Managing the Complexities of Provider Partnerships with a Focus on Value and Outcomes

PRESENTERS

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PREMIER THERAPY
embrace the difference

OBJECTIVES

- The participant will be able to describe the goa characteristics, and critical measures of a successful hospital partner

- The participant will be able to describe an IDT approach to reducing risk of re-hospitalization, achieving desired clinical outcomes measure, the documentation required to develop and maintain partnerships

PARTNERSHIP

What you should know about partnering with Hospitals:

UNDERSTAND PAYMENT MODELS

- Participation in Shared Saving Program (ACO)

UNDERSTAND WHAT IS BEING MEASURED IN QUALITY IMPROVEMENT FOCUSES

UNDERSTAND EFFECTS ON:

- readmission rates
- hospitalquality reporting
- meaningful use of EHR

KNOW CLINICAL SPECIALIZATIONS- CLINICAL PATHWAYS/PROTOCOLS

- Cardiac
- Neuro
- Orthopedic

Successful Partnership

Facility Capabilities should meet partner's need

Structured & Successful Transitional Care

Quality Measures - No Outliers

Low Readmission Rates

Overall Rating - 3 stars or better

Low Cost per Beneficiary

Medically Necessary LOS

Strong Satisfaction Surveys - coming soon!

Services validated through outcomes for clinical and financial success

CMS Quality Strategy

Improving Health Care Delivery Vision

- Better
- Smarter
- Healthier

Focuses on:

- Using incentives to improve care
- Tying payment to value through new payment models

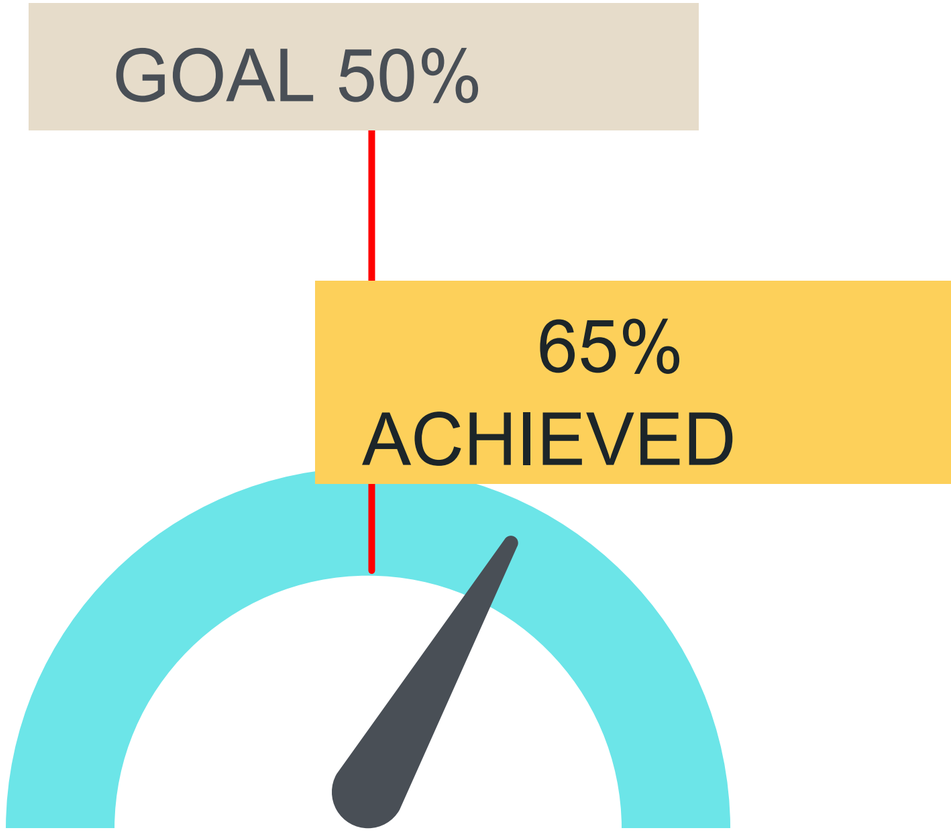
Changing how care is given through:

- Better Teamwork
- Better coordination across care settings
- More attention to population health
- Putting the power of healthcare information to work

CMS'S VALUE BASED GOAL & PERFORMANCE

CMS's goal for 2018 was 50% of all fee-for service Medicare payments to be tied to quality or value through alternative payment models.

According to MEDPAC's Report to Congress in June 2020, about 65% of the beneficiaries who have both Part A and Part B coverage are now in 2 other payment models that have stronger incentives to manage overall spending.



Hospital Accountability:
Hospital Inpatient Quality Programs

- Hospital Quality Reporting Program (IQR)
- Hospital Value Based Purchasing Program (HVBP)
- Hospital-Acquired Condition Reduction Program (HAC)
- Hospital Readmission Reductions Program (HRRP)

Care Compare (reports on most of the measures used in the above)

Hospital Quality Reporting Program (IQR)

"Pay for Performance" Quality Reporting which utilizes a variety of measures to determine quality of care:

- Healthcare Associated Infection Measures
- Clinical Process Measures
- Electronic Clinical Quality Measures
- Hospital Consumer Assessment of Healthcare Providers and System Survey
- Claims Based Measures

Many of the measures are used in other Quality Progr
including VBP

https://www.qualitynet.org/inpatient/iqr/measures

Hospital Value Based Purchasing Program (HVBP)

"Pay for Performance" Program that adjusts hospitals' payments based on their performance on 4 domains that reflect hospital quality:

- Clinical outcomes domain (Mortality and Complications Measures)
- Person and community engagement domain (Survey)
- Safety domain (Hospital Acquired Infections Measures)
- Efficiency and cost reduction domain (Medicare spending per Beneficiary Measure)
  - Includes 30 days after hospital discharge

Hospital-Acquired Condition Reduction Program (HAC)

Reduces payments to hospitals (25% worst performing) based on how they perform on measures of hospital-acquired conditions

Includes:

- Claims based composite measure regarding patient safety
- Five Infection Measures

Hospital-Readmission Reductions Program (HRRP)

Encourages hospitals to improve communication and care coordination to better engage patients and caregivers in discharge plans and, in turn reduce avoidable readmissions.

- CMS calculates the payment reduction and components results for each hospital based on its performance on six readmission measures during a 3-year performance period

Hospital Readmission Measures

30-day risk standardized unplanned readmission measures

- CHF
- Pneumonia
- Acute Myocardial Infarction
- COPD
- Total Hip Arthroplasty (THA) and Total Knee Arthroplasty (TKA)
- Coronary Artery Bypass Graft (CABG) surgery

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HRRP/Hospital-Readmission-Reduction-Program.html

OTHER HOSPITAL CONSIDERATIONS

ALTERNATIVE PAYMENT MODEL PARTICIPATION

- BPCIA
- ACOs
- CJRR

Are you maintaining key partnerships?

Do you know what your convener uses to measure success?

Skilled Nursing Facility Value-Based Purchasing Program (SNFVBP)

WHAT:

Rewards skilled nursing facilities with incentive payments for the quality of care they give to people with Medicare

WHEN:

Started in fiscal year 2019

WHY:

Promotes better clinical outcomes for skilled nursing facility patients and makes their care experience better during skilled nursing facility stays

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/SNF-VBP.html

DATA COLLECTION FOR SNFVBP

- CMS has established SNF baselines for readmissions from 2015 data collection
- Feedback reports for each facility started in October 2016, through CASPER system
- Performance Period (comparison data) started January 1, 2017
- Performance data posted on readmissions on Nursing Home Compare website starting October 2017
- Payment impact began October 2018 (FY 2019)
  - SNF payments were reduced by 2%
- Currently in FY2021 performance period which started 10/1/2020

SNF VBP MEASURE - SNFRM

- SNFRM estimates risk-standardized rate of all-cause, unplanned hospital readmissions of Medicare SNF beneficiaries within 30 days of discharge from their prior proximal acute hospitalization
  - Hospital readmissions are identified through Medicare claims
  - Tracks readmissions within 30 days after discharged from a prior hospitalization, not d/c from a SNF
  - Readmissions within 30-day window counted regardless of whether the beneficiary is readmitted directly from SNF or had been discharged home from SNF
- Includes all Medicare Fee For Services patients
- Risk-adjusted based on:
  - patient demographics
  - principal diagnosis in prior hospitalization
  - co-morbidities, and
  - other health status variables that affect probability of readmission
- Excludes planned readmissions since these are not indicative of poor quality

SNFRM EXCLUSIONS

- Anyone less than 18 years
- SNF stays with a gap of greater than 1 day between discharge from the prior hospitalization, proxim
  hospitalization and the SNF admission
- SNF stays where the resident was discharged from the SNF against medical advice
- SNF stays in which the principal dx for prior proximal hospitalization was for the medical treatment
  cancer or pregnancy
- Forms the basis for the SNF performance on the measure and value-based incentive payments
  determined by comparing all SNFs' performance scores
- Will be replaced by the SNFPPR in future rulemaking

Update: Due to COVID, this measure is suppressed for 2022 program year. All participating SNFs will receive a score of 0, have the 2% withheld and then receive 1.2% or 60% of the withhold.

