Elements for Effective Care Transitions / Ideas & Resources for Post-Acute Care Providers

Goal: Reduce rehospitalizations through the identification of best and promising practices

Ideas			
Assessing & Developing Clinical Capabilities	**How to Identify Key Community Providers**	**Developing & Growing Provider Relationships**	**Data: What to Collect and How to Report It**
• Higher acuity calls for greater competency and increased skill set of all healthcare professionals, especially nurses • Implement evidence-based clinical guidelines • Care Paths / INTERACT • Accept Admissions 24/7 • Onsite laboratory with diagnostic ability • Lab turn-around time 15 minutes for hematology and chemistry • Onsite ECG with interpretation services • Radiological services—24 hour capability • Onsite Advanced Practice Nurse • ACLS certified staff • 24 RN Staffing • 24 hour respiratory therapy / pulmonary program in place • IV therapy, including onsite PICC line insertion • Emergency code cart / AED • 24 Hour Case Manager or Transitional Coordinator • Milliman Care Guidelines • Review Advance Directives • Medication reconciliation • Discharge management process • Advance Care Planning • Specific education for non-licensed personnel to identify initial changes in condition	• Recognition that hospitals are no longer the focus of managing care of chronic diseases • Engage Chief Nursing or Medical Officer of the hospital • Focus on shared goals including reducing readmissions to hospital, healthcare acquired infections, improving safety • Explore links with Accountable Care Organizations, Bundled Payment Care Initiatives, Managed Care Organizations – see http://innovation.cms.gov/	• Arrangements to allow discharged patients from the hospital to be admitted into a SNF within 30 days • Monthly meetings between hospital and SNF with focus on outcomes • Hold a quarterly meeting with hospitalists and medical directors • Hold a quarterly meeting with ER physicians to discuss expectations and clinical capabilities. Promote INTERACT • Consider a shared resource "Nurse Navigator" • Participation in Health Information Exchange • Include educational event for hospital staff related to SNF clinical/operational/regulatory topics.	• Quality measures • Utilize Long Term Care Trend Tracker, AHCA member benefit • Rehospitalization rates including actual, expected, ratio and risk adjusted rates • Length of stay • Discharge to community • Functional measures including self-care and mobility • Drill down rates of rehospitalization for pneumonia, heart failure, COPD, total hip replacement, total knee replacement and others • Understand how hospitals are collecting, measuring and recording data • Developed a common outcome language • Regularly review data in QAPI meetings • Share dashboard of pertinent data with hospitals and other partners

Developed by Rehospitalization Subcommittee of AHCA Clinical Practice Committee – January 13, 2015

