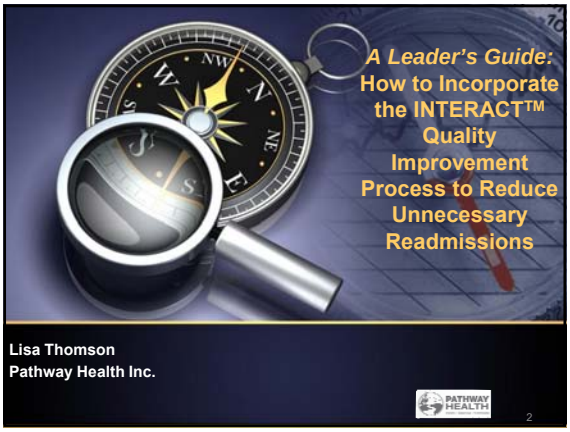
## Disclosure of Commercial Interests

- 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

## New Era of Healthcare Quality and Efficiency






INTERACT


## INDUSTRY LANDSCAPE



## Industry Landscape

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




## Healthcare Challenges

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

## 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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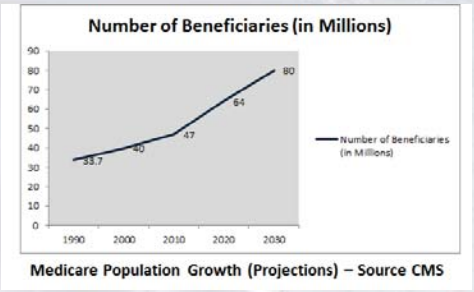
## Medicare Growth Impact




Medicare Population Growth (Projections) – Source CMS

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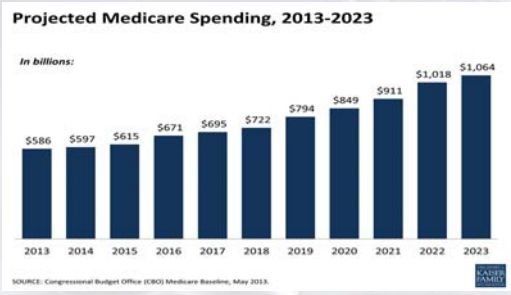
## Medicare Growth

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## Industry Landscape- AHRQ

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

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 | 1,149 | 4.8 | 17.9 |
| Chronic obstructive pulmonary disease and bronchiectasis | 77,900 | 4.2 | 924 | 3.8 | 21.5 |
| Cardiac dysrhythmias | 69,400 | 3.8 | 835 | 3.5 | 16.2 |
| Urinary tract infections | 56,900 | 3.1 | 621 | 2.6 | 18.1 |
| 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

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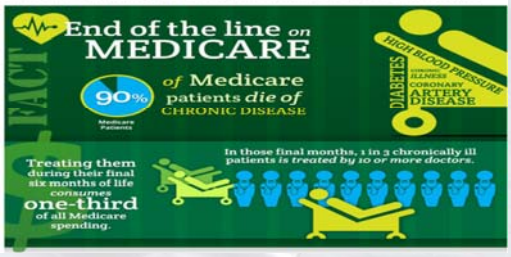
## Challenges Post Acute Care

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.

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## Efficiencies and Expectations Narrowing Network

**Quality, Clinical Integration and Value**

**Patient Engagement and Satisfaction**

**Care Integration, Transitions, Collaboration**

AFFORDABLE CARE ACT

Performance Measures and Expectations

**Chronic Disease Management**

**Compliance**

**Value Based Care**

## REFORM DRIVERS OF CHANGE

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## Reform Initiatives


19

## ACA Partners to Improve Outcomes

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

OFFICE OF INSPECTOR GENERAL
U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OIG

DEPARTMENT OF HEALTH & HUMAN SERVICES USA
Office of the Inspector General

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## 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

Center for Medicare & Medicaid INNOVATION

**Collaboration and Redesign**

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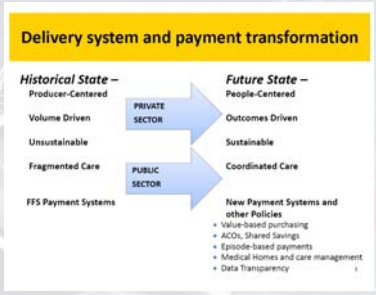
## Innovation Center





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## 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!


