Providing operational and financial consulting services to senior care and community-based organizations

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Drive Facility-wide Quality of Care Improvements through Post-Acute Analytics

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Learning Objectives

- Understand the benefits of post-acute data transparency to achieve measurable performance goals and improve patient care
- Identify key facility performance metrics to monitor clinical improvements and reduce costs at both the patient and facility level
- Learn best practices and strategies to reduce readmissions, mitigate risk, and increase hospital referrals

Why data transparency is the most important performance metric for health care

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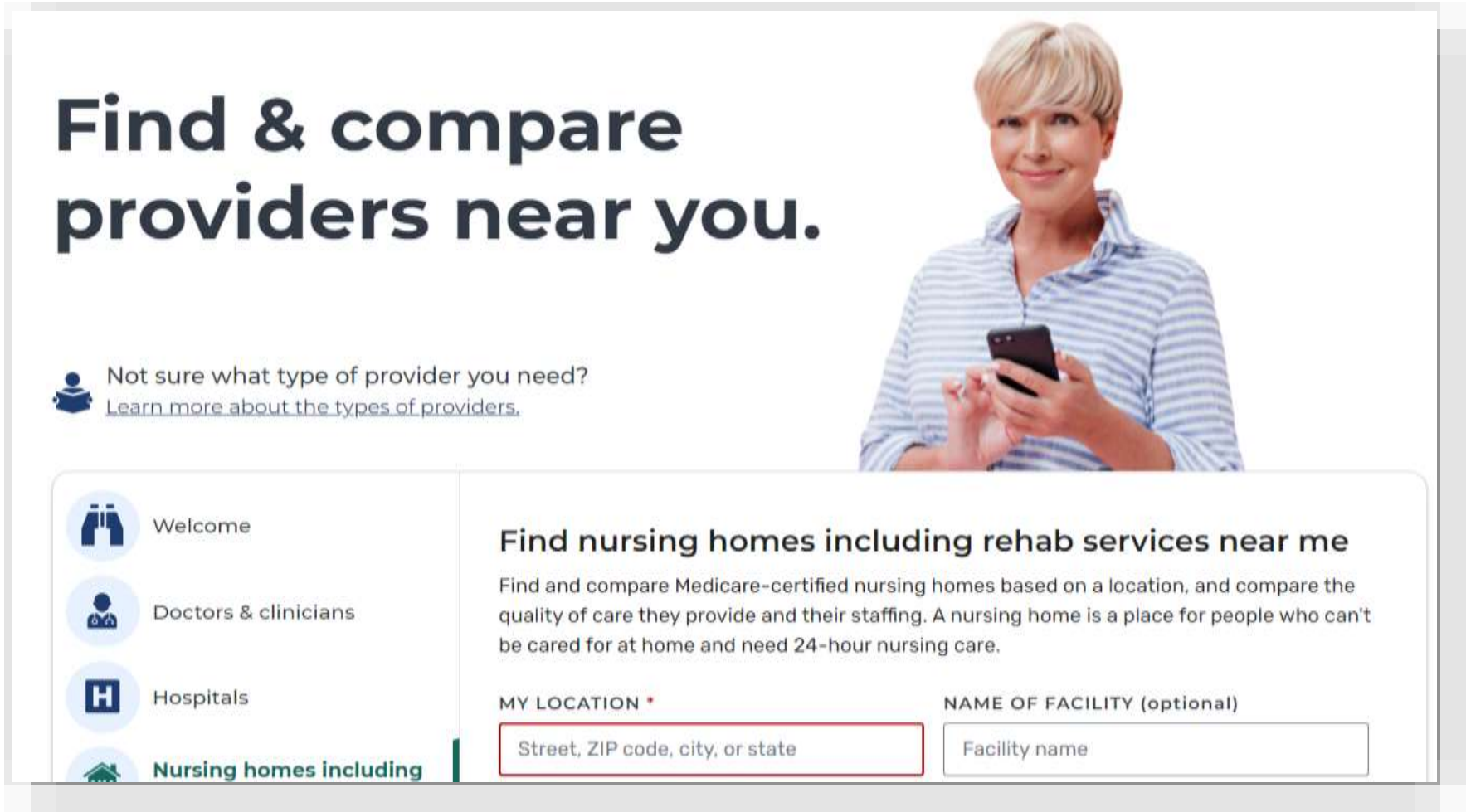
Nursing Home Compare



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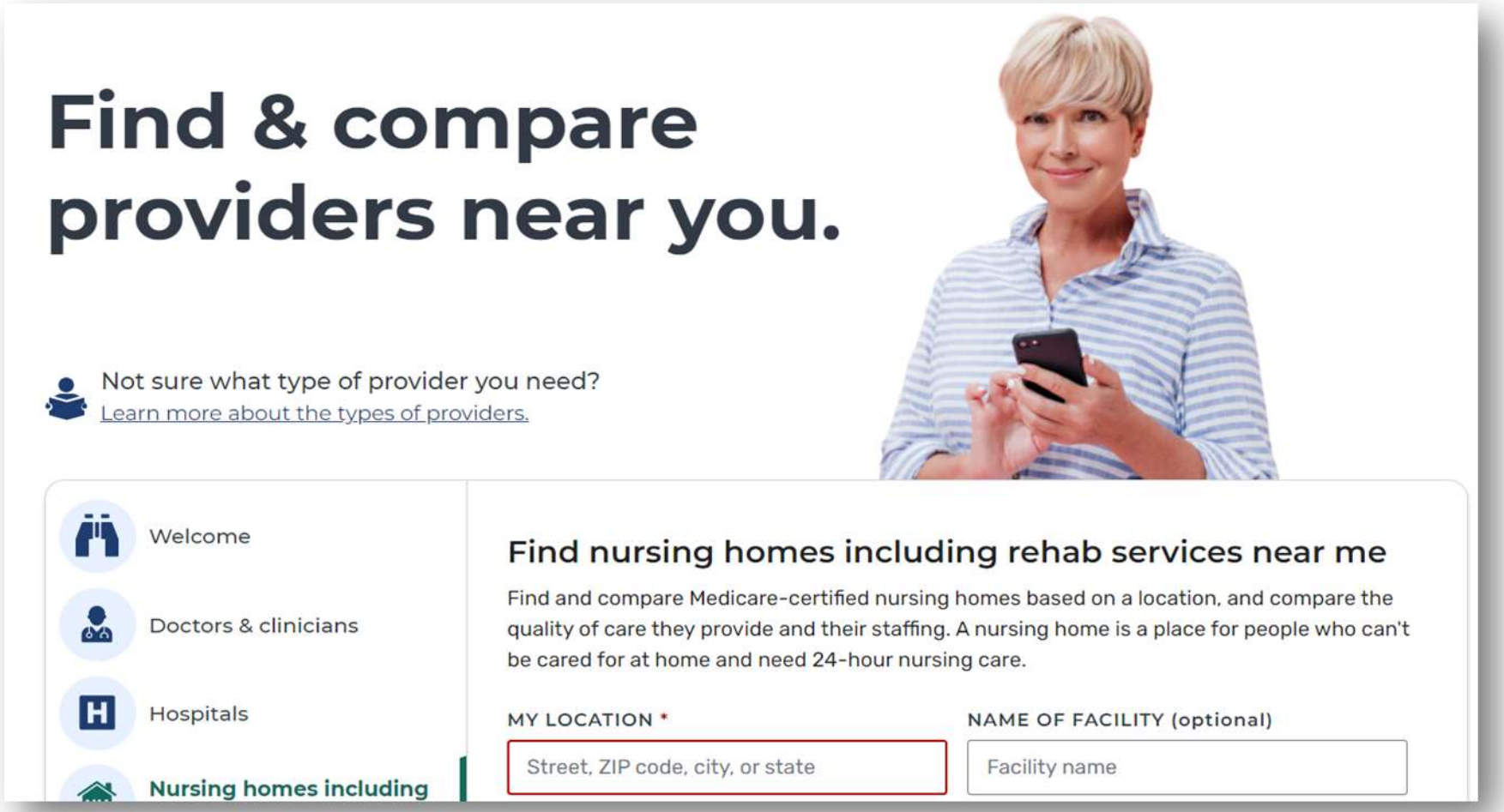
Home Health Services Compare



