Addressing Long Term Care Readmissions in an Integrated Health System

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LTC Readmissions

Objectives:
• Define readmission rates from LTC settings
• Describe the nurse’s role in influencing readmissions
• Evaluate the INTERACT II tools and the impact on readmission rates across the care continuum

Why is this important?
• Unplanned/unnecessary re-hospitalizations are prevalent and costly (Jencks et al, 2009):
  - Medicare: 20% in 30 days; 34% in 90 days and 56% in one year
  - 50.2% had no bill for MD visit between index admission and readmission
  - LOS for second stay is longer
  - About 10% of readmissions are planned
• No clear definition for potentially preventable readmissions

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Wisconsin Readmissions

In one year nearly 30,000 people in Wisconsin experienced a readmission

LTC Readmissions

<table>
<thead>
<tr>
<th>Wisconsin Discharge Dispositions</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Self Care</td>
<td>52%</td>
</tr>
<tr>
<td>Skilled Nursing Facility (SNF)</td>
<td>22.7%</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>10%</td>
</tr>
<tr>
<td>Inpatient Rehab Facility (IRC)</td>
<td>2.4%</td>
</tr>
<tr>
<td>Other Hospital</td>
<td>2.2%</td>
</tr>
<tr>
<td>Intermediate Care Facility (ICF)</td>
<td>2%</td>
</tr>
</tbody>
</table>

LTC Readmissions

Retrospective study on rehospitalization rates, diagnoses and discharge location for 75+yo between 7-30 days post discharge (Hain, 2012)

- 6,809 Patients
- 12% Re-hospitalization rate:
  - SNF 15%
  - HH 13%
  - Home 8%

Conclusion: Nursing has a significant impact on re-hospitalization rates
LTC Readmissions

SNF 30 day readmissions (Ouslander 2011)
- 2007-2008 Medicare FFS beneficiaries 75yo+
- 30% DC to SNF
- 18% Readmitted with 30 days
- Of the readmissions, 1/3 readmitted in 7 days
- Index admission with highest readmissions:
  - GU (30%)
  - CV (25%)
- Readmission reasons:
  - HF, UTI, Renal Failure, Pneumonia/COPD

Nursing Impact on LTC Readmissions

- Acuity of LTC is increasing with Sub Acute Rehab (SAR) transfers
- Nursing can impact transitions through education, protocols and collaboration
- INTERACT II designed as a quality improvement intervention for SNF/LTC:
  - Reduce readmissions
  - Improve care and outcomes

INTERACT II

“Interventions to Reduce Acute Care Transfers” (Ouslander 2011)
- 25 LTC in 3 states over 6 months
- Provided:
  - Tools (protocols)
  - On site education for staff
  - Teleconference every 2 weeks
  - Facilitated by an NP
INTERACT II

INTERACT II Impact (Ouslander 2011)

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduction in readmissions</td>
<td>17%</td>
</tr>
<tr>
<td>Fully engaged SNFs</td>
<td>24% Reduction</td>
</tr>
<tr>
<td>Not engaged SNFs</td>
<td>6%</td>
</tr>
<tr>
<td>Comparison group</td>
<td>3%</td>
</tr>
<tr>
<td>Cost savings</td>
<td>$7,700</td>
</tr>
<tr>
<td>Projected Medicare savings</td>
<td>$125,000</td>
</tr>
</tbody>
</table>

Wheaton Franciscan Journey

Initial work October 2011

System leadership initiative to address readmissions from LTC and Home Health
- Literature search
- Identified Dr. Ouslander work
- Presented to System leadership as best practice for LTC:
  - Initial, general look at readmissions
  - Identifying trends
  - Develop action plans

November:
- Retrospective review of all 30 day readmissions
- Began to report at monthly DON meetings
- Action plans were created based on initial data and were presented to System CMO
Wheaton Franciscan Journey

January 2012:
• Created word document for INTERACT QI tool (prior was a PDF)
• Nurses responsible for filling out within 24 hours
• Stored on a secure drive for access
• System Home Health and LTC readmission workgroup initiated

Wheaton Franciscan Journey

• February 2012:
  – Developed a goal for each facility
  – 10% reduction from previous year average
• April 2012:
  – First cross site communication
  – Began with initial in-person meeting with nursing and care management leadership from acute care, LTC and Senior Health

Wheaton Franciscan Journey

• June 2012:
  – CNA and RN education on early warning signs of CHF
• July 2012:
  – Participated in WI Metastar readmission collaborative
• August/September 2012:
  – Collaborative meetings with other health systems
Wheaton Franciscan Journey

January 2013:
- Now 15% reduction from CY12
- Creating easier to use QI tool with drop down boxes
- Share with other LTC sites

<table>
<thead>
<tr>
<th></th>
<th>FY12 Baseline</th>
<th>Goal (15% improvement from baseline)*</th>
<th>FY12 Q1</th>
<th>FY12 Q2</th>
<th>FY13 YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Terrace at St Francis</td>
<td>10.56%</td>
<td>8.05%</td>
<td>4.45%</td>
<td>11.80%</td>
<td>7.97%</td>
</tr>
<tr>
<td>Franciscan Woods</td>
<td>9.42%</td>
<td>7.84%</td>
<td>9.10%</td>
<td>8.90%</td>
<td>8.97%</td>
</tr>
</tbody>
</table>

*Baseline data included any outlier months while 15% improvement excluded these months from the average.

Continued work:
- Focus on Palliative Care education for all staff
- Quarterly reporting of readmissions to system workgroups
- Monthly DON readmissions
- Report rates and trends in quarterly Board report
- Finished Metastar collaborative
- Applied for Dr. Ouslander NIH grant October 2012
  - denied due to process and low rates
Lessons Learned

- Need a champion to promote work and continue enthusiasm
- Include staff from beginning
- Make work meaningful, how will this impact residents?
- This is where care is going, leave comfort zone
- Get involved in local, state and national projects

References