Improving Clinical Outcomes Through Partnerships & Complex Care Models
Presented By: Kim Barrows, RN BSN
President Of KB Post Acute Strategic Specialists

Objectives

- Understanding Health Care Reform
- Implementing Specialized Clinical Programs to Assist in Reducing Unnecessary Hospital Readmissions
- Establishing Partnerships with Local Hospitals

ACOs
Bundled Payments
Penalties

The Affordable Care Act

ACO/Bundled Payment- Arizona

Source: Where Innovation is Happening, Centers for Medicare & Medicaid Services
Post-Acute Care Reform

- Oct 1st 2016 - CMS will share with you how you are performing as far as readmissions
- Oct 1st 2017 - Rates will be shared with the public on Nursing Home Compare
- Oct 1st 2018 - Rates will be cut 2%; based on your performance with readmissions you could get 98% of your rate or greater than 100%


Strategies For Success

- Advanced Directives
- Quality Care
- Preferred Provider
- Communication & Collaboration
- Decrease Unnecessary Readmissions
- Resident/Family Satisfaction

Strategies for Success

Advanced Data Collection
Analysis Tracking Log

Tracking Log Considerations

Discharges
- Interact Tools
- Palliative Care/Hospice
- Advanced Directives
- Education
Tracking Log Considerations

✓ Residents that were readmitted within the first 30 days for MI, Pneumonia, Heart Failure, COPD and Elective Knee and Hip Surgeries. Then include all other additional diagnosis.

✓ Were the specialized programs fully implemented?

✓ Which local hospitals are referring patients to you?

✓ What type of residents are you admitting to your facility?

Root Cause Analysis

Emphasis On Quality

▪ Requires documenting valid metrics and proactively implementing and monitoring systems.

▪ How are you being graded:
  - CMS Five Star Report
  - Nursing Home Compare
  - Quality Measures
  - Facility Satisfaction Survey
  - QIS/Traditional Surveys
  - State- Resident Satisfaction Survey
  - State- Family Satisfaction Survey
  - Focus Survey- MDS/Staffing

Metrics
**Metrics**

<table>
<thead>
<tr>
<th>ID</th>
<th>Facility Type</th>
<th>Specific Outcome</th>
<th>Market Entry</th>
<th>Trend</th>
<th>Facility Name</th>
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<tr>
<td>1</td>
<td>Hospital</td>
<td>Improvement Rate</td>
<td>Stable</td>
<td>Up</td>
<td>General Hospital</td>
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<td>2</td>
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<td>Engagement Score</td>
<td>Increase</td>
<td>Down</td>
<td>Community Health</td>
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<td>Consumer</td>
<td>Satisfaction</td>
<td>Stable</td>
<td>Up</td>
<td>Local Pharmacy</td>
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**Who’s Watching...**

- Hospitals
- ACOs
- Consumer
- Survey Agencies
- MCOs

**Selfie**

**Becoming The Preferred Provider**

- Market Analysis
- Develop a Unique Program
- Market the Outcomes

Source: [www.dreamstime.com](http://www.dreamstime.com)
Market Analysis

AHD.com

What's going on around you?

ACOs vs. Bundled Payments

American Hospital Directory

Source: American Hospital Directory

Table of Search Results

Source: American Hospital Directory

Cardiac Program

Mission Statement

Cardio Worx
Program Overview

- Patient Education Booklet
- Competency Testing (Nursing & Therapy)
- Cardiac Condition Meetings
- In-house Lab & Diagnostic Testing
- Teach Back Questions
- Standing Orders
- Stop and Watch Tool
- Care Coordinator/Nurse Liaison
- Readmission Risk Score

Cardiac Approach - Education

Cardiac Disease & Management Techniques
- Pharmacy Management
- Psychosocial Management
- Risk Factor Management
- Wellness Coaching on Lifestyle Changes
- Nutritional Assessment & Counseling
- Peer to Peer Education

Cardiac Approach - Staff Involvement

- ACLS Certification
- Specialized cardiac training for Therapists on the New York Heart Association Functional Classification (NYHA)
- Therapy Equipment - Measurable outcomes
- Start home exercise program at the time of admission
- Follow up phone call by the Care Coordinator/Nurse Liaison
- Working collaboratively with Home Health Agencies to prevent unnecessary hospital readmissions

Cardiac Standing Orders

- Diet
- VS
- Labs
- ABGs
- New
- Nutritional Assessment
- Doing well
- HOV stem
Care Path - Congestive Heart Failure

Source: https://interact2.net/

Resident Condition Meeting

- Admission BNP
- Primary/Secondary
- Recent X-ray/EKG
- Vital Signs
- Shortness of Breath?
- Current Weight (Gain/Loss)
- Edema?
- Any Cardiac Meds?
- Lung Sounds
- Does MD need to be notified?

