INTERACT Implementation Learning in Action Collaborative Webinar 2: Capabilities List

November 5, 2015
11:30 am – 12:30 pm EST

The Carolinas Center for Medical Excellence
Serving South Carolina

AQIN – SC QIO Team:

Sarah Stein Banyai, MPH
Quality Specialist
SStein@thecarolinascenter.org
803.212.7521

Heather Jones, MHA, PTA, CPHQ
Manager Care Coordination
HJones@thecarolinascenter.org
803.212.7584

Marilee Mohr, RN
Quality Specialist
MMohr@thecarolinascenter.org
803.212.75

Karen Southard MHA, RN
State Program Director, SC-AQIN/QIO
KSouthard@thecarolinascenter.org
803.212.7518

Learning In Action Collaborative

During this 6 month, action oriented, virtual collaborative participants will:

- Receive education, coaching, and resources from experts in the field
- Develop strategies to reduce avoidable hospital readmissions
- Learn about evidence-based INTERACT tools and have the opportunity to implement interventions to reduce hospital readmissions: QI tools, capabilities list, transfer forms, SBAR, and STOP and WATCH
- Build a community of practice with their peers and share successes and challenges
- Learn to use data in a meaningful way to improve care

Welcome

- All webinars will be recorded and can be accessed at

  http://atlanticquality.org/initiatives/care-coordination/care-coordination-sc/

- Meeting norms:
  - We will be flexible and understanding with technology
  - We will be attentive and not multitask during the webinar
  - We will be engaged and participate in discussions and peer-to-peer sharing

Collaborative Timeline

(All webinars are scheduled on Thursdays from 11:30 am -12:30 pm EST)

October 8, 2015 – Kickoff Webinar #1: Readmission Tracker

October 19-23, 2015 Check in/Coaching call (15-30 min)

November 5, 2015 – Webinar #2: Capabilities List

November 9-13, 2015 Check in/coaching call (15-30 min)

November 19, 2015 – Webinar #3: Transfer Forms

December 7- 16, 2015 Check in/coaching call (15-30 min)

January 7, 2016 – Webinar #4: SBAR

January 25-29, 2015 Check in/coaching call (15-30 min)

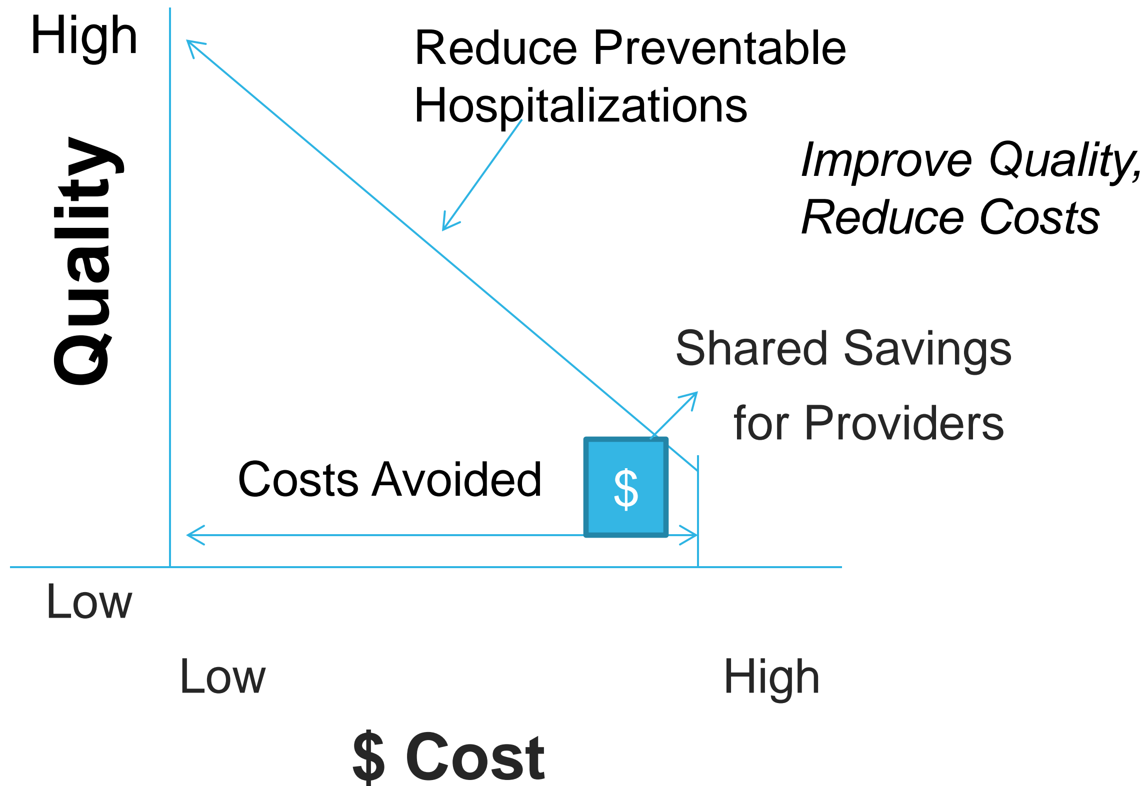
February 18, 2016 – Webinar #5: Stop and Watch

