CALTCM INTERACT III
Get Ahead of Readmissions!

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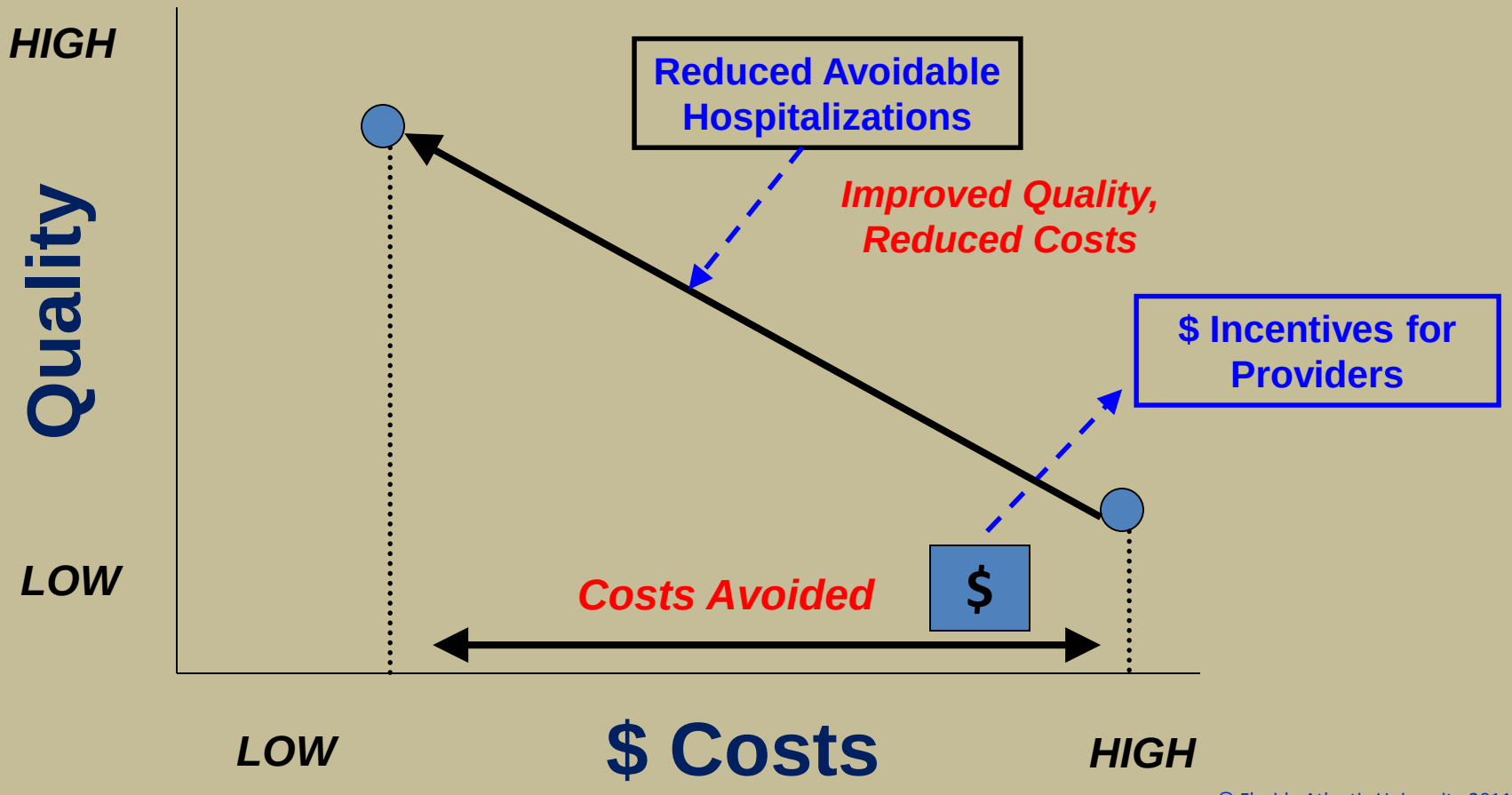
CALTCM INTERACT