Functional Outcome Measurements Circulatory

SBAR Communication

- Improves the quality of information that is communicated to the physician resulting in an accurate diagnosis and treatment.

S - Situation
B - Background
A - Assessment
R - Recommendation
**Teach Back Method**

- Evidenced based Clinical tool that evaluates the resident’s knowledge.
  - Medication
  - Daily Weights
  - Diet

**Stop & Watch Tool**

- Guides frontline staff through brief review of early, often subtle indicators of change in condition.
- Improves communication between frontline staff and the nurse in charge.

**Electronic Medical Records**

- PointClickCare
- RehabOptima
- HealthMEDX
- OPTIMUS EMR
- SigmaCare
- LiNtech

**Telemedicine**

- [Image of a newspaper article about telemedicine]
Telemedicine

Clinical Outcomes - Cardiac

Cardiac Outcomes

<table>
<thead>
<tr>
<th>Cardiac Programs</th>
<th>Applications</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Primary</th>
<th>Secondary</th>
<th>Discharges</th>
<th>30 Day Readmissions</th>
<th>Home</th>
<th>Other</th>
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<td>40</td>
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<td>96</td>
<td>90</td>
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<td>Average LOS</td>
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<td></td>
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<td>26.3</td>
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<td>Effectiveness of Program</td>
<td></td>
<td>Satisfactory</td>
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<td></td>
<td></td>
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<td>Oct</td>
<td>Nov</td>
<td>Dec</td>
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<tr>
<td>Jan</td>
<td>3.2%</td>
<td>Feb</td>
<td>2.4%</td>
<td>Mar</td>
<td></td>
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Orthopedic Programs

30 Day CHF Readmission Rate
Program Overview

- Patient Education Booklet
- Competency Testing & Staff Education
- Infection & Pain Monitoring
- Functional Outcomes
- Decreased Length of Stay
- Teach Back Questions
- Anticoagulant Therapy
- Standing Orders
- Outcome Measurements
- Care Coordinator/Nurse Liaison
- Readmission Risk Score
- Follow Up Call After Discharge

Standing Orders - Knee Replacement

Standing Orders - Hip Replacement

Care Path - Fever
Functional Outcome Measurements - Musculoskeletal

Clinical Outcomes - Ortho

Ortho Program Outcomes

Pulmonary Program

Ortho 30 Day Readmission Rate
Program Overview

- Patient Education Booklet
- Prevention
- Medication Management
- S/S of COPD Exacerbation
- Pneumonia—when to call MD
- Competency Testing (Nursing & Therapy)
- Daily Pulmonary Condition Meetings
- Venous Blood Gas (completed in-house)
- Teach Back Questions
- Stop and Watch Tool
- Standing Orders
- Care Coordinator/Nurse Liaison
- Outcome Tracking
- Pulmonary Rehabilitation
- Smoking Cessation
- Readmission Risk Score
- Follow Up Call After Discharge

Gold Standards For Staging COPD

<table>
<thead>
<tr>
<th>Level</th>
<th>Severity</th>
<th>Measurements</th>
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<tbody>
<tr>
<td>Gold 1</td>
<td>Mild</td>
<td>FEV1 ≥ 80% predicted</td>
</tr>
<tr>
<td>Gold 2</td>
<td>Moderate</td>
<td>50% ≤ FEV1 &lt; 80% predicted</td>
</tr>
<tr>
<td>Gold 3</td>
<td>Severe</td>
<td>30% ≤ FEV1 &lt; 50% predicted</td>
</tr>
<tr>
<td>Gold 4</td>
<td>Very Severe</td>
<td>FEV1 &lt; 30% predicted</td>
</tr>
</tbody>
</table>


Standing Orders

Care Path-Shortness Of Breath
Pulmonary Condition Meeting

- Diagnosis - PNA, COPD, Resp. Failure, etc.
- Lung Sounds
- Vital Signs
- Oxygen (LPM)
- Dyspnea at rest?
- Accessory Muscles?
- S/S of confusion or drowsiness?
- Edema?
- Peak Flow Meter
- Incentive Spirometer