OTHER COMING CHANGES TO VBP PROGRAM

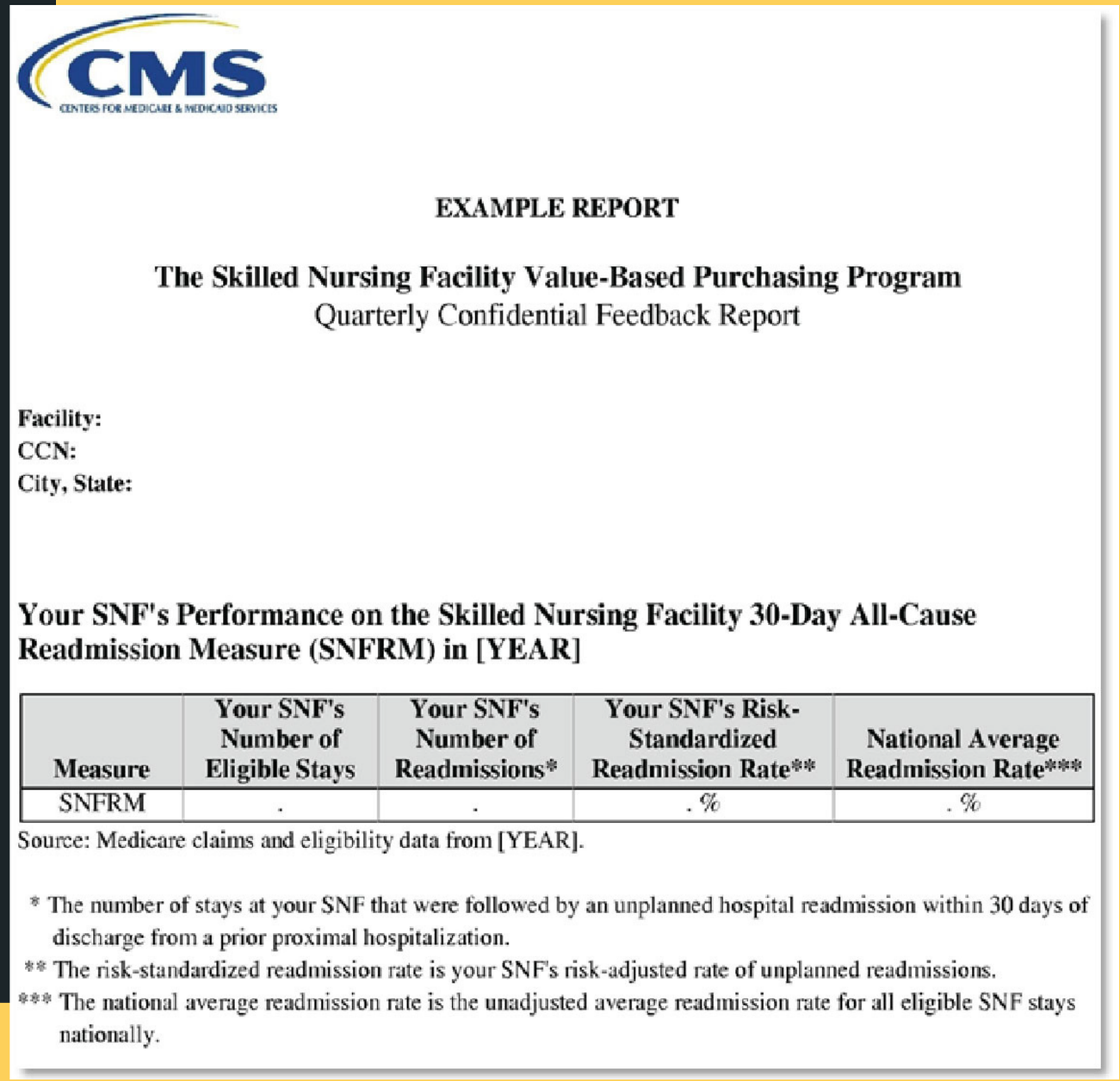
Consolidated appropriations act includes provision to expand program with up to 9 additional measures starting in FY 2024 including:

- Functional Status Measures
- Patient Safety
- Care Coordination
- Patient Experience
- Resident Survey and Staff Turnover

Will include all residents regardless of payer

CONFIDENTIAL FEEDBACK REPORT

Reference:
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/SNF-VBP-quarterly-report-template.pdf



CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

EXAMPLE REPORT

The Skilled Nursing Facility Value-Based Purchasing Program
Quarterly Confidential Feedback Report

Facility:
CCN:
City, State:

Your SNF's Performance on the Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM) in [YEAR]

Measure	Your SNF's Number of Eligible Stays	Your SNF's Number of Readmissions*	Your SNF's Risk-Standardized Readmission Rate**	National Average Readmission Rate***
SNFRM	.	.	. %	. %

Source: Medicare claims and eligibility data from [YEAR].

* The number of stays at your SNF that were followed by an unplanned hospital readmission within 30 days of discharge from a prior proximal hospitalization.
** The risk-standardized readmission rate is your SNF's risk-adjusted rate of unplanned readmissions.
*** The national average readmission rate is the unadjusted average readmission rate for all eligible SNF stays nationally.

Other SNF Data

- Nursing Home Compare/5 Star Rating
- Health and Fire Safety Inspection results, Staffing, Penalties and Quality Measures including pertinent short stay measures
- Rate of potentially preventable hospital readmissions 30 days after discharge from a SNF (SNF QRP).
- Medicare Spending Per Beneficiary (MSPB) for resident sin SNFs (SNF QRP)
- Rate of successful return to home and community from a SNF (SNF QRP)

% OF RESIDENTS WHO...

- were rehospitalized after a nursing home admission
- have had an outpatient emergency department visit
- got antipsychotic medication for the first time
- improved in their ability to move around on their own
- who experience one or more falls with major injury during their SNF stay (SNF QRP)
- whose functional abilities were assessed and functional goals were included in their treatment plan (SNF QRP)

5 KEYS TO IMPROVE QUALITY

1 

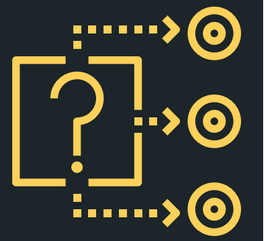
At the global level, awareness and education across a broad spectrum of healthcare workers is necessary

2 

Each facility must identify each resident's individual need

3 

Improvement requires facility to create and examine existing practices and update as necessary

4 

Perform Root Case Analysis

5 

Offer consistent and up-to-date staff education, and have reference tools available to support staff

CONSIDERATIONS TO IMPROVE QUALITY

- Monitor QM scoring monthly through facility level reports
- Address 5 Star Reports frequently in formal IDT meetings
- Identify risk areas
- Root Cause Analysis on poor outcomes and set plan in place
- Circle back and make sure plan/protocols are still effective (forgotten step at times can lead to survey issues)

Reginald M. Hislop III, PhD., Maureen McCarthy, RN, BS, RAC-MT, CQP, Five Star Quality Rating System Technical Users Guide, HCPRO, 2017.

IMPROVE QUALITY

- Stay current to all regulations and performance expectations through CMS sources, consultants, webinars and conferences
- QAPI approach with IDT members to all risk areas
- Surveyors are looking for Performance Improvement Plans for QMs or other areas to see that a facility is dedicated to improving their overall quality of services

Reginald M. Hislop III, PhD., Maureen McCarthy, RN, BS, RAC-MT, CQP, Five Star Quality Rating System Technical Users Guide, HCPRO, 2017.

Is Therapy an active IDT member in your quality improvement process?

