysis and Systemic Action
   - Systematic approach to determine when in-depth analysis is needed
   - Understand the problem, causes, implications of change
   - Structured approach to determine identified problems
   - Root Cause Analysis
   - Systemic look to prevent events and promote sustained improvement

Five Elements of QAPI

1. Five Elements of QAPI
2. Governance and Leadership
3. Feedback, Data Systems and Monitoring
4. Performance Improvement Projects (PIPs)
5. Systematic Analysis and Systemic Action
Step 1: Leadership Responsibility and Accountability

- Senior leaders create an environment that promotes QAPI and is working on improving care and services
  - Provide guidance for the quality improvement initiative to achieve breakthrough levels of performance
  - Link the goals of improving transitions in care and reducing readmissions to the strategic priorities of the organization
Ask the Key Questions

- Do you know the facility’s readmission rate for all residents?
- Is reducing the readmission rate a strategic priority for the facility? Why?
- Have you declared your improvement goals?
- What will help you drive success in your quality improvement initiatives?
- What initiatives to reduce readmissions are already underway or planned in your organization, and how could they be better aligned?
- How much experience do your executive leaders, mid-level managers, and front-line providers and staff have in process improvement? What resources (e.g., expertise in quality improvement, data analysis) are available to support improvement efforts?
- How will you provide oversight for the improvement projects, learn from the work, and spread successes?
- What other provider organizations should be engaged in this work?

Optional Financial Analysis

- Analysis by Administrator
  - Financial and staffing implications of occupied versus empty beds and bed holds
  - Cost in terms of staff time, number of steps, and number of ancillary staff involved in completing the entire discharge process as well as the entire admission process
  - Cost in terms of business staff time involved in preparing and submitting final bill(s)
  - Cost in losing rehospitalized residents to another SNF
  - Cost of unused medications and supplies that cannot be returned
  - Implications of poor patient and family satisfaction for reputation

Step 2: Develop a Deliberate Approach to Teamwork

- An effective team includes:
  - Having a clear purpose
  - Having defined roles for each team member to play
  - Having commitment to active engagement from each member

- Who are potential team members within the SNF?
  - Patients, family members, or other designated caregivers
  - Executive leaders such as directors of nursing, administrators, or other leaders supporting this work
  - Nurse managers, direct care staff, educators
  - Physicians including the SNF Medical Director, primary care physicians
  - Consultants (Pharmacy, Hospice, etc.)
Step 8: Identify Your Gaps and Opportunities

- Review sources of information to determine if gaps or patterns exist in your systems of care that could result in quality problems
  - Look at MDS data for patterns
  - Resident and family satisfaction
  - ER/hospital use
  - Staffing (all days/shifts), Staff proficiency and Caregiver turnover
  - Clinical records
  - Local and National databases

Step 8: Identify Your Gaps and Opportunities

- Early team tasks include a diagnostic assessment and review of historic data like readmission rates, transfers from long-term care centers to hospitals, patient perception data, etc.
  - Perform an in-depth review of the last five residents that have been admitted to your facility to identify opportunities for improvement.
  - Evaluate trends in your organization’s resident experience data, on the informal feedback and any survey data obtained over the last year
    - Focus on information about the resident’s experience with their transition to and from skilled nursing
  - Review 30-day all-cause readmission rates to identify opportunities for improvement
    - include at least 12 months of data
    - look at various segments of the population

Geographic Hospitalization Patterns

- Oregon 15.7%
State of Oregon Heart Attack Readmission Rates

St Charles Medical Center
AMI Readmission Rate: 15.6

Legacy Mount Hood Medical Center
AMI Readmission Rate: 21.0

Do You Know Your Rehospitalization Rate?

