TRANSITIONS TO THE COMMUNITY PROGRAM: PREVENTING HOSPITAL READMISSIONS AND IMPROVING RESIDENT OUTCOMES

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One in four patients discharged to a skilled nursing facility (SNF) will be readmitted to the hospital within 30 days. Only half of all patients discharged to the community from a SNF remain home for greater than a month. Many of these readmissions and unsuccessful discharges to the community are potentially avoidable. Research has shown the majority of readmissions occur during the transition of care from one setting to another. These staggering statistics have forced the health care community to improve the transitions of care in order to reduce hospital readmission rates, decrease cost, and improve outcomes.

In 2009, the Centers for Medicare and Medicaid Services (CMS) focused their attention on reducing unplanned hospital readmissions. From initiating public reporting to implementing incentive-based payments based on readmission rates, CMS has put a spotlight on the quality of care as measured by readmission performance in the post-acute care setting. There are multiple quality measures contained in the Quality Reporting Program (QRP) and Value-Based Purchasing Program (VBP) focused on readmissions, such as:

- Discharge to the Community - Post Acute Care (PAC) SNF QRP
- Potentially Preventable 30 Day Post Discharge Readmission SNF QRP
- Skilled Nursing Facility 30 Day All-Cause Readmission Measure SNF VBP

POSITIVE IMPACT OF LOWER READMISSION RATES

Through teamwork, laser focus, and relentless persistence, SNF's have much to gain with low readmission rates. Some of the benefits include:

1. A potential increase in Medicare payment rates based on the facilities performance in the SNF VBP program.
2. Increased referral base from hospitals who view the SNF as an over performing post-acute care provider of choice.
3. Lower costs from providing reduced medical care.
4. Higher resident and family satisfaction. A happy customer will tell others about their positive experience at the SNF!
5. Lower risk of exposure to hospital based infections and less medical complications for the resident.
6. Positive impact on Quality Measures which are publicly reported on Care Compare, and used to help determine a facility's 5 Star Rating. A higher 5 Star Rating indicates good quality of care and lower risk for the residents at the SNF. These are key qualities consumers consider when making decisions about where to receive post-acute care. Other important signs to watch for are:

QUALITY MEASURES THAT IMPACT 5 STAR RATING
% of short stay residents who have had an outpatient ED visit
% of short stay residents who were re-hospitalized after a SNF admission
of hospitalizations per 1000 long stay resident stays
of outpatient ED visits per 1000 long stay resident days
Rate of successful return to home and community from a SNF

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EFFECTIVE INTERDISCIPLINARY COMMUNICATION

Hospital transfers from a SNF are stressful for residents and staff. Research has shown that residents with Diabetes, COPD, Sepsis, Heart Failure, and surgical orthopedic interventions are at the greatest risk for hospital readmission. Ensuring the interdisciplinary team (IDT) can effectively identify and communicate adverse changes in a resident's baseline status or an exacerbation of symptoms provides an integral component of the communication process. Prompt detection of changes in mentation, vital signs, pain, and skin integrity support early intervention, and management of the resident's clinical status in the facility.

A comprehensive and proactive interdisciplinary rounding systems such as Resident Rounds and Dining Rounds performed quarterly enable the IDT to perform a holistic review and are designed to provide a strategic discussion of the resident's status. Potential risk factors and changes in the resident's functional status, cognition, skin integrity, weight, and swallowing abilities can be assessed using each member's individualized skill set. Implementing resident-centered care plans address residents concerns, minimizes resident risk and optimizes resident status and their quality of life.

MEDICATION RECONCILIATION

Medication reconciliation is the process of comparing a resident's new medication orders with all the medications the resident had been taking prior to changing levels of care. According to Forster et al. 11% of patients experience adverse drug events within 30 days of discharge from the hospital, of which approximately one third can be prevented. Research shows that appropriate medication reconciliation upon admission to the facility, and prior to discharge to the next level of care, can reduce the number of adverse drug events, improve quality of care, reduce resident injury, and reduce hospital readmission rates in the post-acute setting.

TRANSITIONING TO THE NEXT LEVEL OF CARE

A robust resident centered approach when transitioning to the next level of care should be begin upon admission. The unique skill set of each member of the IDT is required to assess and meet the needs of the resident to ensure a safe discharge.

Identifying and promptly addressing a residents' potential barrier to discharge is imperative. Instituting early processes for the necessary support systems, durable medical equipment needs, and further follow up services that may be required in the rehabilitation process are vital to the residents transition of care. Throughout the resident's stay, the IDT needs to consistently re-assess functional levels and safety of the resident ensuring the discharge plan and level of support upon discharge are on course for a successful discharge.