Opportunities for All of Us



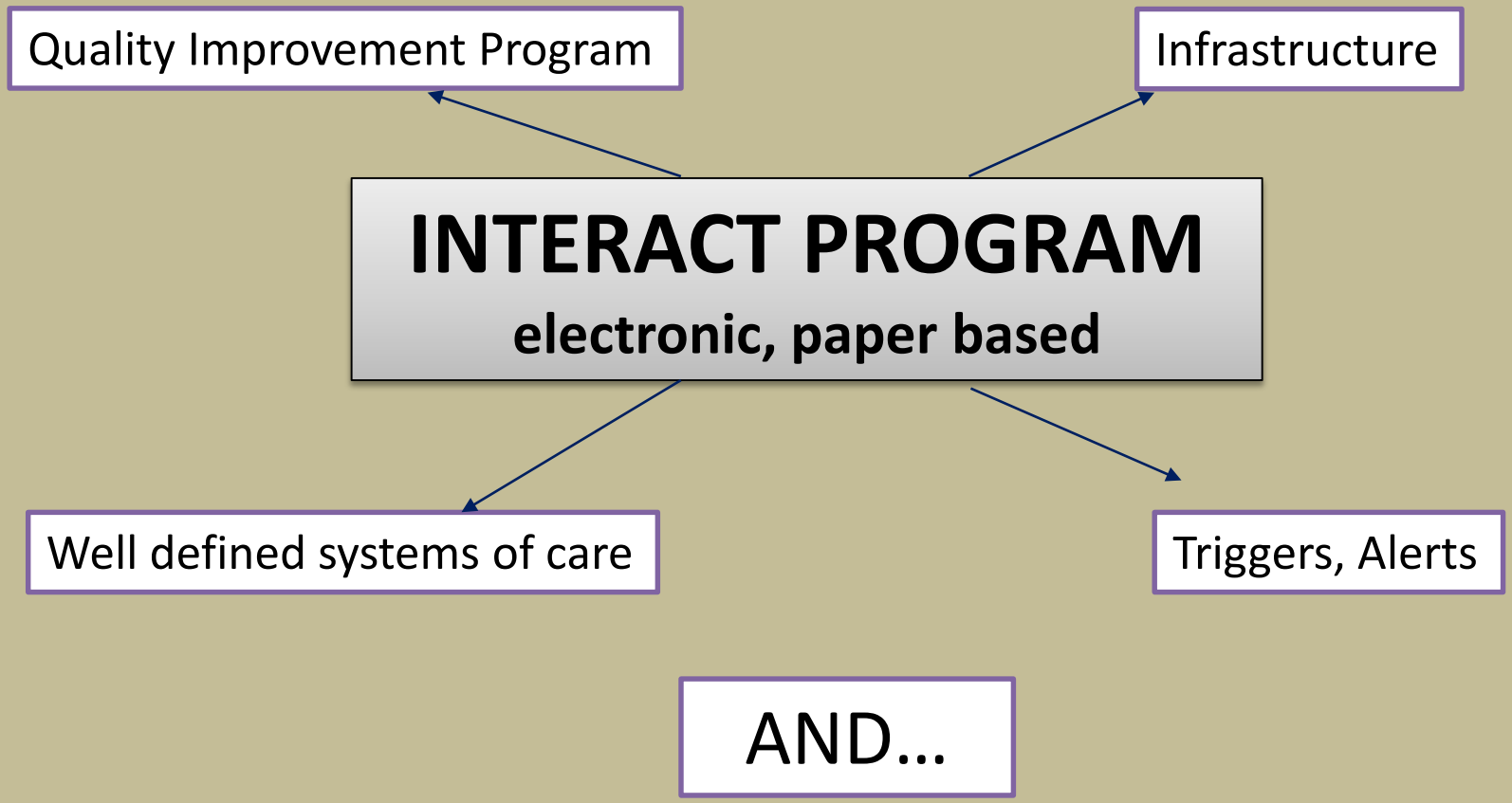
Changes in Medicare Financing
ACT NOW!