AHCA AMERICAN HEALTH CARE ASSOCIATION
NCAL NATIONAL CENTER FOR ASSISTED LIVING

IMPROVING LIVES *by* DELIVERING SOLUTIONS *for* QUALITY CARE

Resources

Please note all are available for viewing on AHCA/NCAL website

Assessing & Developing Clinical Capabilities	How to Identify Key Community Providers	Developing & Growing Provider Relationships	Data: What to Collect and How to Report It
Sharing advanced INTERACT Success! ***Recorded On April 22, 2014*** ***(60 minutes)*** ***http://webinars.ahcancal.org/session.php?id=13085*** In this informative session, participants will have the opportunity to hear how four different organizations advanced the use of INTERACT within their setting. INTERACT has played a key role in helping many organizations reduce unnecessary hospitalizations. Ideas on how to use these tools, how to spread them throughout the organization, how to get buy–in, and the fabulous results of these determined leaders will be some of the stories you will hear. **Learning Objectives:** 1. Discover ways to advance the use of INTERACT 2. Question leaders who have successfully implemented advanced INTERACT 3.consider ways to advance INTERACT in participant's setting **Sharing advanced INTERACT Success! (Part 2)** ***Recorded On May 7, 2014 (60 minutes)*** ***http://webinars.ahcancal.org/session.php?id=13181*** In this fascinating program, you will have the opportunity to hear two unique stories of communities, in two separate counties, that	**How Can I Get Beyond the Basics of Hospital Readmission and Become a Preferred Provider?** ***Recorded on October 27, 2014 (60 minutes)*** ***http://webinars.ahcancal.org/session.php?id=14819*** The program briefly explains the impact that Healthcare Reform is having on the healthcare industry on both the acute and post-acute care side. There is a strong emphasis on the importance of accurate data analysis and on implementing potential solutions for facilities. The clinical programs along with the use of cutting edge technology have shown to improve clinical outcomes, allowed centers to become preferred providers for local hospitals and have significantly reduced unnecessary hospital readmissions. **Learning Objectives:** 1. Discuss the history of hospital readmission and its impact on the industry. 2. Discuss and analyze the types of data necessary to appropriately measure hospital readmission rates.	**A Model for Collaboration between Hospitals and Assisted Living Communities** ***Recorded On July 17, 2013*** ***(60 minutes)*** ***http://webinars.ahcancal.org/session.php?id=11182*** The webinar will examine emerging models in which hospitals and assisted living facilities collaborate to manage the continuum of care for ALF residents more effectively, with the objective of reducing unnecessary ER visits and hospital admissions. The program will examine the populations that represent the most risk for health systems attempting to develop effective population health strategies for the Medicare population. Developing tailored joint programs with ALFs is a valuable element of such an approach when carefully constructed. **Learning Objectives:** 1. Understanding the risks that the ALF population presents to ACOs and risk-bearing provider networks.	**It's Not Just the Data, It's What You Do with It** ***Recorded On August 19, 2014*** ***(60 minutes)*** ***http://webinars.ahcancal.org/session.php?id=13750*** Join My InnerView by National Research Corporation to discover how to use your data as a powerful ally to achieve quality initiative goals, improve performance, and gain even more referral partners. **Learning Objectives** 1. Find out how to most effectively survey and ask the right people, the right questions, at the right time. 2. Once you've collected the right data, discover how to set realistic improvement goals in the most impactful areas. 3. Learn how to use your data to get the attention of hospitals and health systems and drive more referrals. **Outcomes Reporting - Be Ready to Negotiate with a Hospital CFO** ***Recorded On July 24, 2012*** ***(60 minutes)*** ***http://webinars.ahcancal.org/session.php?id=9106***

put INTERACT to work to improve care. First you will hear how a community worked together to develop INTERACT with their local hospital. This impressive story shares how a combined group of nursing centers worked together on implementation despite being competitors. Additionally, a second group in another County, worked on implementation by creating a change package for a Medicaid Collaborative. Through a remarkable mentoring program with an "All Teach , All Learn" structure, those with more advanced skills in using INTERACT tools became mentors to other organizations, helping the community to create better care. In this valuable educational program you will see that the best way to be successful is to work together! **Learning Objectives** 1. Recognize new ways that INTERACT can be advanced in your community or organization 2. Consider ways to connect with other community members 3. Identify ways to employ mentoring as a strategy for advancing INTERACT **Culture Change to Reduce Hospitalization Using Person-Centered Care** ***Recorded On July 30, 2013 (60 minutes)*** ***http://webinars.ahcancal.org/session.php?id=11208*** Hospitalizations can be a detriment to our residents, impacting their quality of life and	3. Describe potential solutions within your center that will positively affect clinical outcomes. 4. Describe how progress is measured after implementation. 5. Discuss measures to ensure continuous quality improvement. **Accountable Care Organizations: What They Are and Why You Need to Know!** ***Recorded On May 18, 2011 (120 minutes)*** ***http://webinars.ahcancal.org/session.php?id=6905*** The Affordable Care Act (ACA) established Accountable Care Organizations (ACOs) as a new way to organize providers around managing the delivery of care for a defined population of Medicare beneficiaries. As these new ACOs begin to emerge and mature, they are actively seeking stronger relationships with post-acute care providers, especially skilled nursing facilities. This webinar will provide a comprehensive overview of the ACO environment and discuss current trends in provider contracting. In addition, the presenters will present the "ACO Contracting Guide," a new tool developed by AHCA for members to use in their own negotiations with ACOs. Speaker Jan Murray will	2. Identifying emergent best practices in coordinating care between health systems and ALFs. 3. Identifying emergent communication protocols that streamline and improve care transitions. **Referral Partnerships: A Data-Driven Approach to Cross Continuum Healthcare Coordination** ***Recorded On June 19, 2013 (60 minutes)*** ***http://webinars.ahcancal.org/session.php?id=10959*** With the rise of accountable care organizations (ACOs), readmission penalties, and bundled payment initiatives, providers from across the healthcare continuum are seeking partnerships with long term care organizations to create smother care transitions and reduce hospitalizations. **Learning Objectives** 1. Learn how and what to communicate to hospitals, health systems, and home health agencies for potential referrals 2. Understand what your data is telling you to uncover valuable quality improvement opportunities 3. Find out why your satisfaction scores open more doors to referrals	On October 1, 2012, hospitals in the bottom quartile for readmissions will face across-the-board cuts from Medicare. SNFs are in a powerful position to use data to their competitive advantage, and become attractive partners to hospitals in trouble…or to hospitals on top who want to stay on top. Data is key to competitive advantage. **Learning Objectives:** 1. What are outcomes reports? 2. What outcomes do hospitals want to see from SNFs, as described by 3 major health systems? 3. What outcomes data can I produce to be attractively positioned at the negotiating table? 4. How does my performance compare against my peers, and can I use AHCA Trend Tracker to help? 5. Which hospitals area struggling in my backyard? Where can I easily see hospital readmission rates on a map? 6. How can I use outcomes reports to my competitive advantage while driving continuous improvement?

