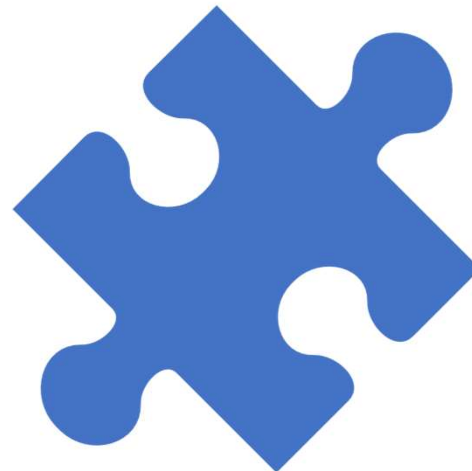
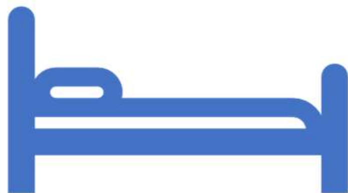




The Mystery of the Preventable Hospital Readmission

NMHCA Leadership Symposium
March 2023

Patricia Whitacre, RN,
New Mexico Health Care Association
Andrea (Andy) Romero, RHIT,
Comagine Health

Objectives:

Identify readmission elements/factors that are within your facility's control

Identify your crime fighting (readmission-busting) team

Identify the clues for best practices in lowering readmission rates

Explain how readmission rates factor into Medicare/Medicaid VBP programs

Some quick statistics:

- 18% of patients discharged to a post-acute setting are readmitted within 30 days.
- $4.34 billion dollars- national annual cost for readmissions to healthcare systems.
- $10,353- average per patient readmission cost to a healthcare system.
- Elderly patients are 2x more likely to die within 30 days of readmission and they are 4X more likely to face death within 100 days of readmission

- Agency for Healthcare Research and Quality (AHRQ): https://www.ahrq.gov
- Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP) https://www.ahrq.gov/research/data/hcup/index.html
- State Inpatient Databases (SID): https://www.hcup-us.ahrq.gov/sidoverview.jsp

The highest number of disease conditions causing the most hospital readmissions include :*

Chronic Heart Failure (CHF-congestive heart failure)

Chronic Obstructive Pulmonary Disease (COPD)

Sepsis

Urinary Tract Infection

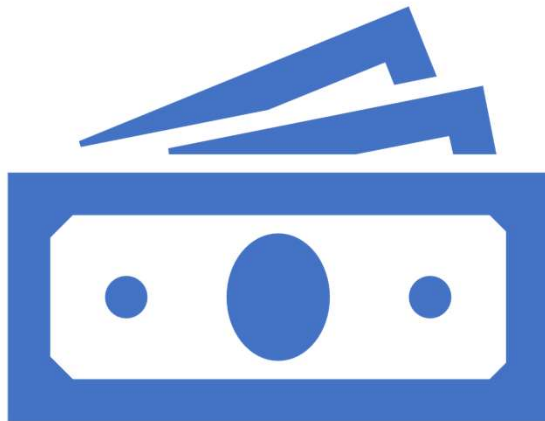
Pneumonia

- *as reported by Centers for Medicare and Medicaid Services (CMS)
- Percentages indicate hospital readmission rate per 100 patient admissions. These five clinical conditions cause the most readmissions for Medicare patients in a 30-day period. Source: Agency for Healthcare Research and Quality, Center for Delivery, Organization and Markets Healthcare Cost and Utilization Project (HCUP), State Inpatient Databases (SID)

Medicare and Medicaid

Performance and Reimbursement

Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program



The SNF VBP Program began rewarding SNFs with incentive payments based on quality measure performance on October 1, 2018.

The program currently scores SNFs on unplanned, all-cause hospital readmissions for SNF residents within 30 days of discharge from a prior hospital stay to a SNF.

As required by statute, the program reduces SNFs' Medicare Part A payments by two percentage points, then redistributes approximately 60% of those funds as incentive payments.

Skilled Nursing VBP cont’d

- The Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program offers Medicare incentive payments to SNFs paid under the SNF Prospective Payment System (PPS) based on their performance on specified measures of readmissions
  - SNFs are assessed on both improvement and achievement and scored on the higher of the two.
- Provides strong incentives for facilities to coordinate care
- Aims to protect patients from potential harms or adverse events associated with hospital readmissions
- Builds on previous quality improvement efforts in the skilled nursing facility sector and other Medicare VBP Program
- Nursing Home Compare

Measures

- Percentage of short stay residents who were rehospitalized after a NH admission
- Percentage of short-stay residents who have had an outpatient ED visit
- Number of hospitalizations per 1000 long-stay resident days
- Number of outpatient ED visits per 1000 long-stay resident days
- Rate of successful return to home and community from a SNF
- Rate of potentially preventable hospital readmissions 30 days after discharge from a SNF

Percentage of short-stay residents who were re-hospitalized after a nursing home admission
Lower percentages are better

