Disclosure of Commercial Interests

I have commercial interests in the following organization(s): NA

List the Name of Your Employer:

- Lisa Thomson, CMSO
- Pathway Health
- What the company does? Pathway Health is a professional services organization which provides consulting and education services to post acute providers across the nation

- List all commercial interests. Note if you are employed by a company, you have a commercial interest in that company.
- If you are not employed, do not consult for anyone, and have no financial investments in organizations in the health care industry, then you may state that you "have no commercial interests." **"have no commercial interests."**

A Leaders Guide: How to Incorporate the INTERACT™ Quality Improvement Process to Reduce Unnecessary Readmissions

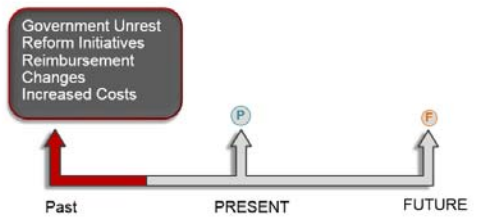
INTERACT®

Lisa Thomson, Chief Marketing and Strategy Officer
Pathway Health

Background

INDUSTRY LANDSCAPE

Background



INTERACT Interventions to Reduce Acute Care Transfers PATHWAY HEALTH 4

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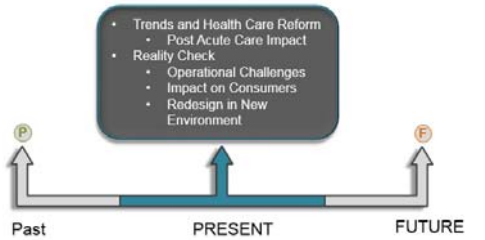

INTERACT Interventions to Reduce Acute Care Transfers PATHWAY HEALTH 5

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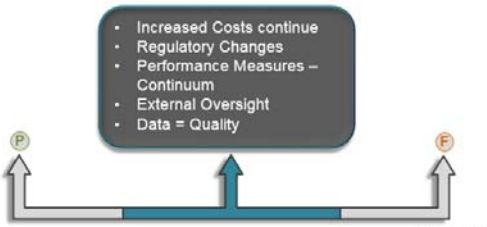

INTERACT Interventions to Reduce Acute Care Transfers PATHWAY HEALTH 6

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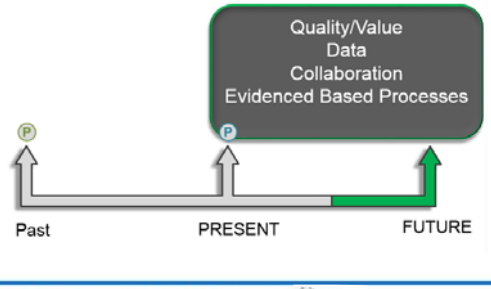
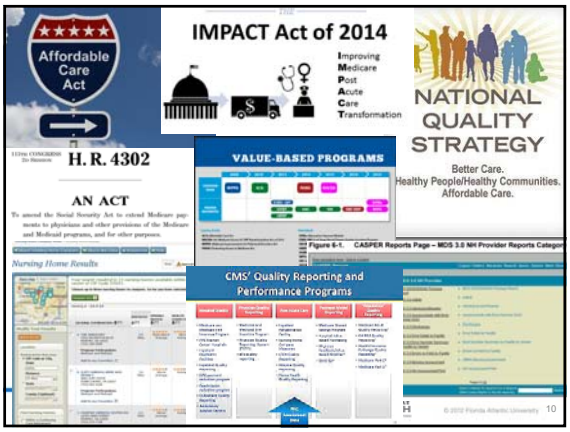


Background

Background

Government Response

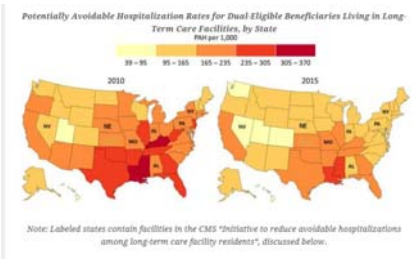


Background

1 in 4 patients admitted to a SNF are re-admitted to the hospital within 30 days at a cost of $4.3 billion

Mor et al. Health Affairs 29: 57-64, 2010

Background



https://blog.cms.gov/2017/01/17/data-brief-sharp-reduction-in-avoidable-hospitalizations-among-long-term-care-facility-residents/

Background

National Quality Strategy

The **Affordable Care Act (ACA)** required the Secretary of the Department of Health and Human Services (HHS) to establish a ***national*** strategy that will improve:

- The delivery of health care services
- Patient health outcomes
- Population health

