Objectives

- Identify the three focus areas of health care reform and the potential impact these changes will have on acute, post-acute, and long-term care providers.
- Identify INTERACT’s role as a program to improve care when persons residing in nursing facilities have acute changes in condition.

Let’s get started ....

Objectives

- Identify teaching strategies to carry out root cause analysis of hospital transfers on both a case level & on a systems level.
- Discuss the importance of leadership for integration of quality into daily practice.

Background

Identify the three focus areas of health care reform and the potential impact these changes will have on acute, post-acute, and long-term care providers.

Health Care Reform

The Affordable Care Act is focused on a triple aim:

- Improving quality of care
- Improving health
- Making care affordable

This presents major opportunities to improve geriatric care in the U.S.
Why It Matters

- Hospital transfers are common, resulting in complications in older persons.
- Some hospital transfers are preventable.
- Care can be improved, resulting in fewer complications, reducing cost.

Risks for complications increase.
- Delirium
- Poly-pharmacy
- Falls
- Incontinence and catheter use
- Hospital acquired infections
- Immobility, deconditioning, pressure ulcers

Studies of Preventable Hospitalizations

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


In 2004 in NY, Medicare spent close to $200 million on hospitalization of long-stay NH residents for “ambulatory care sensitive diagnoses”


CMS Special Study in Georgia

<table>
<thead>
<tr>
<th>Expert Ratings of Potentially Avoidable Hospitalizations 200 Hospitalizations/20 Nhs Across 64 Pps</th>
<th>Avoidable?</th>
<th>Avoidable?</th>
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<tbody>
<tr>
<td></td>
<td>Definitely/Probably YES</td>
<td>Definitely/Probably NO</td>
</tr>
<tr>
<td>Medicare A</td>
<td>69%</td>
<td>31%</td>
</tr>
<tr>
<td>Other</td>
<td>65%</td>
<td>35%</td>
</tr>
<tr>
<td>HIGH Hospitalization Rate NH</td>
<td>75%</td>
<td>25%</td>
</tr>
<tr>
<td>LOW Hospitalization Rate NH</td>
<td>59%</td>
<td>41%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>68%</td>
<td>32%</td>
</tr>
</tbody>
</table>

Reducing Readmissions for Value-Based Healthcare

As of October 2012, CMS penalizes hospitals for excess readmission rates, starting with those related to heart failure, AMI, and pneumonia.

Readmission Rate by State:

- 16.7% or less
- 16.8% - 19%
- 19% or more

Fee-for-Service Must Change

- Financial incentives in the Medicare fee-for-service program incentivize overuse of diagnostic tests and procedures that do not benefit many elderly people, resulting in morbidity & unnecessarily high costs.
- By far, the most costly example in the geriatric population is potentially preventable hospitalizations.

Medicare

Health Care Financing Changes

- Pay for Performance (P4P)
  - No payment for certain complications
  - Disincentives for avoidable hospitalizations
- Bundling of Payments
  - Sharing cost of episodes of care
- Accountable Care Organizations (ACOs)
  - Hospitals, physicians, home health agencies, & SNFs responsible for care of a defined group of persons
- State Dual Programs & Medicaid Managed Care
- Other models

Market Forces- New Models of Care

- "Care Coordination/Home Telehealth: The systematic implementation of health informatics, home telehealth, and disease management to support the care of Veteran patients with chronic conditions."

- Walgreens WellTransitionsSM provides discharge services to help hospitals and health systems reduce readmissions.

2013 OIG Work Plan

- Nursing Homes—Hospitalizations of Nursing Home Residents
  - "We will determine the extent to which Medicare beneficiaries residing in nursing homes have been hospitalized. We will also determine the extent to which hospitalizations were a result of manageable or preventable conditions..."

SNF Readmission Penalties?

- "We recommend reducing payments to SNFs with relatively high rates of re-hospitalizations. Avoidable re-hospitalizations of SNF patients increase Medicare’s spending, expose beneficiaries to additional disruptive care transitions, and can result in hospital-acquired infections or other adverse health consequences."

