

Disclosure of Commercial Interests

- I have commercial interests in the following organization(s):
 - Pathway Health Inc.
 - Chief Marketing and Strategy Officer
 - Pathway Health Inc.
 - Pathway Health is a professional management and consulting organization serving clients in the long-term care and post-acute care industry.



1

A Leader's Guide: How to Incorporate the INTERACT™ Quality Improvement Process to Reduce Unnecessary Readmissions



Lisa Thomson
Pathway Health Inc.



2

The journey Begins...



3









INDUSTRY LANDSCAPE

PATHWAY HEALTH 7



Industry Landscape

- Trends and Health Care Reform
 - Post Acute Care Impact
- Reality Check
 - Operational Challenges
 - Impact on Consumers
 - Examples of Redesign in New Environment

PATHWAY HEALTH 8




Healthcare Challenges

- Government Unrest
- Reform initiatives
- Reimbursement Changes
- Increased Costs
- Regulatory Changes
- Performance Measures - Continuum
- External Oversight
- Providers who “play will stay”

PATHWAY HEALTH 9

Current Industry Landscape

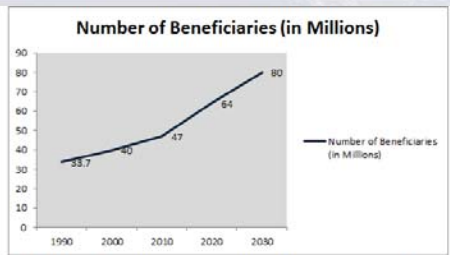
- Increase quality
- Decrease costs
- Increase efficiency
- Safety
- Care transitions
- Move care to lower cost settings
- Data = Quality
- Clinical Integration and Readiness
- Innovation




10


Medicare Growth Impact

Number of Beneficiaries (in Millions)



— Number of Beneficiaries (in Millions)

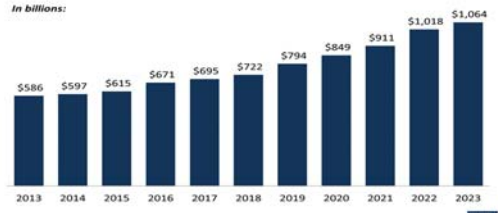
Medicare Population Growth (Projections) – Source CMS


11


Medicare Growth

Projected Medicare Spending, 2013-2023

In billions:



SOURCE: Congressional Budget Office (CBO) Medicare Baseline, May 2013.


12

Industry Landscape- AHRQ

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


Table 2. Two 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, 2013.

Principal diagnosis for index hospital stay	Number of readmissions		Cost of readmissions		Readmission rate (per 100 admissions)
	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, \$)	Percentage total cost as a percentage of total costs of Medicare readmissions	
Congestive heart failure, unspecified	134,500	7.3	1,747	7.3	24.6
Epilepsies (except in labor)	62,900	6.1	1,410	5.9	21.3
Pneumonia (except that caused by tuberculosis or another bacterial disease)	66,900	4.8	1,145	4.8	17.9
Chronic obstructive pulmonary disease (not in acute phase)	77,900	4.2	824	3.8	21.5
Cardiac dysrhythmias	69,400	3.8	870	3.8	16.2
Ulcers (not elsewhere classified)	56,500	3.1	621	2.6	18.1
Acute and unspecified renal failure	63,000	2.9	683	2.8	21.8
Acute myocardial infarction	61,300	2.8	693	2.9	19.8
Complication of device, implant or graft	47,200	2.6	742	3.1	19.0
Acute myocardial infarction	46,900	2.5	568	2.4	14.5
Total	778,188	39.3	6,373	39.8	16.8

ICD-9-CM Classification Software (CCS) code.

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

Source: Hospital outcome statistics from a nationwide database for patient care from the Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Medicare Cost and Utilization Project (HCUP), Data released September 2015, 2013.

 13

Challenges Post Acute Care

Nine of 10 Medicare patients die of chronic disease, and caring for them in their final six months of life absorbs one-third of all Medicare dollars. During that time, more than a third of chronically ill Medicare patients are treated by 10 or more doctors.

FACT End of the line on **MEDICARE** of Medicare patients die of CHRONIC DISEASE

90% of Medicare patients die of CHRONIC DISEASE

DIABETES **HIGH BLOOD PRESSURE** **RENAL FAILURE** **CONGESTIVE HEART FAILURE** **ARTERY DISEASE**

In these final months, 1 in 3 chronically ill patients is treated by 10 or more doctors.

Treating them during their final six months of life consumes **one-third** of all Medicare spending.

 14



CHANGE AHEAD

 15



Efficiencies and Expectations Narrowing Network

Quality, Clinical Integration and Value

Performance Measures and Expectations

Patient Engagement and Satisfaction

Chronic Disease Management

Care Integration, Transitions, Collaboration

Compliance

Value Based Care

PATHWAY HEALTH

REFORM DRIVERS OF CHANGE

PATHWAY HEALTH

Reform Initiatives

19

ACA Partners to Improve Outcomes

20

Redesign

Innovation Center A new engine for revitalizing and sustaining the Medicare, Medicaid and CHIP programs and ultimately to help to improve the healthcare system for all Americans.

- Flexibility and resources
- Test innovative care models
- Test innovative payments models
- <http://innovations.cms.gov>

Collaboration and Redesign

21

Innovation Center

Delivery system and payment transformation

<p>Historical State – Producer-Centered</p> <ul style="list-style-type: none"> Volume Driven Unsustainable Fragmented Care FFS Payment Systems 	<p>PRIVATE SECTOR</p> <p>PUBLIC SECTOR</p>	<p>Future State – People-Centered</p> <ul style="list-style-type: none"> Outcomes Driven Sustainable Coordinated Care <p>New Payment Systems and other Policies</p> <ul style="list-style-type: none"> • Value-based purchasing • ACOs, Shared Savings • Episode-based payments • Medical Homes and care management • Data Transparency
--	--	--

Payment Models

- ACO's and Next Generation ACO
- Bundle Payments for Care Improvement
 - Defined by episodes for care
 - Set target price and quality measures
 - Model 2 and 3
- Medicare Share Savings Program
- Medicare Acute Care Episode
- Integrated Health Networks (many)
- Dual Eligible Programs
- PACE
- And More!