Resident and caregiver education must be a primary focus of the IDT, and occurs throughout the entire rehabilitation stay, not just on the day prior to discharge. Follow up services like outpatient therapy, home health services, Meals-on-Wheels, housekeeping services, and follow up doctor appointments must be considered and scheduled in advance prior to discharge. Developing a strong relationship with outpatient clinics, ALF's, and home health care agencies are an integral part of the process to ensuring a smooth transition to the next level in the continuum of care.

The resident/caregivers must have a clear understanding of discharge instructions, recommendations and follow up appointments and be allowed opportunities to ask questions, or request further training.

PREFERRED THERAPY SOLUTIONS'

"Transitions to the Community Program" integrates 3 focus areas into the resident's plan of care to successfully reduce readmission rates. It's comprised of the ALERT Program, the Functional Transitional Room, and the Safe Transitions to Home Treatment Modules.

The "ALERT" Program (**A**cknowledge the resident, **L**ocation of issue, **E**valuation of the issue, **R**eport the issue, **T**reatment adjustments) provides a formal system to promote effective communication of abnormal or outside of baseline measurements amongst the IDT. It can be used as the primary method of communication in the facility or to enhance or replace an inefficient one.

The Functional Transitional Room is a learning and practicing

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environment for residents and caregivers to try out their new skills prior to discharge. It provides the IDT a practical way to assess the resident's functional level and safety, recognize additional areas of risk, and ensure the discharge plan and level of support upon discharge are still appropriate.

Safe Transitions to Home Treatment Modules provide a platform to provide ongoing resident and caregiver training throughout the rehabilitation stay. This element of the program addresses key risk factors that significantly impact a safe transition to the next level of care. Each module contains resident and caregiver information, and evidenced based intervention resources for the IDT.

Home Safety Module includes resident/caregiver education on general home safety checks, tools and tips, a home safety checklist, and a remote or on-site home assessment forms to be used by the rehabilitation team. Follow-up recommendation documentation that provide clear instructions for environmental modifications, use of adaptive equipment, and any assistance the resident may require upon discharge.

Fall Prevention Module includes resident/caregiver education in fall prevention and in floor recovery. Evidence based fall risk assessments are completed by the rehabilitation team to identify and treat impairments in strength, balance, vision, sensation and with safety awareness.

Medication Management Module includes resident/caregiver education on their specific prescribed medication list, and utilization of pill cards/boxes and reminder applications to ensure compliance with medication prescription. Resources are provided to the IDT to assist in medication reconciliation prior to discharge.

Self-Monitoring Module includes resident/caregiver education on pre-existing and or new diagnoses including CHF, COPD, DM, and Orthopedic conditions, compliance with precautions, monitoring of vital signs, body weight, blood glucose, skin integrity, oxygen safety, joint protection and breathing exercises. Empowering residents and their caregivers to identify adverse reactions in their clinical status builds confidence when alerting their medical team of changes and concerns.

The COVID Transitions Home Treatment Module promotes safe infection control practices in this COVID-19 world. Resident/caregiver education includes safe infection control practices in the community and in the discharge environment, proper mask use, and appropriate hand hygiene. Resources for energy conservation, proper breathing techniques, activity tolerance guidelines, and safe sheltering in place are also available.

In summary, evidence suggests the rate of avoidable readmissions to the hospital can be reduced. Whether it's the Preferred Therapy Solutions' model or one of your own, an interdisciplinary resident centered approach which utilizes effective communication, team collaboration, identification of high risk residents, medication reconciliation and comprehensive and efficient discharge planning to the next level of care will lead you on the path to success.

SOURCES

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- Risk factors for hospital readmission in older adults within 30 days of discharge – a comparative retrospective study | BMC Geriatrics | Full Text (biomedcentral.com)
- Five Ways Post-Acute Care Providers Can Minimize Hospital Readmissions | McKesson
- Best Practice Strategies to Reduce Hospital Readmission Rates | TCS (tcshealthcare.com)
- CMS.gov

ABOUT PREFERRED THERAPY SOLUTIONS

Preferred Therapy Solutions is a full-service rehabilitation management organization dedicated to providing state-of-the-art clinical, management, billing, and information technology solutions to the post-acute and long-term care industry. Preferred Therapy Solutions is able to assist in developing a strategic road map designed to increase SNFs market share by identifying potential referral targets and providing useful information on competitor's performance. Preferred Therapy Solutions abilities significantly enhance the quality, productivity, scope, and efficiency of any facility's rehabilitation department while maintaining a focus on achieving high levels of patient satisfaction and providing excellent customer service.