Preventing Hospital Readmissions through Seamless Transitions of Care: the Benefit of Partnerships

Emily Goetzke, MSN, RN Mankato Clinic, Ltd.
Angela Stevens, RN, DON Ecumen Pathstone Living
Jeni Kolstad, MSW, LGSW Mankato Clinic, Ltd.
Jennifer Zieske, Mgr Mankato Clinic, Ltd.

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Objectives:

- Describe challenges when patients are transferred to and from skilled nursing facilities
- Identify the positive impact of informal organizational partnerships in managing care transitions
- Discuss opportunities for partnerships in your own community

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- 10 locations in 5 communities
- Over 135 physicians/healthcare providers
- Primary care services offered at 6 locations
- Over 20 specialties offered
- 725+ employees
- Caring for south central MN patients for over 95 years
- Locally and independently owned by our physicians

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- Care Center/SNF located in Mankato, MN
  - 69 beds (39 LTC, 30 STC)
- Assisted Living
  - 82 apartments (21 Memory Care)
- Home Care
  - 230+ Clients
- 260+Employees

- Established in 1937 as a Nursing Home for Women

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History of our partnership

- Identifying the players
  - 6 SNF's
  - Mankato Clinic
  - MCHS – Mankato hospital
  - Blue Earth County Public Health
- Identifying the issues
- Tackling the issues
- Formalizing our structure

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The Issues: Care Transitions

- Hospital to SNF
- SNF to Hospital
- SNF to Home
- Home to SNF

The hospitalized elderly today.....

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Erma is going to be discharged to a skilled nursing facility at 11 A.M. tomorrow.

What could go wrong with this transfer of care that would put Erma at a risk for readmission??

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Admission to the SNF

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Transitions of care – Hospital to SNF:

What is important…….

- Communication
  - Pending referral vs. actual referral
  - Timing of hospital discharge
  - Plan of care, incomplete referral forms
- Provider assignments and handoffs
  - Who covers in the interim?
    - Problems with incomplete orders
  - Patients hospitalized with Specialty Care only
- Medication reconciliation
  - Medication lists not accurate
    - Home medications not included
    - Incomplete information
    - Dose ranges
  - Pain medication requirements – scripts, pain management needs

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Action Plan: Communication

- Complete Referrals
- Timely notification re: pending discharges
- Contact information on Referral Form for follow up

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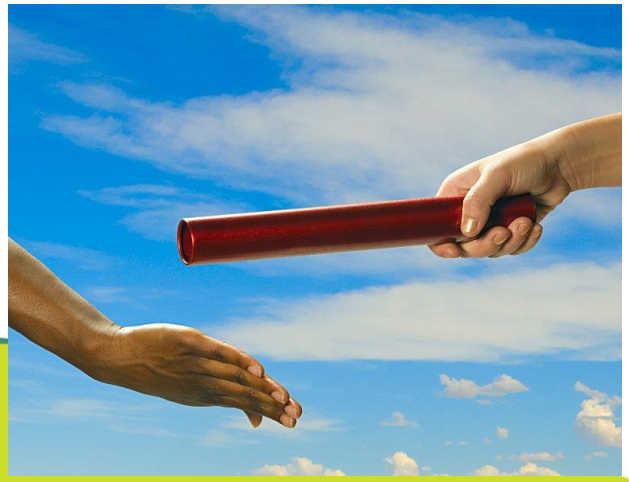
Action Plan: Provider Handoffs

- Hospitalist Responsibility: 24 hours after discharge
- A hospitalist will be consulted for **all** patients admitted to acute care
- Standing Order coverage
- SNF provider team scheduling
  - PCP follow up within 7 days of discharge



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Action Plan: Medication Reconciliation

- Hospitalist to order **all** medications
- Hospitalist to write prescriptions for one week
- Medications cannot be ordered as dose ranges.
- Hospitalists to include reason for taking medication
- Patients to be assessed for pain and medicated before discharge to SNF

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Transitions of Care: SNF to Hospital