Reform Drivers of Change

IMPROVE QUALITY OF CARE

PATHWAY HEALTH 25

National Quality Strategy

The **Affordable Care Act (ACA)** requires 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

PATHWAY HEALTH 26

The strategy is to concurrently pursue three aims:

Better Care

Healthy People
Healthy
Communities

Affordable
Care

PATHWAY HEALTH 27

National Quality Strategy

PRIORITIES	LONG-TERM GOALS
M Making care safer by reducing errors caused by the complexity of care	Reduce preventable hospital admissions and readmissions. Reduce the incidence of adverse health care-associated conditions. Reduce harm from inappropriate or unnecessary care.
E Ensuring that each patient and family is engaged in partnership in their care	Improve patient family, and caregiver experience of care related to quality, safety, and access across settings. The experience will include, but not be limited to, using a shared decision-making process, identifying culturally sensitive and understandable care plans. Enable patients and their families and caregivers to compare, coordinate, and manage their care appropriately and effectively.
P Promoting effective communication and coordination of care	Improve the quality of care transitions and communications across care settings. Improve the quality of life for patients with chronic illness and disability by reducing the burden of care and enhancing self-management and self-care. Increase shared responsibility and integration of care across and health care settings.
E Ensuring the most effective prevention and treatment of disease	Promote and advance health through community interventions that result in improvement of social, economic, and environmental factors. Promote and advance health through interventions that result in adoption of the most important healthy lifestyle behaviors across the lifespan. Promote and advance health through adoption of effective clinical preventive services across the lifespan in clinical and community settings.
M Making the most of the care we get	Promote healthy living and well-being through community interventions that adopt an holistic range of social, economic, and environmental factors. Promote healthy living and well-being through interventions that result in adoption of the most important healthy lifestyle behaviors across the lifespan. Promote healthy living and well-being through adoption of effective clinical preventive services across the lifespan in clinical and community settings.
S Making systems work better	Ensure affordable and accessible high-quality health care for people, families, providers, and governments. Promote and advance health through interventions that result in adoption of the most important healthy lifestyle behaviors across the lifespan. Promote healthy living and well-being through adoption of effective clinical preventive services across the lifespan in clinical and community settings.

28

Organizational Data

QUALITY

29

Quality Measures

Visit the HHS Measure Inventory



30

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




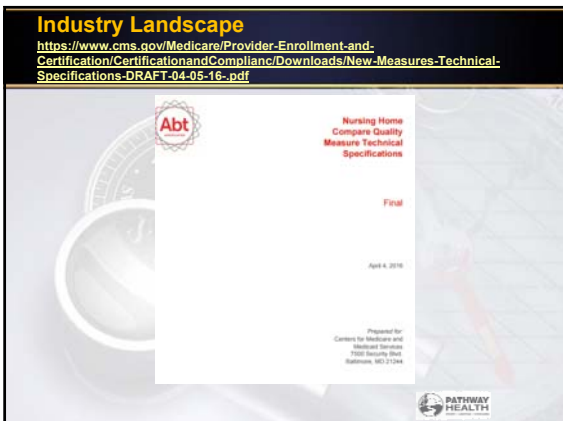
Public Data - Five Star

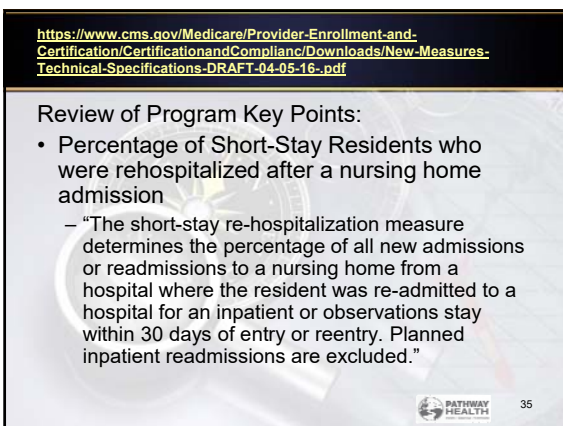


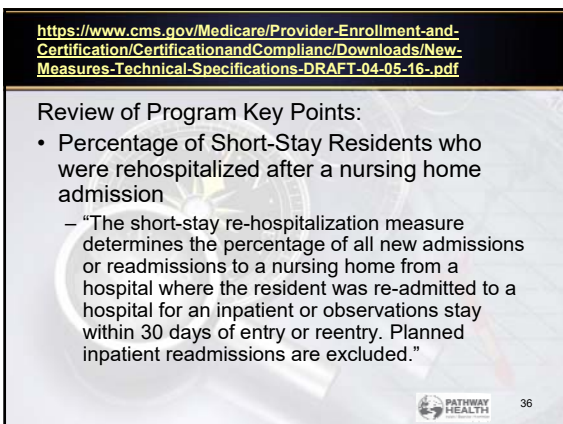
CMS FY 2015

- **Implement Bundled Payment for PCA providers by 2019**
 - Savings of \$8.7 billion in 10 years
- **Adjust Skilled Nursing Facilities Payments to Reduce Hospital Readmissions**
 - 19 percent of Medicare patients that are discharged from a hospital to a SNF are readmitted to the hospital for conditions that could have been avoided.
 - \$1.9 billion in savings over 10 years










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

“1. Planned readmissions are those in which one of a 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. Pregnancy diagnosesReadmissions to psychiatric hospitals or units are also classified as planned readmissions.
2. Admissions for acute illness or for complications of care are not classified as “planned.” Even a typically planned procedure performed during an admission for an acute illness would not likely have been planned.”



37

Industry Landscape

“Observation stays are included in the measure regardless of their diagnosis”



38

Industry Landscape

<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Downloads/Improvements-NHC-April-2016.pdf>



39

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

Information on the SNFVBP Program:

The screenshot shows the CMS.gov website with a navigation menu and a main content area titled "The Skilled Nursing Facility Value-Based Purchasing Program (SNFVBP)". The content includes sections for "What's the SNFVBP Program?", "When does the SNFVBP Program start?", "Why's the SNFVBP Program important?", and "How will the program work?". The page number "40" is visible in the bottom right corner.