February 29- March 4, 2015 Check in/coaching call (15-30 min)

March 10, 2016 – Webinar #6: Lessons Learned and Next Steps

The INTERACT Program

Opportunities for You and Your Facility



Quality Assurance Performance Improvement

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Process Improvement Principles

Resident Focus

Leadership Involvement

Team-Based

Data and QI Tools

Just Culture

Prevent Overcorrection

Staff Empowerment

Continuous Improvement

INTERACT tools are meant to be used together in your daily work in the nursing home or home health agency.

INTERACT tools will help identify common causes of readmission.

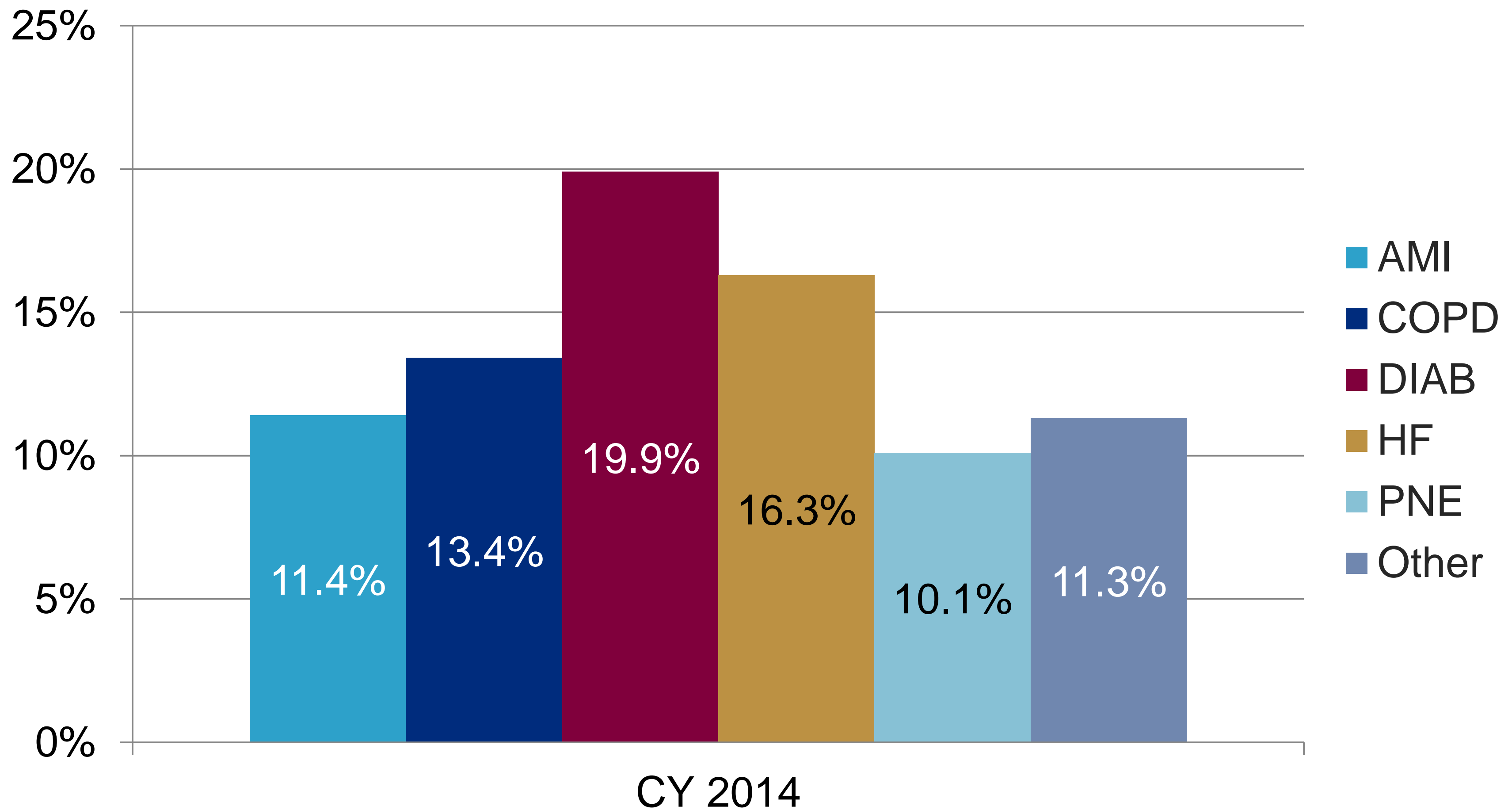
INTERACT aligns with QAPI initiatives.

