ltqa
LONG-TERM
QUALITY ALLIANCE

annual meeting

Nursing Homes and Care Transitions

Facilitator: David R. Gifford, MD, MPH
Joseph G. Ouslander, MD
Lorenzo Pelly, MD

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WHITE PAPER

measurement of potentially preventable hospitalizations

PREPARED FOR THE LONG-TERM QUALITY ALLIANCE

Katie Maslow
Joseph G. Outlander, MD

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How is a "Preventable", "Avoidable", "Unnecessary" Hospitalization Defined?

- **Diagnostic codes from administrative data**
  - Selected Ambulatory Care Sensitive Diagnoses (*AHRQ definitions*)
  - Modified lists of ACSD
  - Broader list of specific diagnoses (*used in the CMS report on dual eligible beneficiaries*)
- **Other methods**
  - Structured medical record review by experienced clinicians (*used in the CMS study in Georgia NHs*)

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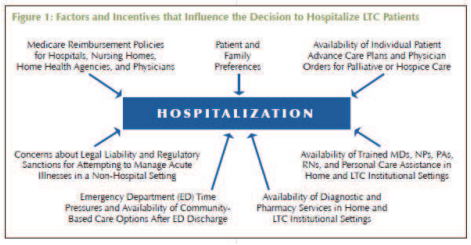
- ***Defining "Preventable", "Avoidable", "Unnecessary" hospitalizations is complicated because numerous factors and incentives influence the decision to hospitalize***



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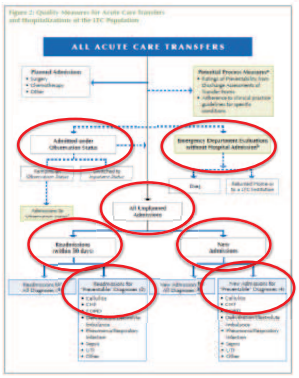

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ACUTE CARE TRANSFER LOG

INTERACT

Facility Name _____ Month/Year ____/____

Resident Room Number	Date of most recent admission to the facility	Admitted to the facility from* (circle)	Status at time of Transfer* (circle)	Date of Transfer	Time of Transfer (circle a.m. or p.m.)	Outcome of Transfer (check which applies)		Hospital Diagnosis for ED visit or admission
						ED visit only (returned to facility)	Admitted to the hospital	
	___/___/___	Hosp H O	S LT O	___/___/___	a.m. p.m.			
	___/___/___	Hosp H O	S LT O	___/___/___	a.m. p.m.			

The INTERACT Program: What is It and Why Does It Matter?

Joseph Ouslander, MD — Florida Atlantic University
Gerri Lamb, PhD, RN, FAAN — Arizona State University
Laurie Herndon, GNP — Mass Senior Care
Ruth Tappen, EdD, RN, FAAN — Florida Atlantic University
Jo Taylor, RN, MPH — The Carolinas Center for Medical Excellence

INTERACT Supported by grants from the Retirement Research Foundation and The Commonwealth Fund

The INTERACT Program: What is It and Why Does It Matter?

The INTERACT Interdisciplinary Team

Joseph G. Ouslander, MD	Florida Atlantic University
Laurie Herndon, GNP	Mass Senior Care Foundation
Gerri Lamb, PhD, RN, FAAN	Arizona State University
Ruth Tappen, EdD, RN, FAAN	Florida Atlantic University
Sanya Diaz, MD	Florida Atlantic University
John Schnelle, PhD	Vanderbilt University
Sandra Simmons, PhD	Vanderbilt University
Annie Rahman, MSW	California Association of LTC Medicine
Jo Taylor, RN, MPH	The Carolinas Center for Medical Excellence
Mary Perloe, GNP	The Georgia Medical Care Foundation
Dan Osterweil, MD	California Association of LTC Medicine
Alice Bonner, PhD, GNP	Center for Medicare and Medicaid Services

In collaboration with participating nursing homes

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The INTERACT Program: What is It and Why Does It Matter?

INTERACT™

(“***Interventions to Reduce Acute Care Transfers”***)

Is a **quality improvement program** designed to improve the care of nursing home residents with acute changes in condition

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The INTERACT Program: What is It and Why Does It Matter?

INTERACT™

- Includes evidence and expert-recommended clinical practice tools, strategies to implement them, and related educational resources
- The basic program is located on the internet:

http://interact2.net

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The INTERACT Program: What is It and Why Does It Matter?

Acknowledgement

The INTERACT Program and Tools were initially developed by Joseph G. Ouslander, MD and Mary Perloe, MS, GNP at the Georgia Medical Care Foundation with the support of a contract from the Center for Medicare and Medicaid Services.