The Road to VBP per HR 4302

The diagram is a vertical timeline with five red arrow-shaped boxes pointing to the right, each containing a date and a description of an event. The dates are 10/1/14, 10/1/15, 10/1/16, 10/1/17, and 10/1/18. The descriptions are: "Data gathering and review!!!", "HHS - Establish SNF all-condition hospital readmission measure PRIOR to 10/1/15", "HHS - Establish SNF all-condition risk-adjusted preventable hospital readmission measure - HHS - Begin providing 'confidential feedback' to SNFs quarterly", "PUBLIC REPORTING - Readmission Measure on Nursing Home Compare Site", and "Medicare reimbursement rates for SNF will be based partially on their performance scores beginning on October 1, 2018." The page number "41" is visible in the bottom right corner.

1. Initiatives

NEW! IMPACT legislation (Improving Medicare Post-Acute Care Transformation Act)


- standardized platform/assessment tool
- Quality Measures
- SNF Performance Measures
- Public reporting of Data
- Re design NH Compare
- New Payment Model

Acute, Skilled Nursing, Home Care, Hospice

The diagram is a horizontal timeline titled "Timeline of Major Deliverables in the IMPACT Act of 2014". It shows a sequence of events from 2014 to 2017. Key events include: "New of revised SNF Quality Measures (pending)", "Standardized assessment tool for SNF and other post-acute settings", "SNF Performance Measures", "New Payment Model", and "Public Reporting of Data". The page number "42" is visible in the bottom right corner.

Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014

- Bi-partisan bill introduced in March, U.S. House & Senate; passed on September 18, 2014 and signed into law by President Obama October 6, 2014
- Requires Standardized Patient Assessment Data for:
 - Assessment and Quality Measures
 - Quality care and improved outcomes
 - Discharge Planning
 - Interoperability
 - Care coordination




43

Standardized Patient Assessment Data

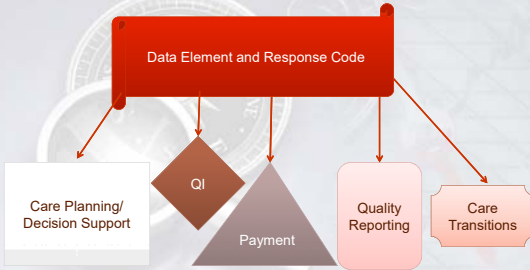
- Data categories:
 - Functional status
 - Cognitive function and mental status
 - Special services, treatments, and interventions
 - Medical conditions and co-morbidities
 - Impairments
 - Other categories required by the Secretary

Use of Standardized Assessment Data:
HHAs: no later than January 1, 2019
SNFs, IRFs, and LTCHs: no later than October 1, 2018




44

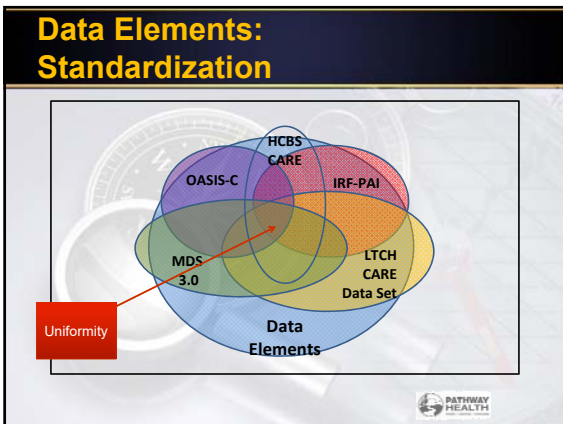
One Response: Many Uses

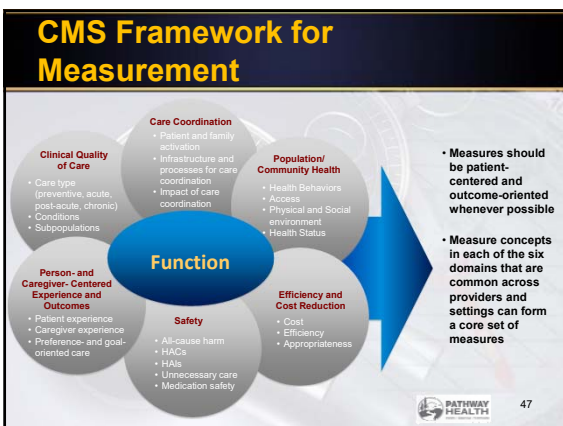


```
graph TD; A[Data Element and Response Code] --> B[Care Planning/ Decision Support]; A --> C[QI]; A --> D[Payment]; A --> E[Quality Reporting]; A --> F[Care Transitions];
```



45





2. Initiatives

Safe Care Transitions – Patient Safety

New Measurement

- Care Transitions
- Patient Education
- Medication Reconciliation
- Transfer protected information

Acute, Skilled Nursing, Home Care, Hospice, Assisted Living, HME, Physicians, others coming soon!

PATHWAY HEALTH

3. Initiatives

Bundle Payment methodology by 2017!

- Medicare Value Based Purchasing
- Performance based pay
- Quality metrics
- New-Performance Measures

Acute, Skilled Nursing, Home Care, Hospice, Assisted Living, HME, Physicians, others coming soon!



49

4. Initiatives

Hospital Readmission Reduction Program

Acute, Skilled Nursing, Home Care, Hospice, Coming Soon... Assisted Living

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

Frequency of Rehospitalization of Short Stay Nursing Home Residents, by State, 2006




Source: CMS, Transitions and Long-term Care: Reducing Preventable Hospital Readmissions among Nursing Facility Residents.

50

SNF Readmission Measure

Readmission Measure (HR 4302)

- **10/1/15** – All-cause all-condition hospital readmission measure
- **10/1/16** – Resource Use Measure
 - Measure to reflect an all-condition risk adjusted potentially preventable hospital readmission rate for SNF
 - Quarterly feedback to SNF on performance from CMS
 - Public Reporting of readmission rate!



51

HR 4302 Components For SNF VBP

- SNF Performance Scores
- SNF Ranking Based on Performance Scores
- Readmission Rate – first measure
- Quality Measures – alignment with health care providers
- Value Based Incentive Payment
- Public Reporting

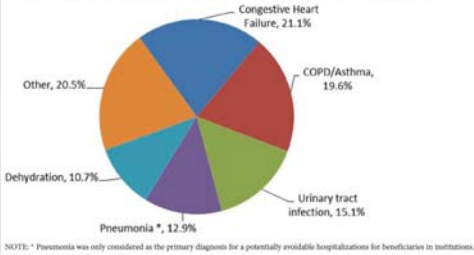


READMISSIONS – WHY THIS FOCUS?