https://interact2.net/

Alignment of QAPI and INTERACT

QAPI	INTERACT
Improves communication	Provides communication tools
Driven by leadership and empowers staff to be part of the decision making	Leadership sets the charter and works with staff to implement
Standardize practice	Evidence-based tools
Data drives the change	Data helps identifies the opportunity to improve
Provides a system to monitor effectiveness of care	Provides tools to analyze process, provides care paths to deliver care in a consistent manner
Systemwide improvement	Utilize PDSA cycles and spreads success across the organization
Organizes the change plan into a performance improvement project	INTERACT is a performance improvement project

SC Diagnosis-Specific Readmissions



SC overall readmission rate is 11.7%

Tracking in Real Time

- Track and trend transfer measures using QI Tool
- Conduct root cause analysis using QI Tool
  - Analyze transfers
  - Look for common patterns
- Choose interventions based on your findings

Acute Care Transfer Log

You can use this tool as a worksheet for recording all acute care transfers during a month. Print more pages as needed. This tool is not necessary if you use the **INTERACT Hospitalization Rate Tracking Tool**, which allows you to enter the data directly into an Excel spreadsheet, and calculates rates and generates reports. A similar tracking tool is available through the Advancing Excellence Campaign in America's Nursing Homes at www.nhqualitycampaign.org

Facility Name ______________________ Month/Year ______ / ______

Resident ID	Date of Most Recent Admission to Facility	Admitted to Facility from[1] *(circle)*	Status on Admission[2] *(circle)*	Date of Acute Care Transfer	Time of Transfer *(circle AM or PM)*	Outcome of Transfer[3] *(circle)*	Reason for Transfer[4]
	/ /	Hosp H O	PAC LTC	/ /	AM PM	IP OBS ER	
	/ /	Hosp H O	PAC LTC	/ /	AM PM	IP OBS ER	
	/ /	Hosp H O	PAC LTC	/ /	AM PM	IP OBS ER	
	/ /	Hosp H O	PAC LTC	/ /	AM PM	IP OBS ER	

INTERACT Hospital Rate Tracking Tool

January 1, 2015

Confidentiality is important. Please do not transmit this form with resident-identifying information. Instructions for de-identifying this tool are provided in the Common Qs & As tab.

http://www.interact2.net

Action Item to Consider – Let's Discuss

Go back and review the last three months of readmissions using the QI Tool and then complete the summary page.

What did you find is the primary reason for the returns to the hospital?

Do you need to increase your NH/HHA capacity to meet higher acuity?

You are on the way to your first PIP.

