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Sink or Swim: Navigating Value-Based Care and Reducing Hospital Readmissions

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View the entire course including any applicable handouts/resources. Complete a post-test assessment. You must score 80% or better on the post-test and complete the course evaluation to earn a certificate of completion for this activity. If required, Select Rehabilitation will report attendance to CE Broker.

ABOUT THE COURSE AUTHOR

Dr. Kathleen Weissberg, (MS in OT, 1993; Doctoral 2014) in her 30 years of practice, has worked in rehabilitation and long-term care as an executive, researcher and educator. She has established numerous programs in nursing facilities; authored peer-reviewed publications on topics such as low vision, dementia quality care, and wellness; has spoken at numerous conferences both nationally and internationally, for 20+ State Health Care Associations, and for 25+ state LeadingAge affiliates. She provides continuing education support to over 30,000 therapists, nurses, and administrators nationwide as National Director of Education for Select Rehabilitation. She is a Certified Dementia Care Practitioner, Certified Montessori Dementia Care Practitioner, Certified Fall Prevention Specialist, and a Certified Geriatric Care Practitioner. She serves as the Region 1 Director for the American Occupational Therapy Association Political Action Committee and is an adjunct professor at Gannon University in Erie, PA.

POST-TEST

1. Which of these statements best defines value-based care?
 - a) Value-based care is a system where healthcare providers are solely paid based on the volume of services they provide
 - b) Value-based healthcare is a system that emphasizes quality, outcomes, and patient satisfaction
 - c) Value-based care is a system solely focused on cutting costs
 - d) Value-based care is a single standardized care model across the country

2. Which of these is not considered a proven care management methodology shown to impact readmissions and improve care outcomes?
 - a) Identify high risk patients
 - b) Improve transitional care
 - c) Ensure patients understand post-discharge instructions
 - d) None of the above – they all are proven methodologies
3. Which of the following is not a key principle related to value-based care models?
 - a) Patient-centered care
 - b) Utilization of emergency department services when available
 - c) Enhanced care coordination
 - d) Preventive services and chronic disease management
4. Which of these is not a direct impact of value-based care on patient outcomes?
 - a) Improved quality of care
 - b) Patient engagement and satisfaction
 - c) Increased quantity of services delivered
 - d) Cost efficiency
5. As we transition to value-based care, which of the following must occur?
 - a) Increase access to acute care services
 - b) Providers must shift from single episodes (silos) to treatment across the care continuum
 - c) Charge forward without patient buy-in
 - d) Frequently use only retrospective data

The post-test and corresponding course evaluation can be accessed at:
https://www.surveymonkey.com/r/Sink_or_Swim_On_Demand

Or by using the following QR Code:



If all course requirements have been met, a certificate will be emailed from Select Rehabilitation to the email address reported in the course follow-up survey.


Any questions or issues related to this course should be directed to Dr. Kathleen Weissberg, National Director of Education for Select Rehabilitation at kweissberg@selectrehab.com

If accessibility of learning is required, please contact Kathleen Weissberg at kweissberg@selectrehab.com for appropriate accommodations.

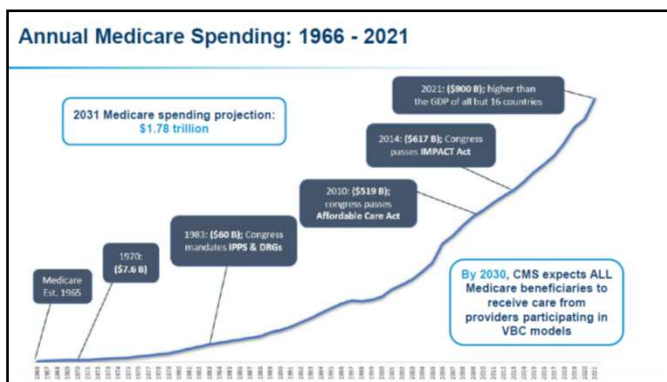
Sink or Swim:

Navigating Value-Based Care and Reducing Hospital Readmissions

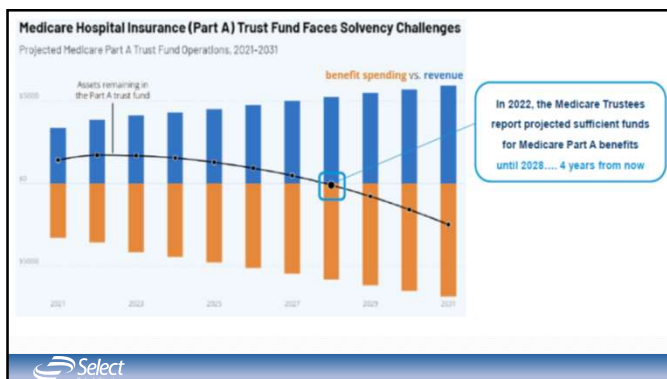
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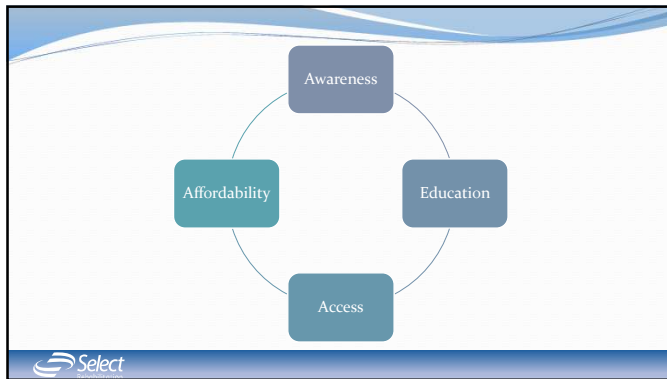
Value-Based Care Overview



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Steps to Follow

Ensure SNF staff are ready and capable to care for the resident

- Confirm understanding of resident's care needs
- Resolve any questions to ensure a good fit between resident and SNF

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Nursing Facility Capabilities List

• Emergency interventions	• Turnaround time for new meds
• Diagnostic Testing	• Drains and catheters
• Physician Services	• Nursing Services
• Consultation	• Pulmonary
• Therapies	• Wound care program
• Isolation	• IV capabilities
	• Mechanical feeding

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Confirm Understanding

- Collaboratively plan/communicate details of transfer via phone or in person
- Review current clinical and functional status
- Ensure understanding of care needs and details required to implement immediate care needs
- Compare current status to the transfer criteria and resolve discrepancies and questions
- Revise standardized transfer criteria and process as needed
- Obtain contact information for consulting physician



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Operational Strategies

- Early communication re: referral – 2 models
 - Quick, on-site clinical assessment of the patient by a nurse
 - Marketing/admissions coordinator presents information to the receiving facility's clinical team
- Conducting a clinical assessment ensures the person on paper is the person who arrives at the facility
- Ensure a system is in place to obtain the most current information



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Hospital to SNF Transfer Form

- | | |
|-----------------------------------|--|
| • Patient/Family information | • Nursing care provided |
| • Advance Directives | • Follow up required |
| • Physician and/or specialist | • Medical history |
| • Vital signs/current condition | • Procedures performed |
| • Mental status | • Allergies |
| • Diagnosis and treatment | • Skin assessment |
| • High Risk Conditions/Treatments | • Fall risk assessment |
| • Medications | • Questions to aid with bed assignment |



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Avoiding Gaps

- Identify/discuss concerns regarding clinical status
- Identify gaps between clinical status and transfer criteria
 - Does clinical status place resident at risk for complications after transfer?
 - Resolve any concerns or defer transfer if safety cannot be ensured
- Ensure medication, treatment, equipment are available



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Typical Failures

- Confusion about transfer criteria
- Incomplete clinical information
- Failure to assess resident needs
- Inaccurate perception of SNF assets and limitations
- Premature hospital discharge
- Lack of timely pre-authorization



