

Hospital Readmissions Survival Guide

The Long-Term Care Provider's Ultimate Survival
Guide to Incorporating INTERACT™ into Health
Information Technology (HIT)

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In this survival guide, we'll give you the tips you need to demonstrate to local hospitals and ACOs how your facility can help prevent costly patient readmissions, which is critical to the survival of many acute providers and key to Long-Term Care facilities maintaining a steady stream of referrals and revenue.

Long-term care providers will play an integral role in helping acute hospital providers reduce preventable readmissions by 20%

Introduction

The Drivers Behind Reducing Hospital Readmissions

In 2004, nearly one-fifth of all Medicare recipients were hospitalized within 30 days of discharge. Nearly 90%¹ of these hospitalizations were classified as unplanned resulting in a \$17.4 billion cost to the Medicare program. Due to the massive healthcare expenditures associated with rehospitalizations, there is a tremendous amount of buzz around reducing 30-day hospital readmissions and the growing need to decrease the risk for them.

In 2011, one-quarter of Medicare residents in Long Term Care were transferred to hospitals for inpatient admissions annually, costing Medicare \$14.3 billion.² Due to the associated resident risk and high costs, resident transfer and hospitalization rates have received the increasing scrutiny of government agencies, ACO's and national associations.

Healthcare reform efforts targeted at reducing readmissions are here to stay, with significant penalties for preventable hospital readmissions, under Section 3025 of the Affordable Care Act. October 1, 2012, marked CMS' requirement to reduce payments to acute hospitals with excess readmissions under the new Hospital Readmissions Reduction Program, with 1 percent of a hospital's entire Medicare billings, climbing to 2 percent in 2013 and 3 percent by 2014, and financial penalties for senior care providers with excess readmissions starting in 2018. As of September 2013, in a response to an OIG report stating that CMS should be instructing state agency surveyors to review hospitalization rates as part of the survey process, CMS responded that it is actively developing a re-hospitalization quality measure for all-condition hospital readmissions for Medicare SNF residents; further emphasizing the need to focus on the problem and implement strategies now. Hospitals needing to reduce their statistics will start to increasingly depend on LTC partners to affect reductions in

rates and make these rates criteria for partnerships moving forward. In this survival guide, we'll give you the tips you need to demonstrate to local hospitals how your facility can help prevent costly patient readmission, which is critical to the survival of many acute providers and key to LTC facilities maintaining a steady stream of referrals and revenue.

The Role of LTC Providers in Reducing Readmissions

LTC providers are affected by a number of factors when it comes to hospitalizing a resident. These include but are not limited to:

- Resident and/or family preferences or requests
- Medicare/Medicaid reimbursement policies across the healthcare spectrum
- Legal/regulatory concerns for managing acute conditions in a non-acute setting
- Ability to provide palliative and/or hospice care
- Availability of trained staff in the facility
- Availability of Lab and Pharmacy services
- Emergency department pressure to treat and discharge

Regardless of these factors, LTC providers will play an ongoing integral role in helping acute hospital providers meet the requirement to reduce preventable readmissions by 20%, which will save \$15 billion in costs and prevent 1.6 million readmissions, and reduce harm to patients by 40% resulting in \$20 billion in costs and 1.8 million fewer patient injuries.³ The hospital's readmission performance will measure the excess readmission ratio against a national average for the hospital's set of patients with acute myocardial infarction, heart failure, and pneumonia conditions to calculate their specific ratio. As acute hospital providers review sources of admissions and readmissions, significant focus will be placed on

¹Jencks SF, Williams MV, Coleman EA: Rehospitalizations among patients in the Medicare fee-for-service program. *N Engl J Med* 2009, 360(14):1418-1428.

²OIG Report, November 2013, Medicare Nursing Home Resident Hospitalization Rates Merit Additional Monitoring, Daniel R. Levinson

³A New Frontier in Patient Safety, JAMA, June 1, 2011 - Vol. 305 No 21

17% reduction in hospital readmissions with the implementation of INTERACT™

reducing or eliminating those that have a significant impact on their readmission rates. LTC providers that have the proper policies, programs, and procedures in place to monitor, manage, and avoid readmissions will benefit from higher hospital referral rates and ultimately revenue.