- Medicare 30-day rate
  - Denominator: Medicare/PPS admissions (5-day or return assessment) to the SNF from an acute care hospital
  - Numerator: Those Medicare admissions that return to an acute care hospital within 30 days of entry to the SNF
- Rates usually yearly
  - Rolling 12-month rate
- Resident Roster
- Root cause analysis
QAPI and Rehospitalization (An Example)

- Facility QAPI committee identifies increased trend in residents being rehospitalized within 30 days of admission
- Further research reveals rehospitalization rate has increased above national benchmark
- PIP is chartered and PIP team assembled
  - Nurse manager, Admissions director, Social worker, Medical Director, CNA

Step 9: Charter PIPs

- Chartering implies that the team has been entrusted with a mission, and that it reports back to the Steering Committee at intervals
  - A PIP is more than a casual effort - it entails a specific written mission to look into a problem area
  - The PIP team should include people in a position to explore the problem (usually direct caregivers)
- Being part of a formally chartered PIP team must be interpreted as an important assignment that team members and their supervisors must take seriously
- PIP team establishes appropriate goals for organizational quality measures, informal improvement initiatives, and PIPs.
Step 10: Plan, Conduct and Document PIPs

- During a PIP you will try out some changes and then see whether or not they made a difference in the area you were trying to improve.
- In the PLAN stage, the team learns more about the problem, plans for how improvement would be measured, and plans for any changes that might be implemented.
- In the DO stage, the plan is carried out, including the measures that are selected.
- In the STUDY phase, the team summarizes what was learned.
- In the ACT phase, the team and leadership determine what should be done next. The change can be adapted (and re-studied), adopted (perhaps expanded to other areas), or abandoned.
- Report back to Steering Committee

Step 11: Getting to the “Root” of the Problem

- Root Cause Analysis (RCA)
  - Primarily focuses on systems and processes, not individual performance
  - Structured method of analysis is designed to get to the underlying cause of a problem
  - Looks for the reasons behind the reasons. This process will generally lead to the identification of more than one root cause
  - Leads to identification of effective interventions that can be implemented in order to make improvements
- RCA focuses primarily on systems and processes, not individual performance

Getting to the root of the problem

- There is danger in starting with a solution without thoroughly exploring the problem. Multiple factors may have contributed, and/or the problem may be a symptom of a larger issue.
Root Cause Analysis (RCA)

- Analyze high rehospitalization rate within 30 days of admission: Why?
  - Assess internal discharge planning process and systems to identify and act on early change in condition
  - What is the relationship with acute care facility?
  - Target problem diagnoses and/or levels of risk to start with
  - Assess Staffing (RNs, LPNs)
  - Staff competencies
- Other resources: Pharmacy, Radiology, etc.
- Physicians, Physician Extenders, NPs
  - Availability and reliability
  - Response to staff
- Families
  - Understanding of disease processes
  - Communication about when to hospitalize

The Business Implications...

- What if you market your observed [unadjusted] low rehospitalization rate but it’s really due to low acuity?
- What if you get passed by because your observed [unadjusted] high rate is due to higher acuity?
- Share your case-mix adjusted rate regardless of finding.

Analysis: The Relationship of Patient Acuity on Rehospitalization Experience...

- Patient acuity plays a major role in the SNF’s ability to prevent rehospitalization
- Acuity, diseases and conditions all impact this experience
- PointRight modeled the 30-day rehospitalization risk for individual Medicare SNF admissions using MDS 3.0 data from over 2000 facilities
- Independent variables were stable indicators present on first MDS assessment
- Using the model to calculate an expected rate, we computed an adjusted rate:
  - \( \frac{\text{Observed rate}}{\text{expected rate}} \times \text{(national average rate)} \)
QAPI and Rehospitalization

- Analysis of prior rehospitalization data to identify areas of focus
  - Diagnoses of discharged residents
  - Day of discharge
  - Length of Stay-cumulative rehospitalization rate
- Identify gaps in the system and areas for improvement

A Closer Look at One SNF

30-Day Rehospitalization Rates by Diagnosis
Cumulative Rehospitalization Rate Reveals Opportunity

When are Patients Coming to You?

Rehospitalization Rate Within 3 Days: When are They Admitted?
Rehospitalization Within 30 Days: When are They Leaving?

Your Analysis: Case Study One
1. What are facility Strengths and Weaknesses?
2. Looking at 30-day rehospitalization rates, where are there improvement opportunities?
3. When do most patients come to you?
4. When do most patients return to hospital?
5. What admitting day of week is challenging for 3-day rehospitalizations?

