Advancing Excellence, QAPI and INTERACT: common themes and initiative alignment around care transitions and hospitalizations

Alice Bonner, PhD, RN
Associate Professor
Northeastern University
November 20th, 2014

Disclosure
I am the former Director of the CMS Division of Nursing Homes. I am not currently a CMS official; I work as a contractor for CMS.

This handout is intended for use by this audience only. Please do not distribute.

Objectives
• Describe the 5 elements of QAPI and how QAPI can provide the foundation for other quality initiatives
• Discuss how using Advancing Excellence to select goals and measure outcomes may lead to better care, better health and lower costs (the triple aim) and can meet the intent of the QAPI requirement in the Affordable Care Act
Objectives

• Discuss how INTERACT or similar quality improvement models can be used as a platform for building and working with cross continuum teams to optimize care transitions
• Identify ways to ensure person-centered care using a strength-based approach

Well-Being Model


The Face of the Issue
Margaret Donovan

- 83 years old, was living at home
- Previous good health but recent problems
- Eyesight and hearing deficits
- Increasingly forgetful. House is run down; cluttered; poor lighting; stairs
- High blood pressure, CHF, COPD, arthritis, other co-morbidities
- Taking 5 medications irregularly
- Hospitalized twice in last year – due to a fall, dizziness and pain
- Now she's in your SNF or AL after a hospitalization for pneumonia

Is Mrs. Donovan at risk for rehospitalization?

- What can be done to mitigate the risks?
- Nursing process
  - Comprehensive Assessment
  - Problem identification/diagnosis
  - Care plan implementation
  - Monitoring
  - Evaluation

The Elderly and Disabled Populations are Growing Fast
Over 65 population

U.S. Census Bureau Population Projections

Changes in Cause of Death
Alzheimer’s is Continuing to Increase

People with Disabilities Are Increasing, too

Adults Age 18 or Older Reporting Disability by Sex and Age Group, United States

Source: CDC

Alzheimer's is Continuing to Increase
Sensory Impairments a Substantial Problem for Elders

Service Needs Are Changing

- Short-term, during immediate care transitions
  - Getting people back to work
  - High tech home, AL or SNF care
- Longer term care planning needs
  - Particularly people with cognitive impairment

Medicaid Spending in Long-Term Care
Who will make the case for person-centered care, quality and safety?

Meet Josie King

Partnership for Patients
Partnership for Patients: Better Care, Lower Costs

Nationwide public-private partnership to tackle all forms of harm to patients. CMS’ goals:

40% Reduction in Preventable Hospital Acquired Conditions over three years
- 1.8 Million Fewer Injuries
- 60,000 Lives Saves

20% Reduction in 30-Day Readmissions in Three Years
- 1.6 Million Patients Recover Without Readmission

Potential to Save $35 Billion in Three Years

National Vision

- Strong, Public Leadership Commitments – The Boards of all “Partnership” hospitals/nursing homes publicly embrace the aims of the initiative and remove barriers to progress.
- “Raise the Floor” – Every hospital/nursing home in the nation adopts and completely implements a set of evidence-based interventions.
- “Raise the Bar” – Vanguard hospitals/nursing homes seek to define and eliminate all-cause harm and preventable readmissions on an extremely ambitious timeframe (making their work transparent to all others with interest). QAPI adds other goals for nursing homes as well.
- Smooth Transitions between Care Settings – Hospitals, nursing homes, AL, communities, patients and families will devote new attention to making sure that transitions into and out of SNFs are well coordinated.

What are some of the resources successful cross continuum teams use to identify ways to reduce harm and unnecessary transfers?

- Advancing Excellence (AE) nursing home staff stability toolkit, consistent assignment, hospitalization tools/resources
- INTERACT (Interventions to Reduce Acute Care Transfers)
- Project RED, BOOST; measurement using the Care Transitions Measure (CTM-3)
- Culture of Safety (Team STEPPS)
A Proactive Approach to Improving Quality and Safety:

Transforming nursing homes through continuous attention to quality of care and quality of life

Why QAPI Now?

Section 6102(c) of Affordable Care Act

• Regulation
• Program of Technical Assistance for NHs
  – Tools & resources
  – Training materials

Description: What is QAPI?

• QA is a process of meeting quality standards and assuring that care reaches an acceptable level. Nursing homes typically set QA thresholds to comply with regulations.
• PI is a pro-active and continuous study of processes with the intent to prevent or decrease the likelihood of problems. PI identifies areas of opportunity and tests new approaches to fix underlying causes of persistent/systemic problems.
QA + PI = QAPI

QA and PI combine to form QAPI, a data-driven, proactive approach to:
• Improve the quality of life, care, and services in nursing homes
• Identify opportunities for improvement
• Address gaps in systems or processes
• Develop and implement an improvement or corrective plan
• Continuously monitor effectiveness of interventions.