Respiratory Therapists

http://dlsii.com/blog/respiratory-therapist/adviceforaspiringrespiratorytherapists/

Respiratory Assessment

Functional Outcome Measurements - Respiratory System
Clinical Outcomes

Pulmonary Outcomes

Wound Program

- Mist Therapy
- Negative Pressure Therapy
- Lymphedema Treatment
- Comprehensive Wound Care

Clinical Outcomes

Pulmonary 30 Day Readmission Rate
Neurological Program

I-STAT System

- An advanced handheld diagnostic tool that provides real-time, lab-quality results within minutes.
- Used for the Cardiac and Pulmonary Programs
- Comprehensive Point-of-Care Testing
- Diagnostic Testing (results ranging from 2 min to 17 min)
  - Electrolytes and Hematology
  - Blood Gas
  - Chemistry
  - Cardiac Markers
  - Coagulation

www.abbottpointofcare.com

C.O.R.E Readmission Risk Calculator

LACE Scores

Care Coordinator/Nurse Liaison

- Roles
  - Ensure all program specific interventions are in place
  - Monitor each patient's progress within the program
  - Assist with discharge planning
  - Follow up phone calls after discharge
  - After discharge, if the patient needs to seek medical care have them readmitted back to the facility instead of the ER unless the issue is life-threatening.

Physician & NP/PA Expectations

- Required presence in facility
- Rounding with nursing staff
- Quarterly meeting involvement
- Offer education and in-services for staff/families
- New admissions seen within 48 hours
- Available for family conferences
- Facility leadership involvement
- Supportive of programs to reduce admissions

Home Health
30 Day Rehospitalizations

<table>
<thead>
<tr>
<th>Unplanned Hospital Readmission</th>
<th>Average (%)</th>
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<tbody>
<tr>
<td>National Average</td>
<td>16%</td>
</tr>
<tr>
<td>Arizona</td>
<td>15%</td>
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<tr>
<td>New Mexico</td>
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<tr>
<td>Colorado</td>
<td>14%</td>
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<tr>
<td>Utah</td>
<td>14%</td>
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<tr>
<td>Nevada</td>
<td>15%</td>
</tr>
<tr>
<td>California</td>
<td>14%</td>
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</table>

Home Health Compare Website:
http://www.medicare.gov/homehealthcompare/search.html

Partnerships
Becoming The Preferred Provider

- Design unique programs & document outcomes to present to local hospitals
  - Invest in staff training & education
  - Invest in equipment
  - Implement data tracking and analysis
  - Identify Champions within the organization
  - Present measurable outcomes
  - Monitor for 30 day readmission rate
  - Be a solution to the hospital's problem
- Consider a Care Coordinator/Nurse Liaison & develop partnerships with like-minded companies to ensure a warm hand-off.

Bridging Connections

- Tri-Health Hospitals
  - Bethesda North
  - Good Samaritan

www.trihealth.com

Bridging Connections

- The Jewish Hospital

http://www.journal-news.com

Bridging Connections

- Mercy-Anderson
- Mercy-Fairfield
- Mercy-Clermont
- Mercy-West

http://www.emr.com/mercy-hospital-anderson
Bridging Connections

• Atrium Medical Center

Centers Of Advanced Quality Outcomes

Jewish Hospital- Preferred Provider
Telemedicine For Heart Failure Management

Marketing Points
- Capitalize on the program’s uniqueness
- Improved nursing assessment skills
- Improved clinical outcomes
- Reduction in unplanned rehospitalizations
- Positive reputation among hospitals, MCOs and the community
- Improved Customer/Family Satisfaction

SNF Initiative
- Mark Parkinson, American Health Care Association/National Center for Assisted Living
  - "If you wait until you're excluded from the network, you're too late. The party's probably over."
- Josh Luke, Ph.D., FACHE, Founder of the National Readmission Prevention Collaborative
  - "SNFs should actively be seeking out partnerships with hospitals and other organizations..."

Movement Towards Bundling
- "Providers can kiss fee for service payments goodbye" says Kathleen Sebelius
- "Costs are coming down and quality is improving"

Kathleen Sebelius, Department of Health and Human Services
McKnight’s Long Term Care News, May 2015 Vol 36, No. 5
Kim Barrows RN, BSN
President of KB Post Acute Strategic Specialists
kbarrows@kbpass.com
513 818 5146

REFERENCES
Centers for Medicare & Medicaid Services. Medicare Readmissions Penalties by Hospital (Year 3). October 2, 2014