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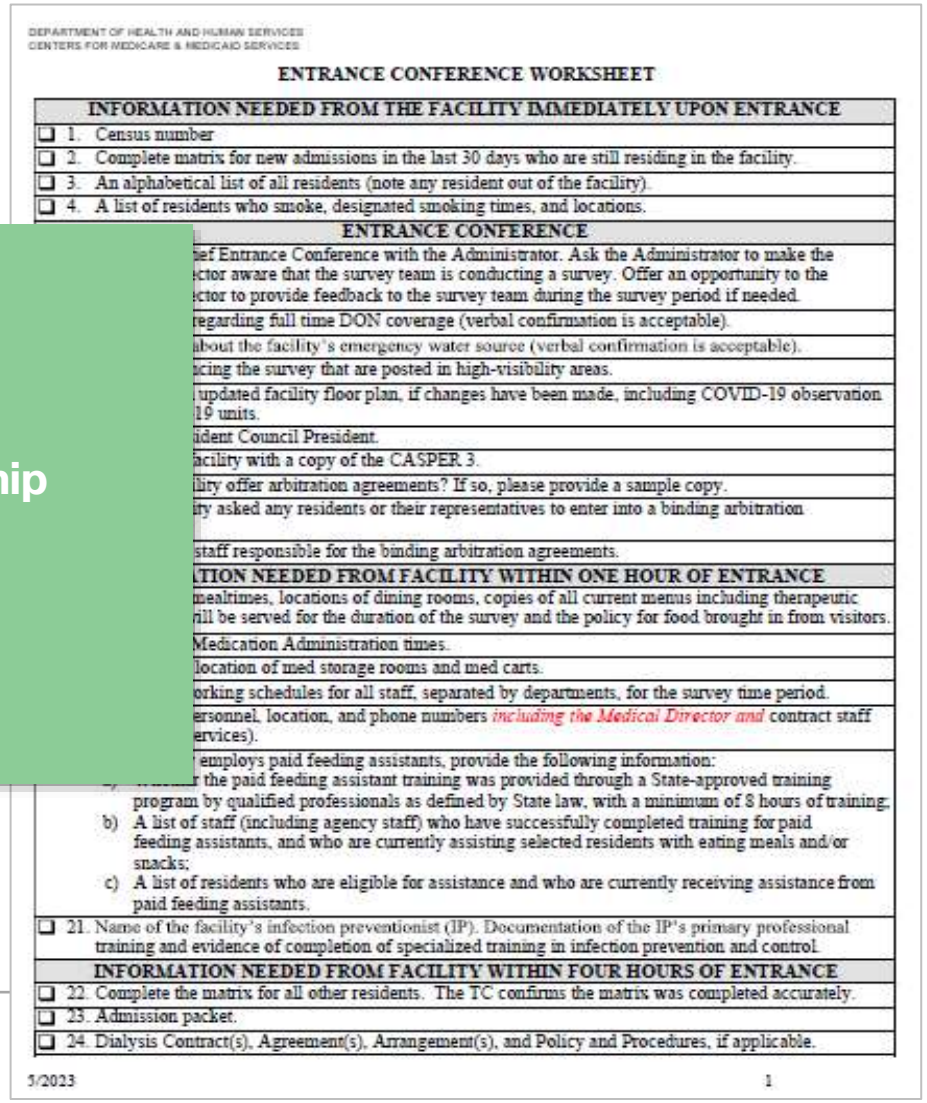
Data Required within 4 Hours of Entrance

30. Infection Prevention and Control Program Standards, Policies and Procedures, to include the Surveillance Plan, and Antibiotic Stewardship Program.

31. Influenza / Pneumococcal Immunization Policy & Procedures.



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

ENTRANCE CONFERENCE WORKSHEET

INFORMATION NEEDED FROM THE FACILITY IMMEDIATELY UPON ENTRANCE
❑ 1. Census number
❑ 2. Complete matrix for new admissions in the last 30 days who are still residing in the facility.
❑ 3. An alphabetical list of all residents (note any resident out of the facility).
❑ 4. A list of residents who smoke, designated smoking times, and locations.
ENTRANCE CONFERENCE
ief Entrance Conference with the Administrator. Ask the Administrator to make the ctor aware that the survey team is conducting a survey. Offer an opportunity to the ctor to provide feedback to the survey team during the survey period if needed.
regarding full time DON coverage (verbal confirmation is acceptable).
about the facility's emergency water source (verbal confirmation is acceptable).
cing the survey that are posted in high-visibility areas.
updated facility floor plan, if changes have been made, including COVID-19 observation 19 units.
ident Council President.
acility with a copy of the CASPER 3.
lity offer arbitration agreements? If so, please provide a sample copy.
ty asked any residents or their representatives to enter into a binding arbitration
staff responsible for the binding arbitration agreements.
TION NEEDED FROM FACILITY WITHIN ONE HOUR OF ENTRANCE
mealtimes, locations of dining rooms, copies of all current menus including therapeutic rill be served for the duration of the survey and the policy for food brought in from visitors.
Medication Administration times.
location of med storage rooms and med carts.
orking schedules for all staff, separated by departments, for the survey time period.
ersonnel, location, and phone numbers *including the Medical Director and* contract staff ervices).
employs paid feeding assistants, provide the following information: r the paid feeding assistant training was provided through a State-approved training program by qualified professionals as defined by State law, with a minimum of 8 hours of training; b) A list of staff (including agency staff) who have successfully completed training for paid feeding assistants, and who are currently assisting selected residents with eating meals and/or snacks; c) A list of residents who are eligible for assistance and who are currently receiving assistance from paid feeding assistants.
❑ 21. Name of the facility's infection preventionist (IP). Documentation of the IP's primary professional training and evidence of completion of specialized training in infection prevention and control.
INFORMATION NEEDED FROM FACILITY WITHIN FOUR HOURS OF ENTRANCE
❑ 22. Complete the matrix for all other residents. The TC confirms the matrix was completed accurately.
❑ 23. Admission packet.
❑ 24. Dialysis Contract(s), Agreement(s), Arrangement(s), and Policy and Procedures, if applicable.

