SC Nursing Homes Using INTERACT to Reduce Avoidable Acute Care Readmissions

Wanda Bartschat, MSA, RHIA, CPHQ
The Carolinas Center for Medical Excellence

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Goals for Today

Inform attendees about nursing home activities in SC to reduce avoidable hospital readmissions.

- Provide a brief overview of QAPI in long-term care.
- Discuss INTERACT as a QAPI compliance program.
- Introduce INTERACT tools.
Long-Term Care Readmission Facts

• 25 percent of Medicare beneficiaries readmitted within 30 days.

• $4.34 billion potentially spent unnecessarily annually.

• 30 percent of rehospitalizations occur for residents who have been in a nursing home seven days or less.

• Adults in the U.S. received only 54.9 percent of recommended care.
Long-Term Care Readmission Facts

According to the Agency for Healthcare Research and Quality (AHRQ):

• 90 percent of readmissions within 30 days are unplanned
• Likely the result of a break in the clinical process.
• Only half of rehospitalized patients see a physician prior to readmission.
QAPI Requirement Background

• Nursing home QAPI-mandated in Affordable Care Act in 2010.
• Legislation requires CMS to establish QAPI program standards and provide technical assistance to nursing homes.
• Five requirements must be met.
• Final regulations are not released yet.
Element 1: Design and Scope

QAPI Program must:

- Be ongoing
- Be comprehensive
- Address full range of services
- Utilize best available evidence to define and measure goals
- Should address clinical care, quality of life, resident life, and care transitions
Element 2: Governance and Leadership

Governing body/administration

- Develops and leads QAPI program
- Must assure program is adequately resourced (time, equipment, staff, training, etc.)
- Staff held accountable but not punished (just culture)

Requires input from
- Facility staff
- Residents and families
Element 3: Data, Feedback & Monitoring Systems

Facility must:

• Put systems in place to monitor care and services
• Draw data from multiple sources
• Monitor care processes and outcomes
• Compare against benchmarks/targets
• Track, investigate, and monitor each adverse event to prevent recurrence
Element 4: Performance Improvement Projects (PIPs)

Facility conducts PIPs to examine and improve care or services in areas that are identified as needing attention.

- May be concentrated on one area or facility-wide
- Involves gathering information systematically
- Develops and tests interventions for improvement
Element 5: Systematic Analysis and Systemic Action

• Facility uses a systematic approach to determine when in-depth analysis is needed to fully understand the problem, its causes, and implications of a change
• Must be thorough and structured
• Must develop policies and procedures and processes that demonstrate proficiency in use of root cause analysis

Continuous learning and continuous improvement key components
Six Steps to Prepare for QAPI

1. Use data at a high level to identify major areas of opportunity to prevent readmissions to the hospital.
2. Analyze what the facility is doing right and where it can improve.
3. Focus on one area of improvement at a time.
4. Develop quality improvement processes, training programs, and accountability measures. In parallel, start collecting data on the new processes to track improvement.
Six Steps To Prepare For QAPI (cont’d)

5. Monitor, identify, and mitigate high-risk areas, such as falls and injuries, restraint use, pain, pressure sores, wandering, and weight loss.

6. Continuously alter internal processes and analyze the data to ensure continuous quality improvement and to demonstrate that the facility does not contribute to issues such as the rehospitalization of residents. This is where INTERACT fits.
## Alignment of QAPI and INTERACT

<table>
<thead>
<tr>
<th>QAPI</th>
<th>INTERACT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improves Communication</td>
<td>Provides communication tools</td>
</tr>
<tr>
<td>Driven by Leadership and empowers staff to be part of the decision making</td>
<td>Leadership sets the charter and works with staff to implement</td>
</tr>
<tr>
<td>Standardize Practice</td>
<td>Evidenced Based tools</td>
</tr>
<tr>
<td>Data drives the change</td>
<td>Data helps identify the opportunity to improve</td>
</tr>
<tr>
<td>Provides a system to monitor effectiveness of care</td>
<td>Provides tools to analyze process, provides care paths to deliver care in a consistent manner</td>
</tr>
<tr>
<td>System wide improvement</td>
<td>Utilize PDSA cycles and spreads success across the organization</td>
</tr>
<tr>
<td>Organizes the change plan into a performance improvement project</td>
<td>INTERACT is a performance improvement project</td>
</tr>
</tbody>
</table>
What is INTERACT?

- Evidence-based quality improvement program designed to improve the early identification, assessment, documentation, and communication about changes in the status of residents in skilled nursing facilities.