14.1%
National average: 22.1%
New Mexico average: 19%

Percentage of short-stay residents who have had an outpatient emergency department visit
Lower percentages are better

10.3%
National average: 11.8%
New Mexico average: 16.3%

Number of hospitalizations per 1,000 long-stay resident days
Lower numbers are better

Not available [9]
National average: 1.59
New Mexico average: 1.34

Number of outpatient emergency department visits per 1,000 long-stay resident days
Lower numbers are better

Not available [9]
National average: 1.02
New Mexico average: 1.50

Rate of successful return to home or community from a SNF
Higher rates are better

No different than the national rate
56.6%
National average: 52.7%

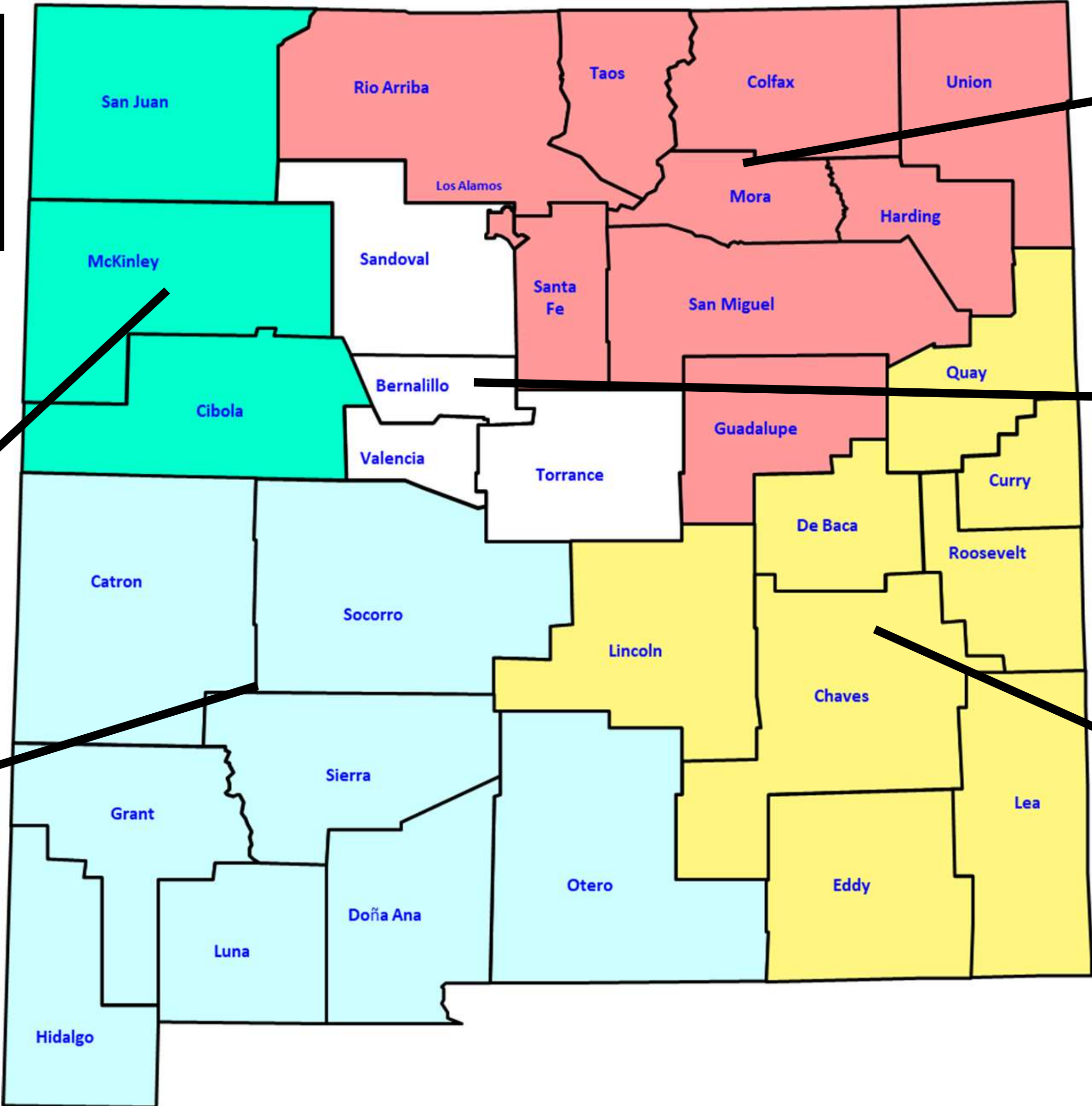
Rate of potentially preventable hospital readmissions 30 days after discharge from a SNF
Lower rates are better

No different than the national rate
7.5%
National average: 7.8%

New Mexico:
- Percent Bonus: 36%
- Percent Penalty: 61%
- No Change: 3%
- Grand Total: 70