Five element framework for NH QAPI

✔ Design and Scope
  ✔ Person centered care
✔ Governance and Leadership
✔ Feedback, Data Systems and Monitoring
✔ Performance Improvement Projects
✔ Systematic analysis and systemic action

Design and Scope

• Comprehensive, ongoing program
• Includes all departments & functions
• QAPI Plan addresses safety, quality of care, QoL, resident choice, transitions
  – Integration with the larger community, other partners such as hospitals, home health
• Based on best available evidence
Governance & Leadership

• Boards/owners & executive leadership are visible and engaged
• They dedicate sufficient resources to QAPI
• They do more than just review data – they act on it!
• Leadership is stable enough to promote sustainability

REAL LEADERS WEAR SNEAKERS!!
Feedback, Data Systems, and Monitoring

- Multiple sources, including residents & staff
- Benchmarking & targeting
- Adverse events

Performance Improvement Projects (PIPs)

- Prioritized topics (the number of PIPs depends on the program)
  - High risk, high volume, problem-prone areas
  - Not necessarily clinical topics
- Teams chartered
- Plan-Do-Study-Act or PDSA cycle

Performance Improvement: tracking both process and outcomes, managing through change
Systematic Analysis and Systemic Action

- Root cause analysis
- Systems thinking
- Systemic changes as needed
- Includes thinking about care across settings

QAPI Toolkits and Resources

- QAPI at a Glance
- QAPI process tools
- QAPI topic tools
- On-Line Learning modules
- Evidence & best practices
- Case studies
- On-line resource library

http://go.cms.gov/Nhqapi

How does QAPI align with other national quality initiatives around care transitions?

QAPI represent a shift to a systemic, comprehensive, data-driven, proactive approach to quality management and sustained improvement. This approach is exemplified in various quality initiatives such as

- National Partnership to Improve Dementia Care
- National Nursing Home Quality Care Collaborative
- CMS demonstration projects to reduce SNF hospitalizations – 7 sites use INTERACT and other interventions
- Advancing Excellence Quality Campaign
About the AE Campaign

- Mission: to make nursing homes better places to live, work and visit
- Largest national coalition (30 organizations) of nursing home stakeholders working together to help nursing homes improve care
- Voluntary for nursing homes (61.5% or 9,626 NHs registered!)
- Based on measurement of meaningful goals
- The data show that target setting works!
- www.nhqualitycampaign.org

About the AE Campaign

- National, Voluntary, Aligned

Registered Participant
- Register/Update Profile
- Select Goals

Active Participant
- Submit Data

Quality Improvement Resources for 9 Goals

- Hospitalizations
- Staff Stability
- Pressure Ulcers
- Medications
- Antipsychotics
- Consistent Assignment
- Infections
- C. difficile
- Mobility
- Person-Centered Care
- Pain Management
Organizational Goals

- Hospitalizations
- Staff Stability
- Pressure Ulcers
- Medications
- Antipsychotics
- Consistent Assignment
- Infections
- C. difficile
- Mobility
- Person-Centered Care
- Pain Management

Data and Quality Improvement Process

- How do I know where I am?
- Where do I want to be?
- What processes are associated with my outcome?
- When I change a process, how do I know it had the effect I wanted?

QAPI Strategy Number 5

Be a Continuous Learning Organization

5.b Change Concept: Track your progress:
- Measure important indicators of care relevant and meaningful to residents you serve
- Set stretch goals — Choose national, state or local performance benchmarks to beat
- Get everyone involved in setting
- Openly and transparently share performance data
QAPI Strategy Number 5

5.c Change Concept: Test, test, test!
- Identify and support a change agent for improvement project
- Choose someone to keep momentum
- Use a change methodology like PDSA (Plan, Do, Study, Act)
- Use templates and tools that are easy to use and guide systems thinking
- Use a multi-department and multi-disciplinary approach to improvement
- Involve people who care about the process being improved
- Set specific goals that staff and leadership personally own, believe in and understand their role in achieving
- Set up a scoreboard for staff to monitor progress towards important goals
- Celebrate success and find creative ways to reward and recognize staff who contribute to achievement of goals

AE Tracking Tools Support Both QA & PI

- Easy view of individual records allowing prescription-level scrutiny
- Matrix of individual data allows scanning for prescribing patterns
- Summary information helps identify opportunities to improve

The INTERACT Quality Improvement Program

A Practical Approach To Safely Reducing Rehospitalizations

Laurie Herndon, APRN-BC, GNP
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 Centers for Medicare & Medicaid Services (CMS).

- The current version of the INTERACT Program was developed by members of the INTERACT interdisciplinary team under the leadership of Dr. Joseph G. Ouslander, M.D. with input from many direct care providers and national experts in projects based at Florida Atlantic University (FAU) supported by The Commonwealth Fund.

INTERACT Strategies

1. Prevent conditions from becoming severe enough to require hospitalization through early identification and evaluation of changes in resident condition
2. Manage some conditions without transfer when this is feasible and safe
3. Improve advance care planning and the use of palliative care plans when appropriate as an alternative to hospitalization for some residents
4. Improve documentation and communication within LTC facilities and programs, and between LTC and acute care

Background: Why Focus on Rehospitalizations?