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Screening Tools

- Identify patients at risk of readmission
 - Risk scores
 - Risk identifiers



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The 8P Screening Tool

- Identifies risk factors for adverse events post-hospital discharge
- Clinical, demographic, logistical factors
- Risk identification system rather than a risk score
- Each risk identified is matched with a risk-specific intervention



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The 8P Screening Tool

1. Problems with medications
2. Psychological
3. Principal diagnosis
4. Physical limitations
5. Poor health literacy
6. Patient support
7. Prior hospitalization
8. Palliative care



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LACE Index Scoring Tool

- Identify patients at risk of readmission -- not specifically potentially preventable readmission
- Limited number of factors measured
- LOS cannot be calculated accurately until the last day of hospitalization, limiting real-time use.



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LACE Index Scoring Tool

- Step 1. Length of Stay
- Step 2. Acuity of Admission
- Step 3. Comorbidities
- Step 4. Emergency department visits

Score Risk of Readmission: > 10 High Risk



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What Are We Doing to Provide Care?



- Medication reconciliation
- Internal communication
- Care meetings – do we focus on status or barriers?
- Analytics and outcomes?
- Satisfaction surveys?
- Protocols and pathways?
- Role of the NP
- Therapy addressing function



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Medication Reconciliation Worksheet

- Develop accurate and safe medication orders at the time of admission
- Track medications recommended by the hospital at discharge
- Seek clarification and resolution as needed
- Clarify medications taken prior to hospitalization not d/c list



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Stop and Watch

- Seems different than usual
- Talks or communicates less than usual
- Overall needs more help than usual
- Participated in activities less than usual
- Ate less than usual
- N
- Drank less than usual



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Stop and Watch

- Weight change
- Agitated or nervous more than usual
- Tired, weak, confused, or drowsy
- Change in skin color or condition
- Help with walking, transferring, toileting more than usual



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Decision Support Tools

- Change in Condition Cards
 - Help determine whether to report specific symptoms, signs, and lab results immediately, vs. non-immediately
- Care Paths
 - Decision support tools providing guidance on recognition, evaluation, management of conditions that commonly cause hospital transfers



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Early Recognition

- Nurse practitioners on-site to quickly intervene and provide treatment
- Early recognition may allow resident to stay at the facility
- Study in Missouri that placed APRNs found decrease of hospitalizations by 33% and a Medicare savings of \$1,376 per person



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Physician Communication

- Before Calling MD
 - Evaluate the resident and complete a progress report
 - Check vital signs – blood pressure, pulse, respiratory rate, temperature, pulse ox, and/or finger stick glucose if indicated
 - Review chart
 - Have relevant information available



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Physician Communication SBAR

- Situation
- Background
- Assessment or Appearance
- Request



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Goal is to address and reroute BEFORE they present at the ED. If they're at the ED, it's too late.




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Preparing for Successful Discharge

Protocols!


- Full team including SW, nursing, therapy
- To ensure that all critical elements are addressed
- Addressing high risk re-admissions (e.g., AMI, COPD, CHF)
- Focus on low and rising risk patients to ensure they do not become high risk




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Care Pathways & Mandatory Time Outs

- Medical equipment ordered?
- Education complete?
- Medications ordered?
- Follow up appointments scheduled?
- Family meetings?
- Transportation?
- Early referrals



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Weathering

"The process of wearing or being worn by long exposure to the atmosphere"

The term "weathering" was coined in 1992 by Dr. Arline Geronimus when she studied the cumulative impact of repeated experience with social and economic adversity on health.

"What are your patients enduring?"
"What challenges are your patients facing?"

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How Are We Planning for Discharge?

"We are exceptional at treatment, but not at discharge."

There is no "discharge" -- they are our patients for life.