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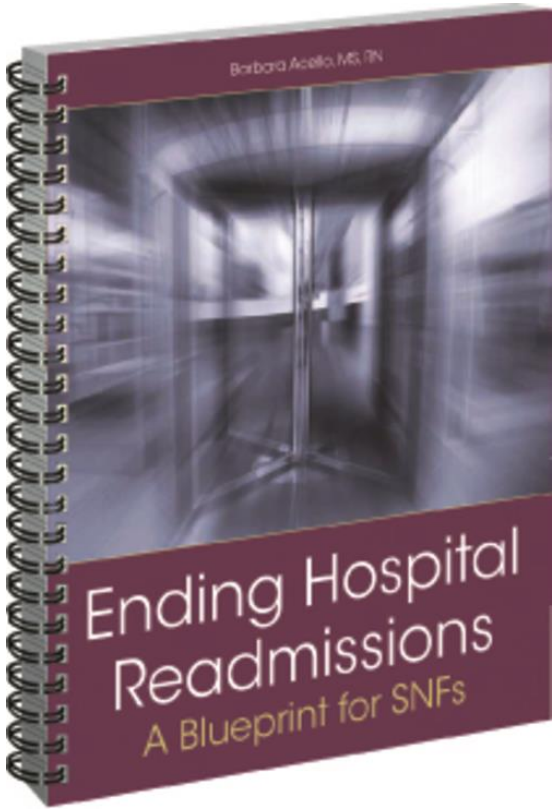
How do we decrease readmissions?



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2016 Research study:

Purpose: Identify opportunities for process improvements and education that may help prevent ED visits, hospitalizations, and readmissions

Ouslander, J. et al. (2016). Lessons learned from root cause analyses of transfers of skilled nursing facility (SNF) patients to acute hospitals: Transfers rated as preventable versus nonpreventable by SNF staff. *Journal of the American Medical Directors Association*, *17*, 256-262.

http://dx.doi.org/10.1016/j.jamda.2015.11.018

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Method:

- 64 SNF's collected data on readmissions using standardized tool
- 4856 RCA's on hospital transfers collected over a 12 month period

Ouslander et al. (2016)

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Findings:

- Transfers precipitated by multiple symptoms
- Family preference accounted for 16% of transfers
- No trends on day of week admission
- 29% occurred on evening or night shift
- 20% occurred within 6 days of SNF admission
- 23% were identified by staff as “potentially preventable”

Ouslander et al. (2016)

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Opportunities for improvement:

- 23 % Changes could have been detected earlier
- 18% Communication could have been better
- 36% Condition could have been managed in the SNF with available resources
- 27% Earlier discussion of preferences/advance directives

Ouslander et al. (2016)

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Recommendations:

- Train nursing staff in structured communication (SBAR approach)
- Use evidence based order sets for managing changes in conditions
- Promote earlier discussion of patient preferences and advance directives

Ouslander et al. (2016)

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Why were our patients readmitted?

Studying the data:

- Inpatient vs. ED only
- Discharge DX from SNF
- Readmit DX
- Provider ordering readmit
- Date of discharge
- # days post hospital
- Date/time/day of week of readmit
- Date of SNF provider apt (length of time between admit to SNF and when provider SNF visit)
- Clinic/PCP

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Resident	Date of Transfer	Day	Purpose of Stay	Payer (Ty	Primary Physician	Primary Clinic	Ordered By	D/C Dx	Reason	Other Reas
[redacted]	1/6/2016 10:30	Wednesd	Post Acute	Private Pa	Stephanie Putzier	Mankato Clinic		UTI	Unresponsive	
	1/24/2016 11:42	Sunday	Post Acute	Private Pa	Daniel Anderson	Mankato Clinic	Heun, Mitchell	Dehyrati	Respiratory Infection	
	3/4/2016 16:00	Friday	Chronic Long-Term	Private Pa	Stephanie Putzier	Mankato Clinic	Putzier, Stephanie	Pneumo	Other	Blood Suga
	3/11/2016 11:53	Friday	Post Acute	Medicare	Richard Peller	Mankato Clinic	Peller, Richard	aortic va	Chest Pain	
	3/12/2016 22:30	Saturday	Post Acute	Private Pa	Eric Storvick	Mankato Clinic	Pollema, Andrea	Hgb	Abnormal Hemoglobin or Hematocrit (low)	
	3/12/2016 23:30	Saturday	Post Acute	Private Pa	Stephanie Putzier	Mankato Clinic	Pollema, Andrea	Left ORIF	Shortness of Breath (bronchitis, pneumonia)	
	3/24/2016 16:20	Thursday	Chronic Long-Term	Private Pa	Stephanie Putzier	Mankato Clinic	Putzier, Stephanie	CVA	Other	Weakness,
	3/29/2016 17:51	Tuesday	Chronic Long-Term	Private Pa	Daniel Anderson	Mankato Clinic	Anderson, Daniel	NSTEMI	Other	INR 8.3/we