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Reform Drivers of Change

## IMPROVE QUALITY OF CARE

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## 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

NATIONAL QUALITY STRATEGY

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## The strategy is to concurrently pursue three aims:


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## National Quality Strategy


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## Organizational Data

## QUALITY

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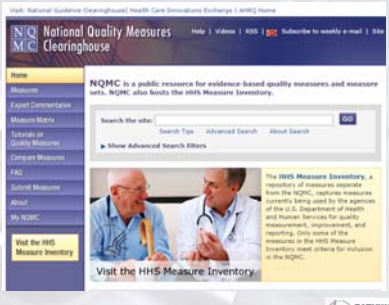
## Quality Measures

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## 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

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## Industry Landscape

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


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

Review of Program Key Points:

- 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. Planned inpatient readmissions are excluded."

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

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https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliianc/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 diagnoses …..Readmissions 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."

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## Industry Landscape

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

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## Industry Landscape

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


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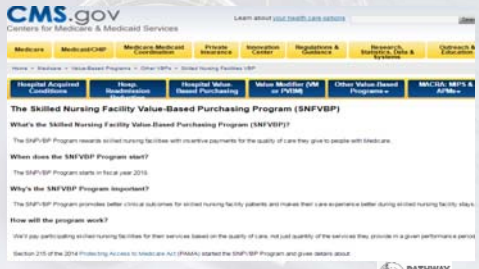
## Industry Landscape

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

Information on the SNFVBP Program:

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## The Road to VBP per HR 4302

- 10/1/14 — Data gathering and review!!!
- 10/1/15 — HHS - Establish SNF all-condition hospital readmission measure PRIOR to 10/1/15
- ~~10/1/16~~ — HHS - Establish SNF all-condition risk-adjusted preventable hospital readmission measure . HHS - Begin providing "confidential feedback" to SNFs quarterly (Now April 1st 2016)
- ~~10/1/17~~ — PUBLIC REPORTING - Readmission Measure on Nursing Home Compare Site (Now April 1st 2017)
- 10/1/18 — Medicare reimbursement rates for SNF will be based partially on their performance scores beginning on October 1, 2018.

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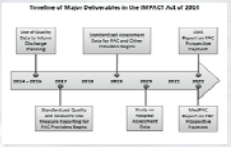
## 1. Initiatives

***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**



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## 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

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## 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

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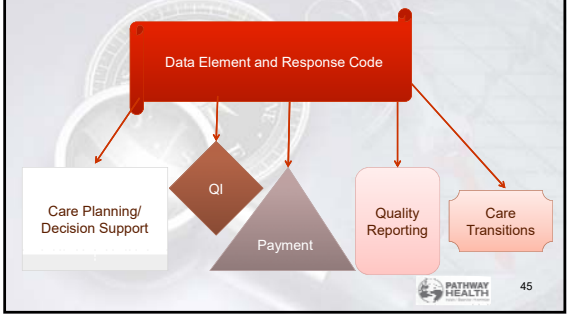
## One Response: Many Uses

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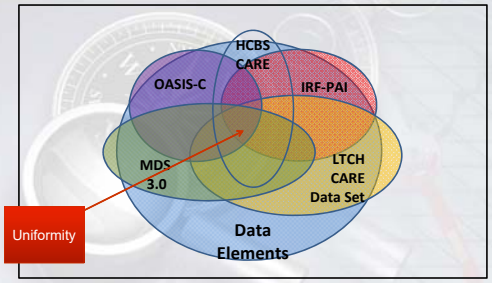
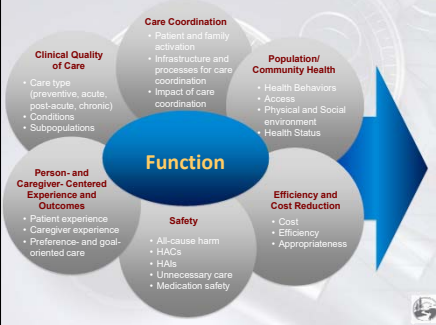
## Data Elements: Standardization




## CMS Framework for Measurement




- **Measures should be patient-centered and outcome-oriented whenever possible**
- **Measure concepts in each of the six domains that are common across providers and settings can form a core set of measures**

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## 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!***

## 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!**


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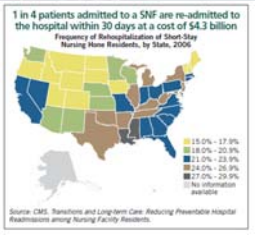
## 4. Initiatives

Hospital Readmission Reduction Program

**Acute, Skilled Nursing, Home Care, Hospice, Coming Soon… Assisted Living**

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## 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!