QUALITY MEASURES

- The QM rating has information on 15 different physical and clinical measures for nursing home residents that therapy can improve
- Each outlying area should be analyzed and the IDT, including Therapy, should set a plan to improve

Quality Measures	PREMIER THERAPY'S Partnering Support	
Falls	• Fall Prevention Program • Root Cause Analysis by IDT • Stop and Watch list • Adapt Environment • Adaptive Equipment • Visual Assessments	• Medication Schedule • Nutrition Assessment • Cognitive Assessment • Caregiver Training • Medication Review/Supplements
ADL loss	• ADL Training • ADL Scoring/Documentation Training • Adaptive Equipment	• Adapt Environment • Cognitive Assessment • TIP Program
Restraints	• Restraint Reduction Program • Adaptive Equipment • Behavior Management • Cognitive Assessment	• Wound Assessment • Pressure Relief • Scheduled Rest Periods • Medication Review
Antipsychotic Use/Depression	• Behavior Management Program • Cognitive Assessment • Nutritional Assessment • Adapt Environment	• BrainStorm Program • Medicine Review • Caregiver Training • Activity Programming
Weight Loss	• Dysphagia Assessment and Treatment • Caregiver Training • Medicine Review	• Cognitive Assessment • Restorative Dining Program • Adaptive Equipment • Alternative Diets
Bowel and Bladder/UTI	• TIP program • ADL Training • Transfer Training • Adaptive Equipment	• Caregiver Training • Scheduled Bathroom Breaks • Nutrition/Hydration • Cognitive Assessment

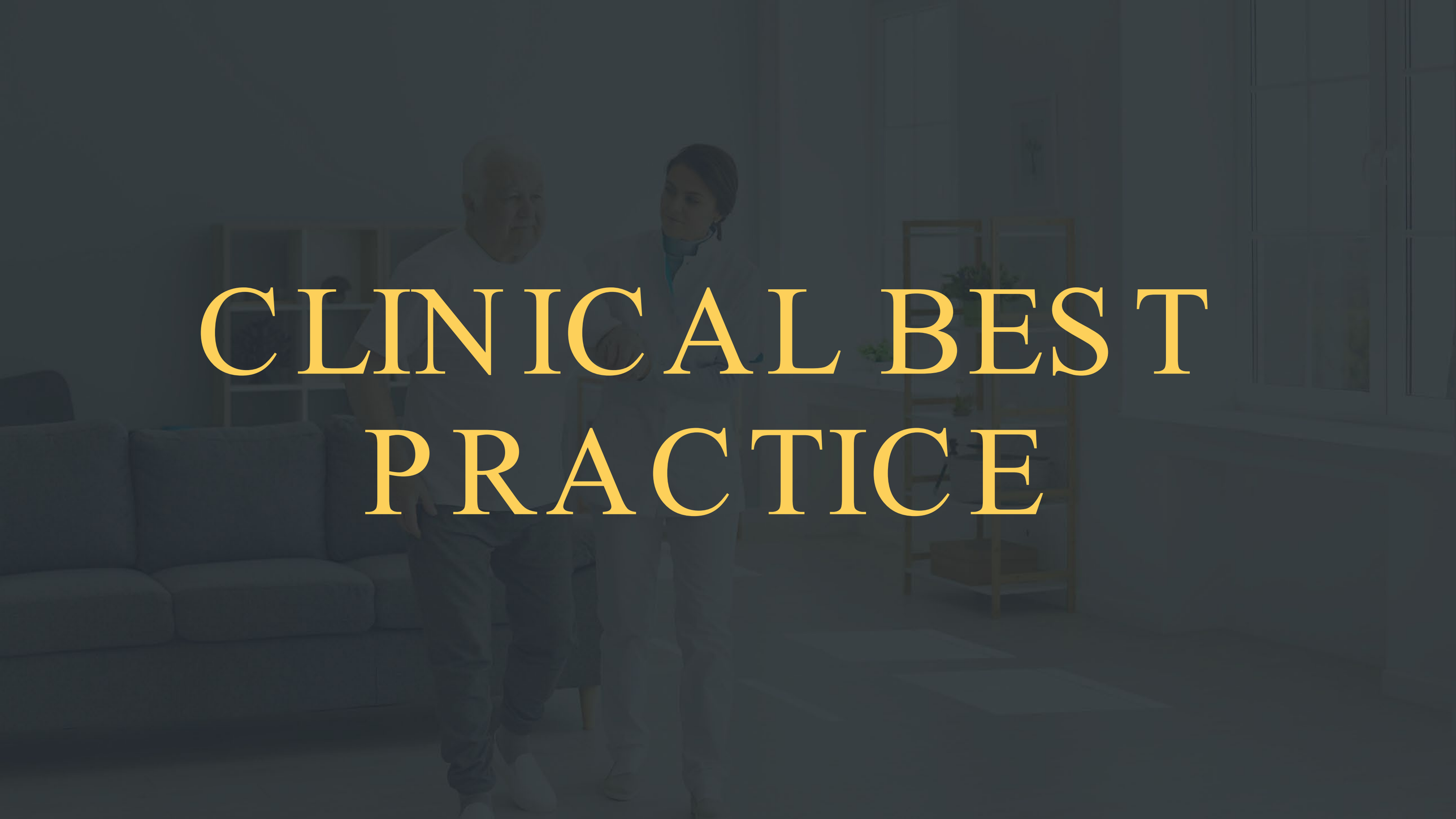
QUALITY MEASURES

Quality Measures

Short Stay Quality Measure: *Percentage of short-stay residents…*	Quality Incentive Measures	CASPER QM	Reported on Care Compare	Contributes to 5 Star	QRP	Therapy Can Impact	MDS Contributing Items	Tips for Removing Items from CASPER Report
who were re-hospitalized after a nursing home admission.			✓	✓		✓	Claims based	
who have had an outpatient emergency department visit.			✓	✓		✓	Claims based	
who got antipsychotic medication for the first time.		✓	✓	✓		✓	N0410A	Nothing will removed them once they trigger due to lookback scan of 100 days
who improved in their ability to move around on their own.		✓	✓	✓		✓	Must have valid 5 day or admission and DC assessment; G01101B1, G0110E1, G0110D1	Review admission vs discharge GG assessments for improvement
who needed and got a flu shot for the current flu season.			✓				O0250C	
who needed and got a vaccine to prevent pneumonia.			✓				O0300A	
whose functional abilities were addressed and functional goals were included in their treatment plan			✓		✓	✓	5 day and dc assessment GG items with goal in self-care/	
with pressure ulcers that are new or worsened			✓	✓	✓	✓	M0300 B-D	
experiencing one or more falls with major injury.			✓	✓	✓	✓	J1900C	
Rate of successful return to home & community from a SNF			✓	✓	✓	✓	Claims based	
Rate of potentially preventable hospital readmissions 30 days after discharge from a SNF			✓		✓	✓	Claims based	
Medicare Spending Per Beneficiary (MSPB) for residents in SNFs.			✓		✓	✓	Claims based	
Long Stay Quality Measure: Percentage of long-stay residents…		**CASPER QM**	**Reported on Care Compare**	**Contributes to 5 Star**	**QRP**	**Therapy Can Impact**	**MDS Contributing Items**	**Tips for Removing Items from CASPER Report**
who got an antipsychotic medication.		✓	✓	✓		✓	N0410A	Set ARD 7 days after resident stops taking medication
who have had a fall		✓				✓	J1800	Set ARD for the day of the fall; schedule MDS to be completed 276 days later
experiencing one or more falls with major injury.		✓	✓	✓		✓	J1900C	Set ARD for the day of the fall; schedule MDS to be completed 276 days later
(high-risk) with pressure ulcers.	✓	✓	✓	✓		✓	M0300 B-G	Set ARD for 7 days after ulcer heals
with a urinary tract infection.	✓	✓	✓	✓		✓	I23300	Set ARD for the first day when all 4 symptoms would not be present in the last 30 days
who have/had a catheter inserted and left in their bladder.	✓	✓	✓	✓		✓	H0100A	Set ARD for 7 days after catheter removal