Northwest Region:
- Bonus: 4/8 Nursing homes
- Payment Incentive % (-1.98 to 1.52)

Southwest Region:
- Bonus: 4/15 Nursing homes
- 1 No Change
- Payment Incentive % (-1.98 to 0.73)



Northeast Region:
- Bonus: 3/10 Nursing homes
- Payment Incentive (-1.98 to 1.36)

Metro Region:
- Bonus: 9/22 Nursing homes
- Payment Incentive (-1.98 to 1.50)

Southeast Region:
- Bonus: 4/15 Nursing homes
- 1 No change
- Payment Incentive % (-1.98 to 1.32)

Map Image Source - https://ibis.health.state.nm.us/resource/EpiConcepts.html
Data Source - https://khn.org/news/medicare-cuts-payments-to-nursing-homes-whose-patients-keep-ending-up-in-hospital/

FY 2023 Scoring and Payment Adjustments

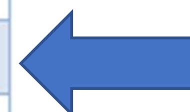
CMS suppressed the use of SNF readmission measure data

Assigned each SNF a performance score of zero

Each SNF receives an incentive payment multiplier equal to 60% of the 2% withhold, resulting in a 1.2% payback percentage

Medicare Value-Based Purchasing

SNF VBP Program year	Baseline period	Performance period
FY 2019[a]	CY 2015 (1/1/2015–12/31/2015)	CY 2017 (1/1/2017–12/31/2017)
FY 2020	FY 2016 (10/1/2015–9/30/2016)	FY 2018 (10/1/2017–9/30/2018)
FY 2021	FY 2017 (10/1/2016–9/30/2017)	FY 2019 (10/1/2018–9/30/2019)
FY 2022	FY 2018 (10/1/2017–9/30/2018)	4/1/2019–12/1/2019[b]
FY 2023	FY 2019 (10/1/2018–9/30/2019)	FY 2021 (10/1/2020–9/30/2021)
FY 2024	FY 2019 (10/1/2018–9/30/2019)	FY 2022 (10/1/2021–9/30/2022)
FY 2025	FY 2019 (10/1/2018–9/30/2019)	FY 2023 (10/1/2022–9/30/2023)



Phase One Review and Corrections: December and June of each Calendar Year
Phase Two Review and Corrections: 30 days after dissemination of the annual PSRs (typically August

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE18003.pdf

NM MCO Medicaid VBP & Provider Fee SB 246

- In the Centennial Care 2.0 Contract with NM MCOs (3), HSD required them to have Value Based Purchasing contracts with NFs. Project goal is to improve quality of care, reduce avoidable hospitalizations, and optimize health for all New Mexico Medicaid members receiving services in NFs by 2023*
- Goals for the NF VBP program are:

  - Better value for Medicaid funds spent on care

  - Create an incentive for nursing home providers to improve or maintain high quality

  - Increase access to services for Medicaid beneficiaries

  - Provide a performance-based mechanism for distributing the VBP "bucket" of funds raised by the Provider Quality Surcharge Act (SB246)

*payouts based on Medicaid bed days with quarterly payments, voluntary participation

Home Health Value Based Purchasing

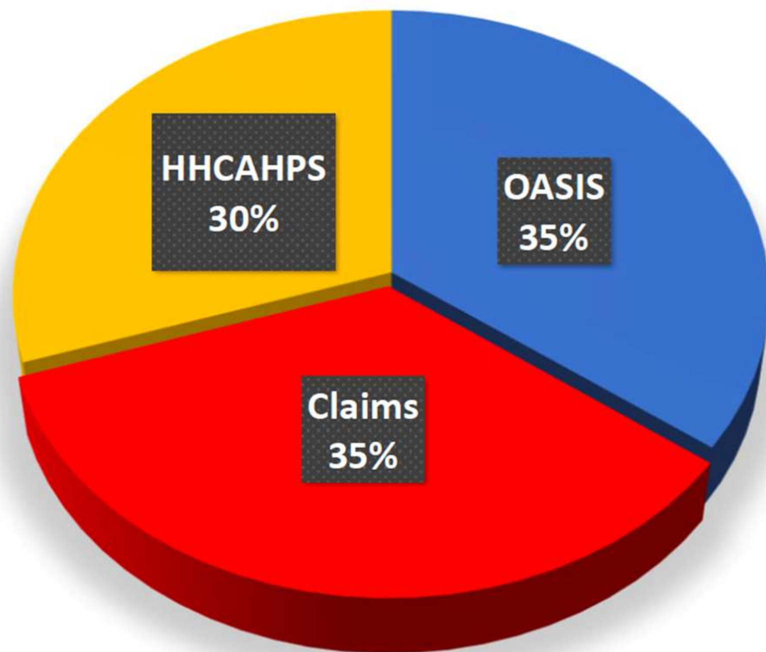
- CMS estimates $2.276 billion in savings in 4 years (CY 2023-2027)
- CY 2022 Pre-implementation year
- CY 2023 First performance year- expanded model
- CY 2025 First payment year based on CY 2023 performance