Opportunities for Post Acute Care

1. Reduced Preventable Hospitalizations (Higher occupancy)
2. Reduced readmissions
   - Reduced mortality & morbidity
3. Reduced costs
   - Reduction in services, avoiding unnecessary/ineffective care
4. Workforce capacity for Providers/Patients
Promoting Hospital Partnerships

- "When hospitals look at how many SNFs they’re sending patients to, they realize they don’t need to send to so many.”
  – A Medical Director with Kindred Health Care

- “There used to be 50 facilities taking Medicare patients in San Diego County. Now there are 5.”
  – LTC CEO

- "If you don’t pay attention to this issue, you may be closed in 5 years.”
  – Joe Ouslander, Health Policy & Aging Fellowship “Elevator Speech”

Quality Improvement

Identify INTERACT’s role to improve care when persons residing in nursing facilities have acute changes in condition.

Prerequisites to QI

- Systems Thinking
  – Belief that the parts of a system can be best understood through understanding their relationship with each other, rather than in isolation

- Critical Thinking
  – The process we use to conceptualize, analyze, synthesize, and evaluate information in order to come up with an answer or a conclusion

Improvement Opportunities

Population Level
  – Proactively look at trends & patterns in order to improve performance

Individual Care Level
  – Reactively aimed at identifying specific system/process breakdowns in order to improve performance*

*Also known as Case-Based Improvement Opportunities

There’s A Difference

- Data
  – Numbers or symbols

- Information
  – Data that has been processed in order to answer the
    who?, what?, when?, and where?

- Knowledge
  – Being able to apply data and information to answer the how?

- Understanding
  – When we can appreciate why?

- Wisdom
  – Evaluation of our understanding

Another Way To Look At It
**PDSA Cycle**

- **Plan**
  - Ideas
  - Small scale tests
  - Changes that result in improvement

- **Do**
  - Implementation of change

- **Act**
  - Follow up tests
  - Data

- **Study**
  - Observations
  - Data obtained from existing databases & systems

---

**How to Measure/Monitor**

- Tally sheets
- Checklists
- Questionnaires
- Feedback interviews
- Observation
- Daily reviews
- Chart audits
- Data obtained from existing databases & systems

---

**What to Measure / Monitor**

**Process Measures**

- Are they still working for us?
- Are we using them?
- Are we using them correctly?

  - If a process or procedure is changed as part of an action, it is important to know if the change actually occurred, & if so, how.
  - If the outcome improves, you want to know if that was linked to an actual change in process.

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**Examples of Process Measures**

- # of persons that had a fall risk assessment tool completed in the expected time frame
- # of persons with a Braden score of 12 or lower that received a Wound/Ostomy Certified Nurse consult

---

**What to Measure / Monitor**

**Outcome Measures**

- Measure outcomes
- Impact on the person
- Did the change in process have the desired result?
- Measuring process is not enough if outcome is to assess whether the change put in place had desired effect.
- To change the outcome – eliminate recurrence of the event.

---

**Examples of Outcome Measures**

- # of persons admitted after hospitalization for heart failure that are transferred to the ER
- # of persons identified as high risk that developed a facility acquired pressure ulcer
- # of incidents when a person received the wrong medication.
Follow Through

- Appreciate and recognize staff efforts
- Listen to staff when they share the impact of the change
- Share data that shows impact with staff
  - Share with residents and families if appropriate
- Be ready to consider additional analysis or action if the plan is not having the intended effect

Spread Success & Knowledge

- Share with staff & administration
- Go beyond the interdisciplinary (clinical) team
- Potential for further improvement
- Share learning and collaborate with other facilities

QAPI

Quality Assurance and Performance Improvement

QA and PI

<table>
<thead>
<tr>
<th>Quality Assurance</th>
<th>Performance Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reactive</td>
<td>Proactive</td>
</tr>
<tr>
<td>Episode or event-based</td>
<td>Aggregate data &amp; patterns</td>
</tr>
<tr>
<td>Prevent recurrence</td>
<td>Optimize process</td>
</tr>
<tr>
<td>Sometimes anecdotal</td>
<td>Always measurable</td>
</tr>
<tr>
<td>Retrospective</td>
<td>Concurrent</td>
</tr>
<tr>
<td>Audit-based monitoring</td>
<td>Continuous monitoring</td>
</tr>
<tr>
<td>Sometimes punitive</td>
<td>Positive change</td>
</tr>
</tbody>
</table>