Building Partnerships

Readmission Champion

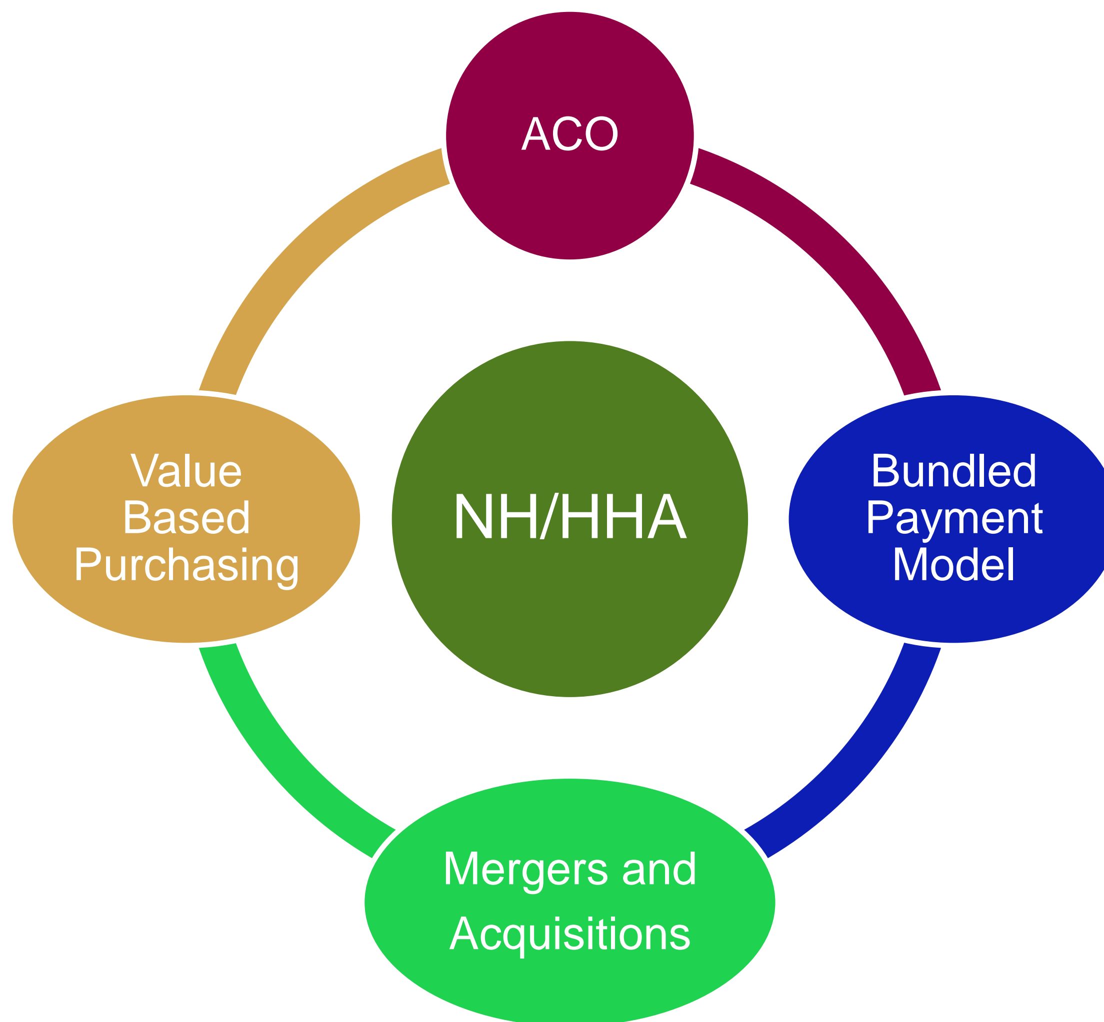
NH/HHA Capability List

Share your QI Goals

Host or join a community care transitions meeting

Engaging Your Hospitals – Communication Tool

Where will you be in 5 Years?



Communication Tools

Capabilities List

- Standardized, pre-populated checklist of nursing home/ home health capabilities for decisions about transfers back into facility

- Distribute to EDs and hospital discharge planners

- Marketing and education tool

https://interact2.net/tools_v4.html

LTC/Skilled Nursing Capabilities List

https://interact2.net/tools_v4.html

Circle 'Y' for yes or 'N' for no to indicate the availability of each item in your facility.

Capabilities	Yes	No
Primary Care Clinician Services		
At least one physician, NP, or PA in the facility three or more days per week	Y	N
At least one physician, NP, or PA in the facility five or more days per week	Y	N
Diagnostic Testing		
Stat lab tests with turnaround less than 8 hours	Y	N
Stat X-rays with turnaround less than 8 hours	Y	N
EKG	Y	N
Bladder Ultrasound	Y	N
Venous Doppler	Y	N
Cardiac Echo	Y	N
Swallow Studies	Y	N
Consultations		
Psychiatry	Y	N
Cardiology	Y	N
Pulmonary	Y	N
Wound Care	Y	N
Other Physician Specialty Consultations *specify:*	Y	N
Social and Psychology Services		
Licensed Social Worker	Y	N
Psychological Evaluation and Counseling by a Licensed Clinical Psychologist	Y	N
Therapies on Site		
Occupational	Y	N
Physical	Y	N
Respiratory	Y	N

Capabilities	Yes	No
Nursing Services		
Frequent vital signs *(e.g. every 2 hrs)*	Y	N
Strict intake and output (I&O) monitoring	Y	N
Daily weights	Y	N
Accuchecks for glucose at least every shift	Y	N
INR	Y	N
O2 saturation	Y	N
Nebulizer treatments	Y	N
Incentive spirometry	Y	N
Interventions		
IV Fluids *(initiation and maintenance)*	Y	N
IV Antibiotics	Y	N
IV Meds – Other *(e.g. furosemide)*	Y	N
PICC Insertion	Y	N
PICC Management	Y	N
Total Parenteral Nutrition (TPN)	Y	N
Isolation *(for MRSA, VRE, etc…)*	Y	N
Surgical Drain Management	Y	N
Tracheostomy Management	Y	N
Analgesic Pumps	Y	N
Dialysis	Y	N
Advanced CPR *(ACLS capability)*	Y	N
Automatic Defibrillator	Y	N
Pharmacy Services		
Emergency kit with common medications for acute conditions available	Y	N
New medications filled within 8 hours	Y	N

Home Health Capabilities List

https://interact2.net/tools_v4.html

Circle 'Y' for yes or 'N' for no to indicate the availability of each item in Home Health.