The most commonly used program by providers today is INTERACT (Interventions to Reduce Acute Care Transfers), a quality improvement program designed to improve the early identification, assessment, documentation, and communication about changes in the status of residents in care facilities. It is also the tool stipulated in the NACL Quality Initiative because of its transferability across the spectrum of care – all homes within a community can use the same tools, speaking the same language. The goal of the program is to improve care and reduce the frequency of potentially avoidable transfers to the acute hospital by:

- Preventing conditions from becoming severe enough to require hospitalization through early identification and assessment of changes in resident condition
- Managing some conditions in the nursing home without transfer when feasible and safe
- Improving advanced care planning and the use of palliative care plans when appropriate as an alternative to hospitalization
- More rapid identification and transfer of residents who do need hospital care

Incorporating INTERACT™ Into Facility Processes

Over a six month period, the INTERACT program was implemented in 25 community-based nursing homes in Florida, Massachusetts, and New York and resulted in a 17% reduction in hospital admissions among the residents.⁴ The reduction was even greater in homes that were more engaged in implementing the INTERACT program and tools.

As with any program designed to improve quality of care and assist staff with identification and communication

of resident issues, providers must develop a thorough and clear project plan for implementation, training, and monitoring. Full implementation of the INTERACT program is not an overnight process and should be consistent with the way that care is provided within the facility.

Selecting the Team

Organizational leadership must be in place to support the time necessary to fully implement the INTERACT program and tools. In addition, careful selection of the implementation team members is crucial. The core team should include the Executive Director or Administrator, Director of Nursing, Medical Director, a lead floor nurse and Certified Nursing Aide (CNA), and Social Worker. Additional team members may come from Rehabilitation, Dietary, Activities, Housekeeping, and the Consulting Pharmacist.

Providers should also identify a project Champion and Co-Champion. These two individuals will be responsible for motivating staff and have the skills to coordinate implementation of the program. In addition, the Champion and Co-Champion should be responsible for obtaining input from frontline staff at all stages of the implementation and used to refine the program rollout.

Determine the Baseline and Gaps

The success of any quality improvement program depends on the ability to measure and track the associated outcomes and determine the overall effect that the changes are having within the facility. Understanding the baseline measurements and comparing against results obtained during the implementation will allow the implementation team to determine what is working well and adapt the implementation through root cause analysis of any issues.

Providers should begin by looking back at the number of hospital transfers for their organization that occurred in the last three to six months using the INTERACT Acute Care Transfer Log. The Acute Care Transfer Log will allow providers to document the outcome of the transfer, as well as the hospital diagnosis for the ER visit or admission.

Once this data has been collected, the implementation team can begin to determine specific types of residents that are being transferred and use the INTERACT Quality Improvement Review Tool to further understand the factors that contribute to these transfers and help to identify opportunities for improvement while focusing on training and implementation to address these specific areas of concern.

As part of the process, the implementation team, led by the Champion and Co-Champion, should work with staff to review current facility processes and compare them with the tools available in the INTERACT program. The goal is to avoid redundancy while using the program to fill the identified gaps in facility processes and avoid additional work for the staff. A key point to remember, is that during the implementation, it may be necessary to replace a current tool or process with one included in the INTERACT program.

Making it Happen

The INTERACT program and tools should be incorporated into the facility's overall quality improvement program and educational activities. Consider what resources are available to devote to the training and what training methods have worked best within the facility for implementing new programs.

Facilities may want to consider finding a local expert skilled in the implementation of the INTERACT program and tools to conduct the staff training. If a local expert is not available, a facility can choose to send key staff members to a state or industry association sponsored INTERACT training program providing a "train-the-trainer" environment. Those individuals can then act as key points of contact for other staff members within the facility.