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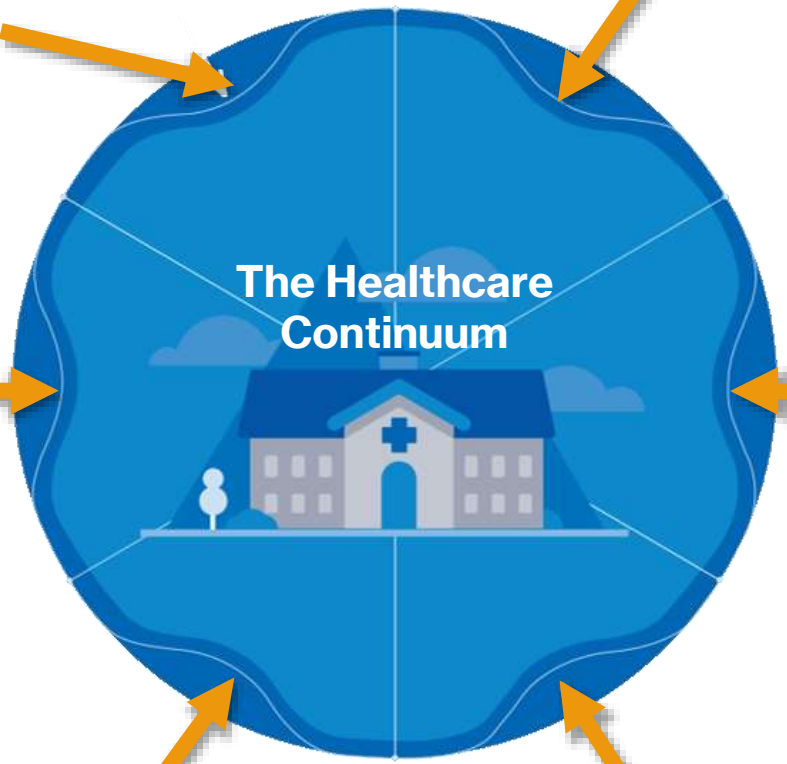
Continuum Changes



Greater accountability for outcomes (VBP)

Reimbursement changes (PDPM)

Quality Management and survey pressures

Staffing, turnover, and scheduling

Sicker patients discharged from the hospital sooner

Disappearing margins

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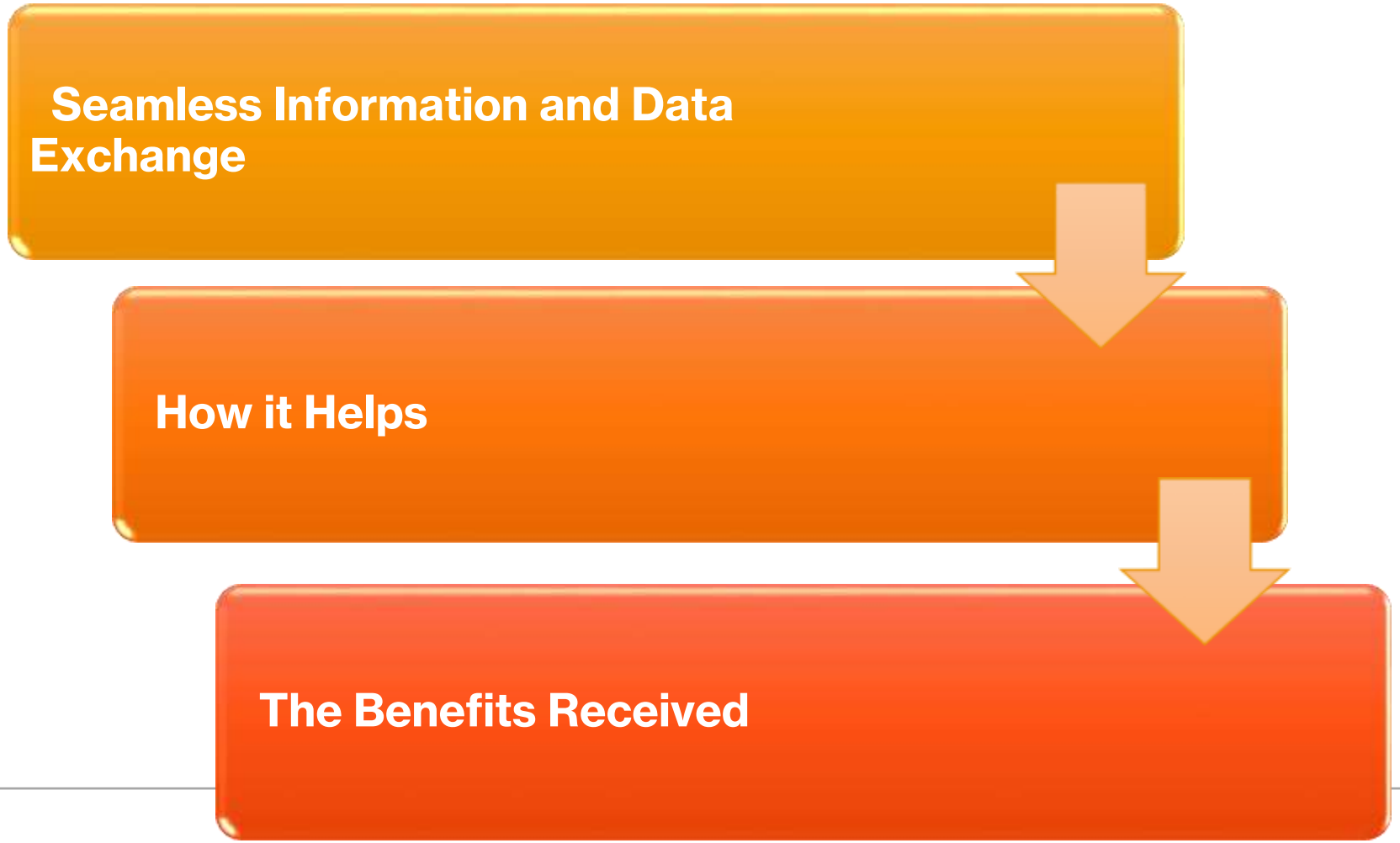
Post-Acute Interoperability



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PAC Analytic Technology – What's Important?

