Reducing Avoidable Hospitalizations
INTERACT, PACE, RA+IT

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Mercy LIFE

Providers must address how to optimize performance in the current environment while also preparing to “jump” from Curve #1 to Curve #2.

Curve #1: FEE-FOR-SERVICE
• All about volume
• Reinforces work in silos
• Little incentive for “real” integration

Curve #2: VALUE-BASED PAYMENT
• Achieving “Triple Aim”, as per IM:
  • Better Care Experience for Individual
  • Better Health for Populations
  • Lower Per Capita Costs

How does a health system prepare for a future world that requires more clinical integration, while the reimbursement system still rewards a position of strength in the current FFS “foot race?”
Changes in Medicare Financing

- **Pay-for-Performance** ("P4P")
  - No payment for certain complications; disincentives for avoidable hospitalizations
- **Bundling of payments** for episodes of care
- **Accountable Care Organizations** that include hospitals, physicians, home health agencies, and SNFs that are responsible for the care of a defined group of patients
Hospital Avoidance

- Myocardial infarction
- Congestive heart failure
- Pneumonia

**2015**
Chronic obstructive pulmonary disease
Total hip arthroplasty (THA) and total knee arthroplasty (TKA) [elective]

Why Is Reducing NH Hospitalization Critical?

1. Hospital transfers are common and often result in complications in older NH residents
2. Some hospital transfers are preventable
3. Care can be improved, resulting in fewer complications and reduced cost
4. Cost savings to Medicare can be shared with NHs to further improve care
5. Financial and regulatory incentives are changing
1 in 4 patients admitted to a SNF are re-admitted to the hospital within 30 days at a cost of $4.3 billion

Figure 3: Frequency of Rehospitalization of Short-Stay Nursing Home Residents, by State, 2006

The Opportunity

Reducing potentially avoidable hospitalizations of NH residents represents an opportunity to:

- Decrease emotional trauma to the resident and family
- Decrease complications of hospitalization
- Decrease overall health care costs
The INTERACT Program: Background and Why it Matters

Some Hospitalizations of NH Residents are Avoidable:

- As many as 45% of admissions of nursing home residents to acute hospitals may be inappropriate  

- In 2004 in NY, Medicare spent close to $200 million on hospitalization of long-stay NH residents for “ambulatory care sensitive diagnoses”  
  Grabowski et al, Health Affairs 26: 1753-1761, 2007
The INTERACT Program: Background and Why it Matters

Opportunities for You and Your Facility

Reduced Avoidable Hospitalizations

Costs Avoided

$ Incentives for Providers

The INTERACT Program: What is It and Why Does It Matter?

- Defining “Preventable”, “Avoidable”, “Unnecessary” hospitalizations is challenging because numerous factors and incentives influence the decision to hospitalize.

- Risk adjustment is very complicated.
Stefanacci RG, Reich S, Casiano, A.

Application of PACE Principles for Population Health Management of Frail Older Adults

Ranking of Impact/Significance of Six Focus Areas in Avoiding ED/Hospital Use

<table>
<thead>
<tr>
<th>Focus Area</th>
<th>Mean Impact Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management of &quot;Red Flags&quot;</td>
<td>2.1</td>
</tr>
<tr>
<td>End of Life Management</td>
<td>3.4</td>
</tr>
<tr>
<td>Caregiver Support</td>
<td>3.4</td>
</tr>
<tr>
<td>Care Coordination</td>
<td>3.5</td>
</tr>
<tr>
<td>Medication Management</td>
<td>4.2</td>
</tr>
<tr>
<td>Participant and Caregiver Healthcare System Literacy</td>
<td>4.4</td>
</tr>
</tbody>
</table>
Management of Red Flags

• Defined as:
  ▪ clinical issues that could progress and require a higher level of intervention,
  ▪ **PCP visits prior to and immediately after ED/hospital visits,**
  ▪ Assessing Care of Vulnerable Elders and National PACE Association Disease Quality Measures.

• Best practices:
  ▪ seeing a participant as soon as any red flags are noticed,
  ▪ evaluation of what led up to every ED visit and admission in order to develop a protocol or checklist for each participant.

End of Life Management

• Defined as including:
  ▪ advance directive completion,
  ▪ assessment and intervention,
  ▪ **health care wishes status,**
  ▪ location of death.

• Best practices:
  ▪ use of national standards and resources such as:
    – American Academy of Hospice and Palliative Care
    – Education in Palliative and End-of-life Care
    – PACE Pathways to Care
Caregiver Support

• Defined as:
  ▪ Interventions that prevent burnout and
  ▪ **Use of respite days**
  ▪ Caregiver touches/notes
  ▪ Caregiver survey

• Best practices:
  ▪ scheduled respite care

Care Coordination

• Defined as:
  ▪ transition of participants from ED, hospital, or nursing home, as well as specialist consultants,
  ▪ **timing of PCP visit pre- and post- ED/hospital/SNF**,
  ▪ timing of assessment of specialist recommendations from appointment.

• Best Practices:
  ▪ follow-up and care plan update after a hospitalization
  ▪ having a full-time case manager to efficiently and correctly manage transitions of care.
  ▪ having PACE PCPs serve as attending physicians in the hospital.
Medication Management

- Defined as:
  - elimination of inappropriate medications
  - management of adherence issues,
  - **hospital/SNF Rx reconciliation**,
  - total Rx used,
  - psychotropic Rx use,
  - Beers Criteria use,
  - sedation score.

- Best practices:
  - pharmacist involvement monthly medication reviews
  - involvement of staff in medication management
  - adding medication administration to red flag checklist,
  - discontinuation and dose reductions while monitoring responses.