Potentially preventable hospitalizations from Medicare and Medicaid Research Review from 2014

Exhibit 4. Highly Prevalent Conditions Associated with Potentially Avoidable Hospitalizations in 2009



Condition	Percentage
Congestive Heart Failure	21.1%
COPD/Asthma	19.6%
Urinary tract infection	15.1%
Pneumonia *	12.9%
Dehydration	10.7%
Other	20.5%



NOTE: * Pneumonia was only considered as the primary diagnosis for a potentially avoidable hospitalization for beneficiaries in institutions.
SOURCE: Chronic Condition Warehouse, 2009.



SNF Readmissions


Some Hospitalizations of NH Residents are Preventable

- Several studies suggest that a substantial percent of hospital transfers admissions and readmissions are unnecessary and be prevented




Readmission Definition

- Definitions of Readmissions "...patients who are discharged from acute care hospital and are hospitalized again within 30 days of discharge."
- Re-hospitalizations are:
 - Unanticipated
 - Unscheduled
 - Clinically related to the initial admission
 - Can be readmitted to a different hospital – not just original hospital
- Bounce Back
 - Complicated or complex transition
 - Frequent flyers



Clinical

IMPACT OF READMISSIONS



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

- At the beauty salon
- Hospitalization
- At risk for complications
 - Delirium
 - Polypharmacy
 - Falls
 - Incontinence and catheter use
 - Hospital acquired infections
 - Immobility, de-conditioning, pressure ulcers

58

Additional Readmission Risks

- Pain
- Depression
- Sadness/Crying
- Despair
- Weakness
- Confusion
- Indecision
- Apprehension
- Anxiety
- Restlessness
- Sleep disturbance
- Dependency
- Insecurity
- Distrust
- Falls
- Change in Functional Ability
- Withdrawal/isolation
- Loneliness
- Negative comments about staff
- Expressing concern
- Being upset
- Resistance
- Anger
- Aggressiveness
- Change in eating habits
- Weight change
- Stomach problems
- Hallucinations

59


Symptoms Leading to DC


- Abdominal pain
- Abnormal lab or test
- Abnormal vital signs
- Altered mental status
- Behavioral symptoms (agitation, psychosis, etc.)
- Bleeding, other than GI
- Blood sugar (high/low)
- Chest pain
- Constipation
- Diarrhea
- Edema (new or worsening)
- EKG abnormality
- Fall(s)
- Fever
- Functional decline
- GI bleeding
- Loss of consciousness
- Nausea/Vomiting
- Nutrition (inadequate intake food/fluid)
- Pain (uncontrolled)
- Shortness of breath
- Skin wound or ulcer
- Trauma (fall-related or other)
- Unresponsive
- Urinary incontinence
- Weight loss

60

Contributing Factors Leading to DC


- Advance care plan not in place
- Practitioner unable to provide face-to-face assessment
- Supplies/Resources
- Medication management
- Equipment not available
- Problems w/nursing staff resources
- Lack of diagnostic services
- Resident preference
- Family preference
- Clinician initiates and insists on DC
- Health plan request
- Care Coordination
- Communication Breaks
- FU with specialty physician
- Safety factors




 61


What is INTERACT™ Quality Improvement Program and Why Does it Matter?

DATA AND OUTCOMES




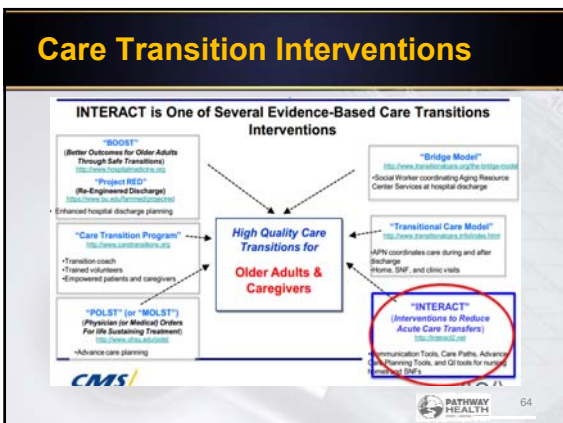
 62

Readmission Data


New Hampshire	35%	0.41%	9
New Jersey	98%	0.82%	63
New Mexico	45%	0.35%	19
 New York	80%	0.73%	148
North Carolina	65%	0.47%	74
North Dakota	4%	0.18%	2
Ohio	63%	0.73%	107
Oklahoma	52%	0.57%	66
Oregon	30%	0.14%	18
Pennsylvania	72%	0.63%	126

Source: Kaiser Health News analysis of data from the Centers for Medicare & Medicaid Services. [Get the data with Datawrapper](http://kaiserhealthnews.org/news/medicare-readmissions-penalties-by-state/)
<http://kaiserhealthnews.org/news/medicare-readmissions-penalties-by-state/>

 63



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.

65

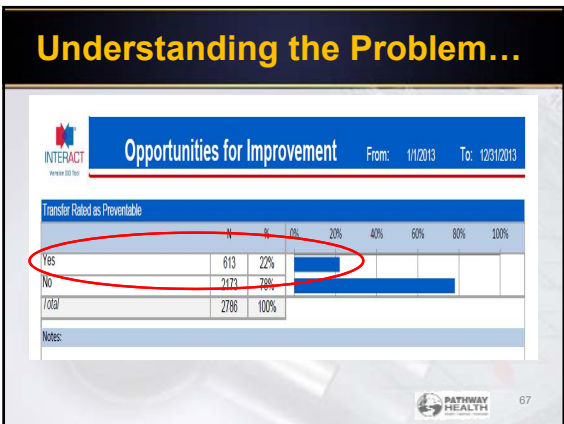
The INTERACT Program: What is It and Why Does It Matter?