Exhibit 7. Model Baseline, HHA Baseline, Performance, and Payment Years based on Medicare-certification through December 31, 2023

Medicare-certification Date	Model Baseline Year*	HHA Baseline Year**	Performance Year (CY)	Payment Year (CY)
1	2	3	4	5
Prior to January 1, 2019	2022	2022	2023	2025
On January 1, 2019 – December 31, 2021	2022	2022	2023	2025
January 1, 2022 – December 31, 2022	2022	2023	2024	2026
On January 1, 2023 – December 31, 2023	2022	2024	2025	2027

* CY 2022 is the Model baseline year used to determine the benchmark and achievement threshold.
** For HHAs certified on or after January 1, 2022, the HHA baseline year will be the first full CY of services beginning after the date of Medicare certification.

Home Health Value-Based Purchasing Weights

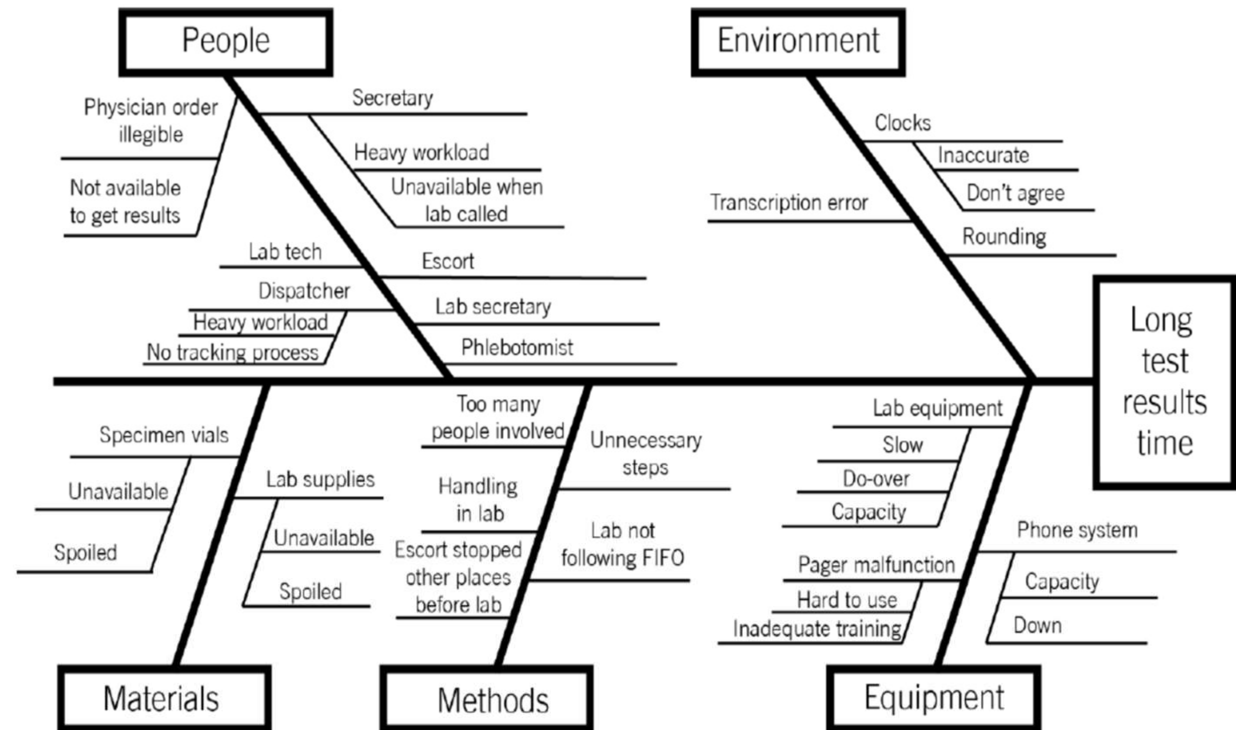


Claims Data Includes:

- Acute Care Hospitalization (ACH) in the first 60 days of home health
- Emergency Department (ED) use without hospitalization in the first 60 days of home health