The current version of the INTERACT Program, including the INTERACT II Tools, educational materials, and implementation strategies were developed by Drs. Ouslander, Gerri Lamb, Alice Bonner, and Ruth Tappen, and Ms. Laurie Herndon with input from many direct care providers and national experts in a project based at Florida Atlantic University supported by The Commonwealth Fund. The Commonwealth Fund is a private foundation supporting independent research on health policy reform and a high performance health system.

The INTERACT Program: What is It and Why Does It Matter?

- Can help your facility safely reduce hospital transfers by:
  1. ***Preventing conditions from becoming severe*** enough to require hospitalization through early identification and assessment of changes in resident condition
  2. ***Managing some conditions in the NH*** without transfer when this is feasible and safe
  3. ***Improving advance care planning*** and the use of palliative care plans when appropriate as an alternative to hospitalization for some residents

The INTERACT Program: What is It and Why Does It Matter?

- The goal of ***INTERACT*** is to improve care, ***not to prevent all hospital transfers***
  - In fact, ***INTERACT*** can help with ***more rapid transfer of residents who need hospital care***

The INTERACT Program: What is It and Why Does It Matter?

A Tale of Three Siblings

- Sadie
- Sara
- Sam

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The INTERACT Program: What is It and Why Does It Matter?

Sadie

A 96 year old long-stay NH resident

- Hospitalized for UTI and dehydration
- Discharged back to the NH after 4 days
- Re-hospitalized 7 days later for dehydration and recurrent UTI

Avoidable?

INTERACT strategy:

- ***Prevent conditions from becoming severe*** enough to require hospitalization through early detection and evaluation

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The INTERACT Program: What is It and Why Does It Matter?

Sara (Sadie's younger sister)

A 92 year old long-stay NH resident

- Hospitalized for a lower respiratory infection, but had normal vital signs and oxygen saturation
- Developed delirium in the hospital, fell, fractured her pubis, and developed a pressure ulcer

Avoidable?

INTERACT strategy:

- ***Manage some conditions in the NH*** without transfer

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The INTERACT Program: What is It and Why Does It Matter?

Sam (Sara and Sadie's older brother)
A 101 year old long-stay NH resident

- Hospitalized for the 4th time in 2 months for aspiration pneumonia related to end-stage Alzheimer's disease
- Transferred to hospice on the day of admission

Avoidable?

INTERACT strategy:

- ***Improve advance care planning*** and the use of palliative care plans when appropriate as an alternative to hospitalization

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The INTERACT Program: What is It and Why Does It Matter?

INTERACT™

- Communication Tools
- Decision Support Tools
- Advance Care Planning Tools
- Quality Improvement Tools

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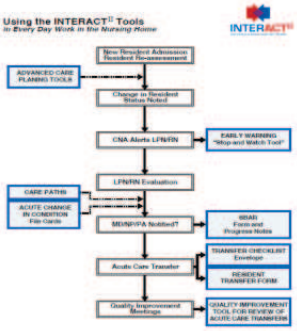
The INTERACT Program: What is It and Why Does It Matter?

The ***INTERACT II*** tools are meant to be used together in your daily work in the nursing home

http://interact2.net



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The INTERACT Program: What is It and Why Does It Matter?

- Questions?
- Comments?
- Suggestions?

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INTERACT
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Decreasing Re-Hospitalizations Improves Resident's Lives

Re-hospitalizations means

- Pain and suffering for the Resident
- A break in quality care
- Unsustainable costs

The Alta Project

- **Milestones Achieved**

A Mind Set

All Committed to Decrease Re-hospitalizations

- Lorenzo Pelly, MD CMD CWSP
- Mary B. Healy, RN QIC
- TMF Specialists & Consultants
- Simon Mata, Administrator
- Norma Guerrero, RN DON
- Nurses
- CNAS
- Housekeepers
- Consultants of Alta Vista Ensign Group

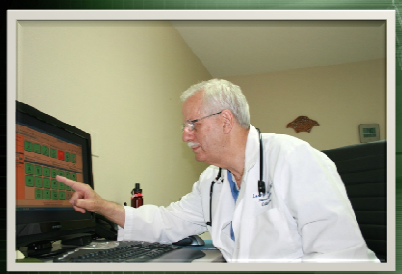
Not One, but We!