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## 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

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## READMISSIONS – WHY THIS FOCUS?

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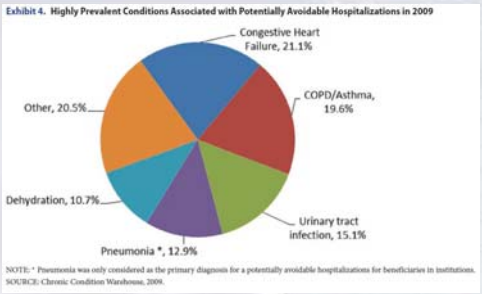
## Potentially preventable hospitalizations from Medicare and Medicaid Research Review from 2014

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## 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

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Clinical

## IMPACT OF READMISSIONS

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## 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**

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## 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

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## 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

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## 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

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

## DATA AND OUTCOMES

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## 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/

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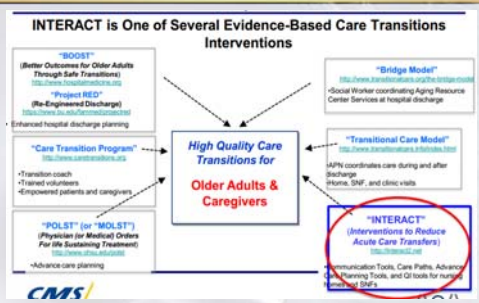
## Care Transition Interventions






## 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.



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

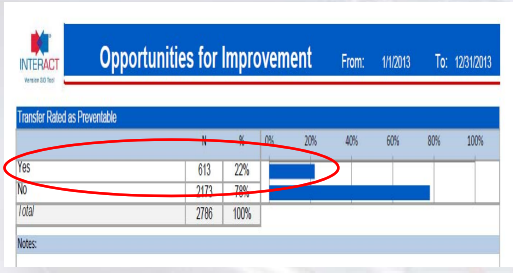
**CMS Special Study in Georgia**
**Expert Ratings of Potentially Avoidable Hospitalizations**

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

## Understanding the Problem…

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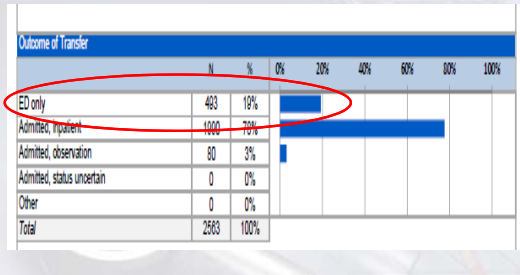


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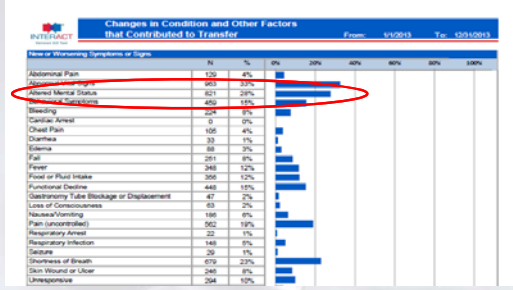

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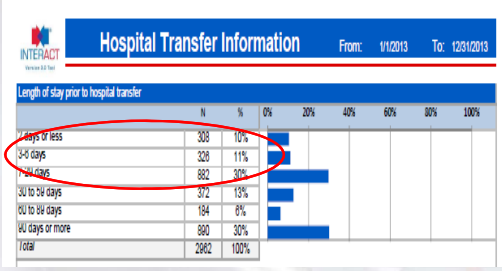
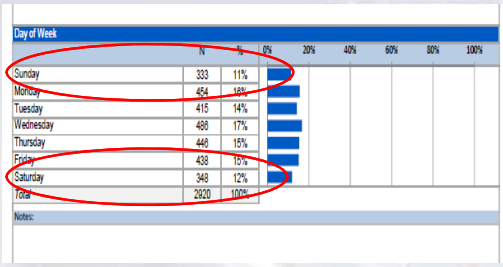