QAPI Background

- Required in the Affordable Care Act, enacted March 2010
- Legislation requires CMS to establish QAPI program standards and provide technical assistance to nursing homes
  - Opportunity for CMS to develop and to test QAPI technical assistance tools and resources program before rule promulgation

QAPI – A Foundation

- For person-centered care
  - Relies on the input of residents and families
  - Measurement of not only process but also outcomes
- For defining quality as "how work is done"
  - Broad scope – entire organization (all staff and all departments)
  - Leadership expected to be a model
- For systems thinking
  - Proactive analysis
  - Data and measurement driven
  - Supported by tools
QAPI – What’s Ahead?

QAPI Tools and Resources
- QAPI At A Glance
- Facility Self-Assessment
- Define guiding principles and scope
- Development of a QAPI plan
- How to create/develop goals

Alignment with State and National Initiatives
- QIO 10th National Nursing Home Quality Care Collaborative
- Advancing Excellence in Nursing Homes Campaign
- Partnership for Dementia Care
- INTERACT

• QIO Expertise and Experience

CMS QAPI Website

http://go.cms.gov/Nhqapi

Overview of INTERACT

A quality improvement program designed to improve the care of nursing home residents with acute changes in condition

INTERACT

Interventions to Reduce Acute Care Transfers

Quality Improvement & INTERACT

• The INTERACT Version 3.0 tools are meant to be used together in your daily work in the nursing home

http://interact2.net

Evidence-Based Care Transitions

INTERACT

BOOST Project RED

POLST (or MOLST)

Transitional Care Model

Interact & QAPI

Improving management of acute change in condition and reducing unnecessary hospital transfers is one potential focus to meet the QAPI requirement
Program and tools have been extensively updated

- INTERACT Version 3.0 Tools should replace the use of INTERACT II tools
- Tools in recommended formats will be available from JKG and MED-PASS via links on the INTERACT website
  - No licensing fee is being paid to FAU (Florida Atlantic University)
  - Pop Up for license on the website is protecting the integrity of the program
- PointClickCare is developing eINTERACT
- Implementation Training Online Curriculum - Medline University 2013

http://interact2.net

- The INTERACT Program & Tools were initially developed by Joseph G. Ouslander, MD, & Mary Perloe, MS, GNP, at the Georgia Medical Care Foundation with the support of a contract from the Centers for Medicare and Medicaid Services (CMS).
- The current version (3.0) of the INTERACT Program was developed by members of the INTERACT Team with input from many direct care providers and national experts in projects based at Florida Atlantic University (FAU) supported by The Commonwealth Fund.
- The Commonwealth Fund is now supporting a "spread" grant through the INTERACT Institute. Pathway Health INTERACT trainers are participants in this portion of the project.

Using the INTERACT Program

- INTERACT Program tools and other resources are available on the internet free of charge at http://interact2.net
- Documents downloaded from the INTERACT website should not be altered and labeled as "INTERACT."
- The INTERACT logo is a registered trademark to FAU.
- The new INTERACT tools have the logo and a tagline.
- The tools have a copyright statement at the bottom of the first page.

INTERACT Goals

- The goal of INTERACT is to improve care, not to prevent all hospital transfers.
- In fact, INTERACT can help with more rapid transfer of persons who need hospital care.

New Implementation Checklist

- Assist organizations in determining the degree to which the INTERACT Quality Improvement Program is being implemented.
- INTERACT implementation requires all of these key components, not just using selected INTERACT Tools.

Safe Reduction of Hospital Transfers

- Preventing conditions from becoming severe enough to require hospitalization through early identification & assessment of changes in resident condition
- Managing some conditions in the NH without transfer when this is feasible and safe
- Improving advance care planning and the use of palliative care plans when appropriate as an alternative to hospitalization for some persons
Root Cause Analysis

Identify teaching strategies to carry out root cause analysis of hospital transfers on a case level and a systems level.

