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News for the South Carolina Action Collaborative for Excellence (ACE) in Long-term Care

Quality Leaders

*Making nursing homes better places to live and work*

# ACE Updates

**A reminder for all ACE facilities to complete the online QAPI Self-Assessment**

Each facility is asked to complete at least one assessment during the ACE Quality Journey. If you have not already done so, please do it today! The online QAPI Self-Assessment is located here: https://isweb.ipro.org/qapi/sc/

***** New ACE website is here! *****

http://atlanticquality.org/initiatives/nursing-home-quality/nursing-home-quality-sc/

Our nurses work in an environment of much higher acuity requiring expert geriatric nursing skills. The ACE website is an excellent way to make sure your staff has the resources they need to perform at the level necessary to provide quality care and to ensure the outcomes necessary to compete within new reimbursement models.

A variety of clinical and organizational change topics as well as QAPI implementation is included with standardized tools, resources, and nationally recognized websites provided for each topic area:

- Antipsychotic medications
- Falls and mobility
- Hospital readmissions
- Pressure ulcers
- Physical restraints
- Infections

- Stabilizing staff
- Development of leadership skills
- Communication skills
- Building teamwork for real-time problem-solving
- Person-centered care

If you have a resource to share or suggestions, please let us know!

# Upcoming Events

**ACE Learning Session II – October 20, 21, and 22, 2015**

***QI Closest to the Resident for Everyday Problem-Solving – Second Key to Success***

Mark your calendars for the second ACE Learning Session scheduled for October 20 (Charleston), October 21 (Columbia), and October 22 (Greenville). Barbara Frank and Cathie Brady return to discuss the use of quality improvement (QI) methods closest to the resident for problem-solving in real time. Training and empowering the frontline is critical for producing positive outcomes for both residents and staff. This session builds on the first ACE learning session and will include easy-to-use tools and resources for improving care and strengthening staff in your facility. Here are highlights:

- Use rounding, just-in-time teaching, and watch lists to prevent avoidable hospitalizations
- Prevent off-label use of antipsychotic medications by engaging staff in collaborative problem solving
- Improve dementia care by understanding residents' behavior as communication

**Please click here to register:**

**October 20 – Charleston**

https://www.eventbrite.com/e/ace-learning-session-ii-charleston-sc-tickets-18557807903

**October 21 – Columbia**

https://www.eventbrite.com/e/ace-learning-session-ii-columbia-sc-tickets-18558000479

**October 22 – Greenville**

https://www.eventbrite.com/e/ace-learning-session-ii-greenville-sc-tickets-18558264268

### INTERACT Implementation: Learning In Action Collaborative – October 8, 2015

Beginning in fiscal year 2019, the Centers for Medicare & Medicaid Services (CMS) will impose a value-based purchasing model for long-term care facilities to reduce avoidable readmissions. Our team would like to help you prepare for the future changes in the health care delivery and payment system. If you participated in the INTERACT Conference in March 2015, you are invited to participate in a short, six month collaborative of monthly webinars designed to help you implement evidence-based interventions that directly impact hospital readmissions.

**Mark your calendars for the collaborative kick-off!**

**Thursday, October 8, 2015**

**11:30 a.m. – 12:30 p.m.**

https://qualitynet.webex.com

Webinar password: **INTERACT**

866-951-1151 | Access code: 414053276

**This is a virtual activity and will provide a great opportunity for peer-to-peer sharing!**

For more information and to register for this FREE educational collaborative, please contact Heather Jones at Heather.Jones@area-i.hcqis.org or 803-212-7584.

# Trending News

### CMS Funding Higher-Intensity Interventions in Nursing Facilities for Residents Who May Otherwise Be Hospitalized Upon an Acute Change in Condition

For the past three years, CMS has partnered with seven Enhanced Care and Coordination Providers (ECCPs) to test a model to improve care for long-stay nursing facility residents. The ECCPs collaborate with 144 nursing facilities across seven states—Alabama, Indiana, Missouri, Nebraska, New York, Nevada, and Pennsylvania—to train staff onsite, to provide preventive services, and to improve the assessment and management of medical conditions.

