REDUCING READMISSIONS FOR SNF PATIENTS

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Objective

- Identify 3 practical strategies you are willing to test to reduce readmissions for patients discharged from hospital to SNF
CROSS-SETTING COLLABORATION
What do we think SNFs need?

- H&P
- Redesigned transfer form
- Same-day discharge summary
- Med rec form
- MOLST/POLST/Advanced Directive
- Access to our EMR

What do you think SNFs need to assume care of your patient?

Have you asked them?
Ask the “receiver”

What does the SNF staff need that they are constantly missing?

- Hard copies for prescriptions on controlled substances
- Last pain medication administration time
- Last toileting
- Baseline and current mobility; baseline and current cognitive status
- Confirmation of picc line placement
- Behavioral health comorbidity information
- Behavioral management strategies (“sundowning”)
- Updated insights re: goals of care discussions (not just code status)
- Insight into discharge planning risks/needs/challenges
- Care plan partner
Readmission Review

- 78M hospitalized for UTI, discharged to SNF; readmitted 1 day for altered mental status
- 69F hospitalized for back pain; discharged to SNF; readmitted 3 days after family called 911 from SNF
- 89F hospitalized for pneumonia; discharged to SNF; readmitted 22 days later from home
Listen to the “receiver”

What are the root causes of SNF readmissions?

- Incomplete information about clinical status
- Incomplete information about functional status
- Incomplete information about behavioral health or “sundowning”
- Missing hard copies of controlled substance prescription
- Missing documentation of placement of tubes or lines (e.g., picc lines)
- Delays in obtaining (rare, expensive) medications
- Change in clinical status but not emergency
- Patient/family dissatisfaction with the facility
- Readmissions following discharge from SNF to home
Redesigning Cross-Setting Care

• Before you decide what the solution is, ask the “receiver” – what will work best for them? *What do they need? How do they need it?*
  • Better form?
  • More complete transfer packet?
  • Warm handoff?
  • Read-only access to EMR?
  • Ongoing collaboration (co-management)?

➤ *Sometimes the best answer is the simpler answer*
➤ *Often it’s best to test improvement ideas to be sure they are helpful*
MANAGING CARE ACROSS SETTINGS AND OVER TIME

5 practical, effective strategies
1. Warm Handoffs with “Circle Back” Call

SNF Circle Back Questions (Hospital calls back SNF 3-24h after d/c):

☑ Did the patient arrive safely?
☑ Did you find admission packet in order?
☑ Were the medication orders correct?
☑ Does the patient’s presentation reflect the information you received?
☑ Is patient and/or family satisfied with the transition?
☑ Have we provided you everything you need to provide excellent care to the patient?

Key Lessons:

- Transitions are a **process** (forms are useful, but need intent)
- Best done **iteratively with communication**

Source: Emily Skinner, Carolinas Healthcare System
Warm Handoffs with “Circle Back” Call
Implementation Tips

Richmond, VA hospital and several partnering SNFs
• 1 point person RN made the post transfer calls
• Each SNF knew the name, contact of that 1 RN at the hospital
• The asked the 6 questions and followed up on all issues

Key tips:
• Point person is key for fostering collaborative relationship
• RN provides “reminder” to floor RN, CM, MD about what was missing
• RN follows up with “issues here” and “issues there”
Circle Back: “Ideas that Work”
Implementation Example

“6 simple questions are making a difference in the Richmond community”

https://www.youtube.com/watch?v=SG28aJhs63s

“Anytime I discover an issue, I always follow up. When I started making the calls, I found issues 26% of the time; last month I only had issues 8% of the time”

- Hospital RN
2. “Warm Follow Up”

“Warm follow-up” – check in call after transfer to SNF

Process with SNFs:
- **Support staff** facilitated logistics (patient lists, meeting time, etc)
- Telephonic “card flipping” between ACO team & SNF

Key lessons:
- **Took a while** to develop collaborative rapport v. “in-charge”
- **No substitute** for verbal communication and problem solving
3. Co-Management Over Time