A Tale of Three Siblings

- Sadie
- Sara
- Sam

Sadie

96-year-old Long-Stay NH Resident
- Hospitalized for UTI and dehydration
- Discharged back to the NH after 4 days
- Re-hospitalized 7 days later for dehydration and recurrent UTI

Preventable?

INTERACT Strategy

Prevent conditions from becoming severe enough to require hospitalization through early detection and evaluation

STOP and WATCH

Improving communication on the frontline means better resident outcomes.

INTERACT Early Warning Tool

- Addresses relevant changes in condition
- Actions and behaviors that are not part of the resident’s normal routine
- A change from the resident’s baseline
- Consistent assignment is a key concept for effect use
STOP and WATCH Purpose

- To guide direct care staff through a brief review of early changes in a resident's condition
- To improve communication between frontline staff and the nurse in charge about early changes in condition

Clinical care to reduce avoidable hospital transfers begins with this tool

Examples of Use

- C.N.A. reports that resident was up 3 times during the night shift because of increased agitation & anxiety.
- Housekeeper notices & reports a resident slept most of the morning, did not respond when she said hello.
- P.T.A. reports the resident's strength & coordination was much less on Friday than it was on Wednesday.
- Daughter reports her father's memory loss has changed since her visit the day before, that even long term memory is impaired for the first time.

Sara

98-year-old Long-Stay NH Resident

- Hospitalized for a lower respiratory infection, but had normal vital signs and oxygen saturation
- Developed delirium in the hospital, fell, fractured her pubis, and developed a pressure ulcer

Preventable?

INTERACT Strategy

Manage some conditions in the NH without transfer when it is feasible and safe

SBAR - Purpose

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

Decision Support Tools

- Change in Condition File Cards
- Care Paths
Change in Condition File Cards

INTERACT Decision Support Tools

- The INTERACT Change in Condition File Cards are meant to be visible and to sit next to the phone for quick reference.
- Originated in L.A. Jewish Home for the Aging, Published in JAGS then in Medical Care in the Nursing Home.
- New version based on AMDA Clinical Practice Guidelines

Care Paths

INTERACT 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
- Educational tools
  - Recommended as posters
  - Use for case-based learning

Expanded List of Care Paths

- Acute Mental Status Change
- Change in Behavior: New or Worsening Behavioral Symptoms
- Dehydration
- Fever
- GI Symptoms – Nausea, Vomiting, Diarrhea
- Shortness of Breath
- Symptoms of CHF
- Symptoms of Lower Respiratory Illness
- Symptoms of UTI

Sam

101-year-old Long-Stay NH Resident
- Hospitalized for the 4th time in 2 months for aspiration pneumonia related to end-stage Alzheimer’s disease
- Transferred to hospice on the day of admission

Preventable?

INTERACT Strategy

Improve advance care planning and the use of palliative care plans when appropriate as an alternative to hospitalization
Advance Care Planning

- ACP should occur at some time shortly after admission
- Decisions should be reviewed regularly and at times of acute changes in condition

Who?

- The MD is responsible for discussing the illness, future issues, risks and benefits of various treatments and writing orders consistent with preferences
- But, ACP is an interdisciplinary team responsibility
- Good decisions that honor resident preferences must be made with a health care team the resident and their decision makers trust

Commonwealth Fund Project

Results – Implications

- For a 100-bed NH, a reduction of 0.69 hospitalizations/1000 resident days would result in:
  - 25 fewer hospitalizations in a year (2 per month)
  - $125,000 in savings to Medicare Part A (using a conservative DRG payment of $5,000 per admission)
- Implemented project costs - $7,700/facility
- Net savings ~ $117,000 per facility per year
- Medicare could share these savings to support NHs to further improve care

Keys to a QI Program

In order to implement a Quality Improvement Program, you must do at least two things:

1. Track, trend, and benchmark well-defined measures
2. Root cause analyses to learn and to guide care improvement and educational activities

Hospital Transfers

- Track and trend transfer measures
- **Conduct root cause analysis**
  - Analyze transfers
  - Look for common patterns
- Choose interventions
**Common Trends**

- Delay in identifying change in condition
- Lack of evaluation before calling physician
- Physician insistence on transfer
- Resident or family expectations
- Communication problems between nurses, or between nurses & primary care clinicians
- Services needed are not available or timely in the facility
- Delay in advance care planning
- Others?