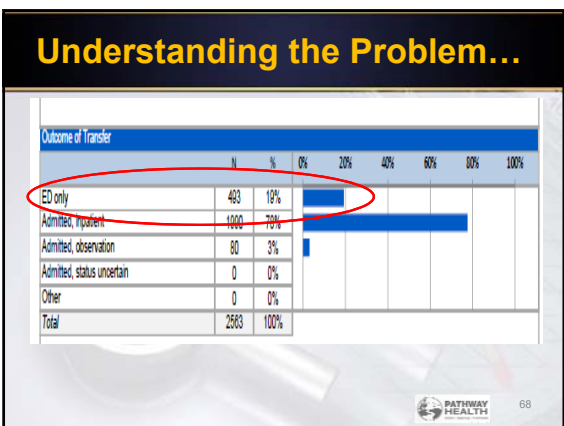
CMS Special Study in Georgia
Expert Ratings of Potentially Avoidable Hospitalizations
Based review of 200 hospitalizations from 20 NHs

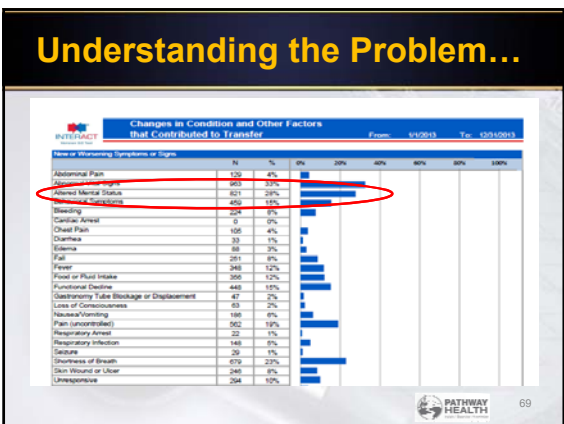
	Was the Hospitalization Avoidable?	
	Definitely/Probably YES	Definitely/Probably NO
Medicare A	69%	31%
Other	65%	35%
HIGH Hospitalization Rate Homes	75%	25%
LOW Hospitalization Rate Homes	59%	41%
TOTAL	68%	32%

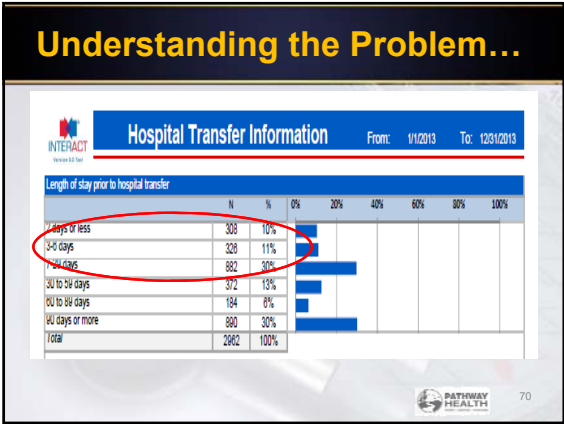
Ouslander et al. J Amer Ger Soc 58: 627-635, 2010

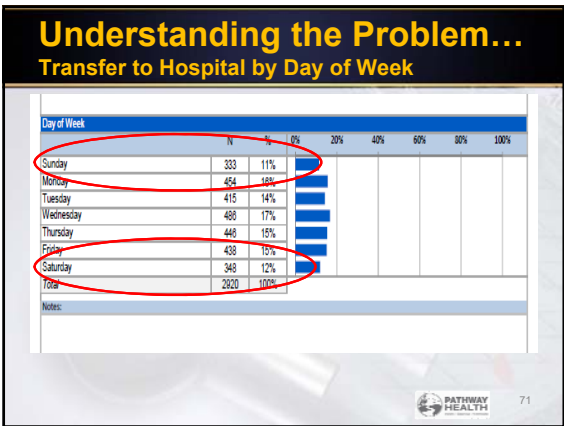
66

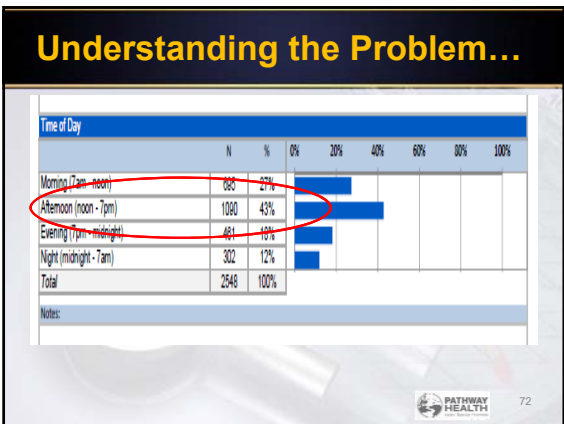












The INTERACT Program: What is It and Why Does It Matter?

CMS Study of Dually Eligible Medicare/Medicaid Beneficiaries

The NEW ENGLAND JOURNAL of MEDICINE

Perspective
PUBLISHED ON LINE

Reducing Unnecessary Hospitalizations of Nursing Home Residents

Joseph P. Speroff, M.D., and Robert S. Burstin, M.D.

Unavoidable and Potentially Avoidable Hospitalizations of Nursing Home Residents Eligible for Both Medicare and Medicaid, 2005.

Over a 1-year period, 10,111 Medicare and Medicaid beneficiaries in the year 2005 (of the total hospitalizations included, 12% were from nursing homes, accounting for 48% of the total costs of avoidable hospitalizations). Data are from the Centers for Medicare and Medicaid Services.

73

Commonwealth Fund Project Results

Facilities	Mean Hospitalization Rate per 1000 resident days		Mean Change	p value	Relative Reduction in All-Cause Hospitalizations
	Pre intervention	During intervention			
All INTERACT facilities (N = 28)	3.99	3.32	-0.69	0.02	17%
Engaged facilities (N = 17)	4.01	3.13	-0.90	0.01	24%
Not engaged facilities (N = 8)	3.96	3.71	-0.26	0.69	6%

Ouslander et al, J Am Geriatr Soc 59:745-753, 2011

74

The INTERACT Program: Background, Payment Reform, and Health Policy Issues

Opportunities for You and Your Facility

75

QUALITY IMPROVEMENT PROGRAM

What is the INTERACT program?