Drivers/Challenges of Rehospitalization

Cause and Effect (fishbone) Diagram Example

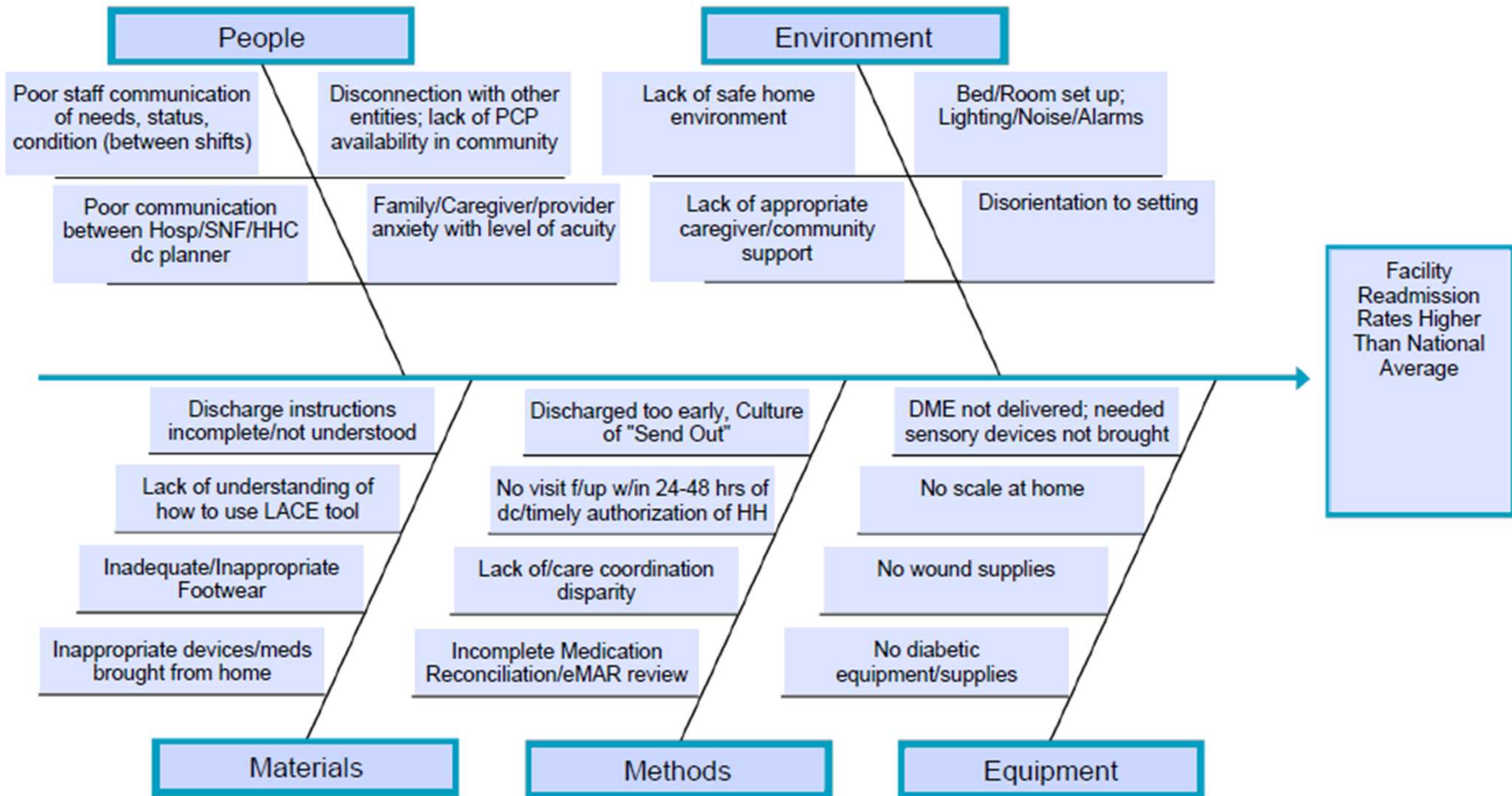


Before filling out this template, first save the file on your computer. Then open and use that version of the tool. Otherwise, your changes will not be saved.