- Capture live clinical data from the EHR
- Use interventional vs. predictive analytics
- No duplicate data entry
- Don't miss key words from nursing / progress / narrative notes
- Provide suggested clinical interventions
- Customizable alerts
- Calculate QMs before CASPER report
- CNA illogical coding analysis

- Immediate risk assessment, readmission risk scoring, readmit and LOS trending by diagnosis
- Infectious disease outbreak monitoring
- Automated, centralized infection control and antibiotic stewardship
- HAI vs. CAI analysis
- Accessibly from IOS or Android devices
- Availability of LIVE Notifications

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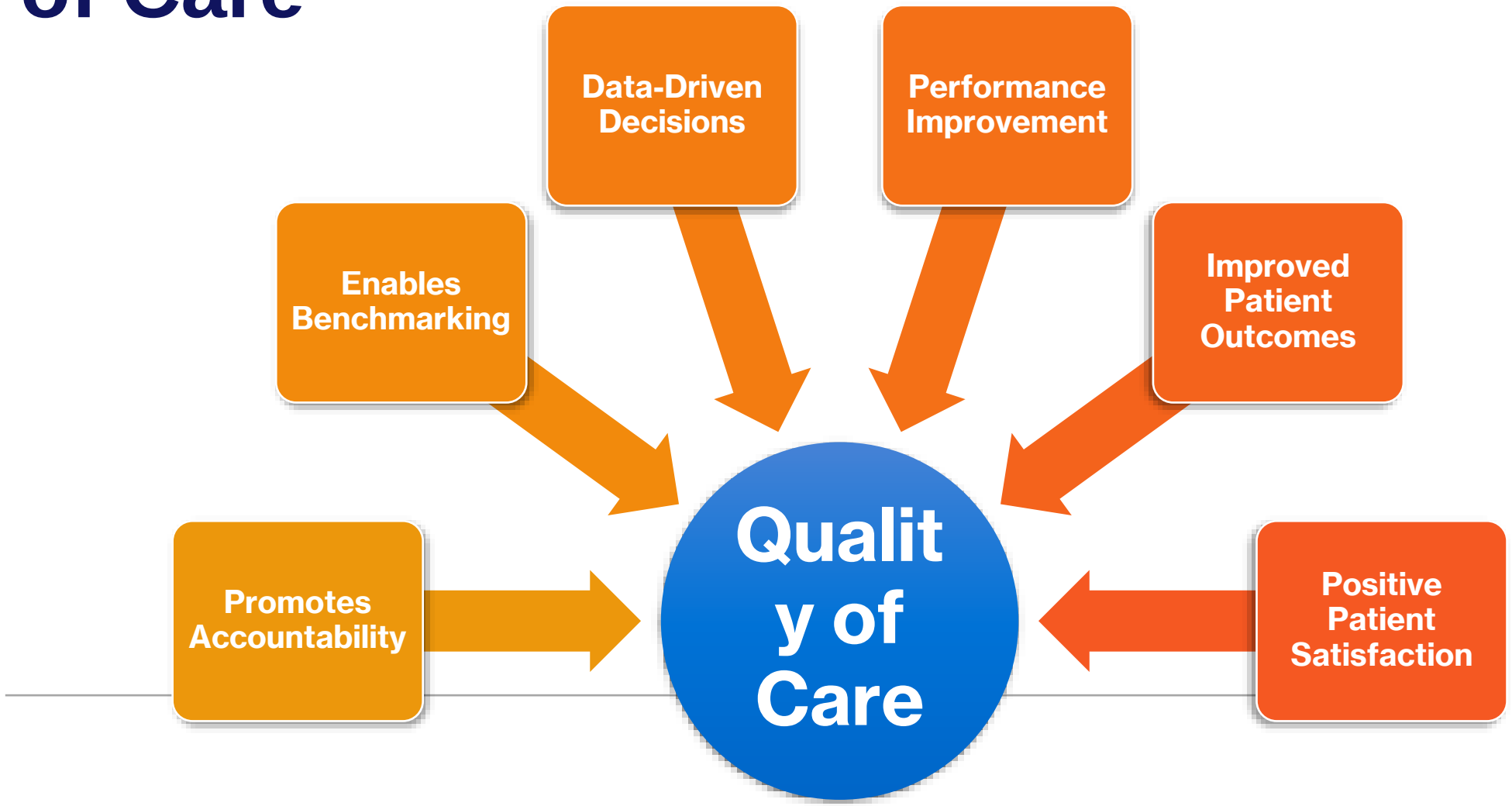
PAC Data Transparency Drives Quality of Care



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Collaborative Care through Interventional Moments

- Data at the patient level
- Unlock the EHR to drive clinical outcomes
  - Identify subtle clinical changes
  - Uncover trends in symptoms
  - Include risk stratification
- Share subtle clinical changes with acute care partner
- Work together to mitigate risk
- Work together on standards of care
- Work together on plan of care at individual level

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Adjust for Acuity & Provide Patient-Centered Care

- Identify and implement Advance Care Planning directives
- Initiate Clinical Care Pathways based on AMDA suggestions
  - Communicate priority care residents to all levels of caregivers and focus of care
  - Disease management and symptom identification
  - Establish alerts based on critical vital signs
  - Infection alerts
- Maximize supervisor oversight
  - Highest license for highest priority care
- Identify residents that require ADL support
  - Manage patient Division of Care based on ADL support

Work together with one or more members of the health care team, each of them make a unique contribution toward achieving a common goal.