Is a **quality improvement program** designed to improve the care of long-term care residents with acute changes in condition

Goals

- 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

Goals

- The goal of **INTERACT™** is to improve care by improving the management of residents with a change in condition
- The goal of **INTERACT™** is **not** to prevent all hospital transfers
- Preventing all or even most transfers is not realistic and could have unintended negative consequences on the quality of care



79

Getting Started: Keys to a QI Program

- In order to implement a quality improvement program you must:
 - ✓ Have strong leadership support for the program
 - ✓ Create a team involving all levels of staff
 - ✓ Be sure contracted staff, including Physicians, are on board!
 - ✓ Track, trend, and benchmark well-defined measures
 - ✓ Perform “root cause analyses” to learn and guide care improvement and educational activities



80

TOOLS OVERVIEW



81

Putting the Tools to Work in Everyday Practice

Quality Improvement Program

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

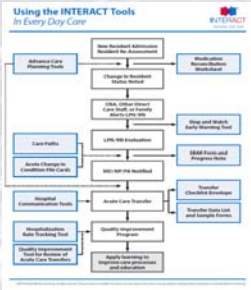
INTERACT™




82

Overview of the INTERACT™ QIP

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



Using the INTERACT Tools in Every Day Care



83

INTERACT™ COMMUNICATION TOOLS



84

Communication Tools Within your Nursing Home

Stop and Watch Early Warning Tool

If you have identified a change while caring for an older nursing home resident, please **stop** the change and notify a nurse. Either give the nurse a copy of this tool or review it with her/him as soon as possible.

S Seems different than usual
T Talks or communicates less
O Overall needs more help than - showering, participating less in activities
P Appears less than usual

A Ate less
I 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 for the change noted on the monitoring high risk patient

Resident's Name: _____
 Date: _____
 Reported to: _____ Date and Time: _____
 Report Received: _____ Date and Time: _____
 Nurse's Name: _____

85

Communication Tools

The Purpose of the SBAR

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

SBAR Communication Form

and Progress Note for LPE/LPN

Before Calling the Provider: NP, PA, Other Health and Professional
 Responsibilities: Review patient chart and information
 Obtain necessary information from other staff
 Review patient's current status and history
 Review patient's current medications and allergies
 Review patient's current lab and test results
 Review patient's current vital signs and other data

Situation

What is the patient's current status?
 How long has the patient been in this situation?
 How long has the patient been in this situation?
 How long has the patient been in this situation?
 How long has the patient been in this situation?
 How long has the patient been in this situation?

Background

What is the patient's history?
 What is the patient's history?
 What is the patient's history?
 What is the patient's history?
 What is the patient's history?

Assessment

What is the patient's assessment?
 What is the patient's assessment?
 What is the patient's assessment?
 What is the patient's assessment?
 What is the patient's assessment?

Recommendation

What is the patient's recommendation?
 What is the patient's recommendation?
 What is the patient's recommendation?
 What is the patient's recommendation?
 What is the patient's recommendation?

Resident Name: _____ Date: _____
 Reported to: _____ Date and Time: _____
 Report Received: _____ Date and Time: _____
 Nurse's Name: _____

86

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 Your Medication Orders (Continue, Stop, Change)

*Samples on the diagram in addition, unmet dose or route of administration, stop date, hold parameters, all items needed for reconciling, also different than before hospitalization, medication duplication

87

Communication Tools

Part 2: Medications Prior to Hospitalization Needing Clarification

Medications Taken Before Hospitalization Not Currently on Hospital Recommended List	Comments (e.g. reason for the medication before hospitalization, and reason it was stopped at the hospital, if any)	Resolution for Final Medication Orders (Continue, Stop, Change)

Resident's Name _____ Date ____/____/____

©2011 Pathway Health. All rights reserved. This document is available for electronic copying and use in accordance with the permission of Pathway Health. 88

Communication Tools

Between the Hospital and Your Nursing Home

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

©2011 Pathway Health. All rights reserved. This document is available for electronic copying and use in accordance with the permission of Pathway Health. 89

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

©2011 Pathway Health. All rights reserved. This document is available for electronic copying and use in accordance with the permission of Pathway Health. 90



Decision Support Tools

Change in Condition File Cards

- 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 Tools

Laboratory Tests/Diagnostic Procedures

(report why the test or procedure was done)

Test/Procedure	Report Immediately*	Non-Immediate
Complete Blood Count	• WBC < 50,000 • Hemoglobin < 8 • Hematocrit < 24 • Platelets < 50,000	• WBC > 10,000 without symptoms or fever
Chemistry	• Blood urea nitrogen (BUN) > 40 mg/dl • Calcium (Ca) < 8.0 mg/dl • Potassium (K) < 3.0 & 6.0 mg/dl • Sodium (Na) < 125 & 155 mg/dl • Blood glucose > 300 mg/dl or < 70 mg/dl (diabetic)	• Glucose consistently > 200 mg/dl • Cholesterol (any value) • Hb A1c (any value) • Albumin (any value) • Bilirubin (any value)
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	Any therapeutic or low level
INR (International Normalized Ratio)	• INR > 6.5 (that warrants)	• INR 3-6.5 (that warrants) • PT (in seconds) 2x control (that warrants)
Urinalysis	Abnormal result in resident with signs and symptoms possibly related to urinary tract infection or symptoms (e.g. fever, burning on urination, 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
Strep	New or unexpected finding (e.g. <i>Strep. pneumoniae</i> , CNS)	OK or long-standing finding, no change

*Unless there are other care needs met by the primary care clinician

Decision Support tools

Symptom or Sign	Immediate	Non-Immediate
Abdominal Pain?	Abrupt onset severe pain or distention, CR with fever, vomiting	MMF diffuse or localized pain, unrelieved by antacids or laxatives
Abdominal Distention?	Rapid onset, CR presence of marked tenderness, fever, vomiting, GI bleeding	Progressive or persistent distention not associated with symptoms
Abdominal Tenderness? (e.g., bloating, cramps, etc...)	Associated with fever, continuous GI bleeding, or other acute symptoms	Persistent discomfort not associated with other acute symptoms
Abrasion	Accompanied by significant pain or bleeding	If bleeding continues or if associated with evidence of local infection
Agitation?	Abrupt onset of significant change from usual, CR associated with fever or new onset abnormal neurological signs	Continued progression or persistence of symptoms
Altered Mental Status	Abrupt significant change in cognitive function from usual with or without altered level of consciousness	Persistent change from usual cognitive function with no other criteria met for immediate notification
Appetite, Decreased	No oral intake 2 consecutive meals	Significant decline in food and fluid intake in resident with marginal hydration and nutritional status
Asthma	Acute episode with wheezing, dyspnea, or respiratory distress	Self-limited episode that was more severe or less responsive to treatment than the usual

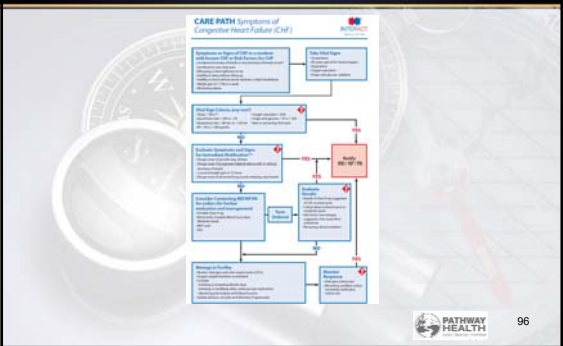
© 2011 INTERACT™ Symptom Care Path. © 2011 INTERACT™ Change in Behavior Care Path. © 2011 Pathway Health. All rights reserved.

