# ACO Success…

## Therapy Can Help!

# Presenters

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# What is an ACO?

- Accountable Care Organization
- Term started in 2006 and was in full swing by 2011
- Goal:  Best quality of care to patient at the least cost

# How is it different from what we're used to?

## Traditional Fee for Service

- Doctors and hospitals are paid independently for all procedures
- Rewarded for doing more
- Reactive care
- Vague benchmarks

## ACO

- Incentivised to be more efficient (bundled payment system)
- Focuses on prevention and managing chronic disease
- Clear benchmarks

# Incentives?

- Being accepted into ACO
- Increased payment for increased efficiency
- Increased census

# Incentives?

- There are 44 ACO Quality Measure Benchmarks
- Therapy plays a major role with 14 of them
- Some examples:
  - ACO #13: Falls: Screening for further fall risk

**Remaining Vertical: Falls Prevention Program**

**Purpose:**

To reduce the incidence of falls and improve safety and function of the residents through clinical assessment and programs by the interdisciplinary team to identify problems and establish plans of care.

**Policy:**

1. All new admits will be assessed through resident/family "What's Your Risk" Assessment and the Nursing Fall Risk Evaluation.
2. Long Term Care residents will be assessed using above tools upon incident or quarterly assessment.
3. Trigger on any assessments used through scoring or incident will be referred to the STAR (Scrutiny of Tumble/Accident Risk) team for further follow up and recommendations.
4. If no trigger, resident will be assessed the following quarter using appropriate tools to

# Incentives?

- ACO #35:
  - SNF 30-day readmission

**H.A.L.T.T. Program** *(Hospital Admissions Lessened Through Therapy)*

**Purpose:** To decrease admissions of residents back to the hospital through improved communications, risk management systems, and consistent IDT meetings.

**Policy:** Upon admission, during daily Stand-Up and quarterly reviews, establish "at-risk" residents are triggered based on clinical issues on the H.A.L.T.T. Target List which will identify residents who need focused documentation and plans by all care staff to reduce the chance of re-admission to the hospital.

**Procedure:**

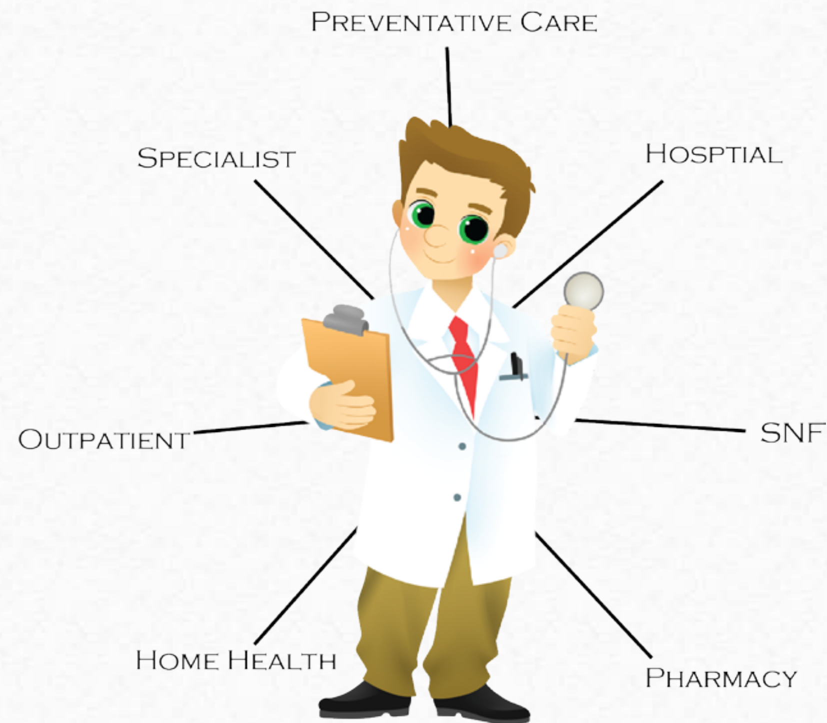
1. Upon admission, during Stand-Up or quarterly reviews, resident risk level is assessed through H.A.L.T.T. Risk List, PLOF report, MDS assessments, or evaluations from nursing, physician, or therapy.
2. Based on the results of the assessment and IDT recommendations, resident may be placed on H.A.L.T.T. Target List.
3. The list will trigger all care staff to watch resident and document any at-risk behaviors or status.
4. Each Target List will be reviewed and updated at Stand-Up meeting daily and/or weekly Rehab Meeting. For long-term care residents, nursing will generate a Functional Decline Form to support need for therapy intervention as appropriate.
5. Communication about status and plans will be completed during Stand-Up meetings.