NATIONAL QUALITY STRATEGY

Background

Triple Aim

Background

Reduce Readmissions

- Readmission Measure - Top Priority
- All Cause, all Condition
- Expected Performance Outcomes
  - Quality Measure
  - SNF Total Performance Score
  - Financial Impact
  - Partnership and Sustainability Impact

Organizational Data

QUALITY

Background

Prepared by Pathway Health

Readmission Measure Legislative Initiative

VALUE BASED PURCHASING

Background

SNF 30-Day All Cause Readmission Measure (SNFRM)

- Readmissions to hospitals identified through Medicare Claims
- Readmissions within that 30-day window are included even if they had been discharged from the facility
- Risk adjusted (demographics, diagnosis in prior hospitalizations, comorbidities, etc.)
- Excludes planned readmissions
- SNFRM will be used for the first year of the program (FY 2019)

VBP

Background

SNF Readmission Measure Exclusions:

- Residents with Cancer
- Residents who do not have Medicare Part A coverage for the full 30 day window and those who do not have Part A coverage for the 12 months preceding the prior hospital discharge

VBP

https://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2016-09-28-SNF-Presentation.pdf

Background

Exclusions continued:

SNF stays including:

- An intervening post-acute care admission within the 30-day window
- More than 1 day between hospital d/c and SNF admission
- Resident discharged AMA
- Principal dx in prior hospitalization = rehabilitation, fitting of prosthetics, device adjustments
- Prior hospitalization=pregnancy

VBP

Readmission Measure Legislative Initiative

FIVE STAR QUALITY RATING

Background

Five Star Quality Rating

Percentage of Short-Stay Residents Who Were Re-Hospitalized After a Nursing Home Admission

Purpose of the Measure

- "If a nursing home sends many residents back to the hospital, it may indicate that the nursing home is not properly assessing or taking care of its residents who are admitted to the nursing home from a hospital."

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliianc/Downloads/New-Measures-Technical-Specifications-DRAFT-04-05-16-.pdf

Five Star

Background

Percentage of short-stay residents who were re-hospitalized after a nursing home admission:

- Fee For Service Medicare part A
- Claims-based quality measure
- April 2016
- July 2016 - Integrated into the Five-Star Quality Rating System

Five Star

Background

- *Percentage of Short-Stay Residents who were rehospitalized after a nursing home admission*
  - "The short-stay re-hospitalization measure determines the percentage of all new admissions or readmissions to a nursing home from a hospital where the resident was re-admitted to a hospital for an inpatient or observations stay within 30 days of entry or reentry."

Five Star

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/New-Measures-Technical-Specifications-DRAFT-04-05-16-.pdf

Background

- "Planned inpatient readmissions are excluded. Note that higher values of the short-stay re-hospitalization measure indicate worse performance on the measure."

Five Star

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/New-Measures-Technical-Specifications-DRAFT-04-05-16-.pdf

Background

Key Point:

"Observation stays are included in the measure regardless of their diagnosis"

Five Star

Background

1. Planned Readmissions
   - Pre-specified list of procedures took place or readmissions for one of the following took place: bone marrow, kidney, or other transplants.
   - Planned diagnosis categories include maintenance chemotherapy and rehabilitation."

Five Star

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/New-Measures-Technical-Specifications-DRAFT-04-05-16-.pdf

Background

2. Admissions for acute illness or for complications of care are not classified as "planned."
   - Planned procedure performed during an admission for an acute illness would not likely have been planned.

Five Star

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/New-Measures-Technical-Specifications-DRAFT-04-05-16-.pdf

Background

Exclusions:

- Enrolled in a Medicare Advantage plan for any part of the stay OR
- Was not enrolled in both Medicare Part A and B for any part of their stay
- Resident has Hospice claims that overlap with the nursing home stay

Five Star

Background

Exclusions:

- Enrolled in hospice care during the nursing home stay; OR
- MDS coded as Comatose (B0100 =[01]) or missing data on comatose on the first MDS assessment after the start of the stay; OR
- Data were missing for any of the claims or MDS items used in the numerator or denominator; OR
- Did not have an initial MDS assessment to use in constructing covariates for risk-adjustment

Five Star

Background

Risk Adjustment

GOAL: account for differences

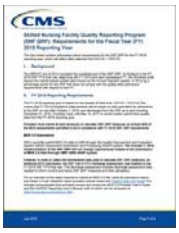
- Patient demographic
- Clinical characteristics

- Covariates
  - conditions/diagnoses that were present at the start of the nursing home stay
  - items from claims that preceded the start of the stay
  - Information from the first Minimum Data Set 3.0 (MDS) assessment with a target date within 14 days of the beginning of the stay.

Five Star

Background

SNF QRP



II. FY 2018 Reporting Requirements

The FY 2018 reporting year is based on one quarter of data from 10/1/16 – 12/31/16.This means that FY 2018 compliance determination will be based on data submitted for admissions to the SNF on and after October 1, 2016, and discharged from the SNF up to and including December 31, 2016. Providers have until May 15, 2017 to correct and/or submit their quality data from the FY 2018 reporting year.