- Goal is to improve care and reduce the frequency of potentially avoidable transfers to the acute care hospital.

**Program is NOT designed to eliminate all hospital admissions**
Goals of INTERACT

- Designed to safely reduce avoidable hospital admissions by:
  - Preventing conditions from becoming severe enough to require hospitalization through early identification and assessment of an acute change in a resident’s condition
  - Managing some conditions in the nursing home setting when feasible and safe
  - Improving advance care planning and the use of palliative care plans when appropriate, as an alternative to hospitalization for some residents
Four Main Components

1. Communication tools
   - SBAR
   - STOP AND WATCH
   - Nursing Homes Capability List
Similar to, but not exactly the same as used in acute care
Stop and Watch
Early Warning Tool

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

Seems different than usual
Talks or communicates less
Overall needs more help
Pain – new or worsening; Participated less in activities
Ate less
No bowel movement in 3 days; or diarrhea
Drank less

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

Name of Resident

Your Name

Reported to

Date and Time (am/pm)

Nurse’s Name

Date and Time (am/pm)
Nursing Home Capabilities List

• Standardized, pre-populated checklist of nursing home capabilities for decisions about transfers back into facility
• Distribute to emergency departments and hospital discharge planners
• Marketing and education tool
**Nursing Home’s Capabilities List**

<table>
<thead>
<tr>
<th>Available on Site*</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emergency interventions</strong></td>
<td></td>
</tr>
<tr>
<td>CPR - basic only</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Diagnostic Testing</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Stat EKG (within 4-6 hrs)</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Stat X ray (within 4.6 hrs)</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Stat lab work (within 4.4 hrs)</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Bladder ultrasound</td>
<td></td>
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<tr>
<td>Cardiac Echo</td>
<td></td>
</tr>
<tr>
<td>Venous duplex</td>
<td></td>
</tr>
<tr>
<td>Physician/NP Services</td>
<td></td>
</tr>
<tr>
<td>7 day/wk visits</td>
<td></td>
</tr>
<tr>
<td>5 day/wk visits</td>
<td></td>
</tr>
<tr>
<td>1-2x/wk visits</td>
<td></td>
</tr>
<tr>
<td>Consultation</td>
<td></td>
</tr>
<tr>
<td>Psychiatry</td>
<td></td>
</tr>
<tr>
<td>One on one</td>
<td></td>
</tr>
<tr>
<td>Therapies</td>
<td></td>
</tr>
<tr>
<td>Physical therapy</td>
<td></td>
</tr>
<tr>
<td>Occupational therapy</td>
<td></td>
</tr>
<tr>
<td>Speech therapy</td>
<td></td>
</tr>
<tr>
<td>Isolation</td>
<td></td>
</tr>
<tr>
<td>VRE, MRSA, c. diff</td>
<td></td>
</tr>
<tr>
<td>Typical turnaround time when new Meds are ordered:</td>
<td></td>
</tr>
<tr>
<td>Nursing Services</td>
<td></td>
</tr>
<tr>
<td>Vital sign monitoring Q.12 hrs</td>
<td></td>
</tr>
<tr>
<td>Vital sign monitoring Q.4 hrs</td>
<td></td>
</tr>
<tr>
<td>O2 saturation monitoring Q.4 hrs</td>
<td></td>
</tr>
<tr>
<td>Peak flow</td>
<td></td>
</tr>
<tr>
<td>Glucose monitoring at least Q.6 hrs</td>
<td></td>
</tr>
</tbody>
</table>

*Availability of certain equipment/services may have changed since this form was updated. Please contact the nursing home directly at the number provided for the most up to date information.
Four Main Components (cont’d)

2. Clinical Decision Making Tools
   • Fourteen Acute Change in Condition Cards
   • Nine Care Paths for Common Conditions
### Decision Support Tools