1 in 4 patients admitted to a SNF are re-admitted to the hospital within 30 days at a cost of $4.3 billion


Rehospitalizations of SNF and AL Residents are Common and Costly
Why Does This Matter?

- At risk for complications
  - Delirium
  - Polypharmacy
  - Falls
  - Incontinence and catheter use
  - Hospital acquired infections
  - Immobility, de-conditioning, pressure ulcers

At the beauty salon

Some Hospitalizations and Readmissions are Preventable

Several studies suggest that a substantial percent of hospital transfers, admissions, and readmissions are unnecessary and can be prevented

Health Care Reform

The Affordable Care Act is focused on the “triple aim:”
- Improving care
- Improving health
- Making care affordable

This presents major opportunities to improve geriatric care in the U.S.
Changes in Medicare and Health Care: Financing and Changing Incentives

- Pay-for-Performance ("P4P")
- No payment for certain complications; disincentives for avoidable hospitalizations
- Bundling of payments for episodes of care
- Accountable Care Organizations that include hospitals, physicians, home health agencies, and SNFs that are responsible for the care of a defined group of patients
- State Duals Programs and Medicaid Managed Care
- Other models - e.g., most recent CMS contracts for reducing unnecessary hospitalizations of long-stay NH residents

Background: Many Are Avoidable

Potentially Avoidable Hospitalizations for Elderly Long-stay Residents in Nursing Homes

Subjects: The population of interest is a cohort of long-stay NH residents. Data are from the Nursing Home Stay file, a sample of residents in 10% of certified NHs in the United States (2006–2008).

Results: Three-fifths of hospitalizations were potentially avoidable and the majority was for infections, injuries, and congestive heart failure.

We Are All In This Together

The Bottom Line: "Collaboration among hospitals and community-based providers is essential for improving transitions between care settings and keeping discharged patients out of the hospital. Fostering partnerships among providers, payers, and health plans can help identify causes of avoidable rehospitalizations and align programs and resources to address them."
CMS Pilot Study Results

1. Tools and implementation strategies were pilot tested in 3 Georgia NHs with relatively high hospitalization rates
2. Tools were acceptable to staff
3. Significant reduction in hospitalizations
4. Significant reduction in transfers rated as avoidable by an expert panel

Facilities | Mean Hospitalization Rate per 1000 resident days | Mean Change | p value | % Relative Reduction in All Cause Hospitalizations
--- | --- | --- | --- | ---
All INTERACT facilities (N = 25) | 3.99 | 3.32 | -0.69 | 0.02 | 17%
Engaged facilities (N = 17) | 4.01 | 3.13 | -0.88 | 0.01 | 24%
Not engaged facilities (N = 8) | 3.86 | 3.71 | -0.16 | 0.69 | 6%

Quality Improvement Tools

- How many transfers from your nursing home?
- When do they occur?
- How many days since admit?
- “Ah ha” moments
- Online version

Quality Improvement Tools

Root Cause Analysis: The Rest of the Story

- Demographics
- What happened
- Contributing factors
- Attempts to manage in SNF
- Avoidable?
- Staff thoughts about this
- Opportunities for improvement
- Cross-continuum review of cases

Communication Tools

Enhanced Nursing Assessment

- Builds on early recognition
- Standard approach
- MD/NP response
- Warm hand over
- How might this complement disease management?
Communication Tools

- Communication Tools Across Settings
  - Nursing Home Capabilities Checklist
  - Medication Reconciliation Worksheet
  - Transfer forms both directions
  - Data lists both directions
  - Can use as platform to start discussion about which elements nurses will use for warm hand off

Communication Tools: Not About The Forms

Decision Support Tools
Decision Support Tools

HIT INTER Tools Must be Visible and Accessible in Everyday Care

Implementation: the Power of One

- For the SNF: one unit, one nurse
- For the hospital: one SNF
- For HH/AL: one case
- For surveyors: one conversation
- For all: one CC meeting
For SNFs/ALs:
Interacting with Acute Care Hospitals

- Be prepared
- Initiate contact
- Know your data
- Share your story
- Know what tools/data/information you want to share
- Set date for next meeting

For SNFs/ALs:
Interacting with Acute Care Hospitals

- Lots of interest in this form
- Bring it with you
- Offer to update regularly
- Be sure you can do what you say you can

Interacting with SNFs/ALs and Acute Care Hospitals

“It is not about the forms: It is about the relationship”

Enhancing the relationship by using the Warm Hand Over
In Summary:

- The future is now. Payment reform is driving change.
- QAPI will be the foundation for quality improvement programs across settings.
- Advancing Excellence provides open access tools, resources and measures of success.
- Acute care hospitals, post-acute care and AL providers can work together around INTERACT, AE resources and other programs. Home health and HCBS providers are also important partners.
- Goal: develop a dynamic working relationship among health care team members across settings, centered around helping the person achieve his/her personal goals

Your Community Efforts

- What has worked well to improve transitions in your community/health system? Why?
- How have you engaged (activated) patients and caregivers?
- What are your biggest challenges?

Questions and Answers

- Thank you!
- Alice Bonner, Associate Professor
a.bonner@neu.edu

Northeastern University