Providers must submit all data necessary to calculate SNF QRP measures on at least 80% of the MDS assessments submitted to be in compliance with FY 2018 SNF QRP requirements.

SNF QRP Quality Measures

The implementation of the SNF QRP on October 1, 2016 does not change requirements related to the process for MDS record submission, however it does introduce new quality measures that providers are required to report data on.

In the FY 2016 SNF PPS final rule, three quality measures affecting FY 2018 payment determination were finalized for adoption into the SNF QRP. These measures and their data sources are listed in **Table 1**, as well as a brief summary of any modifications to the MDS 3.0 that will be implemented on October 1, 2016 as a result of the adoption of these measures into the SNF QRP. The data collection periods and data submission deadlines for these measures for FY 2018 payment determination are also outlined in this table.

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/SNF-QRP-Requirements-for-FY18-Reporting-Year-Fact-Sheet.pdf

Background

Information on the SNFVBP Program:

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/SNF-VBP.html

Scroll down
(next slide)

Background

Readmission Measures

SNFRM AND SNFPPR

SNFRM

- Skilled Nursing Facilities Readmission Measure (SNFRM)
- Measure used to evaluate SNFs in the SNF VBP Program
- SNFVBP
  - Ties portions of SNFs payments to their performance on this measure
  - Calculated by assessing the risk-standardized rate of all-cause, unplanned hospital readmissions for Medicare fee-for-service SNF patients within 30 days of discharge from a prior proximal hospitalization

SNFRM

- SNFRM tracks hospital readmissions, not readmissions to the SNF
  - Readmissions within 30-days after discharge from a prior hospitalization
  - Readmission window starts on the day of or up to 24 hours after discharge from a prior hospitalization
  - Includes all unplanned readmissions
- Prior hospitalization
  - Defined as an admission to an inpatient prospective payment system (IPPS) hospital, critical access hospital (CAH), or psychiatric hospital

SNFRM

- Readmission tracking
  - Identified through Medicare claims - data is collected from SNFs
  - No additional reporting requirements for the SNFRM
- Includes all Medicare fee-for-service Skilled Nursing Facility patients, with the exception of certain measure exclusions.
  - Adjusted to account for patient differences, such as comorbidities, when comparing facility readmission rates

SNFRM and SNFPPR

- The SNFRM will form the basis for the SNF Performance Score for the SNF VBP Program.
  - Facilities' scores under the program will be based on performance on the measure, and value-based incentive payments will be determined by comparing all SNFs' performance scores.
- SNFRM performance information will be made available to each SNF through confidential quarterly feedback reports.
- As required by the SNF VBP Program's statute, CMS has proposed to adopt the SNF 30- Day Potentially Preventable Readmission Measure (SNFPPR). CMS will propose to replace the SNFRM with the SNFPPR in future rulemaking.

SNFRM vs. SNFPPR

- July 29, 2016, CMS adopted the SNFPPR measure for future use in the SNF VBP Program
- SNFPPR measure assesses the risk-standardized rate of unplanned, Potentially Preventable Readmissions (PPRs) for Medicare Fee-For-Service SNF patients within 30 days of discharge from a prior hospitalization
- SNFPPR focuses on **potentially preventable readmissions** rather than **all-cause readmissions**
- CMS will replace the SNFRM with the SNFPPR as soon as practicable.

Scoring Methodology

- **Achievement scoring** compares a SNF's performance rate in a performance period against all SNFs' performance during the baseline period
- **Improvement scoring** compares a SNF's performance during the performance period against its own prior performance during the baseline period For FY 2019.
  - achievement scoring will compare SNFs' 2017 performance to the performance of all facilities during Calendar Year (CY) 2015.

Readmission Measure

ANTICIPATED UPDATES

Background

- Additional Data for Consideration
  - Emergency Room Utilization
  - Disease State/Specific

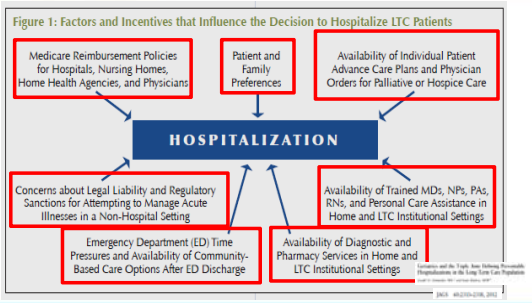
Background

Emergency Department Visits by Nursing Home Residents

- Representative sample of close to 4,000 ED visits during 2005-2010
  - Represents close to 14 million visits during this time period
  - 1.8 visits per NH resident per year nationally
- 54% did not result in admission or observation stay – of these:
  - 63% had normal vital signs
  - 19% had no diagnostic tests in the ED
  - Two-thirds had at least one imaging test; 20% had CT of the head
- Most common diagnoses for visits that did not result in admission:
  - Injury (45%; including superficial injuries and contusions)
  - Infection (11%)
- Substantial proportion had potential for iatrogenic harm:
  - 9% had a bladder catheterization
  - Almost 15% received and 9% left the ED with a prescription for a CNS-acting drug (anxiolytic/sedative, antipsychotic, and/or narcotic analgesic)