Capabilities	Yes	No
Home Health Clinician Services		
Skilled nursing care	Y	N
Physical therapy	Y	N
Occupational therapy	Y	N
Speech-language therapy	Y	N
Medical social services	Y	N
Home Health aide	Y	N
Diagnostic Testing		
Lab tests *(nurse draw blood in home)*	Y	N
Portable X-ray	Y	N
Portable ultrasound	Y	N
Bladder ultrasound	Y	N
Portable Doppler	Y	N
Clinical Programs or Protocols		
Diabetic care and management	Y	N
Cardiac care and management	Y	N
Pulmonary care and management	Y	N
Chronic disease management	Y	N
Pre- and post-operative care	Y	N
Palliative care	Y	N
Psychiatric care	Y	N
Pain management	Y	N
Wound care and management	Y	N
Nursing Services		
Skilled nursing assessment	Y	N

Capabilities	Yes	No
Nursing Services (cont'd)		
Medication management education to promote self improvement	Y	N
Nutritional counseling	Y	N
Injection administration	Y	N
Catheter care and management	Y	N
Nebulizer treatments	Y	N
Infusion therapy	Y	N
Comprehensive patient and caregiver training	Y	N
Ostomy management	Y	N
High-tech nursing	Y	N
Case management	Y	N
Surgical drain management	Y	N
Oxygen management	Y	N
Rehabilitation		
Low vision therapy	Y	N
Fine motor/gross motor re-training	Y	N
Fall/balance program	Y	N
Incontinence therapy	Y	N
Pulmonary rehabilitation	Y	N
Lymphedema therapy	Y	N
Vestibular rehabilitation	Y	N
Additional Information		
Health and transitional coaching	Y	N
Data driven risk assessment	Y	N
Electronic medical record	Y	N

Using the Tool in Different Ways

- Combines the QI Review for readmission and compare to your capabilities list – gaps?
- Allows you to build a business case for service line expansion within the facility
- Establishes a quality scorecard using the most frequent admission DRG/readmission QI review tool and facility capabilities list
- Targets both internal and external education to staff and other providers

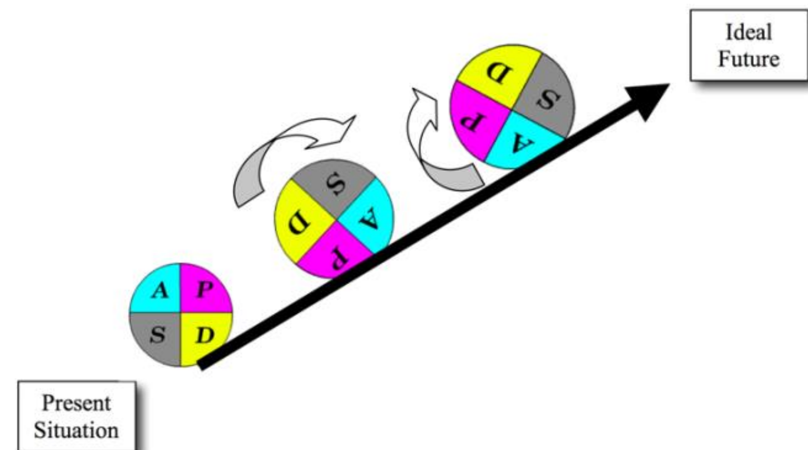
Tips to Begin the Conversation

Plan – Complete checklist

Do – Meet with facility leadership, medical director, and hospital leaders: CNO, CMO, ED director, case management and distribute capabilities list

Study – Observe data collected from acute transfer tool

Act – Educate staff as needed



Action Items:

- Schedule a follow-up call with a member of the AQIN-SC team
- Track and review hospital readmission data using the QI tools
- Share your Capabilities List with your hospitals
- Register for INTERACT Implementation Webinar #3 –

Transfer Forms – November 19, 2015

https://qualitynet.webex.com

Thank you!

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