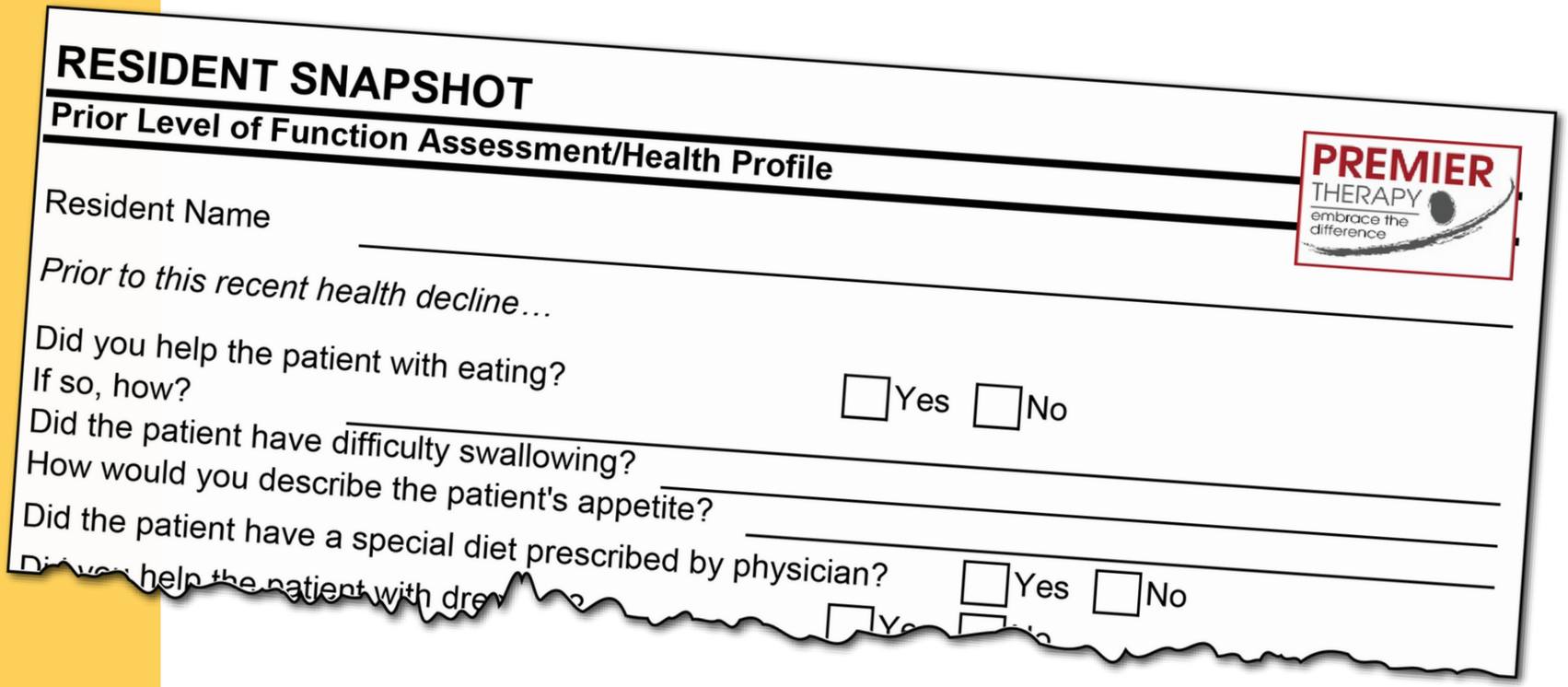
QUALITY MEASURES

Long Stay Quality Measure: Percentage of long-stay residents...		CASPER QM	Reported on Care Compare	Contributes to 5 Star	QRP	Therapy Can Impact	MDS Contributing Items	Tips for Removing Items from CASPER Report
whose ability to move independently worsened.	✓	✓	✓	✓		✓	G0110E1	If resident does not improve, set ARD for 46 days after the ARD that captured the decline. If resident improves, set ARD as soon as resident returns to baseline.
whose need for help with daily activities has increased.		✓	✓	✓		✓	4 late loss ADLs G0110A, B, H, I	If resident does not improve, set ARD for 46 days after the ARD that captured the decline. If resident improves, set ARD as soon as resident returns to baseline
who needed and got a flu shot for the current flu season.			✓				O0250	
who needed and got a vaccine to prevent pneumonia.			✓				O0300	
who were physically restrained.		✓	✓			✓	P0100B-G	Set ARD when a day occurs where the restraint was not used
(low-risk) who lose control of their bowels or bladder.		✓	✓			✓	H0300, H0400	Complete MDS in new quarter without measure triggered
who lose too much weight.		✓	✓			✓	K0300	Complete MDS in new quarter without measure triggered
who got an antianxiety or hypnotic medication.		✓	✓			✓	N0410B,D	Complete MDS in new quarter without measure triggered
who used antianxiety or hypnotic med without a psychotic or related condition		✓				✓	N0410B,D plus dx in I	Complete MDS in new quarter without measure triggered
who have symptoms of depression.		✓	✓			✓	D0200-600	Complete MDS in new quarter without measure triggered
# of hospitalizations per 1,000 long-stay resident days.			✓	✓		✓	Claims based	
Prevalence of behavioral symptoms affecting others		✓				✓	E0220A-C, E0800, 900	Complete MDS in new quarter without measure triggered
Outpatient emergency department visits per 1,000 long-stay resident days.			✓	✓		✓	Claims based	
Other Quality Reporting Measures		**CASPER QM**	**Reported on Care Compare**	**Contributes to 5 Star**	**QRP**	**Therapy Can Impact**	**MDS Contributing Items**	**Tips for Removing Items from CASPER Report**
Drug Regimen Review Conducted w/Follow-Up for Identified Issues			✓		✓	✓	N2001, N2003	
Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury					✓	✓	M0300B-G	
Change in Self-Care Score for Medical Rehabilitation Patients			✓		✓	✓	GG0130A,B,C,E,F,G,H	
Change in Mobility Score for Medical Rehabilitation Patients			✓		✓	✓	GG0170A - P	
Discharge Self-Care Score for Medical Rehabilitation Patients			✓		✓	✓	GG0130 A,B,C,E,F,G,H	
Discharge Mobility Score for Medical Rehabilitation Patients			✓		✓	✓	GG0170A - P	



CLINICAL BEST PRACTICE

RESIDENT SNAPSHOT



identify each resident's individual need

Begins at Admission

EATING

- Indicates risk of poor nutrition or assist needed

SWALLOWING

- Can indicate any choking or aspiration risks
- Description of appetite
- Specialized diet
- Respiratory or endurance problems impacting prior function

DRESSING

- Indicates what level of independence resident may be
- Circulation or skin related problems

AMBULATION/ TRANSFERS/ FALL RISK

- Indicates possible balance problems or falls risk

Begins at Admission

BATHING/ BATHROOM USE

- Indicates level of independence
- Continent of bowel andbladder

COGNITION

- Indicates possible safety concerns
- Behavioral/ Psychological/ Elopement issues
- Sleep patterns

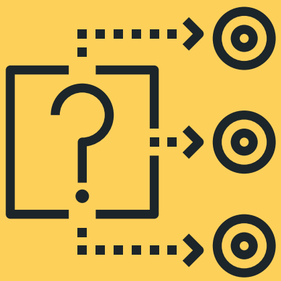
FUNCTIONAL DECLINE/FALLS

- If falling at home more likely to fall in facility
- Pain presence

MEDICATION REVIEW

- Can indicate side effects or poor adjustment to new medications

TRIGGER TO ACTION



root cause analysis

Risk Identification and Tracking

- Add patients who trigger upon admission either from Resident Snapshot/PLOF/Health Profile, trigger on MDS assessments, therapy assessments and/or other referrals to Action List

- Review these patients at the morning meeting or UR with IDT

TRIGGERS FOR ACTION

- Referral from Snapshot
- Fall History
- Reduced intake by mouth/altered diet
- Changes/High number of medications/antipsychotics
- Unstable or changes in vitals
- Fluctuating functional status

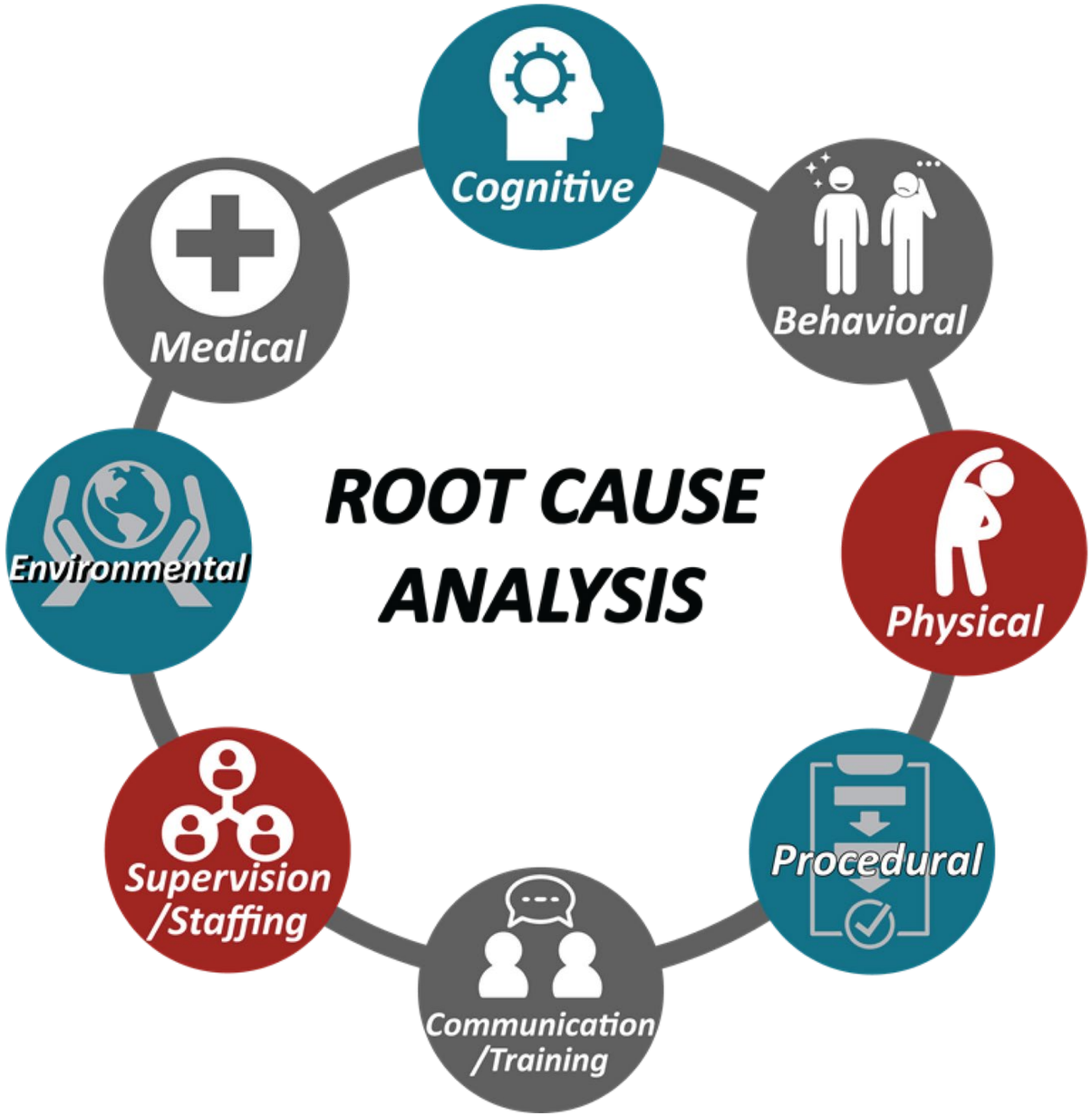
7. Behavior changes/Impaired cognition
8. Pain
9. Skin issues
10. Decreased mobility/ADLs
11. Bowel/Bladder issues
12. Poor sleep patterns