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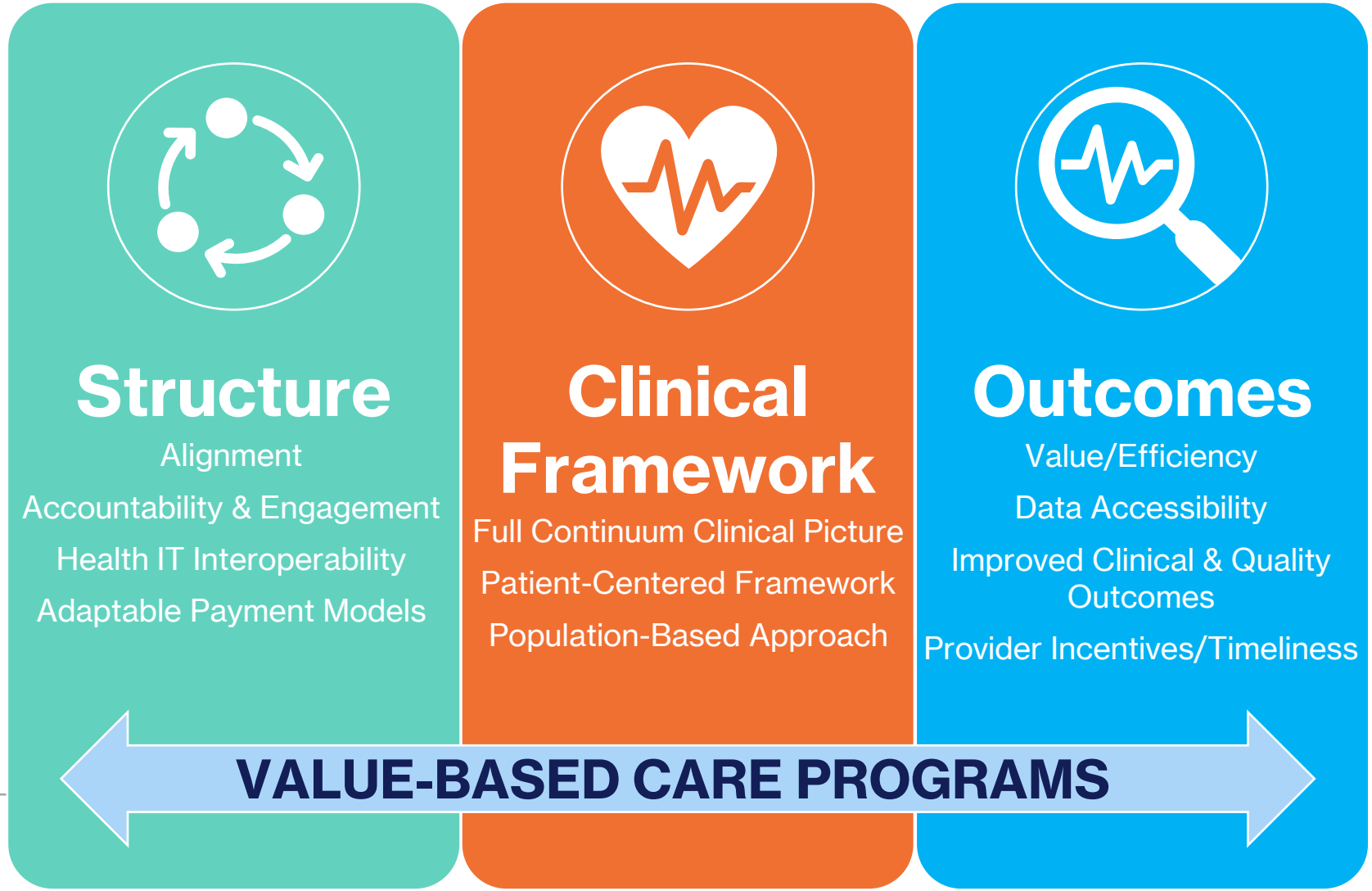
Foundational Principals of VBC Performance



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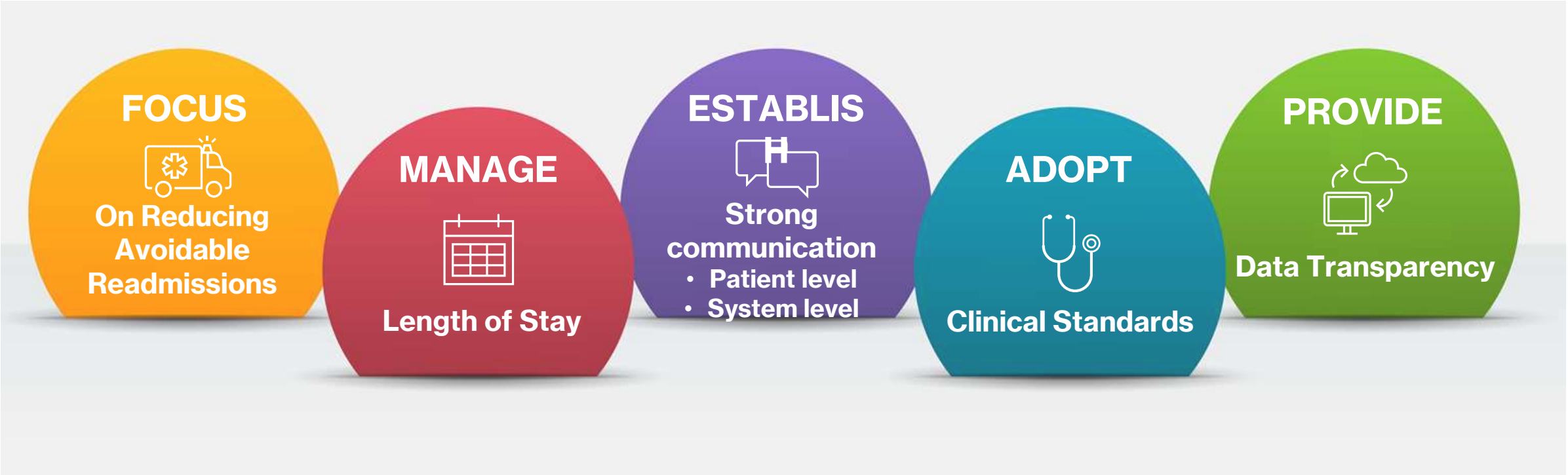
5 Strategies to Become a Strong VBC Provider



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Why is Customer Experience Important?