PATHWAY HEALTH 94

Decision Support Tools: INTERACT™ Care Paths

- 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
- © 2011 Pathway Health. All rights reserved.
- PATHWAY HEALTH** 95

Decision Support Tools



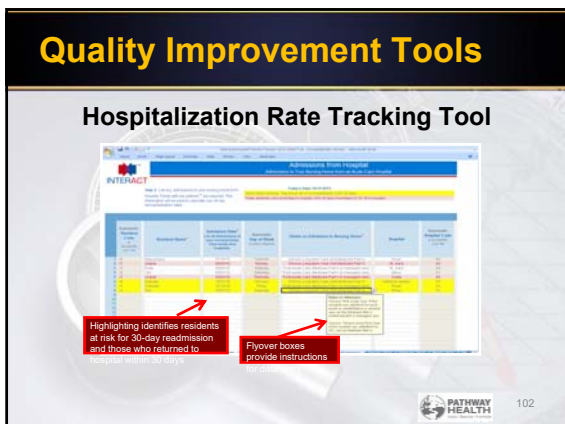












Quality Improvement Tools

Calculating Hospitalization Rates

INTERACT

Overview

- 1. Identify existing data sources that will provide information to calculate hospitalization rates.
- 2. Determine how existing data sources are used to calculate hospitalization rates.
- 3. Identify existing data sources that will provide information to calculate hospitalization rates.
- 4. Determine how existing data sources are used to calculate hospitalization rates.
- 5. Identify existing data sources that will provide information to calculate hospitalization rates.
- 6. Determine how existing data sources are used to calculate hospitalization rates.

Key Hospitalization Rate

- 1. Identify existing data sources that will provide information to calculate hospitalization rates.
- 2. Determine how existing data sources are used to calculate hospitalization rates.
- 3. Identify existing data sources that will provide information to calculate hospitalization rates.
- 4. Determine how existing data sources are used to calculate hospitalization rates.

Calculating Hospitalization Rates

INTERACT

All Acute Care Transfers

103

Quality Improvement Tools

Calculating Hospitalization Rates

INTERACT

Overview

- 1. Identify existing data sources that will provide information to calculate hospitalization rates.
- 2. Determine how existing data sources are used to calculate hospitalization rates.
- 3. Identify existing data sources that will provide information to calculate hospitalization rates.
- 4. Determine how existing data sources are used to calculate hospitalization rates.
- 5. Identify existing data sources that will provide information to calculate hospitalization rates.
- 6. Determine how existing data sources are used to calculate hospitalization rates.

Key Hospitalization Rate

- 1. Identify existing data sources that will provide information to calculate hospitalization rates.
- 2. Determine how existing data sources are used to calculate hospitalization rates.
- 3. Identify existing data sources that will provide information to calculate hospitalization rates.
- 4. Determine how existing data sources are used to calculate hospitalization rates.

Transfer Log

INTERACT

About this Resident

Admission Reason	Resident Name	Purpose of Nursing Home Stay	Payment Status at Time of Transfer	Date of Transfer (to Hospital)	Transfer Time of Day	Discharge By
...
...
...
...

Dropdown lists for easy data entry

Transfers that occur within 30 days of admission from the hospital are highlighted

104

Quality Improvement Tools

Calculating Hospitalization Rates

INTERACT

Overview

- 1. Identify existing data sources that will provide information to calculate hospitalization rates.
- 2. Determine how existing data sources are used to calculate hospitalization rates.
- 3. Identify existing data sources that will provide information to calculate hospitalization rates.
- 4. Determine how existing data sources are used to calculate hospitalization rates.
- 5. Identify existing data sources that will provide information to calculate hospitalization rates.
- 6. Determine how existing data sources are used to calculate hospitalization rates.

Key Hospitalization Rate

- 1. Identify existing data sources that will provide information to calculate hospitalization rates.
- 2. Determine how existing data sources are used to calculate hospitalization rates.
- 3. Identify existing data sources that will provide information to calculate hospitalization rates.
- 4. Determine how existing data sources are used to calculate hospitalization rates.

Hospitalization Measures Tracking

INTERACT

30-Day Readmission Rates

Rates trended by month—in this graph 30-day readmissions from PAC, LTC, and total

Month	Path-Adult Care	Chronic Lung/Heart Care	All Residents
Mar 15	20.0%	20.0%	20.0%
Apr 15	20.0%	20.0%	20.0%
May 15	20.0%	20.0%	20.0%
Jun 15	20.0%	20.0%	20.0%
Jul 15	20.0%	20.0%	20.0%
Aug 15	20.0%	20.0%	20.0%
Sep 15	20.0%	20.0%	20.0%
Oct 15	20.0%	20.0%	20.0%
Nov 15	20.0%	20.0%	20.0%
Dec 15	20.0%	20.0%	20.0%
Jan 16	20.0%	20.0%	20.0%
Feb 16	20.0%	20.0%	20.0%
Mar 16	20.0%	20.0%	20.0%

105

Quality Improvement Review of Acute Care Transfers

Quality Improvement Tool
For Review of Acute Care Transfers

The QIRTM-12 has been designed to help your review team identify opportunities to reduce transfers through the process. Complete the quality review of an acute care transfer and then use the QIRTM-12 to identify areas for improvement and to create an improvement plan.