**The QI Tool**

**Quality Improvement Tool**

*For Review of Acute Care Transfers*

The INTERACT QI Tool is designed to help you analyze hospital transfers and identify opportunities to reduce transfers that might be preventable. Complete this tool for each or a representative sample of hospital transfers in order to conduct a root cause analysis and identify common reasons for transfers. Examining trends in these data with the INTERACT QI Summary Tool can help you focus educational and care process improvement activities.

**The QI Tool Purpose**

1. Walk the QI team through analysis of transfers
2. Call out common reasons for transfers
   - Section 1: Resident Characteristics
   - Section 2: Acute change and other factors
   - Section 3: Actions prior to transfer
   - Section 4: Characteristics of the transfer
3. Focus educational and improvement activities

**Hospital Transfer Reasons**

- Abnormal Vital Signs
- Acute Mental Status Change
- Fever
- GI Symptoms (nausea, vomiting, diarrhea)
- Shortness of Breath
- Symptoms of Lower Respiratory Infection
- Others?

**The QI Summary Worksheet**

- Asks: Where are there the same or similar answers across the completed QI Tools?
- To: Identify trends or patterns in reasons for transfers
  - Focus improvement activities

**Root Cause Analysis**

**Opportunities for Improvement**

- Highlight common potentially avoidable reasons for transfer
- Focus education and improvement activities
  - There are INTERACT tools designed to address common potentially avoidable reasons for transfers
Quality Improvement Review Of Acute Care Transfers

Case Study 1 – Mrs. Lauren Hayes
Case Study 2 – Mrs. Jo Ann Timmons

The Tracking Tools

- Easy view of individual records allows resident-level root cause analysis of event
- Matrix of individual data allows scanning for patterns
- Summary information helps identify opportunities to improve communication and to optimize processes at the system level
**Tracking Hospital Transfers**

What Measures Should You Track?

Unplanned Hospitalization Rates
30-Day Readmission Rate
Emergency Room Visits Only
Transfers Resulting in Observation Stays

**Unplanned Hospitalization Rate**

- **Inpatient status**
  - If uncertain of the status or if first in observation then inpatient, count as inpatient

- **Unplanned**
  - Planned might be a non-emergency surgical procedure, blood transfusions, chemotherapy

- **Adjust for census and number of days in month**
  - Benchmarking and comparison among facilities of different sizes

**Real Comparisons**

Expressed in terms of 1,000 resident days per month

- This allows for comparing “apples to apples”
  - Benchmarks for tracking your own facility’s progress
  - Benchmarks for comparing your facility to other facilities regardless of their size

**Let’s Calculate Rates**

You want to calculate your average unplanned hospitalization rate for the first quarter of 2013. Your census in January was 110, February 112, and March 108.

You transferred a total 40 residents; one was directly admitted for a planned revision of a colostomy, a second for a scheduled hip replacement, and a third for monthly chemotherapy.

Five residents were placed into observation status. What was your average unplanned admission rate per 1000 resident days for this quarter?

**Choices**

a. 3.53  
b. 3.23  
c. 4.04  
d. 3.74

**Rehospitalization Rate**

<table>
<thead>
<tr>
<th>Process</th>
<th>Result</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Inpatient Admissions</td>
<td>40 - 5 = 35</td>
<td>40 residents transferred in total. 5 were in observation only.</td>
</tr>
<tr>
<td>Total Unplanned Admissions</td>
<td>35 - 3 = 32</td>
<td>3 admissions were planned</td>
</tr>
<tr>
<td>Census and Days (for the period)</td>
<td>310 x 90 = 29,700</td>
<td>110 + 112 + 108 = 330 31 + 28 + 31 = 90</td>
</tr>
<tr>
<td>Per 1000 Days (per month)</td>
<td>29,700/1000/3 = 9.9</td>
<td>Divide by 3 since it’s for the quarter.</td>
</tr>
<tr>
<td>Rehospitalization Rate</td>
<td>32/9.9 = 3.23</td>
<td></td>
</tr>
</tbody>
</table>
Discuss the importance of leadership for integration of quality into daily practice.