Burke et al. J Am Med Dir Assn, in press, 2015

Causes of Potentially Avoidable Hospitalizations are Multifactorial



Background – AHRQ *Medicare*

Table 2. Ten conditions with the most all-cause, 30-day readmissions for Medicare patients (aged 65 years and older), listed by total number of readmissions in descending order, 2011

Principal diagnosis for index hospital stay*	Number of readmissions		Cost of readmissions		
	Number of all-cause, 30-day readmissions	Readmissions as a percentage of total Medicare readmissions	Total cost of all-cause, 30-day readmissions (in millions), $	Readmission total cost as a percentage of total costs of Medicare readmissions	Readmission rate (per 100 admissions)
Congestive heart failure; nonhypertensive	134,500	7.3	1,747	7.3	24.5
Septicemia (except in labor)	92,900	5.1	1,410	5.9	21.3
Pneumonia (except that caused by tuberculosis or sexually transmitted disease)	88,800	4.8	1,146	4.8	17.9
Chronic obstructive pulmonary disease and bronchiectasis	77,900	4.2	924	3.8	21.6
Cardiac dysrhythmias	69,400	3.8	835	3.5	16.2
Urinary tract infections	56,900	3.1	621	2.6	19.1
Acute and unspecified renal failure	53,500	2.9	683	2.8	21.8
Acute myocardial infarction	51,300	2.8	693	2.9	19.8
Complication of device; implant or graft	47,200	2.6	742	3.1	19.0
Acute cerebrovascular disease	45,900	2.5	568	2.4	14.5
Total	718,100	39.1	9,371	39.0	19.6

* Clinical Classifications Software (CCS) label

Note: Shaded conditions are currently targeted by the CMS Hospital Readmissions Reduction Program.

Source: Weighted national estimates from a readmissions analysis file derived from the Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), State Inpatient Databases (SID), 2011

http://www.hcup-us.ahrq.gov/reports/statbriefs/sb172-Conditions-Readmissions-Payer.pdf

Background – AHRQ *Medicaid*

Table 3. Ten conditions with the most all-cause, 30-day readmissions for Medicaid patients (aged 18–64 years), listed by total number of readmissions in descending order, 2011

Principal diagnosis for index hospital stay*	Number of readmissions		Cost of readmissions		
	Number of all-cause, 30-day readmissions	Readmissions as a percentage of total Medicaid readmissions	Total cost of all-cause, 30-day readmissions (in millions), $	Readmission total cost as a percentage of total cost of Medicaid readmissions	Readmission rate (per 100 admissions)
Mood disorders	41,600	6.2	286	3.8	19.8
Schizophrenia and other psychotic disorders	35,800	5.3	302	4.0	24.9
Diabetes mellitus with complications	23,700	3.5	251	3.3	26.6
Other complications of pregnancy	21,500	3.2	122	1.6	8.4
Alcohol-related disorders	20,500	3.0	141	1.9	26.1
Early or threatened labor	19,000	2.8	86	1.1	21.2
Congestive heart failure; nonhypertensive	18,800	2.8	273	3.6	30.4
Septicemia (except in labor)	17,600	2.6	319	4.2	23.8
Chronic obstructive pulmonary disease and bronchiectasis	16,400	2.4	178	2.3	25.2
Substance-related disorders	15,200	2.2	103	1.4	18.5
Total	**230,200**	**34.1**	**2,061**	**27.1**	**20.0**

* Clinical Classifications Software (CCS) label

Source: Weighted national estimates from a readmissions analysis file derived from the Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), State Inpatient Databases (SID), 2011.

http://www.hcup-us.ahrq.gov/reports/statbriefs/sb172-Conditions-Readmissions-Payer.pdf

Evidenced Based Practice for Positive Outcomes

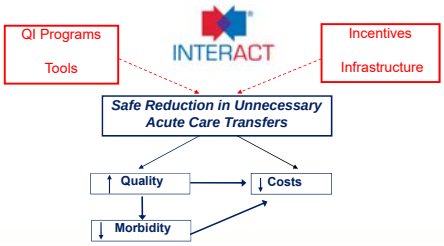
PROVIDER STRATEGY

Readmission Focus

- CMS Expectations
- Performance Outcomes
- Collaboration and Care Transition
- Partners and Payer Expectations
  - Evidenced based process

Background

What is Needed for Success ?