- **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

Opportunities Related to the New QAPI Requirement

- The Affordable Care Act mandates that each facility have a Quality Assurance & Performance Improvement program ***("QAPI")***
- QAPI Program should focus on high volume, problem prone, high cost areas of care
- Improving management of acute change in condition and avoiding unnecessary hospital stays clearly meets the intent of QAPI

What does it take to be successful?



Collaborate with Referring Hospitals

- Identify hospital contacts & build relationship
  - Discharge planning, social services
  - Emergency Dept contacts
- Set up meeting based on an agenda and share your Nursing Home Capabilities list
- Share your Dashboard
- Share your successes
- Offer to work together on Challenges

INTERACT Training Program

http://interact2.net

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 Team with input from many direct care providers and national experts in projects based at Florida Atlantic University (FAU) supported by The Commonwealth Fund.

INTERACT®

Interventions to Reduce Acute Care Transfers

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Quality Improvement Tools

Tracking Hospitalization Rates

- Acute Care Transfer Log – Worksheet
- Hospitalization Rate Tracking Tool

Quality Improvement Reviews - Root Cause Analyses

- Quality Improvement Tool for Review of Acute Care Transfers

Communication Tools

For Communication Within the Nursing Home

- Stop and Watch Early Warning Tool

For Communication Between the Nursing Home and Hospital

- Engaging Your Hospitals - Tip Sheets
- Nursing Home Capabilities List
- NH - Hospital Transfer Form

Decision Support Tools

- Acute Change in Condition File Cards
- Acute Mental Status Change
- Change in Behavior: New or Worsening Behavioral Symptoms
- Dehydration
- Fever

Advance Care Planning Tools

- Identifying Residents Who May be Appropriate for Hospice or Palliative
- Comfort Care Order Set
- Deciding About Going to the Hospital
- Education on CPR
- Education on Tube Feeding

The CALTCM Program

- Plan onsite trainings in YOUR AREA using FAU INTERACT Program
- Bring 3-10 nursing homes together with representatives of referral hospital(s)
- Telephone Coaching for 30 min – focuses on data sharing and actions
- Platform for Collaborative Sharing with other homes and hospitals once monthly

Is the CALTCM Program Effective?

Cluster consisting of 13 NHs, one hospital, one medical group, in one Northern California Community

How the training was structured:

- 1 day face to face training
- Followed by 6 months of 1:1 coaching calls
- Designated champions in each NH
- Commitment to training staff using INTERACT tools
- Attendance at cross-setting meetings with hospital

Outcome Measures used to determine level of success

- 30 day hospital readmission rates
- Self reported communication within and between hospital and the facility
- QI reviews of unplanned admissions
- Percentage of INTERACT implemented
- Participation rate in coaching calls

Primary Results

Pre-Training Hospital Readmission Rates

- 12.40% (source: hospital)

Number of Coaching Calls Attended

- 7 NHs attended 1 – 3 calls
- 6 NHs attended 4 – 6 calls
- Average call attendance = 4

Post Training/Pre-Coaching: Degree of Implementation of Tools

- 4 NHs < 50% Implementation
- 9 NHs > 50% Implementation
- Average Level of Implementation = 62%

Post Training/Post-Coaching: Degree of Implementation of Tools

- 2 NHs < 50% Implementation
- 11 NHs > 50% Implementation
- Average Level of Implementation = 72%

Post-Training Hospital Readmission Rates

- 11.11% (source: hospital)

Summary Results

- Nursing Home engagement is linked to degree implementation of INTERACT tools
- 1.29% Reduction in Hospital Readmission Rates
- Single community focused training has promise as it offers shared resources, problems solving, and additional support
- Other qualitative performance benefits were derived by participants

Secondary Results

- Improved nursing assessment competencies
- Systematic quality improvement process
- Meet QAPI requirements
- Improved communication within the facility
- Improved NH-Hospital communication

Conclusion from previous CALTCM sessions

- Use and integration of more than 50% of the INTERACT tools can result in systems that are effective
- Cross cultural collaboration between payor, provider, hospital and NH is an effective mechanism in avoiding unnecessary hospital readmissions
- Three months of engaged facility coaching achieves optimal implementation
- NH Medical Director and other clinician involvement is critical to reducing unnecessary hospital readmissions

Join with us Now!

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