#### Change in Condition Cards

<table>
<thead>
<tr>
<th>Symptom or Sign</th>
<th>Immediate</th>
<th>Non-Immediate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain</td>
<td>New severe pain, or marked increase in chronic pain</td>
<td>Increase in frequency or severity of pain</td>
</tr>
<tr>
<td>Personality change(^1)</td>
<td>Abrupt significant change from usual, associated with fever, or new onset of abnormal neurological signs</td>
<td>Recent minor but persistent change or fluctuation in behavior, memory, or mood from usual</td>
</tr>
<tr>
<td>Pressure sore</td>
<td>New onset T &gt; 100.5 F in someone with Grade 2 or higher sore</td>
<td>New onset Grade 2 or higher pressure sore, OR progression of pressure sore despite interventions</td>
</tr>
<tr>
<td>Puncture wounds</td>
<td>Deep or open wound, OR with more than minor bleeding</td>
<td>Minor uncomplicated puncture wound</td>
</tr>
<tr>
<td>Rash</td>
<td>Rash in someone taking a new medication, OR one known to cause allergic reaction</td>
<td>Recent onset of localized or diffuse pruritic rash, OR any rash accompanied by other systematic symptoms</td>
</tr>
</tbody>
</table>
Decision Support Tools

Care Path Cards

- Educational tool to aid in evaluation of symptoms
- Includes nine pathways:
  1. Acute MS changes
  2. Changes in behavior – new or worsening
  3. Dehydration
  4. Shortness of breath
  5. Symptoms of UTI
  6. Fever
  7. GI symptoms
  8. Lower Respiratory Infection
  9. CHF
Four Main Components (cont’d)

3. Advance Care Planning Communication Guide

• Starting the conversation
• Conducting the conversation
• Helpful language for discussing end of life care
• The resident or family who “wants everything done”
Four Main Components (cont’d)

4. Internal Quality Improvement Tools
   • Data Collection Forms
   • Excel Spreadsheets that calculate findings and create graphs

![Graph showing quality characteristic over samples with control limits: UCL = 10.860, Center line = 10.058, LCL = 9.256]
Top Barriers Encountered with Nursing Home Participation

1. “We’re in our survey window.”

2. “Our families insist on sending residents to the hospital.”

3. “Our physicians just routinely tell us to send residents.”

4. “It might work on this unit, but it will never work on that unit.”

5. “If we don’t send residents out, we’ll get sued.”
What We Did

• Partnership promoted greater reach than any of us alone:
  ▪ Two CCME team members
  ▪ One SC Health Care Association team member
  ▪ Promoted by LeadingAge SC and SC Chapter of American College of Healthcare Executives

• Through partnership, able to more easily address objections/allay fears

• Through partnership, we have reached approximately 61 percent of all long-term care beds in South Carolina.
How We Did It

Initial INTERACT “boot camp” training in May 2013 reached 61 percent of all nursing facility beds in South Carolina.

- Four regional sites
- Seven-hour sessions
“Boot Camp” Highlights

• Introduction to tools and concepts
• Data to track and tools to do it
• How to implement in your facility
  – Getting started
  – Planning
  – Team creation
  – Training
  – Roll-out
  – Barriers
  – Sustainability
Boot Camp Highlights

• Classroom didactic
• Interactive group sessions
  • Case studies
  • Everyone teaches
  • Everyone learns
• 1:1 networking
• “Homework”
• LISTSERV® contacts
Reach of INTERACT Training to South Carolina Nursing Home Beds by County*

Group 1: >75% of beds in county INTERACT trained

Group 2: 50%–74% of beds in county INTERACT trained

Group 3: 0%–49% of beds in county INTERACT trained

*Through May 2013
Continuing the Momentum

• Additional 1.5 hour face-to-face training refreshers across the state during Quality Leadership Initiative (Phase II) meetings

• Ongoing webinars/teleconferences

• Planning another full-day INTERACT training session for facilities that were unable to attend training held in May 2013
Continuing the Momentum

• Working with a large nursing home corporation to present a full-day training session for its 11 facilities in SC—will increase reach to 67 percent of all nursing home beds

• Presenting INTERACT concepts to the joint SC Association for Healthcare Quality/SC chapter of the American Society of Healthcare Risk Management annual conference in November

• Invited to present introduction to nursing home executives at SC Chapter of the College of Healthcare Executives annual conference in May 2014
Lessons Learned

• SC nursing homes are committed to improving quality of life and safety of their residents. They WANT to work with the acute care hospitals to help reduce avoidable readmissions.

• The SC INTERACT Partnership has been successful in providing educational sessions, technical support, and foundations for long-term quality improvement and care improvement initiatives to SNFs in South Carolina.

• Continuous support will allow the participating facilities to move from planning to implementation to culture change and, finally, sustainability.
Questions?
Contact Information

Theresa Seaberg, RHIT, CCS
Program Manager, Patient Safety & Care Transitions

tseaberg@scqio.sdps.org

Wanda Bartschat, MSA, RHIA, CPHQ
Care Improvement Specialist

wbartschat@scqio.sdps.org