ER Visits

[redacted]	1/1/2016 10:32	Friday	Post Acute	Medicare	Stephanie Putzier	Mankato Clinic	Putzier, Stephanie	Unresponsive		
	2/25/2016 8:45	Thursday	Post Acute	Medicare	Stephanie Putzier	Mankato Clinic	Heun, Mitchell	Abnormal Vital Signs (low/high BP, high respiratory rate)		
	3/8/2016 14:56	Tuesday	Post Acute	Private Pa	Eric Storvick	Mankato Clinic	Storvick, Eric	Other	Hypotention	

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r	Outcome	Original Admission	Last Admission Date	Hospital Discharge	Date of Transfer	Length Of Stay	Dr Visit
	Admitted, Observat	12/23/2015 14:00	1/1/2016 15:44		1/6/2016 10:30	5	1/5/16&1/11/16
	Admitted, Inpatient	1/6/2016 13:00	1/6/2016 13:00	1/6/2016 0:00	1/24/2016 11:42	18	1/11/2016
	Admitted, Inpatient	8/15/2013 12:19	2/17/2016 14:00	2/17/2016 0:00	3/4/2016 16:00	16	2/22/2016
	Admitted, Inpatient	11/19/2015 18:00	2/25/2016 14:00	2/25/2016 0:00	3/11/2016 11:53	15	2/29/2016
	Admitted, Inpatient	3/7/2016 13:00	3/10/2016 11:56	3/7/2016 0:00	3/12/2016 22:30	5	None
	Admitted, Inpatient	3/11/2016 12:00	3/11/2016 12:00	3/11/2016 0:00	3/12/2016 23:30	1	None
	Admitted, Observat	3/3/2016 12:00	3/3/2016 12:00	3/3/2016 0:00	3/24/2016 16:20	21	None
	Admitted, Inpatient	3/9/2016 11:00	3/9/2016 11:00	3/9/2016 0:00	3/29/2016 17:51	20	3/14/2016
	ED Visit Only	12/23/2015 14:00	12/23/2015 14:00	12/23/2015 0:00	1/1/2016 10:32	9	
	ED Visit Only	6/30/2015 12:00	2/24/2016 13:30	2/24/2016 0:00	2/25/2016 8:45	1	
	ED Visit Only	3/7/2016 13:00	3/7/2016 13:00	3/7/2016 0:00	3/8/2016 14:56	1	

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Our Findings:

- No trends
- Patients going to SNF's may be medically unstable
- Patients may be discharged too quickly
- Need for end of life care planning

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Actions to Decrease Readmissions:

- Continued attention
- SNF nursing staff training for effective communication through https://interact2.net
- Encouraging end of life conversations and proactive planning with families
- SNF/Hospital collaboration re: timing of discharge