Participant and Caregiver Health Care System Literacy

- Defined as:
  - appropriate use of health care system resources
  - survey participant and caregiver health care literacy at admission and every 6-12 months

- Best practices:
  - educating participant/caregiver to use health care system appropriately
  - financial information for caregivers.
EOL Resources

www.ePrognosis.org
The information on ePrognosis is intended as a rough guide to inform clinicians about possible mortality outcomes.

www.Dignityincare.ca
Dignity in Care provides practical ideas and tools to support a culture of compassion and respect throughout the health care system.

www.POLST.org
The National POLST Paradigm is an approach to end-of-life planning based on conversations between patients, loved ones, and health care professionals designed to ensure that seriously ill or frail patients can choose the treatments they want or do not want and that their wishes are documented and honored.

Ranking of Impact/Significance of Six Focus Areas in Avoiding NH Placement

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<tbody>
<tr>
<td>Caregiver Support</td>
<td>1.7</td>
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<tr>
<td>Management of “Red Flags”</td>
<td>2.8</td>
</tr>
<tr>
<td>End of Life Management</td>
<td>3.6</td>
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<tr>
<td>Care Coordination</td>
<td>4.2</td>
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Improving Geriatric Care by Reducing Potentially Avoidable Hospitalizations

INTERACT: Definitions and Goals

- INTERACT stands for “Interventions to Reduce Acute Care Transfers”
- It is a program designed to improve the care of nursing home residents by:
  - Identifying situations that commonly result in transfers to the hospital—and working together to manage them effectively and safely in the nursing home without transfer whenever possible
Purpose of Toolkit

- Aid in the early identification of a resident change of status
- Guide staff through a comprehensive resident assessment when a change has been identified
- Improve documentation condition
- Enhance around resident change in communication with other health care providers about a resident change of status

Design of Toolkit

- Feasible and efficient
- Part of the “way we do business”
- Acceptable to staff

INTERACT is One of Several Evidence-Based Care Transitions Interventions

"BOOST" (Better Outcomes for Older Adults Through Safe Transitions)
http://www.hospitalmedicine.org/
- "Project RED" (Re-Engineered Discharge)
https://www.hospitalmedicine.org/
  - Enhanced hospital discharge planning

"Care Transition Program"
http://www.caretransitions.org
- Transition coach
- Trained volunteers
- Empowered patients and caregivers

"POLST" (or "MOLST") (Physician (or Medical) Orders For Life Sustaining Treatment)
http://www.chsu.edu/polst
- Advance care planning

"Bridge Model"
http://www.agingresearch.org/the-bridge-model
- Social Worker coordinating Aging Resource Center Services at hospital discharge

"Transitional Care Model"
http://www.transitionalcare.info/index.html
- APN coordinates care during and after discharge
- Home, SNF, and clinic visits

"INTERACT" (Interventions to Reduce Acute Care Transfers)
http://interact2.net
- Communication Tools, Care Paths, Advance Care Planning Tools, and QI tools for nursing homes and SNFs

High Quality Care Transitions for Older Adults & Caregivers
Can help your facility safely reduce hospital transfers by:

1. **Preventing conditions from becoming severe**
   enough to require hospitalization through early identification and assessment of changes in resident condition

2. **Managing some conditions in the NH** without transfer when this is feasible and safe

3. **Improving advance care planning** and the use of palliative care plans when appropriate as an alternative to hospitalization for some residents

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**Commonwealth Fund Project Results**

<table>
<thead>
<tr>
<th>Facilities</th>
<th>Mean Hospitalization Rate per 1000 resident days</th>
<th>Mean Change</th>
<th>p value</th>
<th>Relative Reduction in All-Cause Hospitalizations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre intervention</td>
<td>During Intervention</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All INTERACT facilities</td>
<td>3.99</td>
<td>3.32</td>
<td>- 0.69</td>
<td>0.02</td>
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<tr>
<td>(N = 25)</td>
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<td></td>
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<tr>
<td>Engaged facilities</td>
<td>4.01</td>
<td>3.13</td>
<td>- 0.90</td>
<td>0.01</td>
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<tr>
<td>(N = 17)</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Not engaged facilities</td>
<td>3.96</td>
<td>3.71</td>
<td>- 0.26</td>
<td>0.69</td>
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<tr>
<td>(N = 8)</td>
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</tbody>
</table>

Commonwealth Fund Project Results - Implications

1. For a 100-bed NH, a reduction of 0.69 hospitalizations/1000 resident days would result in:
   - 25 fewer hospitalizations in a year (~2 per month)
   - $125,000 in savings to Medicare Part A (using a conservative DRG payment of $5,000)

2. The intervention as implemented in this project cost of ~ $7,700 per facility

3. Net savings ~ $117,000 per facility per year
   - Medicare could share these savings to support NHs to further improve care


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1. Advanced Care Planning
2. Medication Reconciliation
3. Change in Resident Status
   - Stop and Watch / Early Warning Tools
   - Signs & Symptoms
   - Care Paths
4. Communication
   - SBAR
   - Transfer Forms
5. Implementation & Quality Improvement
The **INTERACT** tools are meant to be used together in your daily work in the nursing home

http://interact2.net
Highlighting identifies residents at risk for 30-day readmission and those who returned to hospital within 30 days.

Flyover boxes provide instructions for data entry.
Rates trended by month – in this graph 30-day readmissions from PAC, LTC, and total

More Tools...
Rapid Assessment & Initial Treatment (RA+IT)

• Partnership with Hospital ER to provide:
  – Rapid Assessment
  – Initial Treatment
  – Transfer back to SNF with care plan

• Requires:
  – Proactive establishing process
  – Each time thoughtful communication of RA IT rather than admission
  – CQI process between ER and SNF team to access performance
  – Assess impact on hospitalization rate

Pulling it All Together
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