Pay particular attention to targeted HRR diagnosis

RISK ACTION MEETING

- Facility to determine the most appropriate setting to discuss residents
- Can be morning Stand Up, UR or IDT meeting
- Complete comprehensive review of all risk factors
- Can use Pause, What is Root Cause to determine cause and appropriate referrals (can be used during meeting or as part of comprehensive evals)
- Track referrals using assignment sheets at completed
- What reports do you pull regularly for facility outcomes?

ROOT CAUSE ANALYSIS



BEHAVIOR CHECKLIST

Facial Grimace & Behaviour Checklist Flow Charts

Name: _____ Active ❑ Resting ❑ Time: _____

Regular pain medication: _____ Rescue/PRN medication _____

Month:

Date or Time													
FACIAL SCORE													
10													
8													
6													
4													
2													
0													
PRN medication													

Facial Grimace Score: The facial grimace scale scores the level of pain (from 0-10 on the left) as assessed by the caregiver observing the facial expressions of the resident. Assessment is done once daily or more (14 days are indicated above). This assessment of the degree of discomfort should be done at the same time every day and during the same level of activity. Note if rescue/PRN medication is given; yes (y), no (n) or dose.

Behaviour Checklist

10 – always 8 – mostly 6 – often 4 – occasionally 2 – rarely 0 – never

Date or Time													
BEHAVIOUR													
eats poorly													
tense													
quiet													
indicates pain													
calls out													
paces													
noisy breathing													
sleeps poorly													
picks													
PRN medication													

Behaviour Checklist: Behaviour changes can be used to assess pain or distress, and thereby evaluate the efficacy of interventions. At the top of the scoring graph, when the specific behaviour has been observed, it can be rated from 10 (always) to 0 (never). The behaviours being rated and scored over 24 hours are listed down the left column. This chart scores 9 different behaviours over 14 days. The caregiver can expand on the checklist, i.e., rocking, screams, etc. Note if rescue/PRN medication given. Both tools may be adapted for individual use.

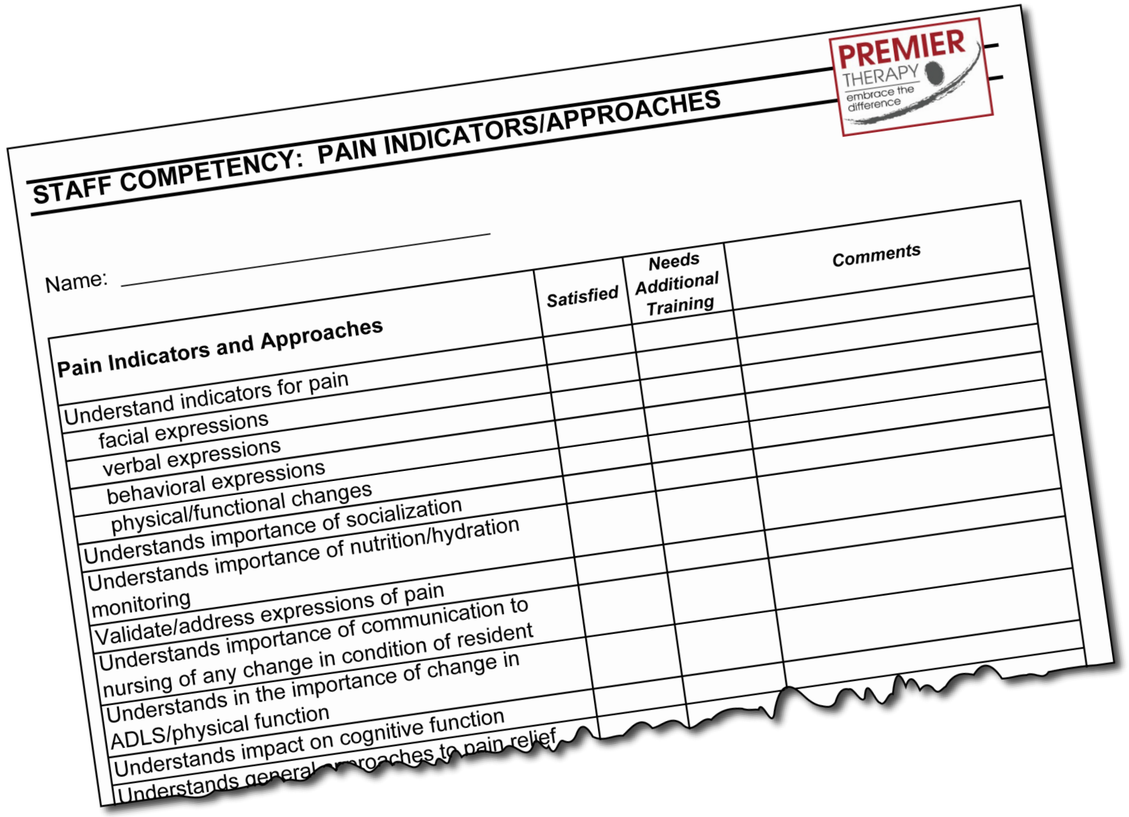
The Facial Grimace & Behaviour Checklist are used with permission from the Palliative Care Research Team, Saint Joseph's Health Centre, Sarnia, Ontario.
Reprinted with Permission. Brignell, A. (ed) (2000). Guidelines for developing a pain management program. A resource guide for long-term care facilities , (3rd ed.)

PROGRAM FLOW

up-to-date education

1. Written status/adaptations /interventions should be present in a private place, so care staff can access it easily during care
2. Nursing should write a note on carryover and positive impact to function and quality of life for resident
3. Nursing will follow for next two weeks for carry over
4. Team will recommend discharge from Action List
5. Residents will be reviewed quarterly
6. Check understanding consistently throughout year

COMMUNICATION & TRAINING



STAFF COMPETENCY: PAIN INDICATORS/APPROACHES

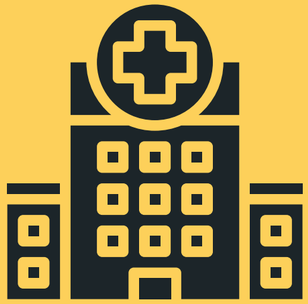
PREMIER THERAPY embrace the difference

Name: _____

Pain Indicators and Approaches	Satisfied	Needs Additional Training	Comments
Understand indicators for pain			
facial expressions			
verbal expressions			
behavioral expressions			
physical/functional changes			
Understands importance of socialization			
Understands importance of nutrition/hydration monitoring			
Validate/address expressions of pain			
Understands importance of communication to nursing of any change in condition of resident			
Understands in the importance of change in ADLS/physical function			
Understands impact on cognitive function			
Understands general approaches to pain relief			

- Specific Care Plan Training - Competency
- Vital Signs
- Clinical Program Education
- Use sign off sheets during training with dates completed, who attended and who instructed

INTERACT 4.5



identify each resident's individual need

- INTERACT stands for Interventions to Reduce Acute Care Transfers

- It is a quality improvement program to improve the identification, evaluation, and communication about changes in resident status

- The program is comprised of communication, care paths, clinical and advance care planning tools for care teams and tracking systems to use to reduce unnecessary readmissions to the hospital

INTERACT 4.5

identify each resident's individual need

SEVERAL OF THE TOOLS CAN BE UTILIZED FOR AT-RISK QUALITY IMPROVEMENT AND TRACKING PROGRAMS:

- Stop and Watch Tool
- SBAR Form
- Hospitalizations Tracking Tool
- Quality Improvement Tool

https://pathway-interact.com/wp-content/uploads/2018/09/INTERACT-V4-Implementation_Guide-June-2018.pdf

INTERACT TOOLS

Stop and Watch
Early Warning Tool

If you have identified a change while caring for
resident, please **circle** the change and notify a
nurse a copy of this tool or review it with her/hi

STOP and WATCH

- Seems different than usual
- Talks or communicates less
- Overall needs more help
- Pain – new or worsening; Participa

- Ate less
- No bowel movement in 3 days; or
- Drank less

- Weight change
- Agitated or nervous more than
- Tired, weak, confused, or drows
- Change in skin color or conditic
- Help with walking, transferring,

Patient / Resident

Your Name *Date and Time (am/pm)*

Reported to *Date and Time (am/pm)*

Nurse Response

Nurse's Name

Quality Improvement Tool
For Review of Acute Care Transfers

The INTERACT QI Tool is designed to help your team analyze hospital transfers and identify opportunities to reduce transfers that might be preventable. Complete this tool for each or a representative sample of hospital transfers in order to conduct a root cause analysis and identify common reasons for transfers. Examining trends in these data with the INTERACT QI Summary Tool can help you focus educational and care process improvement activities.