Select

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Failed Handoffs

- Direct communication is lacking
- Meta-analysis revealed 12-34% of hospital DC summaries reach aftercare providers in time for first post-hospitalization appointment
- DC documentation often contained inaccuracies or lack pertinent information

Alper, E., O'Malley, T., & Greenwald, J. (2020)

Select

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Scope of the Problem

- Inadequate handoff communication can result in:
 - Medication mishaps or discrepancies
 - Unmet expectations of patients and their family
 - Unwanted conditions such as pressure ulcers
 - Confusion with payor-source resulting in billing mishaps
 - Behavior management needs beyond the scope of the facility
 - Failure to meet special dietary needs
 - Readmission to the hospital



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Are We Doing Enough?

- Perspective of patients
 - 28% reported not feeling ready for DC
 - Correlated w/ inadequate symptom resolution, poor pain control, concerns about ability to perform ADL
 - 65% remembered reviewing paperwork, >22% could not ID critical information
 - Led to increased rehospitalization rates
 - 85% reported having a primary doctor, only 56% who had contact info phoned him/her before returning to the hospital



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Preparing for Successful Discharge

- ADL Programs to ensure highest level of function
 - OT, nursing, and restorative
- Medication management and understanding
- Caregiver training
 - Ensure return demonstration
- Home exercise programs
 - Initiated with return demonstration prior to DC



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Prevent Readmissions Post-DC

- How can/will you continue to work with the client after discharge?
 - Client advocate for the episode of care
 - Navigators
- How can you make technology work for you?
 - Web-based home programs, exercises, remote patient monitoring



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- Transportation – roadrunners
 - Food pharmacy
- Diabetes education classes
- Next Side of Care




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- Access to a 24-hour help line?
- Do they know about it?
- Do they use it?
- Options for low acuity patients?
- Help with follow up appointments?
- Re-route to their provider?




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Prevent Readmissions Post-DC

- Who addresses the "social" side of discharge?
 - Were medications delivered timely?
 - Is DME/AE in place?
 - Did the client see MD for follow up?
- One person to coordinate and place phone calls



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SNF to Hospital Transfer Form

- Patient/Family Information
- SNF contact
- Primary MD at SNF
- Code status
- Reason for transfer
- Vital signs and diagnosis
- Usual mental and functional status
- Devices and treatments
- Risks
- Impairments



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Acute Care Transfer Log

- Tracking mechanisms to evaluate timing and nature of readmissions
- Record date, time, status, outcome and diagnosis
- Analyze for trends and hospitalization rates



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Summarize Your Findings

- Resident characteristics
- Changes in condition
- Actions taken prior to the transfers
- Potentially preventable transfers
- Hospital transfer and contributing factors



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Quality Improvement

- Could this transfer have been avoided?
- Were there "early warnings" of a decline in the patient's condition?
- Could precautions have been taken?
- Could the nursing home have provided the acute care the patient needed?



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Typical Failures

- Lack of a clear picture of resident's history, severity of condition, complications
- Medication errors
- Untimely delivery of medications
- Delayed access to lab results
- Lack of follow-up plans or protocol
- Lack of key information
- Lack of clear advance directives
- Incomplete information sharing



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Cross Continuum Partnerships

- Identify opportunities to improve care transitions
- Surface failures, diagnose systemic gaps, test new ideas
- Review and analyze readmission data and data about patient and family experiences
- Review case examples to ID opportunities for improvement
- Link processes where cooperation is required.
- Add patients and family caregivers to the cross-continuum team



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Cross Continuum Partnerships

- Staff from each facility visit others and host others
- Visits are transparent and focus on processes involved in patient transition between settings
- Describe facility-specific processes
- Tell your story and share your outcomes



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What Value Do You Bring


- To the community and beyond ...
 - Wellness
 - Education
 - Lectures
 - Something else?



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Satisfaction to Drive Service

- How do you measure satisfaction?
- How do you measure outcomes?
 - Are metrics used to improve service?



Select

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Other Thoughts ...

- Internal barriers?
- Dual roles?
- Role of the navigator
- Role of the NP

Select

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Key Take Aways

- We must use a whole person approach to care to be successful
- We need to balance LOS with readmissions
- We need to get ahead of value-based care before it becomes more aggressive than it already is

Select

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