While the overall goal of the implementation may be to fully utilize the INTERACT program and tools, the reality may

be that a phased approach for use within the organization is best. This should be part of the plan developed by the implementation team and clearly communicated to all staff by the Champion and Co-Champion. As the INTERACT tools are introduced, older documentation tools and forms should be removed to avoid confusion and encourage the adoption and use of the new ones.

All staff should be included in the INTERACT program and tools training, including senior management. Make sure to include ancillary departments, such as Maintenance, Housekeeping, and Dietary. Another recommendation is to hold a separate training session for resident physicians and nurse practitioners. The INTERACT program focuses on enhancing communication between direct care staff and these individuals, and as such, a targeted in-depth session to discuss this is warranted.

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Marketing to Local Hospitals

Since the changes in regulations by CMS and the ACA directly affect acute hospitals, these organizations are going to be actively seeking to optimize partnerships with downstream organizations that have programs and a proven track record of reducing the potential for readmissions to the acute care setting within the first 30 days of discharge.

Part of the project plan for implementation of the INTERACT program should involve education with local hospitals and other sources of admission to the facility. The team should meet with acute discharge planners

and key staff in person to educate them on the INTERACT program, the implementation project and timelines, and how the program will positively affect their business.

The INTERACT Facility Capabilities List can be used as a starting point for building the presentation. Be sure to communicate what processes will be in place to improve the quality of care the facility provides and how both organizations can work together to reduce avoidable readmissions. Plan on holding follow-up meetings to share results of the program, enhance collaboration between the organizations, and to communicate about the acute transfers that have occurred.

Review and Refine

Don't expect perfection and/or results overnight. As with any new quality improvement program, there is a learning curve experienced by staff as they grow accustomed to the new way of working and for the impact to be reflected in facility outcomes. It may take several months of hard work to fully implement, to complete the training, get the INTERACT tools in place, and integrate the tools into everyday use.

As the frontline staff learn and implement the tools within the organization, the INTERACT project team and Quality Improvement Committee should be reviewing the Quality Improvement Review Tools and Transfer Logs. The findings from these tools will directly impact the next steps in the facility's efforts to reduce hospital readmissions and improve quality of care.

Also imperative, is the need for the project team to actively monitor the results being obtained with the INTERACT program. This is critical in making adjustments to the project and implementation plan before any issues or flaws become embedded in the use process of the program.

In addition to monitoring the facility readmission rate and number of ER visits per 1,000 resident days, organizations eINTERACT™, reduce unnecessary hospital readmissions by bringing the significant quality improvements of the INTERACT™ program to EHR software platforms.

Incorporating INTERACT™ Into Health Information Technology

As numerous research studies have shown, use of the INTERACT program and tools in manual processes can be successful in assisting providers to reduce acute care transfers. Incorporating the tools into health information technology (HIT) systems presents providers with additional opportunities to impact the reduction of readmission rates.

- Ensure compliance with the use of the program and tools
- Eliminate duplication of static information across paper forms
- Increase access to all resident information pertinent to the INTERACT program
- Proactively address issues and concerns through automated reminders and alerts
- Reduce time spent on manual tasks, including calculations and reporting
- Higher likelihood of success of the program through sustainable usage

With the upsurge in the adoption of the INTERACT program by state and national associations, providers now have a complete program to assist with identification of at risk residents and the ability for the staff to proactively communicate issues amongst the interdisciplinary care team. Embedding INTERACT into a provider's HIT system can result in additional efficiencies for staff and a more proactive approach to managing residents at a higher risk of being hospitalized repeatedly. There are several INTERACT tools that providers can and should integrate within their HIT to achieve optimal results.

The first is the Stop and Watch tool, which can be incorporated with the HIT's Point of Care (POC) documentation. By integrating this tool into the normal documentation workflow, nursing assistants can quickly identify and record changes in a resident's condition,

which will trigger alerts for licensed staff to take the appropriate next steps once a change has been documented. All staff, including Dietary, Housekeeping, and Maintenance, should also be trained on how to use the Stop and Watch tool and thus, be trained on how to document identified changes through the provider's POC system. Doing so can significantly reduce the risk of a change in resident condition being identified well after the occurrence or not at all.

