Supporting the Triple Aim

April 17, 2016

OUR VISION
Every nursing home resident in America experiences person-centered quality of life as a result of a stable and empowered workforce, dedicated to improving clinical and organizational outcomes, and engaging in open communication and transparency.

OUR MISSION
Making nursing homes better places to live, work and visit

Organization Members
News Release

U.S. Department of Health & Human Services News Division

Better, Smarter, Healthier Care

• 30% of Medicare FFS payments will be tied to “alternative” models, such as ACOs, bundled payment arrangements by 2016

• 50% of payments will be tied to these models by 2018

The “Triple Aim”
Care Transitions and Reducing Hospital Admissions

The New Currency of Health Care Reform

What CMS Will be Looking For

- Reduced hospital admissions / readmissions
- Reduced TOTAL resource use (bundles)
- Reduced health care acquired infections
- Reduced antipsychotic use
- Expanded 5-star measures
- Staffing and staff turn-over
- Resident satisfaction

All This Will Feed Into Payment

Shared Savings Models
Bundling Payments
Quality Incentives
Value-based Payment for PA/LTC
Penalties
Risk-Bearing Entities Will Look to Decrease Variation in Post-Acute Spending

73% of the regional variation in Medicare spending is due to variation in post-acute care spending.

NH Five-Star Quality Measures

- Long-stay residents
  - % whose need for help with ADLs has increased
  - % of high risk residents with pressure ulcers
  - % of residents who have/had a catheter placed and left in their bladder
  - % of residents who were physically restrained
  - % of residents with a UTI
  - % of residents who self-report mod to severe pain
  - % of residents who newly received an antipsychotic medication

- Short-stay residents
  - % of residents with pressure ulcers that are new or worsened
  - % of residents who self-report mod to severe pain
  - % of residents who newly received an antipsychotic medication

Longer-Term Potential Further Improvements to NH Compare (per CMS)

- Dynamic consumer testing

- Interactiveness: Make the website more interactive to refine search

- Staffing Data: Collect staffing data based on payroll sources, submitted quarterly

- Quality Measures: Add new quality measures (hospitalization measure...others?)
Longer-Term Potential Further Improvements to NH Compare

- NH Characteristics + Capabilities: Add additional information about nursing homes
  - Private rooms
  - Languages spoken
  - Availability of specialty units (rehab, ventilator support...)

- Satisfaction Surveys: Study potential reporting of satisfaction survey results – residents, families, staff

A Step by Step Guide to Building a Quality Assurance and Performance Improvement (QAPI) Program in Your Nursing Home

Examples of Solutions to Measure Quality and Drive Change in Nursing Homes

REGISTRANTS:
Sign up, select 2 goals (one from each category)

PARTICIPANTS:
Demonstrate commitment to performance improvement by uploading data to AE website monthly for 6 consecutive months for 2 goals

Registering & Participating

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Sign up, select 2 goals (one from each category)

PARTICIPANTS:
Demonstrate commitment to performance improvement by uploading data to AE website monthly for 6 consecutive months for 2 goals

www.nhqualitycampaign.org
Nursing Home Engagement

Percent of Homes with Six or More Consecutive Months of Data Entry Among those with Current Goal Selection, July 2014

Monthly AE Website Data Entry

Legend

- 0.0% - 9.99%
- 10.0% - 24.99%
- 25.0% - 49.99%
- 50.0% - 74.99%
- 75.0% - 100.0%

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**Circle of Success**

How do I know where I am?

Where do I want to be?

What processes are associated with my outcome?

When I change a process, how do I know it had the effect I wanted?

How am I doing compared to other nursing homes working on this goal?

**Hospitalizations**

30-day hospital re-admission rate

**External factors:** reduce hospital readmissions

OIG Report – Adverse Events in Nursing Homes

CMS has implemented a payment penalty to hospitals with high 30 d readmission rates for discharges with diagnosis of

- CHF
- Pneumonia
- Myocardial infarction
More

➤ Hospitals participating in ACO or Bundle payment demos can only achieve savings by reducing rehospitalization rates

➤ SGR fix contained legislation that links SNF rehospitalization to SNF Medicare Part A payments
   • Uses a with-hold approach
     ➤ 2% “mathematical” withhold to create incentive pool
     ➤ Incentive pool is 50-70% of the withhold

• Incentive pool is “returned” to facilities based on their rehospitalization performance score
  ➤ Performance score is based on rehospitalization rate OR degree of improvement from prior year(s)
  ➤ Top performers most or all of their withhold and possibly more
  ➤ Middle performers will receive some of their withhold
  ➤ Bottom performers receive less than their withhold or nothing
• First adjustment to a SNF’s market basket will be in Oct 2018 (FY ’19)

➤ Requires public reporting of SNF rehospitalization
  • Confidential feedback reports in 2016
  • Public reporting in 2017
  • Development of a potentially avoidable rehospitalization measure for use in 2019
  • All measures need to be risk adjusted
Hospitalizations

Primary Contributing Reasons for Transfers

Data and Quality Improvement Process

How do I know where I am?