A Second Example
30-Day Rehospitalization Rates by Diagnosis

Cumulative Rehospitalization Rate Reveals Opportunity

When are Patients Coming to You?
Rehospitalization Rate Within 3 Days: When are They Admitted?

Rehospitalization Within 30 Days: When are They Leaving?

Your Analysis: Case Study Two

1. What are facility Strengths and Weaknesses?
2. Looking at 30-day rehospitalization rates, where are there improvement opportunities?
3. When do most patients come to you?
4. When do most patients return to hospital?
5. What admitting day of week is challenging for 3-day rehospitalizations?
Risk Adjustment: Take Away Message

- Many facilities that excel in preventing rehospitalization in one cohort are challenged in others.
- A non-case mix adjusted rehospitalization rate, that is not disease specific, challenges goals for networking with hospitals and ACOs.
- Facility rehospitalization rates are NOT the same as hospital rates; need to manage your cohorts and know your strengths and weaknesses.
- Set up processes to easily identify resident conditions and the reason/diagnosis for returning to the hospital.
  - Investigate RCA of poor outcomes.
- Enhance clinical programming and staff competencies.

Goal Setting: Using the SMART Formula

- The engine of improvement is the Plan-Do-Study-Act (PDSA) cycle.
- A team conducts small-scale tests of change in real work settings — by planning a test, trying it, observing the results, and acting on what is learned.
- Observation may inform improvement because it yields significant learning as a team tests and then implements changes.

PDSA
Step 2: Develop a Deliberate Approach to Teamwork

- A typical front-line improvement team includes:
  - A Day-to-Day Leader for each pilot unit who will drive the work on their respective unit(s)
  - Residents, family members, or resident caregivers
  - Physician or nurse champion
  - Nurse practitioner or physician assistant (if applicable)
  - Nurse manager/supervisor, staff nurses, case manager, certified nursing assistant, nurse educators
  - Dietician
  - Physical therapist/occupational therapist
  - Social workers and/or discharge planners
  - Clinicians and staff from other care settings and/or community-based organizations (e.g., acute care, home health care, area agency on aging, other SNFs)

PDSA: Test the Changes (Why?)

- To decide which of several proposed changes will lead to the desired improvement
- To decide whether the proposed change will work in the actual environment of interest
- To decide which combinations of changes will have the desired effects on the important measures of quality
- To evaluate costs, social impact, and side effects from a proposed change
- To minimize resistance upon implementation

*Start small, observe the results, learn from them, and continue to the next test*

PDSA: Test the Changes (Why?)

- Most changes require a series of successive tests before implementation
- Testing may include
  - Adding more staff to try the change
  - Adding a variety of types of residents and family caregivers
  - Testing on different shifts
    - on the weekdays and on the weekends,
    - when short staffed, well staffed,
    - on days with many admissions, few admissions
- Learn as much as possible and create a process that is failure-proof (i.e., that works as reliably as possible).
PDSA: Testing the Changes

- Precisely specify the work, who does what, when, how, where, etc.
- Make use of human factors principles (e.g., build on existing habits)
  - Use checklists/communication tools to avoid relying on memory
  - Foolproof the process so that it is impossible to do the wrong thing
  - Use standard protocols and training
  - If the responses vary, this may reveal a lack of reliability in how the work is done
- Make sure there is a process in place that identifies failures
  - Learn where failures occur and then design redundancies or remedies if they occur

- Use data to process reliability
  - Track whether new and improved processes are executed as expected
  - Learn whether and how specific changes work as planned
  - When data suggest a lack of process reliability — ask the people who do the job what barriers they face
  - Identify opportunities to execute the new processes more reliably
  - Avoid blaming staff who do the work
  - Assume the problem is from poor process design
- Work with the team to fix it.