- Is a **quality improvement program** designed to improve the care of older people with acute changes in condition in nursing homes, assisted living facilities, and home health care

INTERACT

- Several studies suggest that effective implementation of components of INTERACT are associated with reductions in hospitalizations

http://interact.fau.edu


INTERACT™
QUALITY IMPROVEMENT PROGRAM
INTERACT Interventions to Reduce Acute Care Transfers
PATHWAY HEALTH
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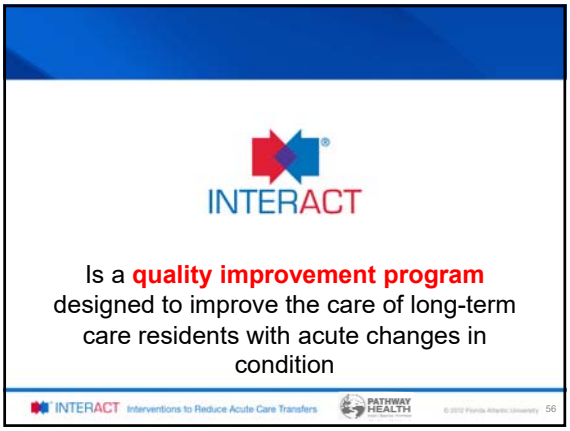
INTERACT®
Is a quality improvement program designed to improve the care of long-term care residents with acute changes in condition
INTERACT Interventions to Reduce Acute Care Transfers
PATHWAY HEALTH
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Goals
INTERACT™
• Can help your facility safely 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
INTERACT Interventions to Reduce Acute Care Transfers
PATHWAY HEALTH
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Where it all began…

Joseph G. Ouslander, M.D. is Professor and Senior Associate Dean for Geriatric Programs at the Charles E. Schmidt College of Medicine, and Professor at the Christine E. Lynn College of Nursing of Florida Atlantic University in Boca Raton Florida. He is a past-President of the American Geriatrics Society and is the Executive Editor of the society's Journal. He is a co-author of *Essentials of Clinical Geriatrics* and *Medical Care in the Nursing Home,* and an editor of *Hazzard's Textbook of Geriatric Medicine and Gerontology*.

Dr. Ouslander's work is now focused on improving the quality of care and quality of life for older people, and reducing unnecessary health care expenditures through programs such as INTERACT.

Overview of the INTERACT™ QIP

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.bu.edu/fammed/projectred
- 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.ohsu.edu/polst
- Advance care planning

High Quality Care Transitions for

Older Adults & Caregivers

"Bridge Model"
http://www.transitionalcare.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://interact.fau.edu/
- Communication Tools, Care Paths, Advance Care Planning Tools, and QI tools for nursing homes and SNFs

INTERACT™ QIP

COMPONENTS

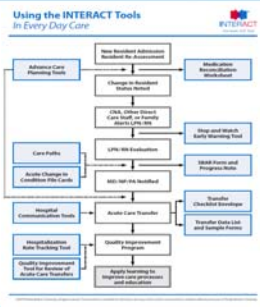
Overview of the INTERACT™ QIP

INTERACT

- Quality Improvement Tools
- Communication Tools
- Decision Support Tools
- Advance Care Planning Tools

Overview of the INTERACT™ QIP

The **INTERACT 4.0** Tools are meant to be used together in your daily work in the nursing home



Overview of the INTERACT™ QIP

INTERACT Strategies

1. **Prevent** conditions from becoming severe enough to require hospitalization through **early identification and evaluation** of changes in resident condition
2. **Manage** some conditions without transfer when this is feasible and safe
3. **Improve advance care planning** and the use of palliative care plans when appropriate as an alternative to hospitalization for some residents
4. **Improve communication and documentation** within LTC facilities and programs, and between LTC and acute care
5. **Integrate into ongoing QI initiatives** (e.g. QAPI)
6. **Embed in Health Information Technology** across care settings

COMMUNICATION TOOLS

Communication Tools

Stop and Watch
Early Warning Tool

If you have identified a change while caring for or observing a resident, please circle the change and notify a nurse. Either give the nurse a copy of this tool or review it with her/him as soon as you can.