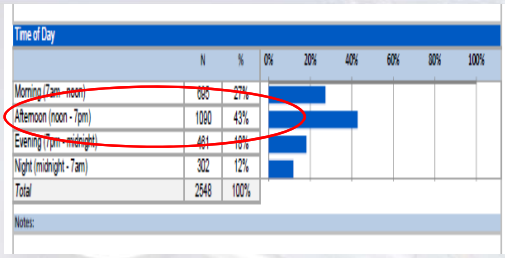

## Understanding the Problem…

### Transfer to Hospital by Day of Week



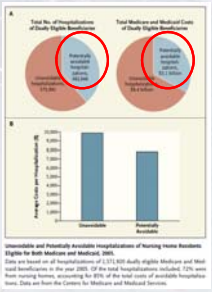



## Understanding the Problem…



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

**CMS Study of Dually Eligible Medicare/Medicaid Beneficiaries**

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## 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 = 25) | 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

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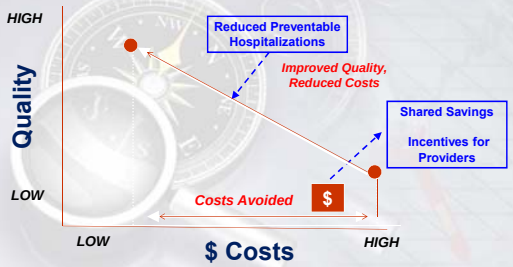
## The INTERACT Program: Background, Payment Reform, and Health Policy Issues

**Opportunities for You and Your Facility**

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INTERACT™

## QUALITY IMPROVEMENT PROGRAM

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## What is the INTERACT program?

INTERACT®

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

PATHWAY HEALTH 77

## 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

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## 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




## 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




## TOOLS OVERVIEW

## Putting the Tools to Work in Everyday Practice

***Quality Improvement Program***

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

**INTERACT™**

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## Overview of the INTERACT™ QIP

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


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## INTERACT™ COMMUNICATION TOOLS

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## Communication Tools Within your Nursing Home


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## Communication Tools

### The Purpose of the SBAR

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


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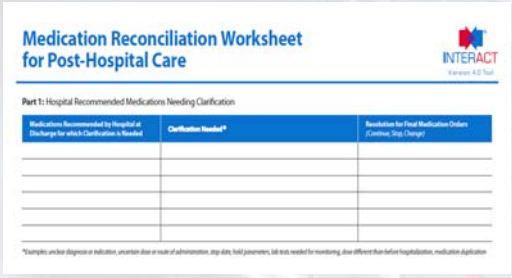
## Communication Tools

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## 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 in the hospital, if known) | Resolution for Final Medication Orders (Continue, Stop, Change) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Residents Name _____ Date ____/____/____



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## 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


Nursing Home Capabilities List

INTERACT

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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


Nursing Home to Hospital Transfer Form

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*INTERACT*™

**DECISION SUPPORT TOOLS**



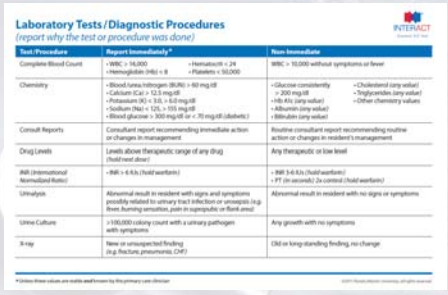
## Decision Support Tools

### 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

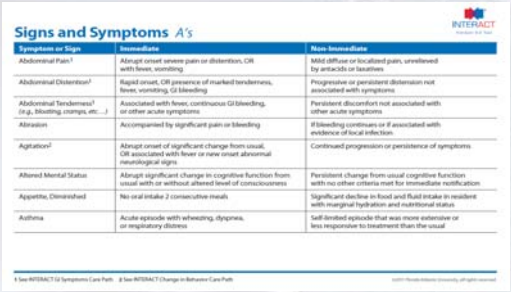


**Laboratory Tests / Diagnostic Procedures**

*(report why the test or procedure was done)*

| Test/Procedure | Report Immediately* | Non-Immediate |
|---|---|---|
| Complete Blood Count | • WBC > 16,000 • Hematocrit < 24 • Hemoglobin (Hb) < 8 • Platelets < 50,000 | WBC > 10,000 without symptoms or fever |
| Chemistry | • Blood Urea Nitrogen (BUN) > 60 mg/dl • Calcium (Ca) > 12.5 mg/dl • Potassium (K) < 3.0, > 6.0 mg/dl • Sodium (Na) < 125, > 155 mg/dl • Blood glucose > 300 mg/dl or < 70 mg/dl (diabetic) | • Glucose consistently > 300 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 > 4.4 (hold warfarin) | • INR 3-4 (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