Patient _____ Age _____

Date of most recent admission to the facility _____ /_____ /_____

Primary goal of admission ☐ Post-acute care ☐ Long-stay ☐ Other __

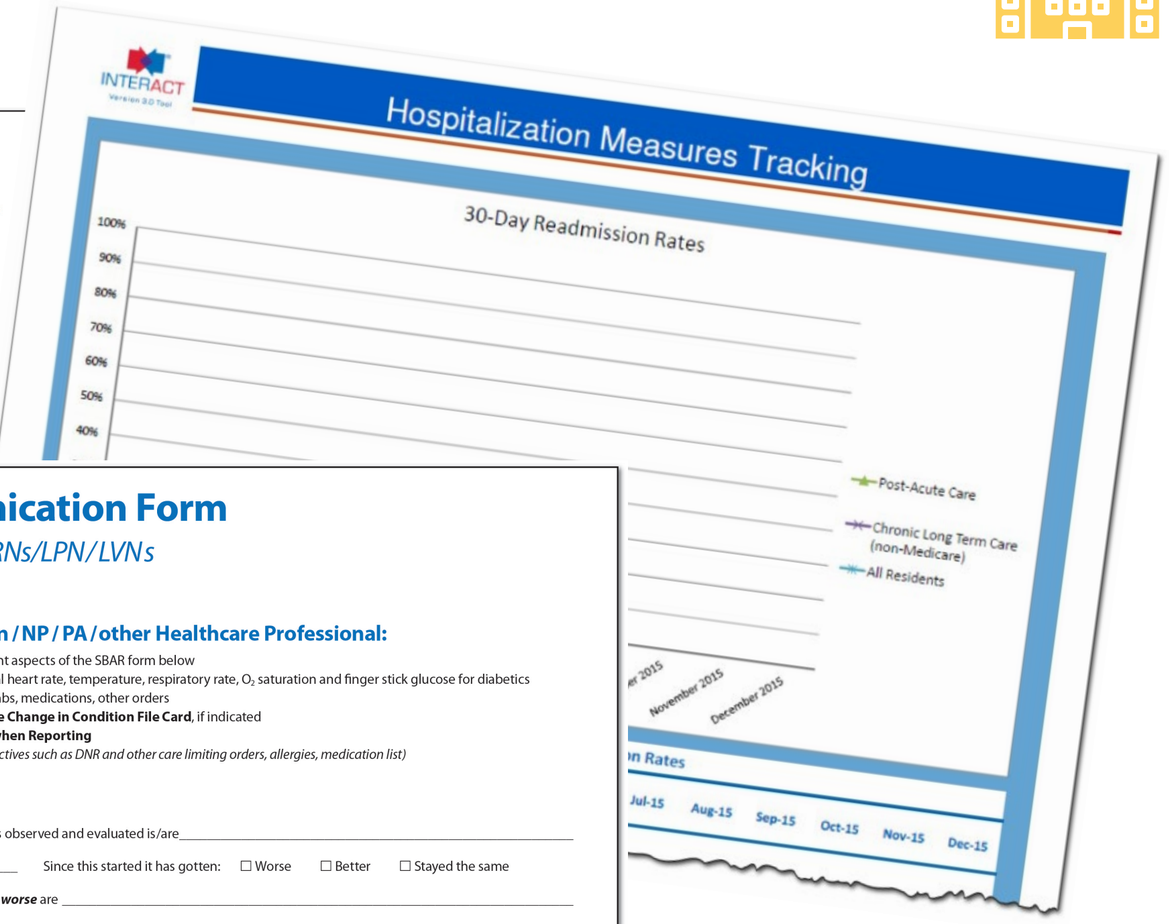
SECTION 1: Risk Factors for Hospitalization and Readmi

a. Conditions that put the resident at risk for hospital admission or readmission:

- ☐ Cancer, on active chemo or radiation therapy
- ☐ CHF
- ☐ COPD
- ☐ Dementia
- ☐ Diabetes
- ☐ End-stage renal disease
- ☐ Fracture *(Hip)*
- ☐ Multiple active diagnoses an *(e.g. CHF, COPD and Diabetes*
- ☐ Polypharmacy *(e.g. 9 or more*
- ☐ Surgical complications

b. Resident hospitalized in the ***past 30 days?*** ☐
(Other than the one being reviewed in this tool)

c. Other hospitalizations or emergency department visits in the ***past 12 months?*** ☐
(Other than the one being reviewed in this tool)



SBAR Communication Form
and Progress Note for RNs/LPN/LVNs

Before Calling the Physician / NP / PA / other Healthcare Professional:

- ☐ **Evaluate the Resident:** Complete relevant aspects of the SBAR form below
- ☐ **Check Vital Signs:** BP, pulse, and/or apical heart rate, temperature, respiratory rate, O_2 saturation and finger stick glucose for diabetics
- ☐ **Review Record:** Recent progress notes, labs, medications, other orders
- ☐ **Review an INTERACT Care Path** or **Acute Change in Condition File Card**, if indicated
- ☐ **Have Relevant Information Available when Reporting**
  (i.e. medical record, vital signs, advance directives such as DNR and other care limiting orders, allergies, medication list)

SITUATION

The change in condition, symptoms, or signs observed and evaluated is/are_____

This started on _____ /_____ /_____ Since this started it has gotten: ☐ Worse ☐ Better ☐ Stayed the same