S Seems different than usual
T Talks or communicates less
O Overall needs more help
P Pain – new or worsening; Participated less in activities

a Ate less
n No bowel movement in 3 days; or diarrhea
d Drank less

W Weight change
A Agitated or nervous more than usual
T Tired, weak, confused, or drowsy
C Change in skin color or condition
H Help with walking, transferring, toileting more than usual

☐ Check here if no change noted while monitoring high risk patient

Patient / Resident
Your Name
Reported to / Date and Time (am/pm)
Nurse Response / Date and Time (am/pm)
Nurse's Name

Communication Tools

SBAR Communication Form
and Progress Note for LPN/LVNs

Before Calling the Physician, NP, PA, other Healthcare Professional

Situation

Background

The Purpose of the SBAR

- Improve communication
- Consistent language
- Standardized criteria
- Clear guidelines
- Communication that is efficient
- Communication that is effective

Communication Tools

Medication Reconciliation Worksheet for Post-Hospital Care

INTERACT Version 4.0 Tool

Part 1: Hospital Recommended Medications Needing Clarification

Medications Recommended by Hospital at Discharge for which Clarification is Needed	Clarification Needed*	Resolution for Final Medication Orders (Continue, Stop, Change)

*Examples: unclear diagnosis or indication, uncertain dose or route of administration, stop date, hold parameters, lab tests needed for monitoring, dose different than before hospitalization, medication duplication

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Communication Tools

Nursing Home Capabilities List

- Hang it in the ED
- Give it to case managers
- Give it to hospitalists
- Give it to on-call primary care clinicians in your facility

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Communication Tools

- **Engaging your Hospitals –Tip sheet**
- **NH - Hospital Data List**
- **Acute Care Transfer Checklist**
- **Hospital - Post Acute Transfer Form**
- **Hospital - Post Acute Data List**

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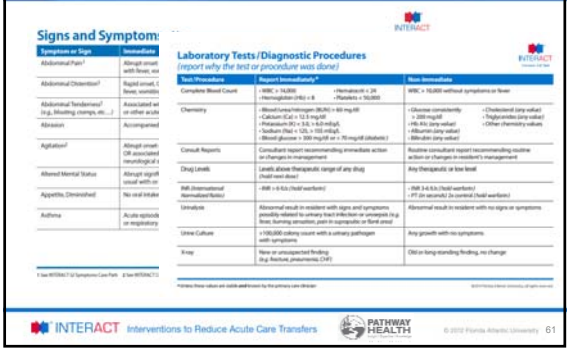
DECISION SUPPORT TOOLS

Decision Support Tools

- Criteria for Immediate Notification
- Criteria for Non-immediate notification
- Agreement and buy-in from Medical Director and Administration
  - Vital Signs
  - Lab results
  - Common signs and symptoms

Decision Support



Signs and Symptoms

Symptom or Sign	Immediate
Abdominal Pain[1]	Abrupt onset with fever, vo
Abdominal Distention[1]	Rapid onset, C fever, vomitin
Abdominal Tenderness[1] (e.g., bloating, cramps, etc…)	Associated w or other acute
Abrasion	Accompanied
Agitation[1]	Abrupt onset OR associated neurological c
Altered Mental Status	Abrupt signifi usual with co
Appetite, Diminished	No oral intake
Asthma	Acute episodi or respiratory

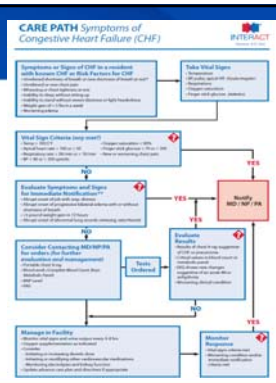
Laboratory Tests / Diagnostic Procedures
(report why the test or procedure was done)

Test/Procedure	Report Immediately*	Non-Immediate
Complete Blood Count	• WBC > 16,000 • Hematocrit < 24 • Hemoglobin (Hb) < 8 • Platelets < 50,000	WBC > 16,000 without symptoms or fever
Chemistry	• Blood Urea Nitrogen (BUN) > 60 mg/dl • Calcium (Ca) > 12.5 mg/dl • Potassium (K) < 3.0, > 6.0 mEq/L • Sodium (Na) < 120, > 155 mEq/L • Blood glucose > 300 mg/dl or < 70 mg/dl (diabetic)	• Glucose consistently > 200 mg/dl • Hb A1c (any value) • Albumin (any value) • Bilirubin (any value) • Cholesterol (any value) • Triglycerides (any value) • Other chemistry values
Consult Reports	Consultant report recommending immediate action or changes in management	Routine consultant report recommending routine action or changes in resident's management
Drug Levels	Levels above therapeutic range of any drug (hold next dose)	Any therapeutic or low level
INR (International Normalized Ratio)	• INR > 4.0 (hold warfarin)	• INR 3.0-3.9 (hold warfarin) • PT (in seconds) 2x control (hold warfarin)
Urinalysis	Abnormal result in resident with signs and symptoms possibly related to urinary tract infection or urosepsis (e.g. fever, burning sensation, pain in suprapubic or flank area)	Abnormal result in resident with no signs or symptoms
Urine Culture	> 100,000 colony count with a urinary pathogen with symptoms	Any growth with no symptoms
X-ray	New or unsuspected finding (e.g. fracture, pneumonia, CHF)	Old or long-standing finding, no change