Template: Cause and Effect Diagram

Team: Awesome Nursing Home **Project:** Reducing Readmissions

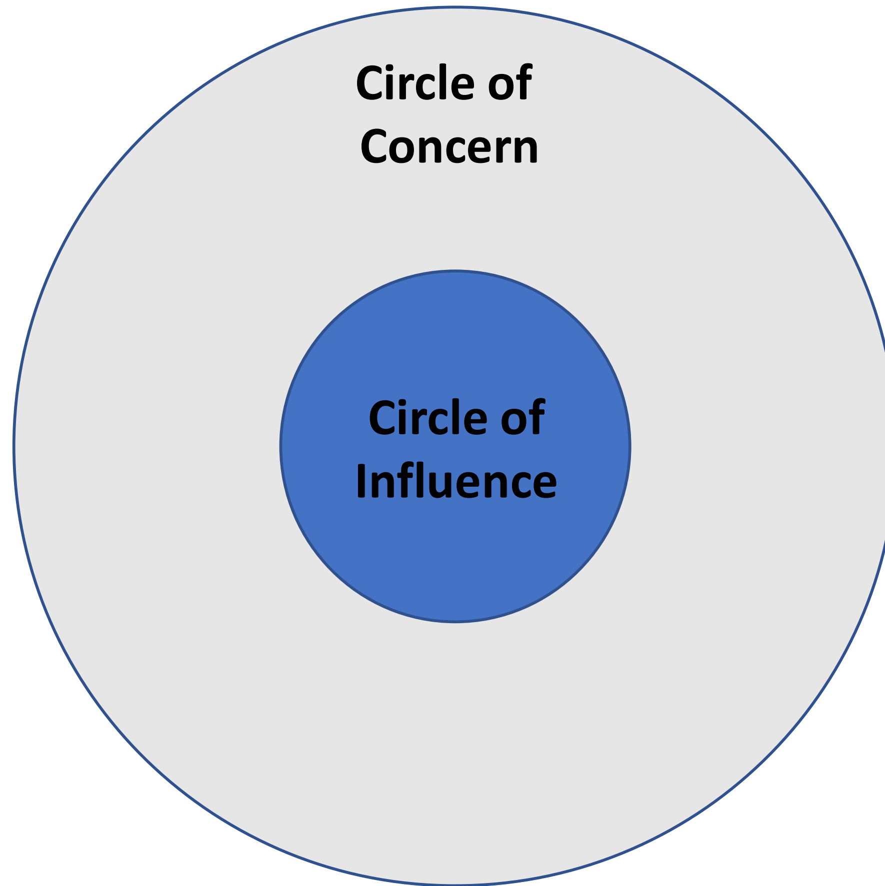
1) Input the effect you'd like to influence.
2) Input categories of causes for the effect (or keep the classic five).
3) Input causes within each category.



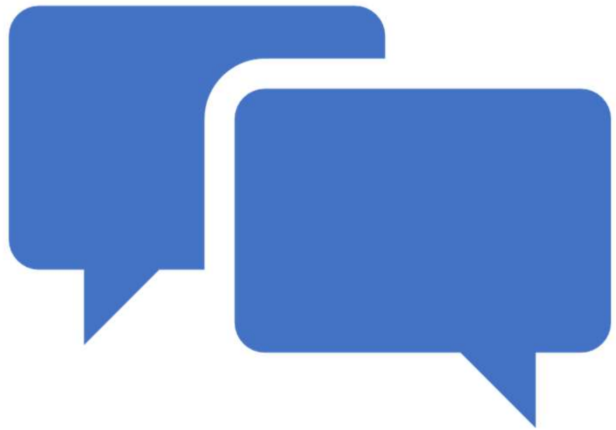
Cause and Effect Diagram: Quality Improvement Essentials Toolkit. Retrieved from: http://www.ihi.org/resources/Pages/Tools/Quality-Improvement-Essentials-Toolkit.aspx?utm_campaign=QI-Toolkit-Promotion&utm_medium=Whiteboard-Video&utm_source=ihi

“Every system is perfectly designed to achieve exactly the results it gets”

First law of Improvement



Stephen Covey. Seven Habits of Highly Effective People. Powerful lessons on Personal Change



Discussion

2019 NMHCA Leadership Symposium- Facility feedback on Best Practices for Hospital Readmissions

- Transition/discharge plans begin on Day 1 whether resident discharges to another facility or home; ask resident what goal is
- Especially with PDPM effective October 1, 2019, facilities must:
  - *Know what type of residents they are admitting, review charts*
  - *Appropriate ICD-10 coding diagnoses, not only hospital but other co-morbidities*
  - *Use EDie capability to ascertain prescription monitoring, ED visits*
- Call the DON, ADON, charge nurse or nurse on call to triage why the resident may be going back to the hospital, discuss rationale, have observations ready to discuss- vitals, pain complaints etc.,
- Get all physicians on board with consistent policy/procedure/criteria for sending resident to the ER, especially nights and weekends
  - *Have infection criteria identified (McGeer, Loeb's)*
  - *provide on-call physicians (extenders) with training regarding the policies and procedures of the facility, same focus/same outcomes*

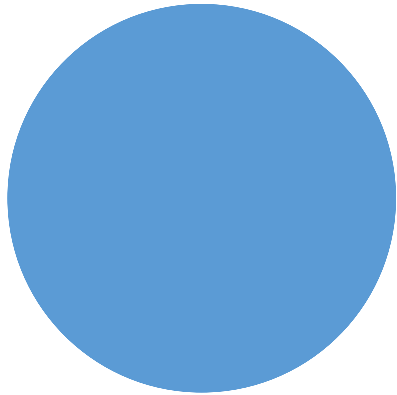
2019 NMHCA Leadership Symposium- Facility feedback on Best Practices for Hospital Readmissions (cont.)