- Customer loyalty
- Customer satisfaction
- Increased word-of-mouth, positive reviews, and recommendations

- Customer Experience > Customer Service
  - Overall perception of community, based on interaction
  - Refers to specific touchpoints within the experience

SNF Focus for Value-based Patients in a Network

- Maintain census while reducing hospital readmissions
  - Readmissions
  - Length of Stay
  - Standardized care pathways – best evidence practice
  - Consider the addition of Advance Practice Providers
- Facilitate effective Care Management
  - Transitions of care
  - Discharge preparation and management
  - Manage chronic disease
- Optimize your reimbursement with QIP incentives
  - Quality metrics
  - Share best practices

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Performance Metric Considerations

- Readmission rate
- Average length of stay
- Five-star rating
- Patient experience
- Patient satisfaction
- Clinical outcomes

Decreased Hospital Readmissions = Referrals

	Leading Causes of Readmissions[1]	How Data Analytics Makes an Impact
#1	**Infection**	Infection risk reports for both structured and unstructured EHR data
#2	**Heart Failure**	Complex alerts including weight gain, shortness of breath, and edema
#3	**Diabetes**	Blood sugar alerts
#4	**COPD**	Respiratory rate and pulse oximetry alerts
#5	**Psychotic Disorders**	Behavioral alerts

(1) Source: Department of Health and Human Services, Agency for Healthcare Research and Quality, Healthcare Cost and Utilization Project (HCUP) Statistical Brief #278: Overview of Clinical Conditions With Frequent and Costly Hospital Readmissions by Payer, 2018 (July 2021)
https://www.hcup-us.ahrq.gov/reports/statbriefs/sb278-Conditions-Frequent-Readmissions-By-Payer-2018.jsp

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Benefits of Utilizing Live Data in VBC Initiatives

- Connecting the continuum for better outcomes and less redundancy
- Earlier identification of change in condition allowing timely intervention
- Ability to share key data with referral partners – strengthening partnerships
- Insight into highest risk patients
- Improved patient outcomes by tracking patient data and analytics
- Enterprise view of facilities with greatest opportunity related to rehospitalization and Quality Measures

Live Data Improving Quality of Care

- Allows for PROACTIVE monitoring of potential triggers
- Provides IDT collaboration to implement interventions
  - Restorative
  - Therapy option – PT, OT, Speech
  - Pain management
  - Toileting
- Look at Quality Measures for Cross Walk interactions
- Provides intuitive monitoring within the 90-day MDS cycle

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Utilize Live Clinical Analysis to Improve Care

Manual Process

Conduct Morning Meeting

Review patients' charts to determine which patients need care first

...

Follow up on Patient Care

Begin rounds to determine what diagnoses are causing a change in condition

Readmission Occurs

Because a diagnosis and interventional care were not identified sooner, the patient is readmitted to the ED

Live Data Analytics Process

8:00am

Conduct Morning Meeting

View live data on each patient, immediately identify high-risk patients, with diagnoses and suggested clinical interventions

8:25am

Follow up on Patient Care

Deploy targeted resources and follow up on action steps to ensure desired outcomes are met and readmission is avoided for those patients who need immediate care

10:30am

10:45am

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Live Data Analytics for Proactive Preventative Care

- Partnering across the Care Continuum; identify high risk patients
  - Break the readmission cycle
  - Eyes on clinical data – identify subtle changes
  - Interventions at the facility – support outpatient testing and treatment efforts
  - Engagement with specialists
  - Educate facility staff on clinical strategies and new technology
- Care Coordination among teams
- Mitigate risk by proactively intervening with care and treatment
- Insight into facility performance versus others
- Data Relevance
  - Patient baselines versus just industry
  - Facility/Enterprise performance compared to State/National level
- Using QAPI metrics to improve care
  - Diagnosis trend
  - Date of Transfer
  - Change of Conditions with interventions
  - Facility/Region/Corporate trends

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Live Data Analytics Can Provide Support Care

- Risk assessments
- Keyword alerts
- Subtle resident-specific baseline changes
- Treatment interventions
- Meet regulatory standards for care
- Recognize infections
- Identify Advance Care Planning potential
- Identify new diagnosis for documentation compliance

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Risk Stratification

- Elements that go into identifying high-risk patients:
  - Number of clinical issues that occurred within last 72-hours
  - Admission recency – fewer days will increase the score
  - Readmission history – have there been any hospital or ER visits in the last 180 days?
  - Assign a diagnosis score, based on specific, active diagnoses / comorbidities
- ***Automate these elements with technology that uses live data to know what is going on with your whole resident population, at-a-glance***

C — **Clinical Alerts**
Number of clinical alerts that occurred in the last 72 hours

A — **Admission Recency**
Based upon number of days since admission, with fewer days increasing score

R — **Readmission History**
Scored if any hospital or ER visits in the last 180 days

D — **Diagnosis Score**
Based upon existence of specific, active diagnoses / comorbidities

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Equip IP with the Right Data

Infection Preventionist guides and informs Antibiotic Stewardship efforts:

- Identifies evidence-based guidelines to inform facility on initiating antibiotics and treating infections
- Educates staff, residents, and families of facility antibiotic use and prescribing policies
- Conducts process surveillance to monitor antibiotic use and assess adherence to antibiotic prescribing and use policies
- Conducts outcome surveillance for infections and antibiotic-resistant organisms to monitor impact of antibiotic stewardship efforts

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Best Practice Considerations

Establish Communication | Facility/Resident Level

- **Who?**
  - Hospital – Post-Acute Case Manager
  - ACO/Bundle – Case Manager
- **When?**
  - At least weekly
  - Ad hoc when condition changes
- **How?**
  - Secure email
  - Weekly virtual meetings
- **Why?**
  - ACO's
  - Bundles
  - Hospital Readmission Reduction Program – HRRP – penalties
- **What?**
  - Clinical changes that may result in readmission
  - Declining clinical status
  - Non-progression

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Adopt Clinical Standards

- Standardization and repetition of care sequences brings better outcomes
- Staff know what is expected and drive care to those standards/outcomes
- Balancing acute care mindset with rehabilitative philosophies
- Concentrating post-acute case types in one area of your facility
- Working with your hospital / health system to identify case types to standardize care and utilize national guidelines

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Communication of the Right Data is Crucial

SBAR Communication Form

and Progress Note for RNs/LPN/LVNs

INTERACT Version 4.0 Tool

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

- ☐ **Evaluate the Resident/Patient:** 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/Patient Description

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

Primary diagnoses _____

Other pertinent history *(e.g. medical diagnosis of HF, DM, COPD)* _____

Medication Alerts

☐ Changes in the last week *(describe)* _____

☐ Resident/patient is on *(Warfarin/Coumadin)* Result of last INR: _____ Date ____/____/____

☐ Resident/patient is on other anticoagulant *(direct thrombin inhibitor or platelet inhibitor)*

Resident/patient is on: ☐ Hypoglycemic medication(s) / insulin ☐ Digoxin

Allergies _____

Vital Signs

BP _____ Pulse _____ (or Apical HR _____) RR _____ Temp _____ Weight _____ lbs. (date ____/____/____)