Decision Support Tools

- All structured the same way
- Provide guidance on when to notify the MD/NP/PA consistent with File Cards
- Suggest evaluation strategies
- Provide recommendations for management and monitoring in the facility

Decision Support



ADVANCED CARE PLANNING TOOLS

Advanced Care Planning Tools

- Advanced Care Planning Tracking Tool
- Advanced Care Planning Communication Guide
- Guidance on how to identify residents appropriate for hospice or palliative care
- Comfort Care Order Set
- Deciding on going to the hospital guidance
- Education on CPR
- Education on tube feeding

Advanced Care Planning Tools

QUALITY IMPROVEMENT TOOLS

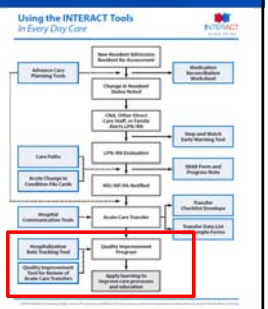
Quality Improvement Tools

- Hospitalization Rate Tracking Tool
- Quality Improvement Review Tool
- Quality Improvement Review Summary

Overview of the INTERACT™ QIP

Quality Improvement Tools

The **INTERACT Version 4.0 Tools** are meant to be used together in everyday care in the nursing home

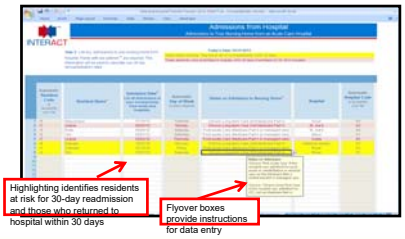


Quality Improvement Tools

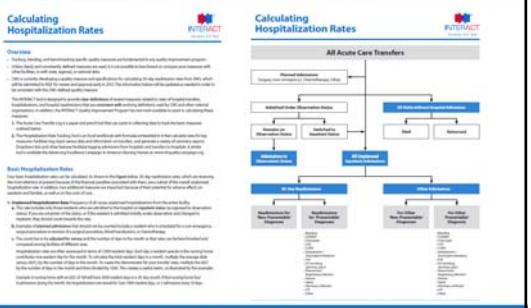
- Hospitalization Rate Tracking Tool
- Quality Improvement Review Tool
- Quality Improvement Review Summary

Quality Improvement Tools

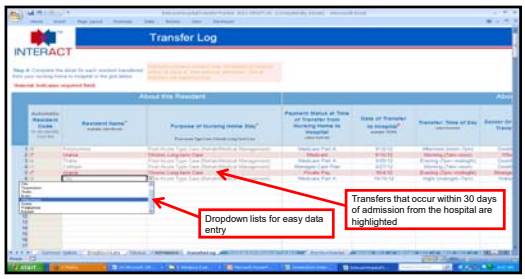
Hospitalization Rate Tracking Tool



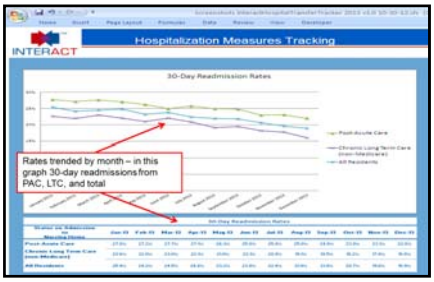
Quality Improvement Tools



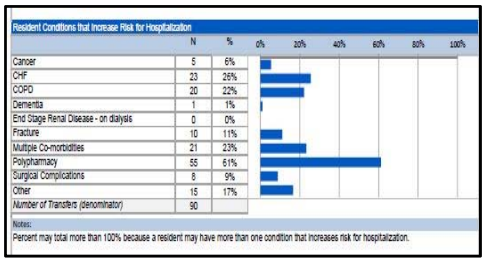
Quality Improvement Tools



Quality Improvement Tools



Sample Reports

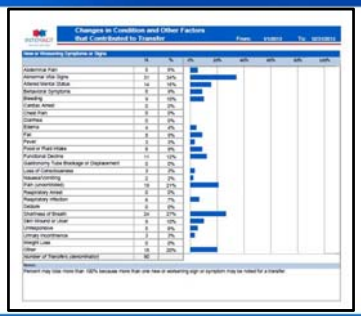


Resident Conditions that Increase Risk for Hospitalization

	N	%
Cancer	5	6%
CHF	23	26%
COPD	20	22%
Dementia	1	1%
End Stage Renal Disease - on dialysis	0	0%
Fracture	10	11%
Multiple Co-morbidities	21	23%
Polypharmacy	55	61%
Surgical Complications	8	9%
Other	15	17%
Number of Transfers (denominator)	90	

Notes:
Percent may total more than 100% because a resident may have more than one condition that increases risk for hospitalization.