resulting in earlier mortality, immobility, or cognitive decline. Assisted living must think about addressing both acute and chronic care while remaining a social model. Now is the time to seek out partnerships with other providers to provide distance monitoring to support the care provided in assisted living so residents can be cared for and not unnecessarily transferred to a hospital. These interventions can be person-centered and individualized. **Learning Objectives:** 1. Understand the importance of safely reducing hospital readmissions 2. Learn about how the tools from the INTERACT™ program, POLST, and others can be used in continuing education. 3. Examine attitudes and individual beliefs about caring for the elderly and the impact these have on culture change. **An innovative Approach to Identifying and Communicating Change of Condition: Introduction to INTERACT 2** ***Recorded On June 28, 2012*** ***(60 minutes)*** ***http://webinars.ahcancal.org/session.php?id=8873*** Explanation of INTERACT history, identify the tools and explain what they are; INTERACT 2 Implementation: Explain the GA initiative and explain how INTERACT was incorporated into daily practice Program Sustainability: How to do initial	discuss "best practices" in SNF-ACO contracting to help members avoid common pitfalls and position them for success. **Learning Objectives:** 1. Learn about the current and future trends in ACO development and contracting. 2. Gain a deeper understanding of the regulatory environment of ACOs, and be able to position your organization as an attractive partner to an ACO. 3. Gain familiarity with AHCA's new ACO Contracting Guide and learn how to use the tool in SNF-ACO contract negotiations.	than proximity or promotional marketing	

training, the need for ongoing orientation, discussion around disease management, ongoing validation (getting out on the floor and making sure information/tools are being used) Facility Benefits from Implementing Interact & Wrap-Up: Having the program in place makes the facility more marketable; Many hospitals already using SBAR and expect nursing facilities to be on-board; Better resident outcomes will result in more referrals from hospitals; Nursing homes save time and money because readmissions are eliminated; Reducing transfers to the hospital will help meet the QAPI requirement; Where to get help and find information - AHCA website, www.INTERACT2.net, QIOs, State LTC Association			

References:

Agency for Healthcare Research & Quality; Re-Engineered Discharge (RED) Toolkit. Accessed November 3, 2014. http://www.ahrq.gov/professionals/systems/hospital/red/toolkit/index.html

AHCA/NCAL Webinar Resource Inventory. Compiled 10.30.2014.

Barrows, K., "Healthcare Management Group Collaborative"; AHCA presentation, 2014

Kaes, L., "Working Together to Achieve the Triple Aim"; Health Care Association of New Jersey. 2014

Medicare Readmission Penalties: http://kaiserhealthnews.org/news/medicare-readmissions-penalties-2015/; scroll down to heading titled 2015 Medicare Readmission Penalties, select the CSV file.