The intent of the new payment model is to reduce avoidable hospitalizations by funding higher-intensity interventions in nursing facilities for residents who may otherwise be hospitalized upon an acute change in condition. Improving the capacity of nursing facilities to treat medical conditions as effectively as possible within the facility has the potential to improve the residents' care experience at a lower cost than a hospital admission. The model also includes payments to practitioners (i.e., physicians, nurse practitioners, and physician assistants) similar to the payments they would receive for treating beneficiaries in a hospital. Practitioners would also receive new payments for engagement in multidisciplinary care planning activities.

"This Initiative has the potential to improve the care for the most frail, most vulnerable Medicare-Medicaid enrollees—long-term residents of nursing facilities," said Tim Engelhardt, Director of the Medicare Medicaid Coordination Office. "By aligning financial incentives, we can improve the quality of onsite care in nursing facilities and the assessment and management of conditions that too often now lead to unnecessary and costly hospitalizations." For more information, go to http://innovation.cms.gov/initiatives/rahnfr/.

# Best Practices

On August 26th in Columbia, SC, nearly 300 stakeholders representing hospitals, skilled nursing facilities, home health agencies, hospice agencies, government agencies, managed care organizations, faith-based organizations, trade associations, and other community partners participated in the third annual Preventing Avoidable Readmissions Together (PART) statewide meeting. This one-day conference was designed to provide information on specific elements, tools, and resources used to assist communities in improving care coordination across all health care settings.

Health educator, bestselling author, and president of Coalition Works, a group that consults with practitioners about how to develop, sustain, and evaluate coalitions for health promotion and disease prevention, Frances Dunn Butterfoss, Ph.D., served as the keynote speaker. In her message, Dr. Butterfoss

encouraged participants to think beyond the idea of partnering with other organizations and to move to action.

Community coalitions share resources, responsibility, and risks. Structured coalitions move away from competition and move toward long-term accomplishments, systems of change, and sustainability. **Her call to action:** *To build a structured coalition model that unites its members around the shared vision of reducing avoidable hospital readmissions.*

The theme of improved communication and building stronger teams continued throughout the day with additional presentations on patient and family engagement, integrating community partnerships within the Accountable Care Organization model, end of life discussions, identifying social determinants of health, post-acute prescription management, and examining discharge summaries.

Pre-registered nursing home staff also had an opportunity to participate in a Clinical Simulation Lab with members of the University of South Carolina School of Nursing faculty. This session provided hands-on learning with a simulation manikin focusing on clinical assessment and communication using the INTERACT Care Paths for congestive heart failure and respiratory illness, two key reasons for hospital readmissions in South Carolina. Participants were trained using real life scenarios so that they could teach nurses at their facility. Presentations from this conference can be found at this link: http://www.scha.org/events/sc-part-care-transitions-2015-statewide-meeting.

# ACE Toolbox

In addition to the tools found on the INTERACT website (https://interact2.net/) and the Advancing Excellence website (https://www.nhqualitycampaign.org/goalDetail.aspx?g=hosp#tab2) for tracking hospital transfers, B & F Consulting designed a very simple-to-use spreadsheet with 10 columns designed to collect basic data that can be used for root cause analysis. Check it out the Hospitalizations Worksheet (http://atlanticquality.org/wp-content/uploads/2015/09/Hospitalizations-Worksheet3.pdf) and make sure you are using at least one tool to track and analyze monthly hospital transfers.

This material was prepared by the Atlantic Quality Innovation Network (AQIN), the Medicare Quality Improvement Organization for New York State, South Carolina, and the District of Columbia, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents do not necessarily reflect CMS policy. 11SOW-AQINSC-TskC.2-15-25