A local hospital calls the Administrator because they are concerned with the facility's high 30 day readmission rate and want to know if they are using the INTERACT program.

The Administrator gets the INTERACT program material (www.INTERACT2.net) and has the DON do an in-service.

However, their rates do not decline and the hospital starts to refer patients to another facility.

Distribute a memo outlining the INTERACT implementation process
Hold a meeting & inform the nursing staff that the facility will begin using INTERACT TOOLS
Hold an in-service & explain INTERACT tools
Provide staff with data about the facility’s rehospitalization performance and tell them to use INTERACT to lower the rate
Daily champion the need to improve care through the use of INTERACT

Facilitating staff-led implementation of change strategies
Leaders set expectations & parameters, then step back
Remain available to coach and help address barriers
Identifying and utilizing champions
Who is enthusiastic and shares the core beliefs?
Who understands the processes you are trying to change and/or those that will be impacted by the change?
Who are the informal leaders in your organization?

The Role of Leadership
Identify rationale, set expectations
Champion the change; get staff excited & engaged
Identify key staff who will support change and lead from within
Volunteers, informal leaders
Provide staff with support to implement change
Help remove barriers
**Champion the Change**

- **Communicate**
  - Develop a campaign with a consistent and repetitive message about re-hospitalization and INTERACT
- **Sell**
  - Help staff make an informed decision based on their identified needs
  - Present information on a psychological and emotional level to spur staff to action
- **Persuade**
  - Help staff discover an emotionally compelling reason for them to adopt INTERACT

**INTERACT Program**

- Comprehensive approach to reduce hospitalizations
  - Quality Improvement Tools
    - Hospitalization Rate Tracking Tool
    - Tools to Review Acute Care Transfers
  - Communication Tools
    - Stop and Watch
    - SBAR
    - Medication Reconciliation
    - Nursing Home Capabilities List
    - Transfer Forms and Checklists
  - Decision Support Tools
    - Acute Change in Condition File Cards
    - Care Paths

**“Evidence Based Practices”**

- Strategies to Adopt EBP
  - Behavior change is needed
  - Staff should lead effort
  - Workflow redesign
- Evidence Based Practices
  - Need Tools, Knowledge, & Skills to use the tools
- Outcome
  - Quality

**Balance Technical vs. Adaptive Change**

- **Technical Change**
  - Technical changes often do not work because the adaptive changes needed to get staff to adopt and to utilize the technical change have not been addressed.
  - New form
- **Adaptive Change**
  - Behavioral change
  - Workflow redesign to complete the new form

**Behavior Change**

- Pre
  - Contemplation
- Contemplation
- Preparation
- Action

**Interacting With Hospitals**

- Engaging Hospitals in Your Program
"We were working on improving processes within the hospital but we also know that because hospital stays are short and patients typically are not fully recovered when they are discharged, we had to involve other providers in the community."

"At the first meeting we realized that the community partners had no knowledge of what we were doing as a hospital to prevent readmissions and that we needed to be educated about the role of the post-acute providers about what happens when they take over the care of the patients."

Timing matters: Is the timing right?
Competing initiatives: What is THE priority for the facility?
Consider roll-out: Can you dedicate one unit to launch?
Delayed launch is better than re-launching one year later!
“N of 1 Trials”

Rapid Cycle PDSA
Pilot Test on 1 Unit, 1 Staff, 1 Resident, 1 Day

- Find staff that are supportive of the change
  – Optimal if they are respected by their peers
- Let organization know you are pilot testing a new program
- Sell the 1 unit, “1 staff” who are conducting the pilot
- Make changes based on staff feedback
- Once a few changes, add additional staff 1 at a time, 1 unit at a time, making changes after each pilot test

AE’s Working Hypothesis

If you have good organizational workplace practices and good care planning practices, the good clinical outcomes will follow and the staff, residents, and families will be happy.

Resource


Thank You

Pathway Health
White Bear Lake, MN
www.pathwayhealth.com
877-777-5463