

# ***Preparing for Health Care Reform***

SNF management will need to develop new operational, management and data collection systems to prevent hospital readmissions and ER visits.

By Diane Peters, RN, NHA, MS

Health care reform promises to bring many changes to the current health care landscape. One of the biggest changes involves hospital data going under the microscope. Beginning in 2012, health care reform changes call for hospitals to face Medicare payment penalties of up to 3 percent of their aggregate Medicare payments. During this time, Medicare will also begin reducing payments to hospitals for avoidable readmissions for three conditions, which will most likely be congestive heart failure (CHF), pneumonia and acute myocardial infarction (AMI). Meanwhile, health care reform measures call for the government to review emergency room department data to identify potentially preventable visits.

## **The Hospital/SNF Link**

If you're a manager of a SNF, this increased scrutiny on hospital data means that you'll also start to feel the pinch from health care reform changes. According to MedPac data, 17.3 percent of Medicare patients were discharged to SNFs in 2009. Of those patients discharged to SNFs, 22 percent were readmitted to acute care settings. In fact, SNFs represented the highest percentage of acute hospital readmissions from post-acute care venues. Hospital readmissions present quality of care issues for residents and families. They also increase Medicare costs.

But readmissions aren't the only issue. Health care reform also aims to prevent avoidable ER visits. This measure is sure to have a profound impact. People made more than 110 million visits to emergency rooms in the U.S. in 2004, reports The National Center for Health Statistics. The 2004 National Nursing Home Survey data indicates that 8 percent of nursing home residents visited an ER within the last 90 days, and 40 percent of these visits were potentially avoidable. More than one-third of these potentially preventable ER visits were related to falls, while 9 percent were for symptoms of cardiac conditions, and 12 percent were for pneumonia.

The survey data further identified residents who had potentially avoidable ER visits had been in the SNF for less than six months and more than 55 percent of the residents potentially avoidable admissions were taking nine or more medications.

## **Impact on the SNF**

Collectively, these health care reform changes mean hospital management teams are now changing the way they look at SNFs. In fact, hospital staffs are beginning to collect data on post-acute settings following discharge and readmissions to the hospital from each care setting type (skilled nursing facility, home health, etc.) During the next 12 to 18 months, hospital staffs will also be identifying hospital readmission rates from specific post-acute care facilities and providers. To stay financially sound, hospital management will now have to work with SNFs that successfully manage post-acute care and prevent avoidable hospital readmissions and ER visits.

## What You Can Do

SNF managers, take heed: To continue working with hospitals, you'll likely need to change the way you're managing your businesses as well. Implement a system to document and articulate to referring hospitals, physicians, insurance carriers and consumers how you effectively and successfully manage care. For example, begin tracking rates of:

- readmission to hospital
- admission to ER
- discharge to community
- readmission to hospital following discharge from SNF to community
- functional status improvement from admission to discharge
- infections acquired while in the SNF
- resident satisfaction of care
- average length of stay for rehab residents—by admission diagnosis
- resident falls—with and without injury.

## Fall Management

In addition to data collection, you need diligent falls prevention and management programs to avoid ER and hospital readmissions. To implement programs, consult evidence-based practice guidelines. Seek out information from other facilities that have demonstrated success in decreasing falls.

Successful falls prevention programs focus efforts on fall prevention processes and systems, while systematically evaluating interventions. A successful program further identifies approaches and interventions for continued improvement. Tailor your program according to the following processes:

- Assess residents' fall risk factors (history of falls, chronic health issues, pain, cognitive impairments, perceptual limitations, psycho-social factors, medication side effects and interactions, effectiveness of assistive devices and environmental factors).
- Implement resident-specific approaches and interventions to prevent falls.
- Solicit staff from all departments to help routinely identify and correct environmental risks.
- Assess and modify each resident's room to decrease risk. For example, adjusting closet shelving and furniture height can help prevent falls from functional reaching.
- Adjust staff schedules to ensure coverage during times identified of increased fall risk. For instance, activity staff might consider scheduling activities in the dining room following an evening meal.
- Revise work practices to decrease fall risk. For example, schedule floor care for the hallway and main areas after residents have retired for the night.

## Chronic Disease and Rehab Management

Besides fall prevention and management, focus more on disease management. Health care reform means the definition of quality will include more than current quality indicators. Quality will also mean demonstrated improvement in chronic disease management and resident function from admission and following discharge.

Work with hospitals and community clinicians (such as home health agencies) to identify and implement evidence-based chronic disease and rehabilitation care management practices. Focus initially on chronic diseases that you identify as preventable hospital readmissions (such as CHF and COPD) and acute conditions (such as pneumonia). For residents admitted for rehabilitation, concentrate on preventing complications (pneumonia, infection, etc.) and improving functional status between admission and discharge.

Actively involving residents and their caregivers in care decisions is the key to successful chronic disease management and rehabilitation. Upon admission, begin education and discharge planning and continually assess resident symptoms, effectiveness of interventions, resident knowledge and understanding of care needs, and evaluation of needs post discharge. To implement a successful chronic disease and rehabilitation management program:

- Actively involve residents in assessment, goal identification, care planning and scheduling of daily activities (medication administration, bathing, recreation, etc.).
- Implement disease-specific, evidenced-based care practices.
- Initiate education and evaluate effectiveness on disease, symptom management, improving ADL function, and preventing complications on admission and consistently throughout the SNF stay.
- Assess the home environment and care needs post discharge and develop plans and interventions to address issues prior to discharge.

Participating in post-acute care delivery in the near future requires you to demonstrate management of quality processes, outcomes and measures. This necessitates a change in the care and operational systems and processes of yesterday. Effective operational and management systems will help move your facility into a new way of health care delivery, expectations, measurement and reimbursement. The challenge is before us and the time to implement changes is now.

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