Step 12: Take Systemic Action

- Broadly implement the change to make it permanent and routine
  - To be effective, interventions or corrective actions should target the elimination of root causes, offer long-term solutions to the problem, and have a greater positive than negative impact on other processes
  - The goal is to make changes that will result in lasting improvement. Avoiding quick fixes and weak actions is vital to achieving that goal.
  - Common solutions such as providing more training/education or asking clinicians to “be more careful” do not change the process or system
  - In addition, interventions must be achievable, objective, and measurable
Classification of Corrective Actions

Weak
- double checks
- warnings/labels
- new policies, procedures, memoranda
- training/education
- additional study

Intermediate
- decrease workload
- software enhancements
- eliminate/reduce distraction
- checklists/triggers/prompts
- enhanced documentation, communication

Strong
- physical changes
- forcing functions or constraints (e.g. cannot continue charting until all fields completed)
- simplifying

Use Available Process Tools and Resources

- Internal Tools
  - Admission data
  - Shift Communication/Change of Condition forms
- Interact Version 3.0
  - Early Warning Tool
  - “Stop and Watch”
  - SBAR Communication Tool and Progress Note
  - Quality Improvement Tool For Review of Acute Care Transfers
  - Advance Care Planning Tools
- AHCA LTC Trend Tracker
  - Free resources for AHCA members
    - Risk adjusted rehospitalization rate

Moving Forward: Staffing

- Staffing patterns
  - Appropriate number and type of staff?
    - Are you staffing to acuity? Five Star levels? RUG acuities? Something else?
    - Consistent assignments
    - RN support and oversight
    - LH with adequate competencies
  - Collaborative interdisciplinary team for care planning;
  - Managing risk assessment results- risk of imminent death, risk of rehospitalization

- Physician / Physician Extender support
  - Evaluate your process for patient/resident evaluation by physician/physician extender

- Multidisciplinary/Interagency Team Development
  - Adequate admission process
Moving Forward: Education

- Staff Education
  - Elements for all staff levels
  - Orientation
  - Competencies updated and reviewed
    - Clinical skill sets
    - "Transition-specific care competencies"
  - Bring consultants and medical services on board with the quality focus
  - Provide "background" information to put into context
- Resident and Family Education
  - Ensure resident and families have opportunity to contribute
  - Materials specific to resident and families
    - End of life, advance directives etc.
    - Disease conditions
- Community Collaboration
  - Partner with health care professionals in community

QAPI Challenges

- Using data systematically to get a comprehensive overview of performance
- Turning data into meaningful information
- Building in systematic resident and family input without bias
- Structuring PIPs
- Applying root cause analysis
- Using systems thinking in all quality efforts
- Breaking out of silos of disciplines, departments, & shifts to work system-wide

QAPI Rewards

"Transforming the lives of nursing home residents through continuous attention to quality of care and quality of life"

- Competencies that equip you to solve quality problems and prevent their recurrence
- Competencies that allow you to seize opportunities to achieve new goals
- Caregivers become active partners in performance improvement
- Above all, better care and better quality of life for your residents

*S&C 11.22.94, April 2011
Conclusion

- Healthcare Reform impacts the daily life of staff and residents
  - Length of stay
  - Care protocols
  - QAPI
  - Insurance coverage
  - Compliance/Transparency
  - And many many other ways!
- The data requirements are apparent, but not always understood
  - Rehospitalization rates
  - Satisfaction
  - Quality

Conclusion

- Not all rehospitalizations should be prevented
  - Acute care may be medically necessary in many situations
  - Accurate assessment of care needs is critical
  - Need to watch carefully for inappropriate “observation care” at hospital
    - CMS looking into this area
- Admit to your scope of services; know your capabilities
  - Strong facility admissions coordinator gathering consistent information on care needs
  - Establish a process for this “new admission” review by the clinical team; be prepared for the resident (treatments, supplies etc.)

Resources:

- Hospital to Home, National Quality Improvement Initiative http://h2hquality.org/
- Interact v 3.0 http://Interact32.net/
- Quality Assurance & Performance Improvement http://go.cms.gov/Nhqapi
- Reducing Rehospitalisations...The Right Way/CMIA http://www.medicaresavvycharity.org
- “QAPI at a Glance” http://go.cms.gov/Nhqapi
- Final FY 2014 Inpatient and SNF Payment Rule, the Federal Register on August 6, 2013, https://www.federalregister.gov/public-input
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