Objectives

- Describe effective interventions to smooth transitions across settings for hospitals, nursing homes, and home health agencies.
- Learn from the successful steps that have been taken by Cedars-Sinai Health System to reduce readmissions.

HSAG-California
Your Partner in Healthcare Quality

- HSAG-California is the Medicare Quality Improvement Organization (QIO) for California.
- The QIO Program is the largest federal program dedicated to improving health quality at the community level.
**HSAG-California**  
**Your Partner in Healthcare Quality** (cont’d)

- QIOs are a major force and trustworthy partner for improvement.
- QIOs in every state and territory are united in a network administered by the Centers for Medicare & Medicaid Services (CMS).

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**Hospital Readmission Penalties**

- Effective October 1, 2012, 197 California hospitals will be penalized for having excess readmissions in congestive heart failure, acute myocardial infarction, or pneumonia.
- Up to 1 percent payment penalty will be applied to a hospital’s base operating DRG amount for all discharges in FY 2013.

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**Hospital Readmission Penalties (cont’d)**

- Penalties are based on July 2008 to June 2011 data.
- Penalties will increase in FYs 2014 and 2015.
- Example: If a hospital’s base operating DRG amount is $1,000 and the payment penalty is 1 percent, then the amount reduced by the penalty is $10 and the payment made to the hospital is $990.
Across the Great Divide:
Care Transitions Between Healthcare Settings

**Medicare FFS Readmission Data April 2011 to March 2012**

**California All-Cause 30-Day Readmission Rates**

<table>
<thead>
<tr>
<th>Setting Discharged To</th>
<th>Number of Discharges</th>
<th>Number of Discharges Readmitted within 30 Days</th>
<th>30-Day Readmit Rate</th>
<th>% of 30-Day Readmits to another hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home</td>
<td>392,005</td>
<td>67,985</td>
<td>17.3%</td>
<td>26.1%</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>176,345</td>
<td>40,139</td>
<td>22.8%</td>
<td>26.4%</td>
</tr>
<tr>
<td>Home Health Agency</td>
<td>123,903</td>
<td>25,553</td>
<td>20.6%</td>
<td>21.8%</td>
</tr>
<tr>
<td>Hospice</td>
<td>15,771</td>
<td>582</td>
<td>3.7%</td>
<td>35.9%</td>
</tr>
<tr>
<td>Other</td>
<td>53,076</td>
<td>10,897</td>
<td>20.5%</td>
<td>41.0%</td>
</tr>
<tr>
<td><strong>All</strong></td>
<td><strong>761,100</strong></td>
<td><strong>145,156</strong></td>
<td><strong>19.1%</strong></td>
<td><strong>26.6%</strong></td>
</tr>
</tbody>
</table>

**Medicare FFS Readmission Data April 2011 to March 2012**

**Number of Days from Discharge to Readmission**

<table>
<thead>
<tr>
<th>Setting Discharged To</th>
<th>Number of Readmissions</th>
<th>1–7 Days</th>
<th>8–14 Days</th>
<th>15–21 Days</th>
<th>22–30 Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home</td>
<td>67,985</td>
<td>36.1%</td>
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<td>17.2%</td>
<td>16.2%</td>
</tr>
<tr>
<td>Other</td>
<td>10,897</td>
<td>38.6%</td>
<td>22.1%</td>
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<td><strong>19.6%</strong></td>
<td><strong>20.0%</strong></td>
</tr>
</tbody>
</table>

**Interventions**

- Hospital Interventions:
  - Better Outcomes for Older Adults through Safe Transitions (BOOST)
  - Project Re-Engineered Discharge (Project RED)
  - Care Transitions Intervention (CTI)
- Nursing Home Intervention:
  - Interventions to Reduce Acute Care Transfers (INTERACT)
- Home Health Intervention:
  - Reducing Acute Care Hospitalizations Best Practice Implementation Package (BPIP)
**Components of Project RED**

- Teach a written discharge plan the patient can understand.
- Assess the degree of the patient’s understanding of the discharge plan (teach-back).
- Make appointments for follow-up medical appointments and post-discharge tests/labs.
- Identify the correct medicines and a plan for the patient to obtain and take them.
- Call the patient within three days of discharge to reinforce the discharge plan and help with problem-solving.

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**Home Health Resources**

- Reducing Acute Care Hospitalizations BPIP
  - Call Me First Posters
  - Hospital Risk Assessment
  - Emergency Care Plan
  - Readmission Data

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*Patient activation trumps all*

Slide courtesy of Dr. J. Brock
INTERACT II

- Designed to manage the acute changes in a nursing home resident
- Goal is to improve care quality, not to prevent all hospital transfers
- INTERACT II Web site http://interact2.net/

INTERACT II Tools

- Communication Tools
- Decision Support Tools
- Advance Care Planning Tools
- Quality Improvement Tools
Early Warning Tool
“Stop and Watch”

- Early warning tool for CNAs to alert license nurse of change
- Goal:
  - Improve CNA observation skills of subtle changes
  - Improve CNA to LVN/RN communication to initiate action BEFORE hospital transfer is unavoidable

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Early Warning Tool
“Stop and Watch” (cont’d)

If you have identified an important change while caring for a resident today, please circle the change and discuss it with the charge nurse before the end of your shift.

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SBAR
Physician/NP/PA Communication and Progress Note for New Symptoms, Signs, and Other Changes in Condition

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Health Services Advisory Group of California, Inc.
and Cedars-Sinai Health System

–6–
**Quality Improvement Tool**

- Reviews transfers to identify opportunities to improve the identification, evaluation, and management of changes in resident condition and other situations that commonly result in transfers.
- Lists reasons why the resident was hospitalized.

**Advancing Excellence Campaign: Safely Reduce Hospitalizations Tracking Tool**

Welcome

Safety Reduce Hospitalizations Tracking Tool v1.2
December 4, 2012

This easy-to-use tool helps you track transfers of residents to the hospital along with information needed for your quality improvement project and root cause analysis. This tool also produces monthly summaries for you to enter on the Advancing Excellence in America’s Nursing Homes website where you will be able to access trend graphs of your progress over time:
http://www.NHQualityCampaign.org
Across the Great Divide:
Care Transitions Between Healthcare Settings

Advancing Excellence Campaign:
Safely Reduce Hospitalizations Tracking Tool
- 30-day readmission rate
- Admissions by day of week
- Transfers by doctor
  - Five doctors who order the most transfers
- Transfers by outcome
  - ED visit only, admitted inpatient or observation
- Transfers by reason
- Transfers by time of day

Advancing Excellence Campaign:
Safely Reduce Hospitalizations Tracking Tool

No Place Like Home Campaign
www.noplacelikehomeca.com

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and Cedars-Sinai Health System
Across the Great Divide:
Care Transitions Between Healthcare Settings

Care Transitions QIO Support Center
http://www.cfmc.org/integratingcare/toolkit.htm

Thank You!
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818-265-4650
jwieckowski@hsag.com

We convene providers, practitioners, and patients to build and share knowledge, spread best practices, and achieve rapid, wide-scale improvements in patient care; increases in population health; and decreases in healthcare costs for all Americans.

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