**Signs and Symptoms** *A's*

| Symptom or Sign | Immediate | Non-Immediate |
|---|---|---|
| Abdominal Pain[1] | Abrupt onset severe pain or distention, OR with fever, vomiting | Mild diffuse or localized pain, unrelieved by antacids or laxatives |
| Abdominal Distention[1] | Rapid onset, OR presence of marked tenderness, fever, vomiting, GI bleeding | Progressive or persistent distension not associated with symptoms |
| Abdominal Tenderness[1] (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[2] | Abrupt onset of significant change from usual, OR 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, Diminished | 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 extensive or less responsive to treatment than the usual |

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## 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

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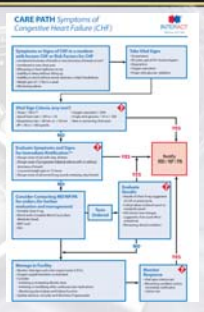
## Decision Support Tools

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## INTERACT™
## ADVANCED CARE PLANNING TOOLS

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## 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

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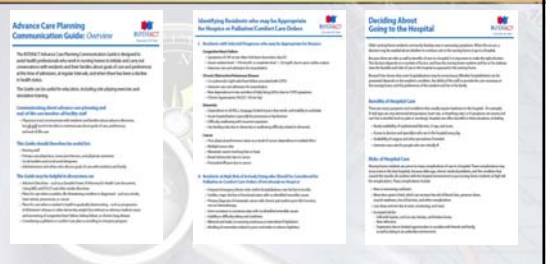
## Advanced Care Planning Tools



99

## INTERACT™ QUALITY IMPROVEMENT TOOLS

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## Quality Improvement Tools

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

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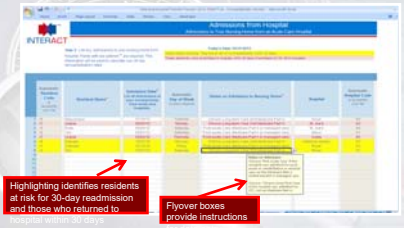
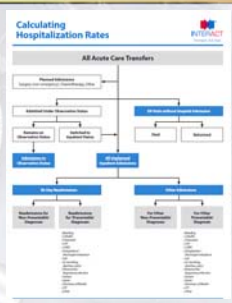
## Quality Improvement Tools

### Hospitalization Rate Tracking Tool



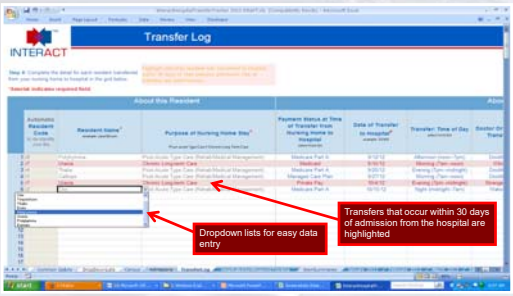

102

## Quality Improvement Tools


PATHWAY HEALTH 103

## Quality Improvement Tools

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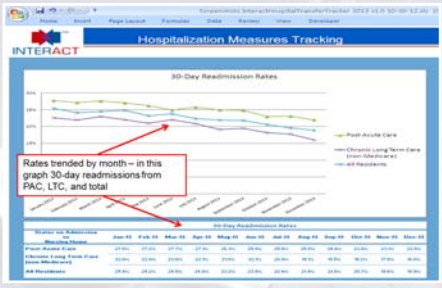
## Quality Improvement Tools

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## Quality Improvement
### Review of Acute Care Transfers

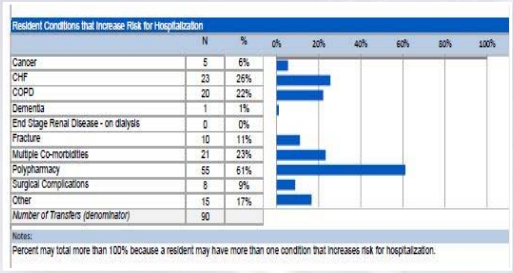



## The Quality Improvement Summary Worksheet

- 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




## 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 | |

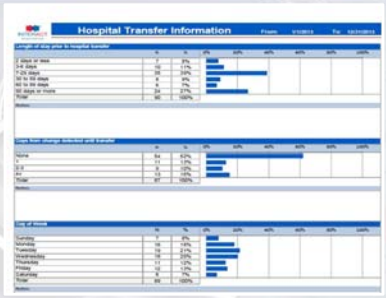


Notes:
Percent may total more than 100% because a resident may have more than one condition that increases risk for hospitalization.