The Alta Pledge - We pledge

- To Provide excellent medical, humane care to all our residents.
- To decrease re-hospitalizations by at least 20%.
- To achieve our goal in less than 2 years.
- To learn from the process and to pass to others the knowledge gained.
- To bend downward the Medicare and Medicaid cost curve

Staff, Residents, and Family

Medical Director – Coach & Traffic Controller



Tools to Achieve our Goals

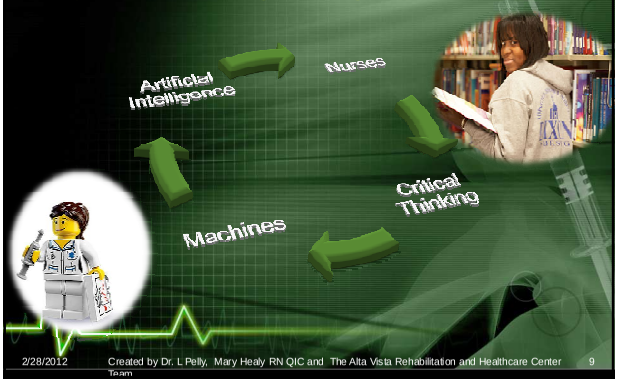
- CTT - Care Transition Team
- NRT – New Resident Team
- STNT – Specially Trained Nursing Team
- PC Option - Palliative Care
- RCA - Root Cause Analysis
- Care Paths
- Paperless – EMR, Order Entry
- Computerized facility

CTT - Care Transition Team integrated by:

- CNA Director
- Housekeeping Director
- DON
- MDS Nurse
- Pharmacist Consultant
- Dietitian
- Marketing Director
- Administrator

Enhance the Role of the Nurse on the Care Team

Expand Critical Thinking in Nursing Staff



STNT - Specially Trained Nursing Team

- STNT members include 1 nurse per shift to cover 24 x 7 the Rehab/Healthcare Center
- STNT nurses receive special training to improve Resident Assessment, Documentation, Critical Thinking and Compliance
- STNT protocols were created to deal with most common clinical scenarios

Alta Vista STNT Cart

NRT - New Resident Team

- DON
- Pharmacist Consultant
- Dietitian
- CNA Director
- MDS Nurse
- Medical Director

Residents prioritized on admission dates

CHF

COPD

Pneu

T2DM

Dots placed under residents names

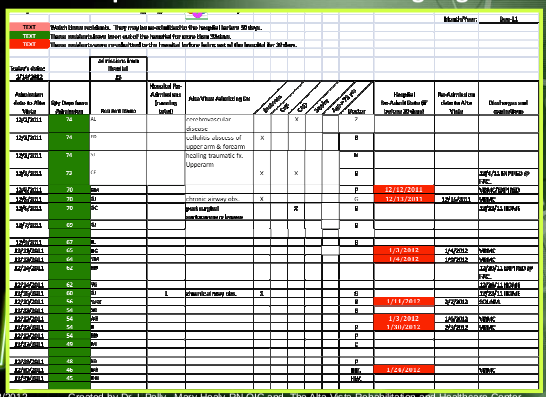
NRT Responsibilities

- Place all new residents close to nurses station
- Review all medications to avoid duplications, omissions and drug to drug interactions
- Dietary recommendations and fluid restrictions are effective immediately
- Vital signs and nursing visits are doubled

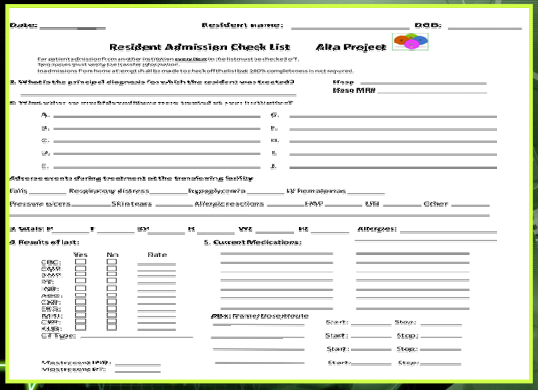
Our Goals and Efforts

- To provide a place that will enrich the quality of life of our residents
- To decrease Re-Hospitalizations
- To minimize financial hardship

Hospital Re-Admission Tracking Log



Resident Admission Check List



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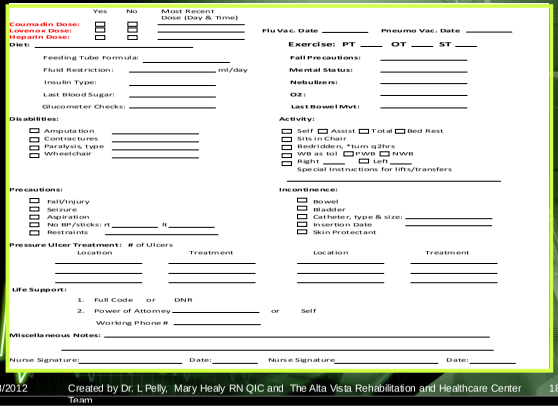


Alta Project Banner
ALTA
PROJECT


This employee has 5 STOPS (the patch is awarded for the first one, and a star for subsequent STOPS).


THE END
Thank You!
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2/28/2012
Created by Dr. L Pelly Mary Healey RN,QIC and The Alta Vista Rehabilitation and Healthcare Center team
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