Data and Quality Improvement Process

What processes should we target?
An analytic tool that can be used to perform a comprehensive, system-based review of critical incidents and adverse health events

Goal is to determine:
• What happened?
• Why did it happen?
• What can be done to reduce the likelihood of recurrence?

Systematic approach to problem solving
• Identify issues as a team
• Frequently ask 5 “Why?” questions
  • Don’t stop at symptoms
  • Get to deeper layers to find root cause
  • Identify relationships between different root causes

Quality Improvement Review Tool

Designed to assist you to review situations that commonly result in transfers in your facility through systematic root-cause analysis

Integrate into facility’s regular quality and educational processes
• Look for common situations you can work on together to improve
• Avoid blaming individuals
The goal of this tool is to review transfers and identify opportunities to:

- improve identification,
- evaluate and manage changes in resident condition and other situations commonly resulting in transfers and,
- prevent transfers to the hospital, when feasible and safe.

This tool is intended to be completed retrospectively after the transfer to look back and identify opportunities for improvement in reducing preventable transfers.

Quality Improvement Review Tool

5 sections

1. Background information
2. Change in condition
3. Evaluation and management
4. Transfer information
5. Opportunities for improvement

www.interact2.net
Quality Improvement Review Tool

www.interact2.net

Quality Improvement Review Tool

www.interact2.net

Identify Patterns and Opportunities

AE Tracking Tool and QI Review Tool will help your home:

➢ Look for patterns in transfers and clinical situations that result in them

➢ Identify situations you believe can be managed safely and effectively without transfer

➢ Work together to develop strategies to manage situations

➢ Develop education on specific topics
Identify Trends

Common reasons for transfers identified in QI tools

- Acute change in condition with unstable vital signs
- Family expectations
- Lack of availability or communication problems with primary care physicians
- Services required are unavailable in the facility
- Lack of advance care planning and advance directives

<table>
<thead>
<tr>
<th>Quality Assurance</th>
<th>Performance Improvement</th>
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</thead>
<tbody>
<tr>
<td>Reactive</td>
<td>Reactive</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>Sometime anecdotal</td>
<td>Always measurable</td>
</tr>
<tr>
<td>Retrospective</td>
<td>Concurrent</td>
</tr>
<tr>
<td>Audio-based monitoring</td>
<td>Continuous monitoring</td>
</tr>
<tr>
<td>What went wrong?</td>
<td>How can we be excellent?</td>
</tr>
</tbody>
</table>
For EACH transfer to hospital, complete the INTERACT QI Review Tool, and record 9 additional items in your AE Tracking Tool.

**Patterns in Admissions Process when Admitting Hospital**
- Day of week
- Hospital
- Use structured communication tool
- Adequate information to care for resident

**Patterns in Transfer Hospital**
- Payment status
- Time of day
- Ordering doctor
- Primary contributing reason
- Use structured communication tool
- Completed RCA
- Review of ACP
- Evaluate acute condition at nursing home with structured communication tool

**Enter three optional fields**
Enter Primary CLINICAL and CONTRIBUTING reasons for transfer & RCA Complete in the Excel workbook.
(Data entry done with dropdown lists for pre-defined responses)

**Use Data to Explore Patterns**
Primary Clinical Reasons for Transfers

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Use Data to Explore Processes

Primary Contributing Reasons for Transfers

Use Data to Explore Patterns

Examine processes

Probing questions

Guiding questions to start an inquiry and start thinking critically about processes.

Use questions along with your data to guide investigation. Point of investigation is to decide what processes are good targets for reworking and improving our outcome.

www.NHQualityCampaign.org
Use data to monitor processes

How well are we doing with RCA (completing INTERACT QI Review) for every transfer?

Note Your Interventions

TO DO LIST

1. Continue entering required fields for all transfers to hospital and all admissions to your home with a recent hospital discharge.
2. Download and make copies of INTERACT QI Review Tool
   http://www.interact2.net/agreement.aspx
3. RCA each transfer to hospital using QI Review Tool
4. Summarize your RCA on RCA Summary Form
5. Enter 3 additional pieces of information into AE Hospitalization Tracking Tool for each transfer.
   a. Primary Clinical Reason for Transfer
   b. Primary Contributing Reason for Transfer
   c. Root-Cause Analysis Completed ("Yes," if you did QI Review Tool and Summary Sheet)
6. Enter your AE data on the website
Summary

Advancing Excellence provides:

- Enhanced quality and value through measurement and benchmarking
- Evidence-based tools and resources

Advancing Excellence supports the triple aim.

www.nhqualitycampaign.org

Thanks for connecting online

Making nursing homes better places to live, work and visit
Putting It All Together In the Post Acute Care Setting

- Where do we go from here?
- How can we provide quality care with limited resources?
- How can we position ourselves to be a preferred provider in a flooded market?