# Incentives?

- ACO #7:  Health/functional status
- ACO #34:  Stewardship of patient resources:
  - In a nutshell, this is managing the money

# Who's in charge?
# Hospitals, Doctors, Insurers?

- Primary Care Physicians

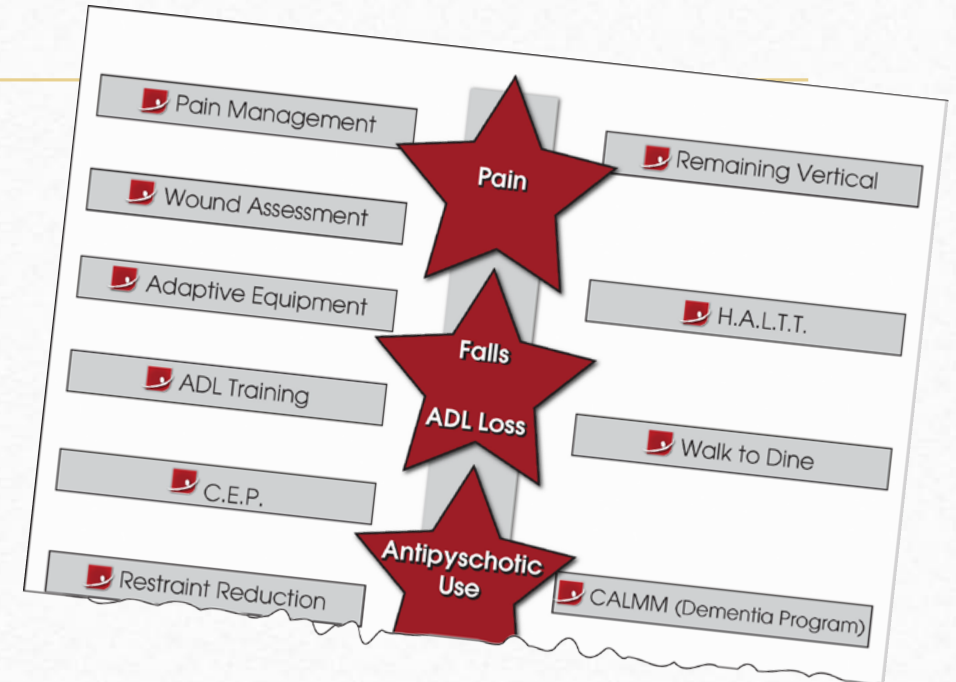


# How can you maximize your success in an ACO?

- There are 4 major SNF focuses
  1. Quality of Care
  2. Communication
  3. Technology
  4. Flexibility

# Quality of Care

- Must achieve and maintain a 3-Star or higher rating



# Quality of Care

- Decrease hospital re-admission rates
  - H.A.L.T.T. Program

**H.A.L.T.T. Risk List**

PREMIER THERAPY embrace the difference

**Purpose:** A running list of patients who have been identified as at-risk for hospital readmission.

List is generated, maintained, and discussed daily by IDT at morning Stand-Up meeting on all current and new residents.

Patients included might have the following issues:

1. Unstable blood sugar
2. CHF or COPD (exacerbated or new diagnosis)
3. Fall risk
4. Reduced intake by mouth (liquid/food)
5. Change in medications
6. Unstable or shifts of mandated vitals (pulse, respiration, BP, temperature)
7. Fluctuating therapy status
8. Changes in behaviors

# Quality of Care

- Proactive Rehab department
  - Eval and treat Day 1
  - Develop individualized plan of care
  - Provide up-to-date functional documentation
  - 7 days/week therapy
  - Involve nursing in therapy goals Day 1 to increase carryover

# Communication

This is key!