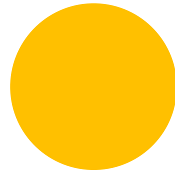
- Facility pharmacist to review all medication regimen for admissions no later than 24-48 hours. Look at medication stop dates, diagnoses, correct dosages, drug/drug contraindications, PT/INR monitoring, sliding scale appropriateness
- Have 24-48-hr family/resident meeting to ensure medication reconciliation is correct, no medications missing or deleted.
- Ensure advanced directives, phone numbers for family correct. If the resident has history of readmissions, discuss how staff will try to prevent readmission (LACE), discuss cons of readmission and how difficult it is for resident
- If resident is a frequent readmission, ensure that advanced directives are updated and in place, discuss appropriateness of Hospice or palliative care intervention

2019 NMHCA Leadership Symposium- Facility feedback on Best Practices for Hospital Readmissions (cont.)

- Proactively address family concerns treating within facility vs. sending to ER; discuss concerns, involve the Medical Director and educate both regarding how resident can be cared for at the facility
- Suggest a resident cognitive screening (BIMS) for family/clinical discussion before resident is discharged home
- One-button cell phone for residents referred for Home Health to help with caregiver anxiety the first few days post-discharge. Residents/family can ask questions and voice concerns
- In QA meetings, focus on residents sent to the hospital, what their admission diagnosis was, why resident was readmitted and what could facility have done to more effectively prevent the readmission *(interdisciplinary input is crucial!)*

Discussion





Who is Your Crime Fighting (readmission-busting) team?

Discharge Planning

- Clinical- explain new diagnoses, any needed labs in the future and why, specialist interventions
- Medication Reconciliation- of vital importance
- **Home visit by Physical Therapist? Get the real home picture**
- HHC referral
- Follow up physician appointments
- Social Services
- Teach Back
- Health Literacy
  - Review of materials – are they understandable?
- Facility follow up within 24-48 hours
- Remind HHC, family that resident can return to SNF (for same diagnosis) within 30-day window

Tools and Technology to support you

LACE: The LACE index identifies patients that are at risk for readmission or death within thirty days of discharge from the hospital.

"L" stands for the length of stay of the index admission.

"A" stands for the acuity of the admission. Specifically, if the patient is admitted through the Emergency Department vs. an elective admission.

"C" stands for co-morbidities, implements the Charlson Co-Morbidity Index.

"E" stands for the number of Emergency Department visits within the last 6 months.

LACE scores range from 1-19 and as mentioned above predict the rate of readmission or death within thirty days of discharge.

A score of 0 – 4 = Low;

5 – 9 = Moderate;

A score of ≥ 10 = High risk of readmission.

LACE form template

L	**Step 1. Length of Stay** Length of stay (including day of admission and discharge)	
	Length of stay (days)	**Score (circle as appropriate)**
	1	1
	2	2
	3	3
	4-6	4
	7-13	5
	14 or more	7
A	**Step 2. Acuity of Admission** Was the patient admitted to hospital via the emergency department?	
	Yes	3
	No	0
C	**Step 3. Comorbidities** If the total score is between 0 and 3, C-score equals to the total score. If the total score is 4 or higher, C-score is 5.	
	Condition	**Score (circle as appropriate)**
	Previous myocardial infarction	+1
	Cerebrovascular disease	+1
	Peripheral vascular disease	+1
	Diabetes without complications	+1
	Congestive heart failure	+2
	Diabetes with end organ damage	+2
	Chronic pulmonary disease	+2
	Mild liver or renal disease	+2
	Any tumor (including lymphoma or leukemia)	+2
	Dementia	+3
	Connective tissue disease	+3
	AIDS	+4
	Moderate or severe liver or renal disease	+4
	Metastatic solid tumor	+6
E	**Step 4. Emergency department visits** Enter this number or 4 (whichever is smaller)	
	How many times has the patient visited an emergency department in the six months prior to admission (not including the emergency department visit immediately preceding the current admission)?	
	Total LACE Score Risk of Readmission **0–4 Low, 5–9 Moderate, > 9 High Risk**	