Sample Reports



Quality Improvement

Review of Acute Care Transfers


Quality Improvement Tool
For Review of Acute Care Transfers

Quality Improvement Tools

- Designed to assist you in summarizing and identifying trends in QI Reviews of individual transfers in order to focus care improvement and educational activities
- Template Excel spreadsheet will be available that assists in summarizing and identifying common factors and trends


Quality Improvement
Summary Worksheet

Using the Tools

INTERACT-ING WITH ACUTE CARE

Communication Tools: INTERACT-ing with Your Local Hospitals

Facility Leaders

- Be prepared
- Initiate contact
- Know your data
- Share your story
- Know what tools/data/information you want to share
- Set date for next meeting

Communication Tools: INTERACT-ing with Your Local Hospitals

Hospital Communication Tools

The **INTERACT Version 4.0 Tools** are meant to be used together in everyday care in the nursing home

Communication Tools: INTERACT-ing with Your Local Hospitals

- Hang it in the ED
- Give it to case managers
- Give it to hospitalists
- Give it to on-call primary care clinicians in your facility

Communication Tools: INTERACT-ing with Your Local Hospitals


Nursing Home to Hospital Transfer Form

The **NH to Hospital Transfer Form** has two pages.

- The first page has information that ED physicians and nurses identified as essential to make decisions about the resident.

Communication Tools: INTERACT-ing with Your Local Hospitals


Nursing Home to Hospital Transfer Data List

The **NH to Hospital Transfer Data List** has recommended contents for transfer forms for incorporation into standard forms and electronic sharing of data

Communication Tools: INTERACT-ing with Your Local Hospitals


Acute Care Transfer Document Checklist

This **Transfer Checklist** can be printed or taped onto an envelope, and is meant to compliment the Transfer Form by indicating which documents are included with the Form

Key Resource for Leadership

http://interact.fau.edu/docs/INTERACT%20Version%204.0%20Tools/INTERACT%20V4%20Implementation_Guide%20Dec%2010.pdf

Next Steps

PREPARE. PLAN. IMPLEMENT.

Prepare

Assess Organization Systems
- Corporate Programs and Outcomes
- Facility specific protocols

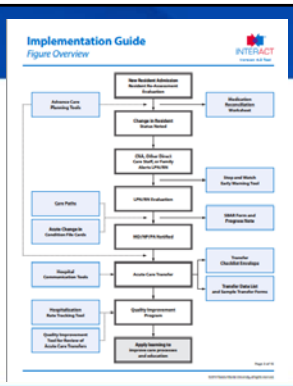
Assess need to change

Benchmark internal systems for review
- Current status
- Industry standards
- Best practice approach

Identify opportunities

Plan

- Team
- Educate
- Process
- Monitor

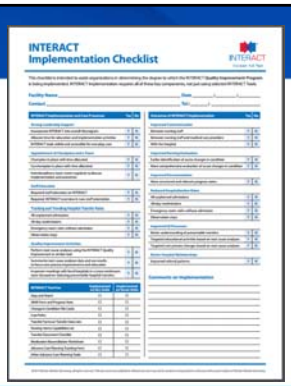


PLAN - KNOW YOUR DATA

Data Elements

Prepared by Pathway Health

Implement



QAPI for Internal and External Data

Together, Quality Assessment and Process Improvement provide the model for:

- effective problem identification
- root cause analysis
- system and culture changes

Establish care delivery improvements to realize healthcare consumer defined goals.

It all comes back to quality

Website

- Includes evidence and expert-recommended clinical practice tools, strategies to implement them, and related educational resources
- The basic program is located on the internet:

http://interact.fau.edu/

In Summary:

- Prepare ALL staff now
- Look at your data
- Develop an Action Plan
- Consider a QAPI, PIP
- Involve the ENTIRE team
- Ongoing re-evaluation
- Monitor Data
- Ongoing Communication
- Always Follow up
- Position Yourself Successfully for the Future

INTERACT Updates

1. **INTERACT Version 4.0 Tools** are on the INTERACT website; the program and tools have been extensively updated, and INTERACT II tools are no longer supported
2. **INTERACT Version 1.0 Tools** for assisted living facilities and home care are being pilot tested and should be available in a few months
3. **INTERACT Version 1.0 Tools** for health systems and ACOs are in development
4. **eINTERACT Specifications** are being developed in collaboration with and the support of PointClickCare


INTERACT
Thank You
Lisa Thomson, CIMT
Chief Marketing and Strategy Officer
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INTERACT Interventions to Reduce Acute Care Transfers
PATHWAY HEALTH
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