- ACO wants to align themselves with the best providers in their market
- How can you be the best?
  1. Preadmission Planning
     - Utilize a tool to collection PLOF information from resident and/or family
     - Plan for individualized equipment needs
     - Collect acute care information/history from hospital

RESIDENT SNAPSHOT
Prior Level of Function Assessment/Health Profile
PREMIER THERAPY
Resident Name
Prior to this recent health decline...
Did you help the patient with eating? Yes No
If so, how?
Did the patient have difficulty swallowing?
How would you describe the patient's appetite?
Did the patient have a special diet prescribed by physician? Yes No
Did you help the patient with dressing? Yes No
If so, how?
Did the patient have any circulation or skin related problems?
Did you help the patient with walking/getting up? Yes No
If so, how?
Any history of falls? How often and under what circumstance?
Did you help the patient with bathing/bathroom use? Yes No
If so, how?
Was the patient continent of bowel and bladder?
Was the patient able to make good decisions? Yes No
Did the patient have behavioral/psychological/elopement issues? Yes No

# Communication

**This is key!**

2. Morning Huddle

- Whiteboard
- Daily review of status goals and d/c planning

# Communication

**This is key!**

3. Family Communication

- Schedule family meeting within 24 hours
- Discuss realistic d/c plans
- Develop a d/c Plan A and Plan B
- Encourage family participation in therapy
- Develop trust

# Communication

This is key!

4. Nursing Communication

- Educate on resident status and goals for increased carryover
- Provide therapy on units and involve nursing staff

# Communication

This is key!

5. QUEST Program

- Premier Therapy has put together a program that streamlines data and provides a detailed flowsheet of what needs to happen next.

# Process Flow for QUEST Program

- *Resident Snapshot*
- Identify Risk Areas
- Capture D/C plans on admission

**RESIDENT SNAPSHOT**

**Prior Level of Function Assessment/Health Profile**

Resident Name ______________________

Prior to this recent health decline…

Did you help the patient with eating? ☐ Yes ☐ No

If so, how? ______________________

Did the patient have difficulty swallowing? ______________________

How would you describe the patient's appetite? ______________________

Did the patient have a special diet prescribed by physician? ☐ Yes ☐ No

Did you help the patient with dressing? ☐ Yes ☐ No

If so, how? ______________________

Did the patient have any circulation or skin related problems? ______________________

# Process Flow for QUEST Program

*(continued)*

- Care Plan Meeting within 24 hours (or by facility policy)
- Utilize ***Interview to Action List***
- Clarify Discharge Plans
- Implement IDT Assignments, Comprehensive Assessments, and ***Pause: What is the Root Cause?***

**Care Plan Interview to Action List**

PREMIER THERAPY embrace the difference

Date: ____________________

Patient Name/Prefers to be called: ____________________

Caregiver: ____________________

**Activities of Daily Living:** bathing/dressing/personal hygiene

What activities of daily living does your family member complete on his/her own?

- ☐ Bathing
- ☐ Dressing
- ☐ Personal Hygiene
- ☐ Self-feeding
- ☐ Other ____________

Does your family member prefer:

- ☐ Showers
- ☐ Baths

**Pause: What is the Root Cause? Decision Tool**

PREMIER THERAPY embrace the difference

**Patient Name:** ____________ **Root Cause/Problem:** ____________

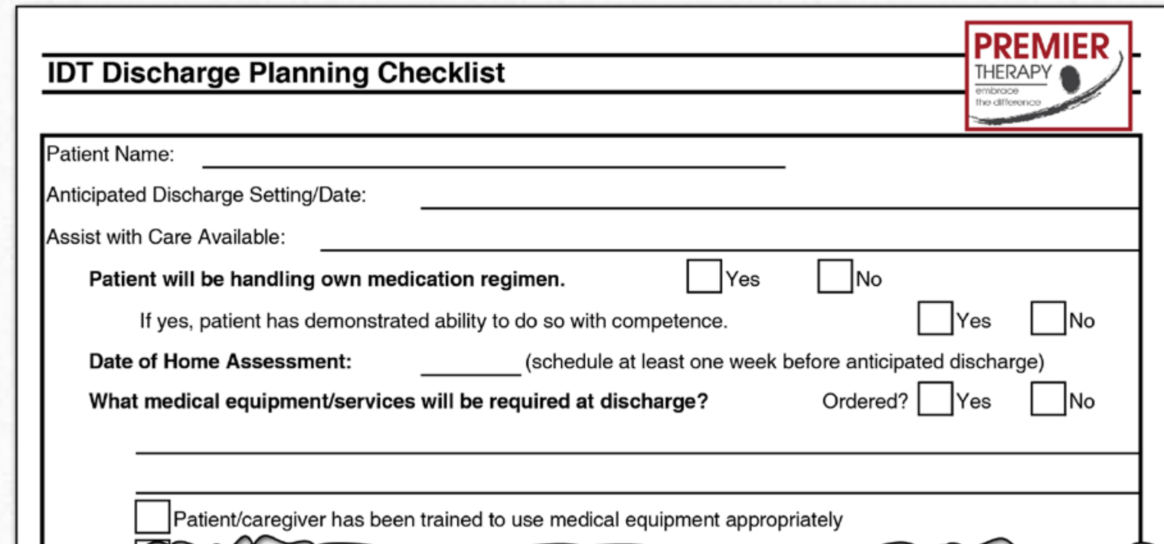
***What factors were involved?***

| Environmental | Medical | Cognitive | Behavioral | Physical | Procedural | Training/ Communication | Staffing/ Supervision |
|---|---|---|---|---|---|---|---|
| *Issues with* | *Issues with* | *Issues with* | *Issues with* | *Issues with* | *Issues with* | *Issues with* | *Issues with* |
| ☐ bed position/safety | ☐ acute illness | ☐ unable to follow commands | ☐ combative | ☐ pain | ☐ transfer status | ☐ pt. status | ☐ schedule |
| ☐ w/c position/safety | ☐ medication change/refusal | ☐ expressive aphasia | ☐ refusals | ☐ gait | ☐ ambulation status | ☐ support needed | ☐ rest periods |
| ☐ layout of room | ☐ unstable vitals | ☐ receptive aphasia | ☐ yelling | ☐ balance | ☐ orientation | ☐ equipment needs | ☐ enough support staff |
| ☐ clutter | ☐ new onset dx | ☐ poor safety judgment | ☐ other: ______ | ☐ strength | ☐ assignments | ☐ lift usage (mechanical) | |
| ☐ lighting | | | | ☐ transfers | ☐ other: | | |

# Process Flow for QUEST Program

*(continued)*

- Review Plan in Morning meeting
- Initiate ***IDT Discharge Planning Checklist***
- Review goals and discharge needs
- Caregiver Education & Training
- Invite D/C practitioners into facility and work with them directly