## Sample Reports



## Sample Reports






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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## 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


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## 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

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## 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.



## 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



## 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

## 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



## 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.



Prepare Now!

## IMPLEMENTATION STRATEGIES

## Organization Change Capability

*Determine organization ability for change*

Assess Readiness | Care Transitions | Data and Technology | QAPI

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## 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**

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## 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

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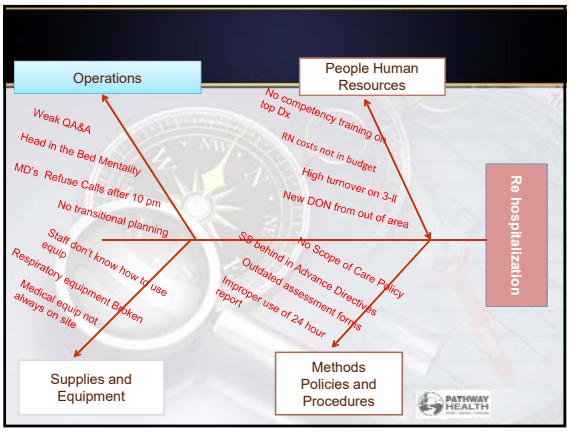


## Policy and Procedures – Assess Readiness

- 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!
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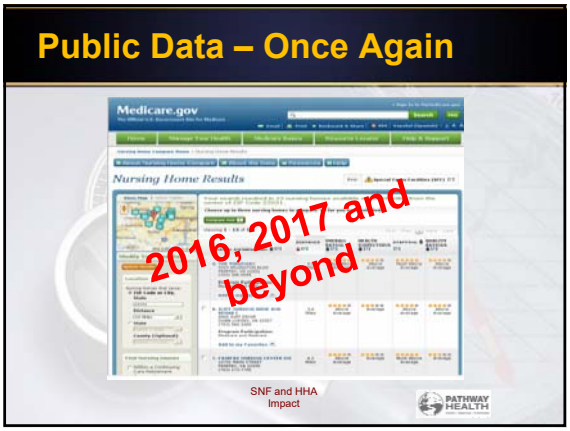
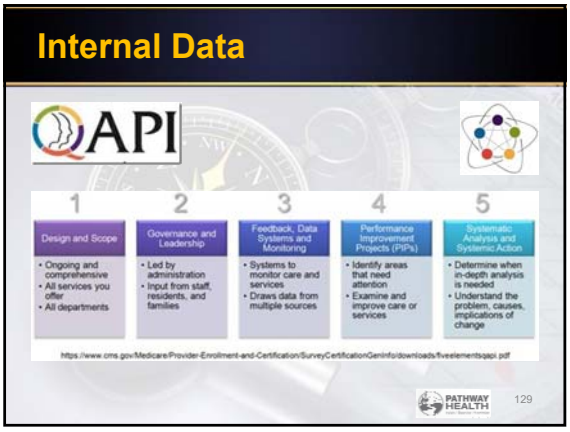

Public Data – Once Again
Medicare.gov
Nursing Home Results
2016, 2017 and beyond
SNF and HHA Impact
PATHWAY HEALTH


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/fiveelementsqapi.pdf
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## 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.

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## INNOVATION

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## Strategic Relationships

***INTERACTing with Referral Sources***

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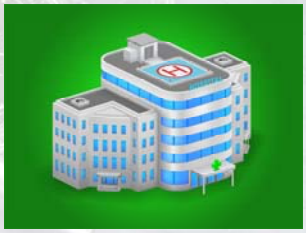

- Organizational Data
- Alignment of Data
- Preferred Partner
- Risk Adjustment

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"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

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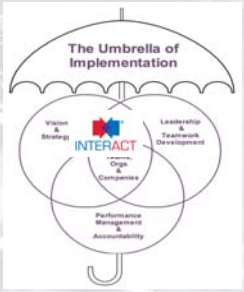
## Getting Staff on Board What does it take?

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## 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

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## Redesign – Innovation


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INTERACT



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*"Great leaders are almost great simplifiers, who can cut through issues or doubt to offer a solution everybody can understand."*

*Colin Powell, Statesman, General Retired*


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Thank You!
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