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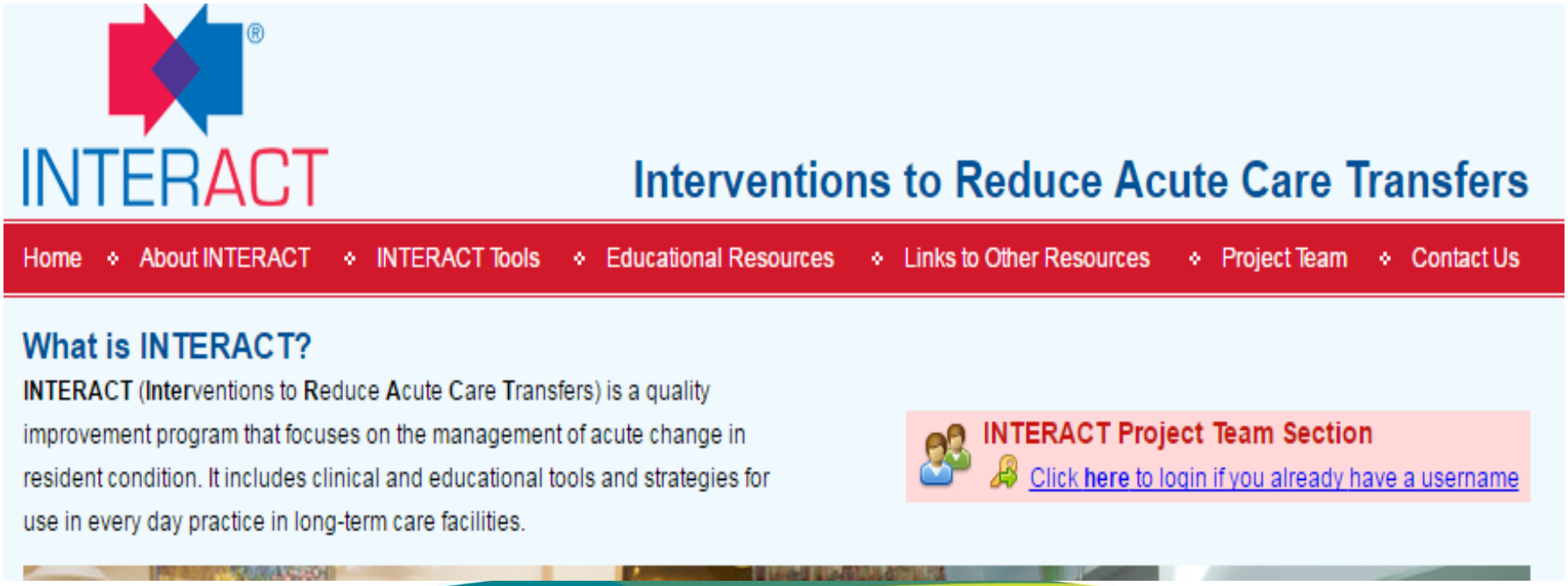
- https://interact2.net/



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Care Transitions: SNF to Home

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Issues:

- Coordination of care after discharge
  - Home Care services
  - DME
  - Insurance coverage
  - Assisted Living options
- Timely scheduling of follow up appointments

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Actions:

- Referrals for Care Management
- Include RN Care Managers in SNF Care Conferences
- Appointment with PCP within 3-5 days

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Next steps:

- Continued Quarterly meetings
- Focus on Readmission Prevention
  - Use of standardized protocols
  - Staff education
  - End of Life conversations

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Your takeaways:

- What barriers have you encountered?

- How can you partner in your own communities?

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References:

- Ouslander, J., Naharci, I., Engstrom, G., Shutes, J., Wolf, D., Alpert, G., . . . Tappen, R. (2016). Root cause analyses of transfers of skilled nursing facility patients to acute hospitals: Lessons learned for reducing unnecessary hospitalizations. *JAMDA, 17*, 256-262. http://dx.doi.org/10.1016/j.jamda.2015.11.018

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Speakers:

- Emily Goetzke, MSN, RN Population Health and Care Management Manager, Mankato Clinic, Ltd. emilyg@mankatoclinic.com
- Angela Stevens, RN, DON Ecumen Pathstone Living angelastevens@ecumen.org
- Jeni Kolstad, MSW, LGSW, Social Worker Mankato Clinic, Ltd. Jenniferko@mankatoclinic.com
- Jennifer Zieske, Bluestone/Extended Care Manager, Mankato Clinic, Ltd. JenniferZ@mankatoclinic.com