**IDT Discharge Planning Checklist**

PREMIER THERAPY embrace the difference

Patient Name: ______

Anticipated Discharge Setting/Date: ______

Assist with Care Available: ______

**Patient will be handling own medication regimen.** ☐ Yes ☐ No

If yes, patient has demonstrated ability to do so with competence. ☐ Yes ☐ No

**Date of Home Assessment:** ______ (schedule at least one week before anticipated discharge)

**What medical equipment/services will be required at discharge?** Ordered? ☐ Yes ☐ No

______

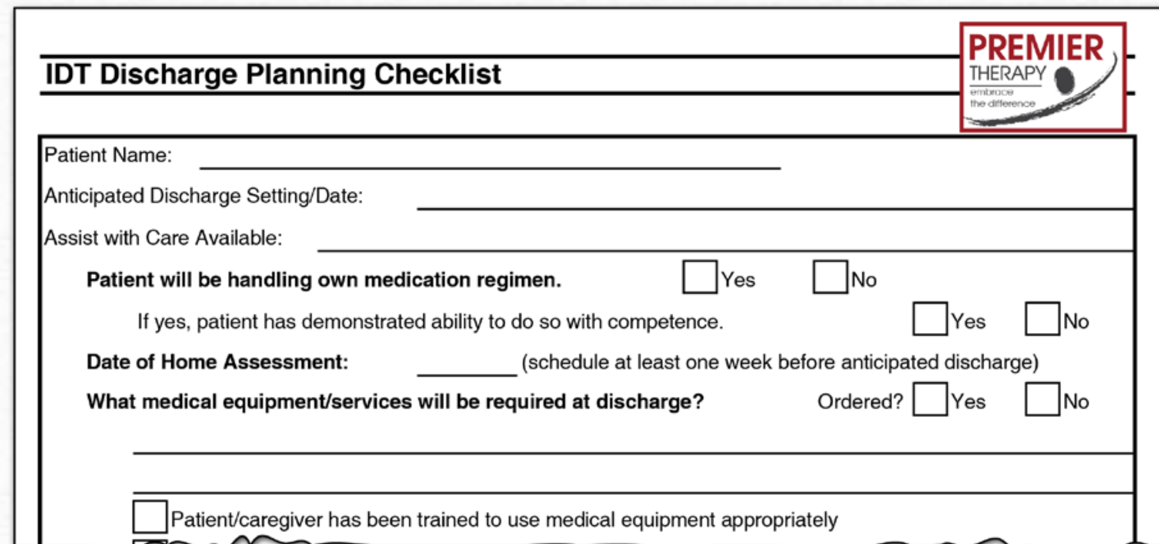
______

☐ Patient/caregiver has been trained to use medical equipment appropriately

# Process Flow for QUEST Program

*(continued)*

- Prior to Discharge:
  - Written instructions for recommendation on equipment/services needed
  - All aspects of care trained and understood by caregivers
  - Complete ***D/C Planning Checklist***



**IDT Discharge Planning Checklist**

PREMIER THERAPY

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# Process Flow for QUEST Program

*(continued)*

- Prior to Discharge:
  - Written contact information given to patient & caregivers via ***Post D/C Follow Up***
  - Date confirmed with patient and caregivers for follow up call

**Post Discharge Follow Up**

Facility Name: ______________________

Follow up call date: ____________ Time: ____________

Facility Phone: ______________________

Facility Contact: ______________________

Facility Contact: ______________________

Facility Contact: ______________________

Therapy Contact: ________ ________ ________

# Process Flow for QUEST Program

*(continued)*

- Utilize ***Post Discharge Script*** for follow up call
- Complete on designated days
- Check compliance and status
- Give guidance as needed

**Script for Follow-Up Calls to Discharged Residents/Caregivers**

24 hrs:____ 7 days:____ 14 days:____ 30 days:____ 45 days:____ 60 days:____

- ☐ Hello and reacquaint with resident.
- ☐ How are things going with ______________________________
- ☐ Mobility?
  - o walking
  - o sit to stand from chair
  - o in and out of bed or car
  - o stairs
- ☐ Appetite?
  - o problems with swallowing

# Technology

**What does your therapy company bring to the table?**

- Therapy software must integrate with facility software
- Allow for ease of sharing information
- Provide real time information sharing
- Improve overall communication especially during evening shift and weekends
- In late 2018, the expectation is a portal to see data in real time

# Flexibility

**How can therapy help you offset decreased LOS and MPDs?**

- Reduction in LOS is inevitable
- Therapy marketing is key
  - Functional program reports provided
  - Meet Your Therapy Team brochure
  - Highlight facility specialties
    - Ex. Vital Stim program, CHF program, Amputation Clinic
- Rehab outcome reports

# SNF Focus Summary

- Offer the best **Quality of Care**
- **Communication** to maximize outcomes with decreased cost
- Have the **technology** to stay in the game!
- Be **flexible** enough to roll with the changes