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

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

<table>
<thead>
<tr>
<th>Ideas</th>
<th>Assessing &amp; Developing Clinical Capabilities</th>
<th>How to Identify Key Community Providers</th>
<th>Developing &amp; Growing Provider Relationships</th>
<th>Data: What to Collect and How to Report It</th>
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<tbody>
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<td></td>
<td>Higher acuity calls for greater competency and increased skill set of all healthcare professionals, especially nurses</td>
<td>Recognition that hospitals are no longer the focus of managing care of chronic diseases</td>
<td>Arrangements to allow discharged patients from the hospital to be admitted into a SNF within 30 days</td>
<td>Quality measures</td>
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<td>Implement evidence-based clinical guidelines</td>
<td>Engage Chief Nursing or Medical Officer of the hospital</td>
<td>Monthly meetings between hospital and SNF with focus on outcomes</td>
<td>Utilize Long Term Care Trend Tracker, AHCA member benefit</td>
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<td>Care Paths / INTERACT</td>
<td>Focus on shared goals including reducing readmissions to hospital, healthcare acquired infections, improving safety</td>
<td>Hold a quarterly meeting with hospitalists and medical directors</td>
<td>Rehospitalization rates including actual, expected, ratio and risk adjusted rates</td>
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<td>Accept Admissions 24/7</td>
<td>Explore links with Accountable Care Organizations, Bundled Payment Care Initiatives, Managed Care Organizations – see <a href="http://innovation.cms.gov/">http://innovation.cms.gov/</a></td>
<td>Hold a quarterly meeting with ER physicians to discuss expectations and clinical capabilities. Promote INTERACT</td>
<td>Length of stay</td>
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<td>Onsite laboratory with diagnostic ability</td>
<td>IV therapy, including onsite PICC line insertion</td>
<td>Consider a shared resource “Nurse Navigator”</td>
<td>Discharge to community</td>
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<td>Lab turn-around time 15 minutes for hematology and chemistry</td>
<td>Emergency code cart / AED</td>
<td>Participation in Health Information Exchange</td>
<td>Functional measures including self-care and mobility</td>
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<td>Onsite ECG with interpretation services</td>
<td>24 RN Staffing</td>
<td>Include educational event for hospital staff related to SNF clinical/operational/regulatory topics.</td>
<td>Drill down rates of rehospitalization for pneumonia, heart failure, COPD, total hip replacement, total knee replacement and others</td>
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<td>Radiological services—24 hour capability</td>
<td>24 hour respiratory therapy / pulmonary program in place</td>
<td>Developed a common outcome language</td>
<td>Understand how hospitals are collecting, measuring and recording data</td>
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<td>Onsite Advanced Practice Nurse</td>
<td>IV therapy, including onsite PICC line insertion</td>
<td>Regularly review data in QAPI meetings</td>
<td>Developed a common outcome language</td>
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<td>ACLS certified staff</td>
<td>Emergency code cart / AED</td>
<td>Share dashboard of pertinent data with hospitals and other partners</td>
<td>Regularly review data in QAPI meetings</td>
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<td>24 RN Staffing</td>
<td>24 Hour Case Manager or Transitional Coordinator</td>
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<td>24 hour respiratory therapy / pulmonary program in place</td>
<td>Milliman Care Guidelines</td>
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<td>IV therapy, including onsite PICC line insertion</td>
<td>Review Advance Directives</td>
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<td>Emergency code cart / AED</td>
<td>Medication reconciliation</td>
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<td>24 Hour Case Manager or Transitional Coordinator</td>
<td>Discharge management process</td>
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<td>Milliman Care Guidelines</td>
<td>Advance Care Planning</td>
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<td>Review Advance Directives</td>
<td>Specific education for non-licensed personnel to identify initial changes in condition</td>
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Developed by Rehospitalization Subcommittee of AHCA Clinical Practice Committee – January 13, 2015
## Resources

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

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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


In this fascinating program, you will have the opportunity to hear two unique stories of communities, in two separate counties, that

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<td>1. Discuss the history of hospital readmission and its impact on the industry.</td>
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<tr>
<td>2. Discuss and analyze the types of data necessary to appropriately measure hospital readmission rates.</td>
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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. Understanding the risks that the ALF population presents to ACOs and risk-bearing provider networks.
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](http://webinars.ahcancal.org/session.php?id=9106)*

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. Learn how to use your data to get the attention of hospitals and health systems and drive more referrals.

Developed by Rehospitalization Subcommittee of AHCA Clinical Practice Committee – January 13, 2015
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...
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
trainin
g, 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:**


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


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