Things that make the condition or symptom ***worse*** are _____

Things that make the condition or symptom ***better*** are _____

This condition, symptom, or sign has occurred before: ☐ Yes ☐ No

Treatment for last episode *(if applicable)* _____

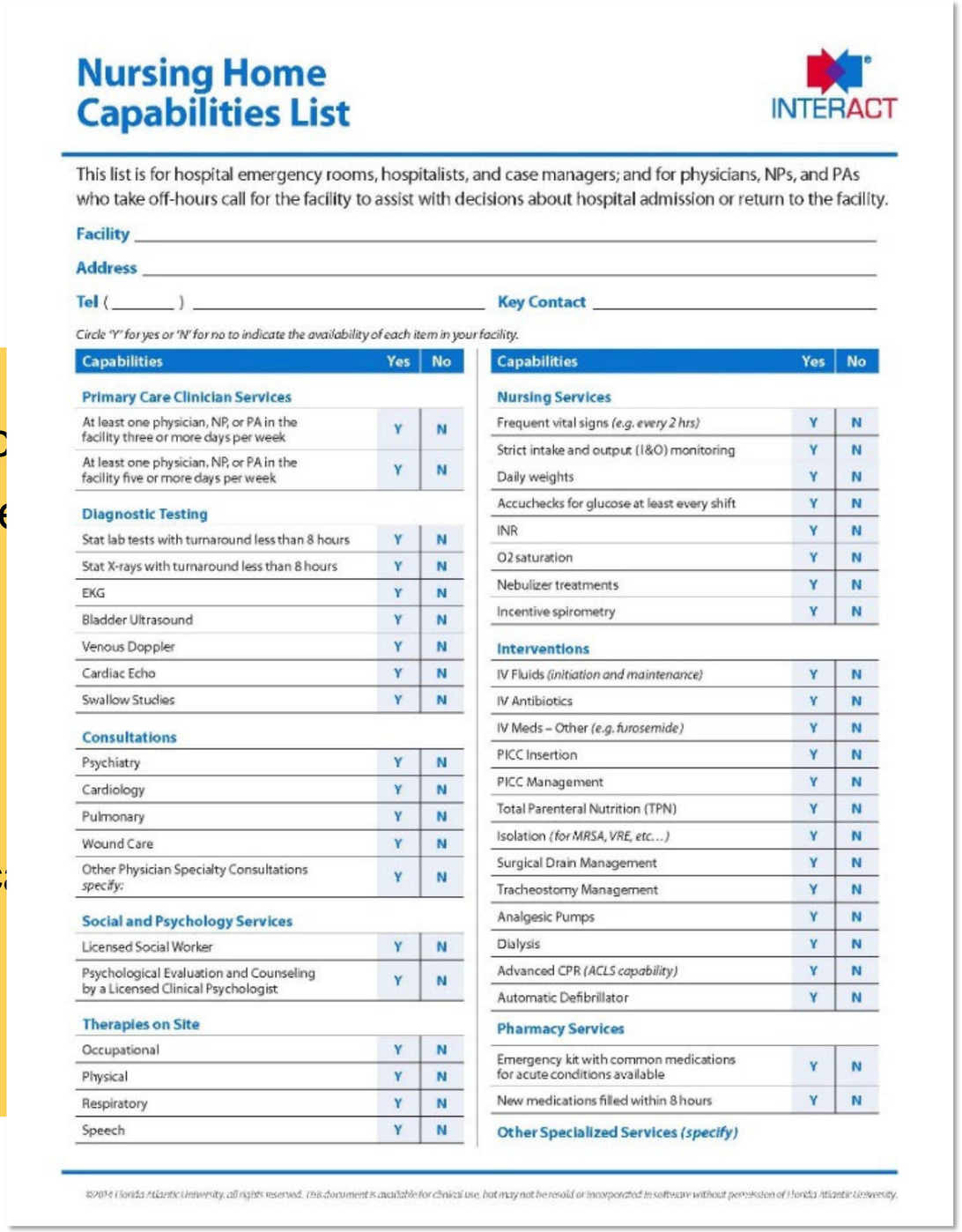
Other relevant information _____

BACKGROUND

Resident Description
This resident is in the facility for: ☐ Long-Term Care ☐ Post Acute Care ☐ Other: _____

HOW CAPABLE IS YOUR FACILITY?

- SNF/NF Capabilities List, which can be useful fo emergency room staff, hospital discharge planne and hospital physicians in understanding the capabilities of eacfacility when making hospitalization andischargedecisions
- The Capabilities List may also be useful in educa new staff, family membeandon callprimarycare clinicians about the facility's capabilities



Nursing Home Capabilities List

INTERACT

This list is for hospital emergency rooms, hospitalists, and case managers; and for physicians, NPs, and PAs who take off-hours call for the facility to assist with decisions about hospital admission or return to the facility.

Facility _____

Address _____

Tel (_____) _____ **Key Contact** _____

Circle 'Y' for yes or 'N' for no to indicate the availability of each item in your facility.

Capabilities	Yes	No
Primary Care Clinician Services		
At least one physician, NP, or PA in the facility three or more days per week	Y	N
At least one physician, NP, or PA in the facility five or more days per week	Y	N
Diagnostic Testing		
Stat lab tests with turnaround less than 8 hours	Y	N
Stat X-rays with turnaround less than 8 hours	Y	N
EKG	Y	N
Bladder Ultrasound	Y	N
Venous Doppler	Y	N
Cardiac Echo	Y	N
Swallow Studies	Y	N
Consultations		
Psychiatry	Y	N
Cardiology	Y	N
Pulmonary	Y	N
Wound Care	Y	N
Other Physician Specialty Consultations *specify:*	Y	N
Social and Psychology Services		
Licensed Social Worker	Y	N
Psychological Evaluation and Counseling by a Licensed Clinical Psychologist	Y	N
Therapies on Site		
Occupational	Y	N
Physical	Y	N
Respiratory	Y	N
Speech	Y	N

Capabilities	Yes	No
Nursing Services		
Frequent vital signs *(e.g. every 2 hrs)*	Y	N
Strict intake and output (I&O) monitoring	Y	N
Daily weights	Y	N
Accuchecks for glucose at least every shift	Y	N
INR	Y	N
O2 saturation	Y	N
Nebulizer treatments	Y	N
Incentive spirometry	Y	N
Interventions		
IV Fluids *(initiation and maintenance)*	Y	N
IV Antibiotics	Y	N
IV Meds – Other *(e.g. furosemide)*	Y	N
PICC Insertion	Y	N
PICC Management	Y	N
Total Parenteral Nutrition (TPN)	Y	N
Isolation *(for MRSA, VRE, etc…)*	Y	N
Surgical Drain Management	Y	N
Tracheostomy Management	Y	N
Analgesic Pumps	Y	N
Dialysis	Y	N
Advanced CPR *(ACLS capability)*	Y	N
Automatic Defibrillator	Y	N
Pharmacy Services		
Emergency kit with common medications for acute conditions available	Y	N
New medications filled within 8 hours	Y	N
Other Specialized Services *(specify)*		

Therapy Support for Partnerships

- Therapy educated on specialization populations in hospital/SNF niche
- Facility education/competencies for conditions/complexities including CMS focuses
- Get residents up and moving early and often to reduce risk of pneumonia, wounds, infection or falls
- Active member in Falls, Wounds, and Pain programs consistently
- IDT members can utilize the STOP and WATCH form to document changes

Therapy support for Partnerships

- Complete comprehensive assessment that may include
  - Environmental modification
  - Vital signs in Plan of Care if appropriate
  - Behavioral modification
  - Patient centered staff training
  - Adaptive equipment
  - Functional maintenance programs
- Be an extra watchdog for changes in vital signs
- Communicate consistently to nursing for early interventions
- 7-day a week availability

Structured Transition of Care Programming

- Educating resident and caregivers so they understand their risks, helps to control disease at a safer and higher functional level (ex. Infection control education with COVID

- Communicate to home health agencies and other discharge settings/caregivers re: equipment, care plan, discharge plans/needs to help resident with a smooth transition to another level of care

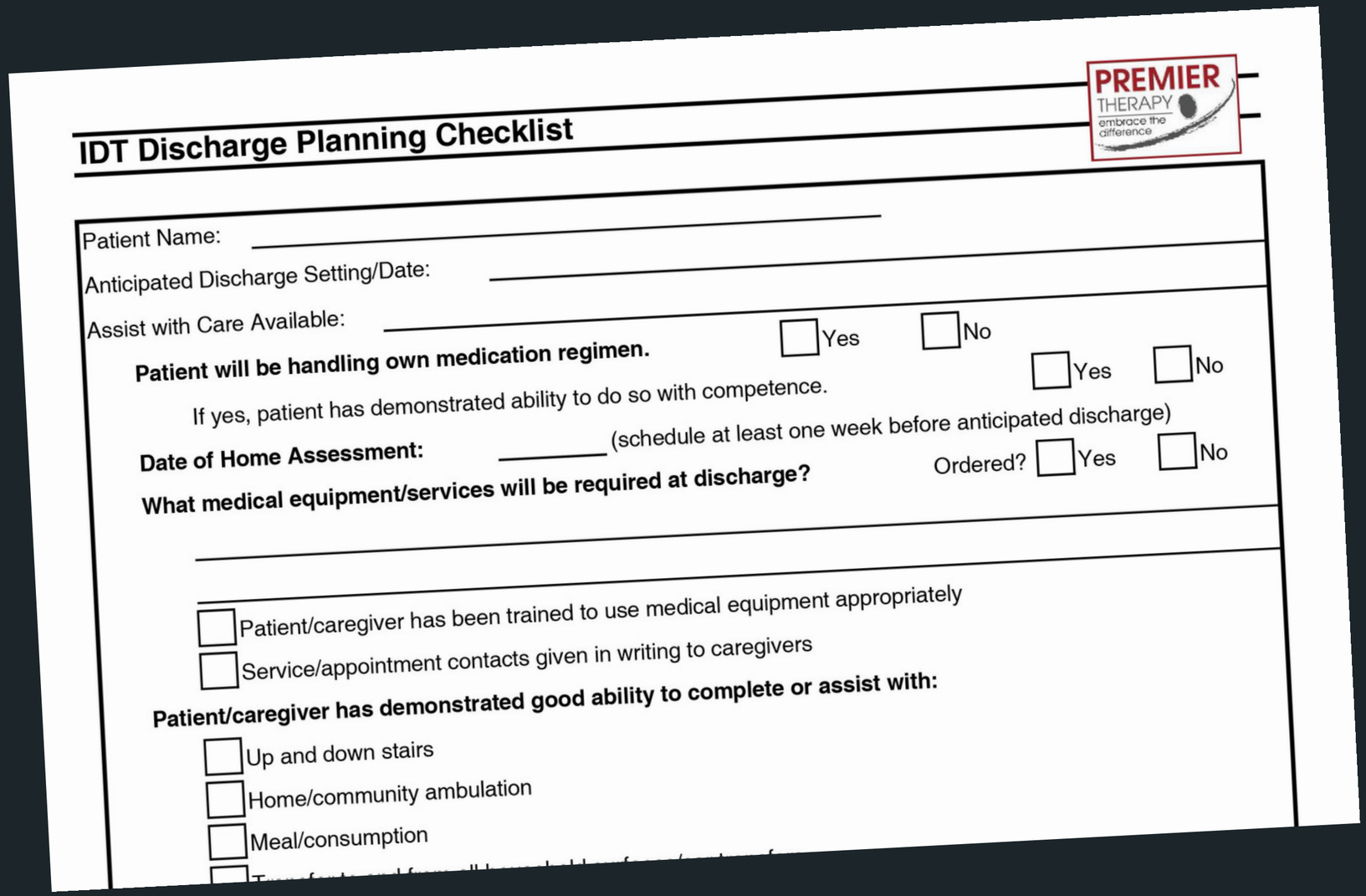
- Formalize discharge process and make it easy for all

