Reducing Hospitalizations From The Skilled Nursing Facility

Presented by
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Skilled Nursing Facility Readmission Measure (SNFRM) NQF #2510: All-Cause Risk-Standardized Readmission Measure

- The intent of the SNFRM is to encourage SNF providers to monitor and reduce hospital readmissions, thereby reducing costs and improving the quality of care Medicare beneficiaries receive during their SNF stay (1).

- Hospital readmissions from SNFs are also expensive. According to Mor et al. (2010), based on an analysis of SNF data from 2006 Medicare claims merged with the Minimum Data Set (MDS), 23.5 percent of SNF stays resulted in a rehospitalization within 30 days of the initial hospital discharge. The average Medicare payment for each readmission was $10,352 per hospitalization, for a total of $4.34 billion. Of these rehospitalizations, 78 percent were deemed potentially avoidable. Applying this figure to the aggregate cost indicates that avoidable hospitalizations resulted in an excess cost of $3.39 billion (78 percent of $4.34 billion) to Medicare (Mor et al., 2010). (1)

- Hospitalizations are expensive, can have complications, are unsettling for SNF residents and most services can be provided in house

- With the information about readmissions and CMS’s increased observation of this measure Wesley’s Administrator in collaboration with the Medical Director reached out to Saratoga Hospital to begin the relationship for monitoring readmission.
Benefits of the relationship between Saratoga Hospital and Wesley

- Most SNF residents sent to the hospital go to Saratoga Hospital and most admissions to Wesley are received from Saratoga Hospital.
- Wesley’s in house and on call providers are employees of Saratoga Hospital.
- Wesley’s Medical Director is a Certified Medical Director Independent from Saratoga Hospital.
- There is one contact person for the hospital and one for the SNF.
- Wesley has 342 beds in house.
  - 19 of those beds are Short term rehabilitation beds.
Saratoga Hospital and The Wesley Community Work Together

- Hospitalizations were tracked starting November 2016, the end of January 2017 started the implementation of processes and procedures to reduce hospitalizations.
  - For those first 3 months we collected data. The number of transfers, their transfer diagnosis and the discharge diagnosis (which at times was not the same) and also recapped at the end of each month.
  - There was a total of 60 transfers 11 were evaluated in the ED and returned to SNF.
  - Over the three month the top 3 diagnosis as transferred were:
    - Altered Mental status 11; 7 also had a sepsis diagnosis secondary
    - Shortness of Breath 5
    - Falls 9; 4 of which had lacerations that required sutures/staples.
Saratoga Hospital and The Wesley Community Work Together

At the end of January Wesley’s Medical Director after reviewing the 3 months of data with the Quality Coordinator, came up with the following plan to begin February 1 2017:

- All New STR admits were to use an Incentive Spirometer for their entire length of stay.
- All new LTC admits and returns from the hospital were to use the Incentive Spirometer for at least the first 30 days of their admission/readmit.
- Suture kits were made available on all the units for the physicians and NPs to use.
- Increase in Lab and X-ray use on weekends and after hours

More recently

- SBAR initiated
- Continued education is provided to staff including updating protocols and enhanced training like insertion and monitoring of IVs

Currently Wesley and a local Orthopedics doctor are interested in looking at telemedicine review fractures to decide if a resident should be transported for care; especially if they are non-displaced fractures.
A resident is assessed at Wesley by the head nurse on staff and a call is made to a provider to update on the current status. If the resident needs something more that Wesley can’t provide they are sent to the hospital.

Saratoga Hospital (Laura) receives a call from Wesley (Rebecca) for an admission to the hospital to allow access to the patient records.

Admission documentation, notes, diagnosis and plan of care is reviewed.

The hospital information is sent to Wesley to track and trend. Saratoga Hospital notes any trends with hospitalizations.
Saratoga Hospital and The Wesley Community Work Together Continued

- Information is reviewed with the Medical Director at Wesley
- Wesley’s Medical Director engages:
  - Nursing and medical staff at Wesley for courses of treatment
  - Providers at Saratoga Hospital
    - ER providers and Hospitalists are advised of what Wesley can do for our residents not only for transfers but to assist in removing people from the ER
    - Families of residents are informed of the plan of treatment once a plan of care has been implemented for the resident’s current condition.
    - Staff at Wesley has been kept up to date on all our staff has to offer and the benefits to staying at the SNF during an acute illness; this is discussed routinely with residents and families
Keep a Transfer Log

This has been updated and adapted since inception
With MLTC requests of hospitalizations we are able to track by:

<table>
<thead>
<tr>
<th>Resident</th>
<th>Date</th>
<th>Time</th>
<th>DOA here</th>
<th>Reason</th>
<th>Ordered by</th>
<th>Hospital</th>
<th>Outcome</th>
<th>Insurance</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>John Smith</td>
<td>12/18/2017</td>
<td>3:30 PM</td>
<td>11/1/2017</td>
<td>Fall; confirmed fracture</td>
<td>Doctor X</td>
<td>Saratoga</td>
<td>Inpatient</td>
<td>Medicare</td>
<td>Hip replacement surgery</td>
</tr>
</tbody>
</table>
All Inclusive Transfers From Wesley to Saratoga Hospital

Goal: 5 or less residents sent to the hospital each month
Current: Average of 9.1 residents sent each month to the hospital
November 2016 to January 2017: Average 20 residents sent to the hospital
Medicare A Residents Only

Medicare A Transfers to The Hospital Within 30 Days of Admission to the SNF

Year to date % 30 day ER visit Med A 1.62%
Year to date % 30 day hospital Med A 2.59%
2016 20.5% returned to the hospital IP/OB under Med A
30 day return
2015 16.93% returned to the hospital IP/OB under Med A
30 day return
Conclusion

- It is important to have one person designated to track and trend at each facility
- Engagement of all involved is important
- Updating skills and education is important for providers
- Thank you for your time and attention! Are there any questions?
Contact Information

- Laura O’Mara - Saratoga Hospital
  - lomara@saratogacare.org

- Rebecca Bowman - The Wesley Community
  - rkbowman@thewesleycommunity.org
Resources


- Mor et al. (2010),