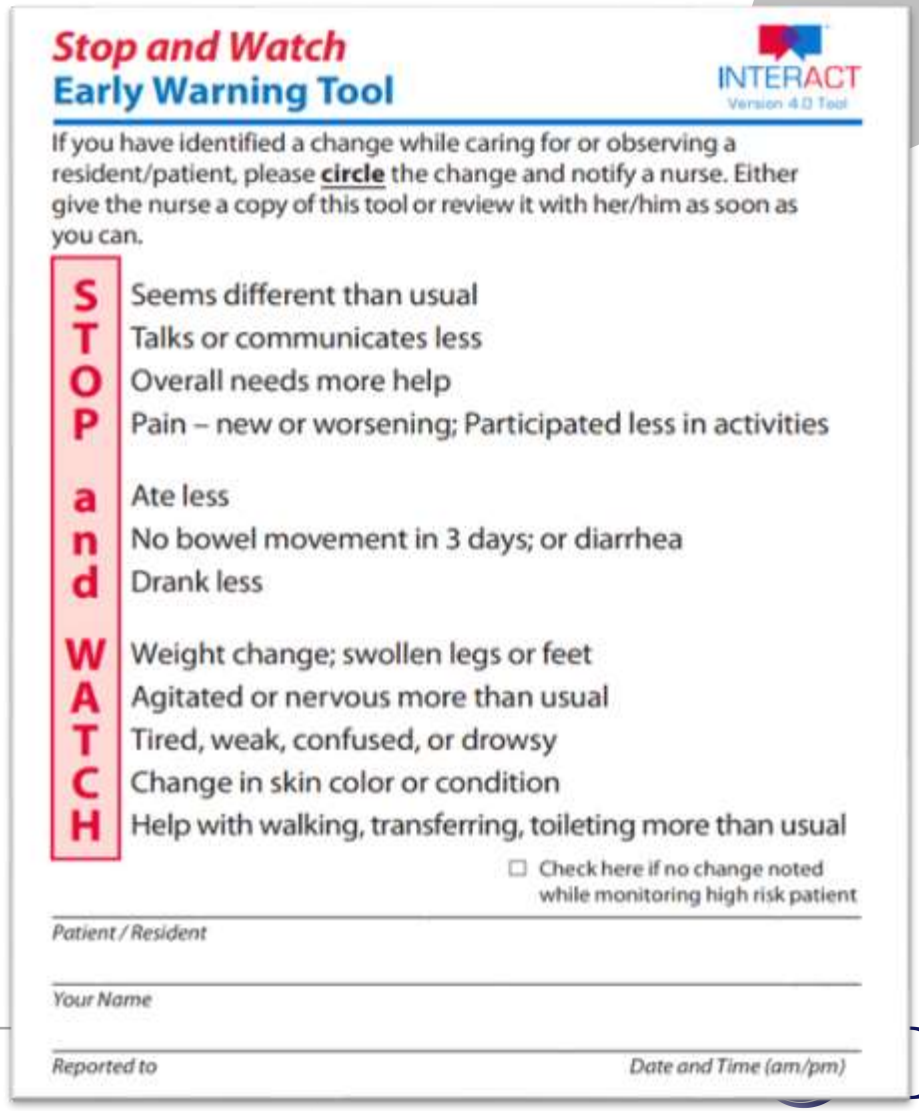
For HF, edema, or weight loss: last weight before the current one was _____ on ____/____/____

Pulse Oximetry *(if indicated)*: _____ % on ☐ Room Air ☐ O_2 @ _____

Blood Sugar *(Diabetics)*: _____

Resident /Patient Name _____

(continued)



Stop and Watch
Early Warning Tool

INTERACT Version 4.0 Tool

If you have identified a change while caring for or observing a resident/patient, please **circle** the change and notify a nurse. Either give the nurse a copy of this tool or review it with her/him as soon as you can.

S Seems different than usual
T Talks or communicates less
O Overall needs more help
P Pain – new or worsening; Participated less in activities

a Ate less
n No bowel movement in 3 days; or diarrhea
d Drank less

W Weight change; swollen legs or feet
A Agitated or nervous more than usual
T Tired, weak, confused, or drowsy
C Change in skin color or condition
H Help with walking, transferring, toileting more than usual

☐ Check here if no change noted while monitoring high risk patient

Patient / Resident

Your Name

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

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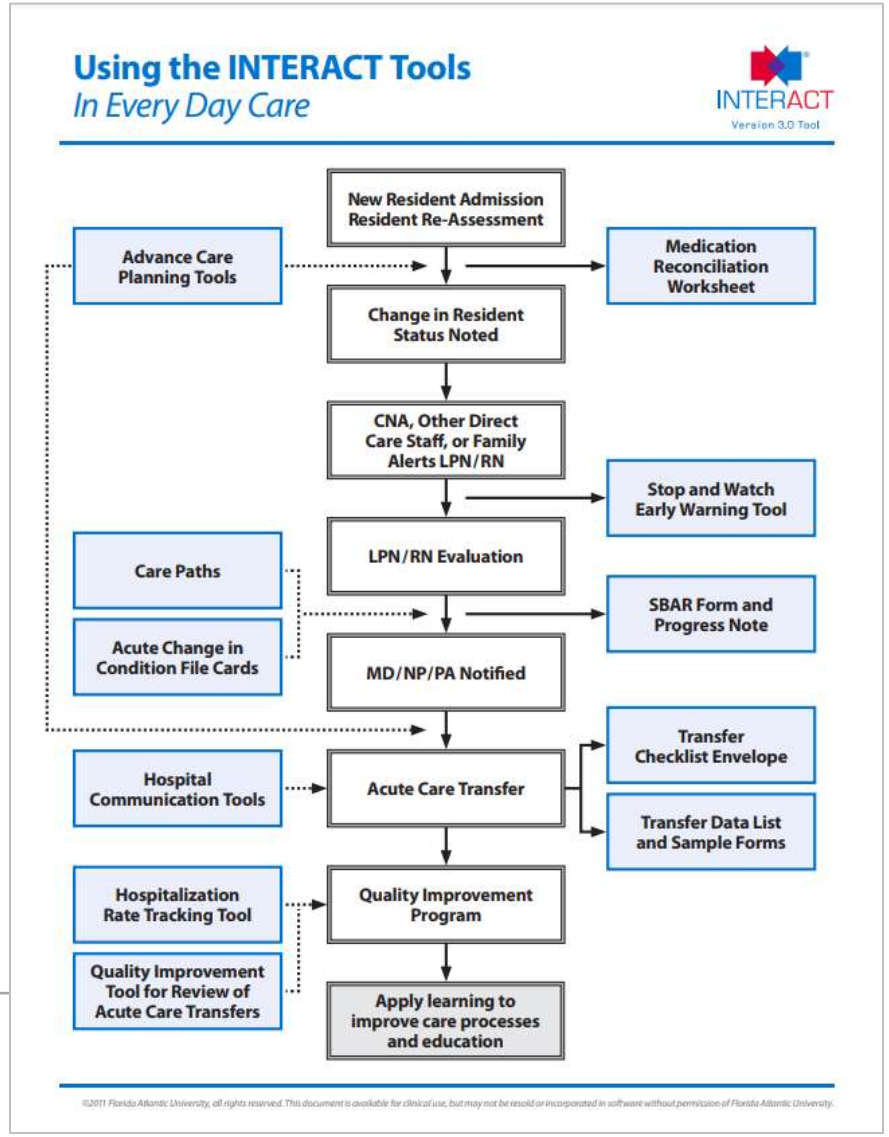
Clinical Pathway Implementation