STRUCTURED TRANSITION OF CARE PROGRAMMING

create and examine existing practices and update

- Early knowledge of Discharge Plans
- Early family meetings and planning
- Medication reconciliation and training prior to discharge
- Home assessments by Therapy/virtual visits
- Written follow up and upcoming appointments
- Contact information at SNF/Therapy to Patient/Caregivers
- Avoid Friday discharges
- Discharge Checklist to make sure all addressed
- Virtual visit to check in
- Check Satisfaction Scores (patient and family) consistently

DISCHARGE CHECKLIST



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

☐ Service/appointment contacts given in writing to caregivers

Patient/caregiver has demonstrated good ability to complete or assist with:

☐ Up and down stairs

☐ Home/community ambulation

☐ Meal/consumption

Other Considerations for Smooth Transitions

TELEHEALTH

- Effective for services furnished on or after January 1, 2014, the TCM service codes can be billed for Telehealth services
- All requirements and State Practice laws apply
- Many waivers were implemented in 2020 with Pandemic

TRANSITION CASE MANAGER

- Liaison with the hospital through SNF
- Works with IDE in SNF to coordinate after care and follow up calls to patient and families
- Coordinates equipment and environmental modifications
- In place to reduce risk of re-hospitalizations and will set SNFs apart from a hospital's perspective
- Virtual vs. Employee

https://edit.cms.gov/files/document/covid-guidance-and-updates-nursing-homes-during-covid-19.pdf

https://www.cms./gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf

SURVEY READINESS- CONSIDER ALL PLAYERS

- DOES THERAPY UNDERSTAND RISK AS IT APPLIES TO SURVEY?
  - IJ - Non-compliance with ROPs which has caused, or is likely to cause, serious injury, harm, impairment or death of a resident
- DOES YOUR STAFF UNDERSTAND DOCUMENTATION RISK AREAS?
- DOES YOUR STAFF UNDERSTAND ALL RISK POLICIES & PROCEDURES, BOTH GENERAL & PATIENT SPECIFIC?
  - Dietary Guidelines
  - Orders
  - Infection/Isolation (COVID)

THERAPY SATISFACTION SURVEY

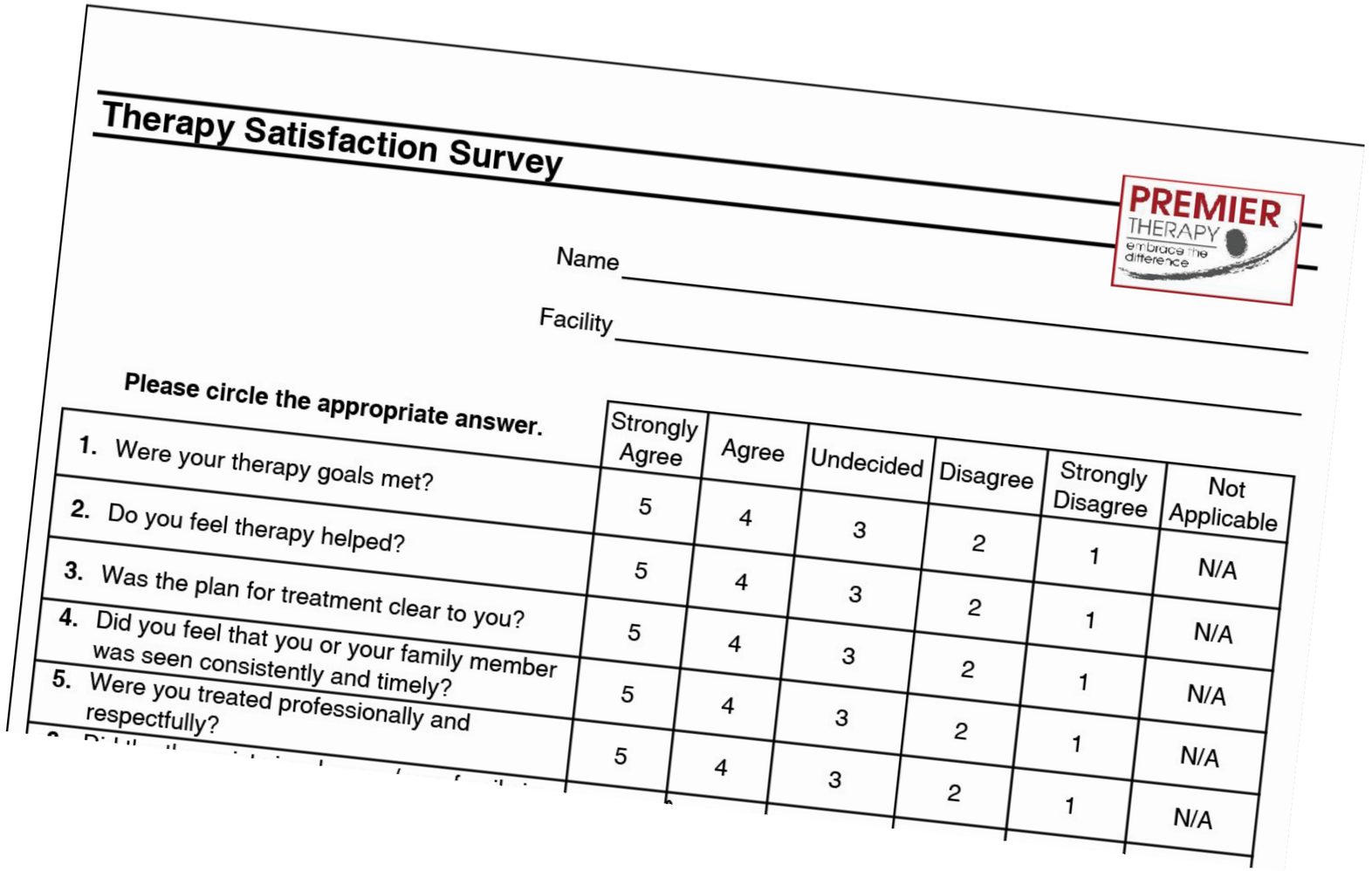
Adjunct to Family and Resident Surveys

Help gauge scores and enable needed changes to be made

Areas in need of improvement can be part of QAPI program

Indirectly could help in transition planning, therefore, decreasing readmissions and referrals

RESIDENT/ FAMILY SATISFACTION SURVEY



Therapy Satisfaction Survey

PREMIER THERAPY embrace the difference

Name _____

Facility _____

Please circle the appropriate answer.

	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree	Not Applicable
1. Were your therapy goals met?	5	4	3	2	1	N/A
2. Do you feel therapy helped?	5	4	3	2	1	N/A
3. Was the plan for treatment clear to you?	5	4	3	2	1	N/A
4. Did you feel that you or your family member was seen consistently and timely?	5	4	3	2	1	N/A
5. Were you treated professionally and respectfully?	5	4	3	2	1	N/A

FINAL THOUGHTS

Culture Change: SNFs are no longer on an island. Facility and therapy staff must integrate and be a part of the change. All community providers must work together to provide best service for best patient outcomes.

IMPROVED QUALITY

\+ FLUID COMMUNICATION

\+ CONSISTENT SYSTEMS

\+ REDUCED COST

SUCCESSFUL PARTNERSHIP

REFERENCES

- www.nhqualitycampaign.org
- American Physical Therapy Association, #Choose PT, MoveForwardPT.com, Accessed July 2016
- Readmissions Reduction Program (HRRP) https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html
- http://www.sheppardhealthlaw.com/2016/09/articles/centers-for-medicare-and-medicaid-services-cms/cms-releases-2017-medicare-hospital-payment-rates-penalties-for-poor-performers/
- Hospital Inpatient Quality Reporting (IQR) Program Measures (cms.gov)

REFERENCES

- CMS' ACO's Pearls of Wisdom https://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2017-04-06-SSP-Presentation.pdf
- Value Based Programs, https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs.html
- SNFVBP https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/SNF-VBP.html
- Reginald M. Hislop III, PhD., Maureen McCarthy, R.N., BS., RAC-MT. CQP, Five Star Quality Rating System Technical Users" Guide, HCPRO, 2017
- INTERACT® Version 4.5 Tools For SNFs/Nursing Homes - INTERACT® Training, Tools, Licensing and Resources (pathway-interact.com)
- http://nsmhpcn.ca/wp-content/uploads/2014/11/FacialGrimaceBehChecklistFlowCharts_RNAOBPG_Pain_and_Supp.pdf

Thank you

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