SECTION 1: Risk Factors for Hospitalization and Readmission

SECTION 2: Describe the Acute Change in Condition and Other Key Clinical Issues that Contributed to the Transfer

106

The Quality Improvement Summary Worksheet

- 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

QIRTM-12 is designed to assist you in summarizing and identifying trends in QI Reviews of individual transfers in order to focus care improvement and educational activities. The QIRTM-12 is designed to assist you in summarizing and identifying trends in QI Reviews of individual transfers in order to focus care improvement and educational activities.

QIRTM-12 is designed to assist you in summarizing and identifying trends in QI Reviews of individual transfers in order to focus care improvement and educational activities.

107

107

Sample Reports

Resident Conditions that Increase Risk for Hospitalization

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 Comorbidities	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.

108

Sample Reports

Changes in Conditions and Other Factors Most Contributing to Transfer

Category	Count	10%	20%	30%	40%	50%
Medical Condition	15	100%	100%	100%	100%	100%
Medical History	10	100%	100%	100%	100%	100%
Behavioral/Emotional	8	100%	100%	100%	100%	100%
Substance Abuse	5	100%	100%	100%	100%	100%
Alcohol	4	100%	100%	100%	100%	100%
Drug	3	100%	100%	100%	100%	100%
Age	2	100%	100%	100%	100%	100%
Gender	1	100%	100%	100%	100%	100%
Race	1	100%	100%	100%	100%	100%
Ethnicity	1	100%	100%	100%	100%	100%
Religion	1	100%	100%	100%	100%	100%
Education	1	100%	100%	100%	100%	100%
Occupation	1	100%	100%	100%	100%	100%
Income	1	100%	100%	100%	100%	100%
Marital Status	1	100%	100%	100%	100%	100%
Legal Status	1	100%	100%	100%	100%	100%
Other	1	100%	100%	100%	100%	100%

109

Sample Reports

Hospital Transfer Information

Category	Count	10%	20%	30%	40%	50%
Medical Condition	15	100%	100%	100%	100%	100%
Medical History	10	100%	100%	100%	100%	100%
Behavioral/Emotional	8	100%	100%	100%	100%	100%
Substance Abuse	5	100%	100%	100%	100%	100%
Alcohol	4	100%	100%	100%	100%	100%
Drug	3	100%	100%	100%	100%	100%
Age	2	100%	100%	100%	100%	100%
Gender	1	100%	100%	100%	100%	100%
Race	1	100%	100%	100%	100%	100%
Ethnicity	1	100%	100%	100%	100%	100%
Religion	1	100%	100%	100%	100%	100%
Education	1	100%	100%	100%	100%	100%
Occupation	1	100%	100%	100%	100%	100%
Income	1	100%	100%	100%	100%	100%
Marital Status	1	100%	100%	100%	100%	100%
Legal Status	1	100%	100%	100%	100%	100%
Other	1	100%	100%	100%	100%	100%

110

Using the Tools

INTERACT-ING WITH ACUTE CARE

111

**Communication Tools:
INTERACT-ing with Your Local Hospitals**



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.

115

**Communication Tools:
INTERACT-ing with Your Local Hospitals**



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

116


**Communication Tools:
INTERACT-ing with Your Local Hospitals**




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

117

**Communication Tools:
INTERACT-ing with Your Local Hospitals**




The **Hospital to Post-Acute Care Data List** has recommended contents for transfer forms for incorporation into standard forms and electronic sharing of data




118

**Communication Tools:
INTERACT-ing with Your Local Hospitals**



INTERACT has a sample **Hospital to Post-Acute Care Transfer Form** that puts the data into a format that is easy to read and flows logically for a receiving clinician.



119



Prepare Now!

IMPLEMENTATION STRATEGIES



120

Organization Change Capability

Determine organization ability for change

Assess Readiness Care Transitions Data and Technology QAPI

PATHWAY HEALTH 121

Assess Organizational Readiness

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

PATHWAY HEALTH 122

Assess Organizational Readiness

Assess Clinical Readiness

- Your Role
- Industry initiatives
- Market initiatives and expectations
- Quality Outcomes
 - Payer and External Expectations
 - Consequences
- Internal competency process
- Right People and Right Roles

PATHWAY HEALTH 123



Policy and Procedures – Assess Readiness

- From Preadmission to Discharge!
 - Assessment Forms (Preadmission -> Discharge)
 - Monitoring requirements
 - Staff Training
 - Care Planning
 - Documentation
 - Notifications

Care Transition Process

<https://www.amda.com/members/flashpapers/papers/TOC/>

- Transition/Discharge Planning and Admission Process
- Comprehensive Communication
- Coordination of Care
- Resident/Family Teaching with evidence of understanding
- Medication Education and Reconciliation
- Shared Accountability
- Resource-AMDA Clinical Practice Guideline: Transitions of Care in the Long-Term Care Continuum

**DATA AND TECHNOLOGY
PREPARE NOW!**

PATHWAY HEALTH 127

Public Data – Once Again

2016, 2017 and beyond

SNF and HHA Impact

PATHWAY HEALTH

Internal Data

QAPI

- 1 Design and Scope**
 - Ongoing and comprehensive
 - All services you offer
 - All departments
- 2 Governance and Leadership**
 - Led by administration
 - Input from staff, residents, and families
- 3 Feedback, Data Systems and Monitoring**
 - Systems to monitor care and services
 - Draws data from multiple sources
- 4 Performance Improvement Projects (PIPs)**
 - Identify areas that need attention
 - Examine and improve care or services
- 5 Systematic Analysis and Systemic Action**
 - Determine when in-depth analysis is needed
 - Understand the problem, causes, implications of change

<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/516elmerbzqapi.pdf>


PATHWAY HEALTH 129

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.



130

INNOVATION



131

Strategic Relationships

INTERACTing with Referral Sources



- Organizational Data
- Alignment of Data
- Preferred Partner
- Risk Adjustment



132

“Engaging physicians” is a challenging area in the effort to mobilize key stakeholders to support community-based efforts to improve care transitions and reduce avoidable rehospitalizations.”


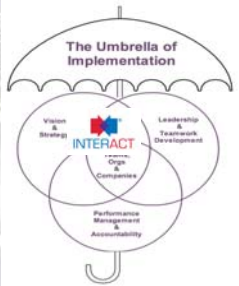


- CFMC, the Medicare QIO for Colorado



133



Getting Staff on Board What does it take?



134

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



135