- Identify risk and change in condition
- Standard evaluation tool across care lines
- Provide thorough and accurate assessments
- Effective and complete transfer of information to physicians and Advance Practice clinicians
- Critical urgent care for changes
- Medication reconciliation process
- Care planning and Advance Care Planning
- Quality Process Improvement
- Documentation



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Prepare and Practice During Clinical Meeting

Data analytics support care to review:

- Risk assessments
- Keyword highlights
- Subtle resident specific baseline changes
- Treatment interventions
- Regulatory standards for care
- Recognize infections
- Advance Care Planning potential
- New diagnoses for documentation compliance

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Care Coordination

- Disease Management and Symptom Identification
  - Establish alerts based on critical vital signs
  - Infection risk alerts
- Maximize Supervisor Oversight
  - Highest license for highest priority care
  - Identify residents with new med orders (ATB, Anti-psych)
- Identify residents that require late loss ADL support
  - Manage patient Division of Care based on ADL Support

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Advance Care Planning

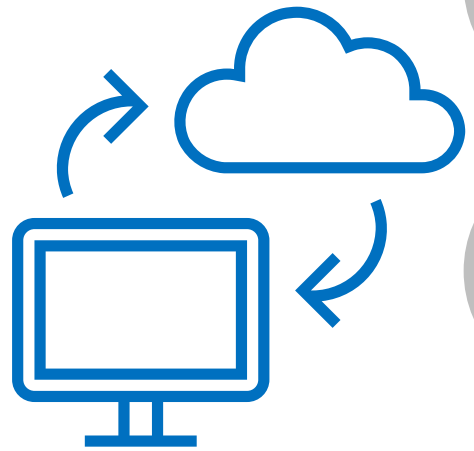
Standards of Care

- Enables structured, meaningful conversations on treatment plans
- May be based on diagnosis/care goals
  - Industry lab and test protocols
  - Industry standard interventions based on AMDA
- Preference focused care and treatment
- Prepares family for trajectory of care
- Reduces hospital readmissions

Resident Rights

- Focuses on patient personal preference
- All providers understand plan if diminished capacity
- Proactive planning for end-of-life place of treatment
- Reduces nurse's moral distress

Hospital and Alternative Care Settings



- Readmission Reviews
  - Readmission rates
  - Root cause analysis
  - Clinical trends in readmissions
    - LOS prior to readmit
    - Case Type or Dx of readmits
    - Time of day/day of week
    - Hospital System

- Hospital or community placement need
- Specialty care provider collaboration
- Provides a coordinated care response
- Shared risk assessment

Increase Point-of-Care

Automate key workflows and reallocate manual labor hours to bedside care

Staff	Duties	Monthly Hours
Infection Preventionist Nurse	Data analysis of every antibiotic order	1 / 20
DON	Reading 24-hour Report	4 / 60
Quality Measures RN	Develop PIPs and drive QMs	8 / 80
MDS Coordinator	Accurate MDS and IPA identification	1 / 10
RN Supervisor	Reduce readmissions and identify patient needs	2 / 30
Therapy	Focus on patient changes for therapy intervention	1 / 30

**The above table represents examples of how data analytics solutions can reduce administrative burden for various roles within your facilities.*

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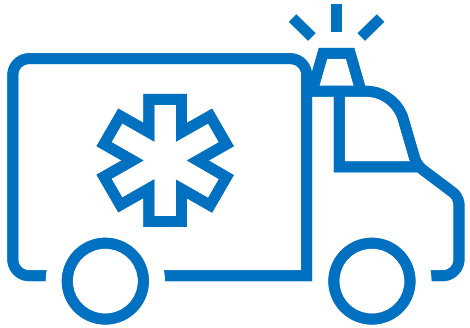
Break the Cycle of Readmissions



Focus on data-driven Quality Metrics for regulatory compliance

- CMS 5 Star Rating
  - Good Housekeeping seal of approval
  - Quality and staffing very important
  - Used when given “choice” to patients and families
- Successful Transition to Community
- Antibiotic Stewardship
  - Point Prevalence
  - Days of Therapy
  - Healthcare Acquired Infections

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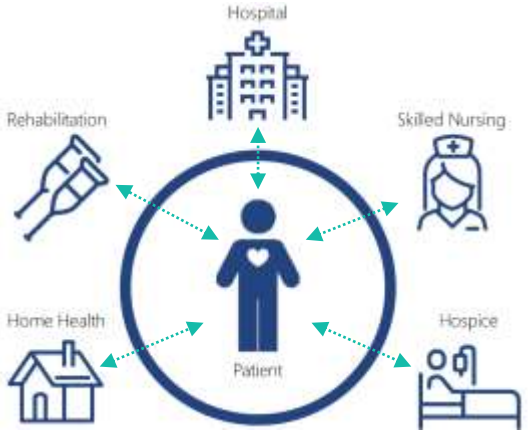
Improve Transitions of Care



- Coordinated clinical information and communication
- Warm handoffs from acute care facility
- Med reconciliation and availability
- Medical supplies available

- "On-boarding" meeting with care team,
  patient, and family
  - Identify goals of care
  - Estimated discharge date
  - Patient responsibility for care
- Advance Care Planning/Advanced Directives

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Clinical Plan of Care

- Resident-centric plan
- Communication tool for all staff
- Clear cut goals to include:
  - Diagnosis specific measures/assessments
  - Patient education
  - Functional status progression
  - Based on national/regional standards
  - Day by day progression
- Estimated discharge date
- Care metric measurements and goals

Long-Term Care's Core Success Factors

1. Quality clinical care
2. Create a positive community and public reputation
3. Successful transitions to community
4. Low readmissions to the hospital
5. Hospital System partnerships for care transition
6. Low turnover of staff and employee satisfaction
7. Effective Infection Control Program and surveillance

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Resource Page

- Nursing Home Compare
- CMS.gov: Quality Measures