Next Steps After Root Cause Analysis: Readmissions

- Many readmissions to acute care settings are the result of co-morbidities and not the admitting diagnosis
- Elderly patients with an acute illness generally have other diseases that are being managed at the same time.
- Length of stay in hospital is shortened and patients are discharged to home or post acute care settings less stable.
- Managing chronic disease processes is key to prevent readmissions
- Insufficient discharge planning is also a causative factor.

Disease Management

- First step in disease management in post acute setting is identification
- Full history from hospital setting
- Medical history from patient or family
- Develop care plan with the interdisciplinary team in conjunction with the patient/family to address health management.
- Begin patient and family education regarding disease management upon admission.
Disease Management

- Staff must be confident in caring for chronic and acute illness in the elderly.
- A benefit of NICHE designation is completion of the GIAP (Geriatric Institutional Assessment Profile) which identifies knowledge deficits and opportunities for improvement.
- Education can be tailored to the individual community needs.
- Attaining GRN (Geriatric Resource Nurse) through NICHE provides expertise in assessment skills, research projects and opportunities for peer education.

Disease Management

- Disease management programs such as COMs Interactive assist with care paths and decision tree models.
- Interact tools are also a great resource for symptom and disease management
- In many settings physician education is just as important as nurse education.
  
  *Still have hospitalist mindset*

Care Path Tools
Disease Management

- Early identification of even subtle changes in condition can prevent exacerbation and rehospitalization.
- Following care paths and decision tree models allows nurses to identify, assess and treat in place.
- Physicians are given appropriate information and are better able to give orders to be carried out in the post acute setting.
- Utilization of the Stop and Watch tool from Interact and completion of the SBAR (Situation, Background, Appearance, Review and Notify) compiles appropriate information to provide to the treating physician.

Interact Stop and Watch Tool
Transitions Between Care Settings

- Information sharing between hospital and post acute care settings and back is challenging
- Use of a common tool ensures that both settings are obtaining the information that is required
- Discharge planning from admission is essential to ensure smooth transitions
- Comprehensive planning for discharge to home can prevent readmission to the hospital
Discharge Planning

- Establishing discharge goals from admission is essential.
- Discharge planning including the family, resident and post discharge care providers initiated within the first seven days of admission.
- Therapy home visits within the first 5-7 days of admission to establish obtainable and reasonable goals individualized for each resident.

Discharge Planning

- Initial contact with resident/patient to address goals and provide pertinent information for their stay.
- Therapy- meet with resident/patient and/or caregivers to begin to develop treatment goals
- Social Services- meet with family and resident/patient to determine needs for post discharge community support.
- Contact with Home Care agency if appropriate to include in discharge planning
- Resident and family education on disease process, medication management and any other needs by the nursing staff throughout skilled stay and documented.

Discharge Planning and Follow-Up

- The initial post discharge appointment with the PCP made prior to discharge home.
- Prior to discharge current medication list sent to the primary care physician office.
- Contact will be made with post discharge support services to ensure all arrangements are made prior to discharge.
- Communication with the Home Care agency should be open.
- Contact with the patient within 48-72 hrs. and between day 21 and 29 post discharge to check home progress.
## Partnerships and Data Sharing

- Preferred provider status is becoming more difficult to obtain
- Decisions are now being based on:
  - Length of stay
  - Cost per episode
  - Overall 5 Star rating
  - Quality Rating
  - 30 day readmission rates
  - Discharge to community

## Partnerships and Data Sharing

- How does data sharing happen?
  - Collaborative meetings with hospitals
  - Acute care discharge planners communication with admission coordinators from post acute providers
  - Leave behind material for ACP for future reference
Conclusion

• Supporting the triple aim involves every team member in all care levels
• Data collection, root cause analysis, and QAPI processes will improve patient outcomes
• Improved outcomes benefits the patient, hospital, and post acute care settings.
Presbyterian Senior Living

Our Mission

“The mission of Presbyterian Senior Living is to offer Christian understanding, compassion and a sense of belonging to promote wholeness of body, mind and spirit.”

Presbyterian Senior Living is a not-for-profit organization, providing retirement and senior care services for more than 85 years. Headquartered in Dillsburg, Pennsylvania, we and our affiliates provide comprehensive services and accommodations to more than 6,000 seniors in 30 locations across the mid-Atlantic region of Pennsylvania, Maryland, Ohio and Delaware.