Both the Care Paths and SBAR tools, used by licensed staff to assess and communicate resident changes, should also be incorporated into the HIT system. Depending on the system used by the provider, this could be done in a variety of methods including utilizing a customized assessment or a templated progress notes module. Where possible, prefilling information in the forms such as current medications, active diagnoses, recent vital signs, and any available allergy information will offer additional gains in efficiency. In addition, alerts to complete the Care Paths and/or SBAR forms based on identified changes in condition through the Stop and Watch items embedded in the POC system can help to ensure timelier follow-up by licensed staff for those residents at risk for acute care transfer.

Another tool that providers find beneficial in the event a resident needs to be moved to an acute setting is the Resident Transfer form. Production of this form from the HIT system will ensure that the standardized set of resident-specific information is provided when a transfer to the emergency department occurs. Given that acute transfers often happen relatively quickly, the system should pre-fill as much resident information from the clinical record as possible to limit the amount of information the licensed staff must provide to complete the form and perform the transfer.

Finally, all acute transfers should be automatically documented to the Acute Transfer Log and the system should produce a Quality Improvement Tool for Review of Acute Care Transfers form for each transferred resident. These tools are critical for use by providers' quality improvement process teams or committees for review of each transfer and discussion of interventions, which may have resulted with the resident remaining in the facility. Such reviews are important to drive changes in the care delivery processes with the goal to further reduce acute care transfers.

Eliminating Multiple, Disparate Systems

While including the above tools within the HIT system is beneficial, it is typically achieved through multiple, disparate applications. However, there is a fully electronic method for providers called eINTERACT™. A joint initiative between Florida Atlantic University and PointClickCare, eINTERACT is the industry's first initiative designed to reduce unnecessary hospital readmissions by bringing the significant quality improvements of the INTERACT program to Electronic Health Record (EHR) software platforms.

eINTERACT™ - an industry's first initiative designed to reduce unnecessary hospital readmissions

By adopting eINTERACT, providers will:

- Improve care by early identification, assessment, documentation, and communication about changes in the status of a resident's condition directly from within their EHR system
- Improve adherence to evidence-based and expert-recommended protocols and related documentation, thereby decreasing legal liability and regulatory sanctions
- Demonstrate proven and federally recommended strategies designed to assist in the reduction of up to 40 percent, and sometimes more, of potentially preventable hospital admissions and readmissions, as well as emergency room visits and observation stays, thereby maintaining revenue and a positive relationship with primary sources of resident admissions
- Avoid potentially higher readmission rate penalties being sought by CMS and the Long-Term Quality Alliance

Conclusion

As acute care providers with excess readmissions face significant financial penalties moving forward, there is a tremendous push to reduce the alarming upward climb in 30-day hospital readmissions. LTC providers will play a key role in helping to prevent costly patient readmission and can achieve this by adopting and incorporating the eINTERACT program within their facilities. By doing so, they will gain the ability to proactively improve early identification, evaluation, documentation, and communication about changes in the status of a resident's condition to reduce post-acute care transfers. Facilities demonstrating that they have adopted proven and industry acceptable standards designed to assist in the reduction of potentially preventable hospital admissions and readmissions will maintain a consistent revenue stream and positive relationships with primary sources of resident admissions.

PointClickCare Technologies Inc. is helping over 14,000 long-term and post-acute care (LTPAC) providers meet the challenges of senior care by enabling them to achieve the business results that matter – enriching the lives of their residents and patients, improving financial and operational health, and mitigating risk. PointClickCare's cloud-based software platform is advancing senior care by enabling a person-centered approach to care, connecting healthcare providers across the care continuum with easy to use, regulatory compliant solutions for improved resident outcomes, enhanced financial performance, and staff optimization. For more information on PointClickCare's ONC certified software solutions, please visit www.pointclickcare.com.



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