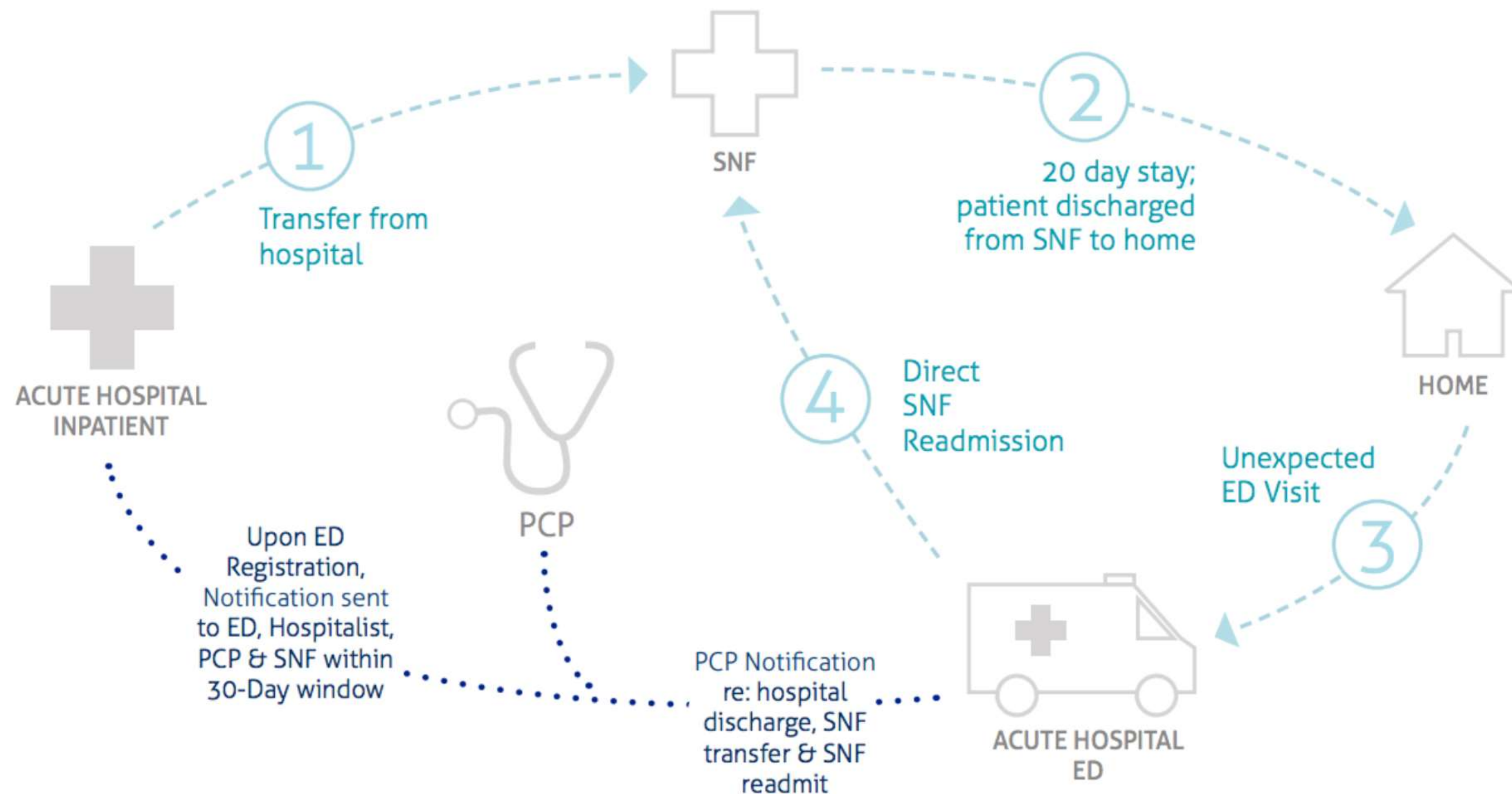
L

A

C

E

EDie System- by Point Click Care, funded by NM's 3 MCOs at no cost to SNFs (Presbyterian, Western Sky, BCBS)



Used with Permission. Source: Collective Medical SNF FAQ sheet

What can SNFs do with EDie information?

- Point Click Care delivers relevant patient information to the right providers at the right time. This actionable information helps SNFs identify complex and at-risk patients and make informed decisions to improve patient outcomes. With the support of Point Click Care, SNFs and other post-acute care providers are empowered to:
  - Strengthen referral relationships
  - Maximize existing resources
  - Gain control over care transitions
  - Reduce unnecessary readmissions
  - Thrive under value-based arrangements

- -Point Click Care

Used with Permission. Source: Collective Medical SNF FAQ sheet

Toolkits and Resources

VBP

- Accessing Your SNF VBP Confidential Feedback Reports tutorial
- Reviewing Your Skilled Nursing Facility Value-Based Purchasing Annual Performance Score Report slides
- SNF VBP Phase One Review and Corrections
- SNF Value-Based Purchasing Program
- Home Health Value-Based Purchasing Model

Toolkits

- Sepsis toolkit – https://comagine.org/resource/1047
- Conversation Project - https://theconversationproject.org/
- INTERACT Program for Skilled Nursing Facilities, Home Health, and Assisted Living - http://www.pathway-interact.com/
- AHRQ Health Literacy Universal Precautions Toolkit - https://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/healthlittoolkit2-tool5.html
- AHRQ Hospital Guide to Reducing Medicaid Readmissions: https://www.ahrq.gov/sites/default/files/publications/files/medread-tools.pdf

Other Resources

- Medicare.gov Find & Compare Providers
- https://mms.mckesson.com/content/clinical-resources/care-management/reducing-hospital-readmissions/
- HHQI Call Me First Posters- http://www.hhvna.com/files/CorporateCompliance/Education2016/VNA2016/Call_Me_First.pdf
- Home Health Quality Measures- Potentially Avoidable Events
- Home Health Care CAHPS Survey

Action Items

What is one action from the Fishbone diagram, Circle of Concern/Influence and Best Practices shared that you can take back to your QAPI committee or leadership in the next 30-60 days.

Who might you add to your readmission busting team?

Questions/ Comments