- **Dedicated Team:** A Point Person
  - ACO or Bundle clinical coordinator

- **Co-Management:** Physical or Virtual Rounds in SNF
  - RN / NP to see patient, discuss plan with SNF staff
  - Respond to changes in clinical status to manage in setting
  - Weekly telephonic rounds ACO/bundle coordinator and SNF
  - LOS, progress toward discharge goals, transitional care planning
  - Tele-medicine consults in SNF to manage on-site

- **Direct admit back** to SNF from home
Co-manage Across the Continuum

*Implementation Tips*

- Hospital-based transitional care staff follow patients regardless of discharge setting
  - Transitional care staff (RN, SW, CHW, etc) follow patients for 30 days post discharge; this includes patients who are in SNF or receiving home care

- Hospital-based transitional care staff (readmission, bundle, ACO) track which patients are discharged to which PAC
  - Hospital-based transitional care staff “round” (see patients, talk with SNF staff, families) in person at facilities
  - Hospital-based transitional care staff “case conference” with SNF-based staff via phone
4. ED Treat-and-Return

• Data & Root Causes:
  • “Why are almost all SNF patients admitted?”
  • “Patients only seen once a month”; “they can’t do IVs”, etc
  • “If they send them here they can’t take care of them”

• Actions:
  • Asked ED providers to consider returning patient to SNF
  • Education: posted INTERACT SNF capacity sheets in ED
  • Simplicity: establish contacts, standard transfer information
  • Reinforce: Thanked providers when ED-SNF return occurred

• Results: Increased number of patients returned to SNF after ED evaluation
ED Treat-and-Return

Source: Dr Steven Sbardella, CMO and Chief of ED
Hallmark Health System Melrose, MA
ED Treat-and-Return
Implementation Tips

• Think twice: *can this person return to the SNF?*
  ✓ *Use the INTERACT SNF capabilities list*

• Make it easy: *SNF identifies point person to facilitate return*
  ✓ *On the INTERACT NH-ED Transfer Form*

INTERACT tools available at: [www.interact2.net](http://www.interact2.net)
5. Treat in Place

*Identify & Respond without Transfer to ED*

**Stop and Watch**

Early Warning Tool

If you have identified a change while caring for or visiting a patient, please circle the change and notify a nurse or supervisor.

Seems different than usual
Talks or communicates less
Overall needs more help
Pain – new or worsening; Participated less in activities
Ate less
No bowel movement in 3 days; or diarrhea
Drank less
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

□ Check here if no change noted while monitoring high risk patient

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Hospital-SNF Collaboration

- Meet | Frequently | Communicate | Directly | Often

- 1 large multi-hospital system’s SNF collaborative meeting schedule:

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Attendees</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarterly</td>
<td>All SNFs in the region (repeated for 3 regions)</td>
<td>Education, networking</td>
</tr>
<tr>
<td>Quarterly</td>
<td>Partner SNFs together (for each hospital)</td>
<td>Coordinated efforts</td>
</tr>
<tr>
<td>Monthly</td>
<td>Individual partner SNFs (for each hospital)</td>
<td>Data, patients</td>
</tr>
</tbody>
</table>
Best Practices in Cross-Setting Collaboration

- Shared understanding of (best-available) data
- Shared understanding of patients and caregivers’ perspective
- Shared understanding of “receivers” perspective
- Clearly identified specific, feasible improvement ideas
- Implementing small tests, learning from “failure,” iterating
- ”Hardwiring” improvements into standard processes
- Regular meetings, joint problem-solving
Recommendations

1. **Target** improvement efforts based on the root causes of readmissions

2. **Develop** personal working relationships with a key contact at each facility

3. **Manage** patients discharged from hospital to SNF and SNF to home

4. **Make it easier** to treat-in-place or treat-and-return to avoid (re)admit
THANK YOU FOR YOUR COMMITMENT TO REDUCING READMISSIONS

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