Quality Improvement Organizations
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HQIN
Health Quality Innovation Network

Recognize and Respond Collaborative: INTERACT® Quality Improvement Tools

October 24, 2023

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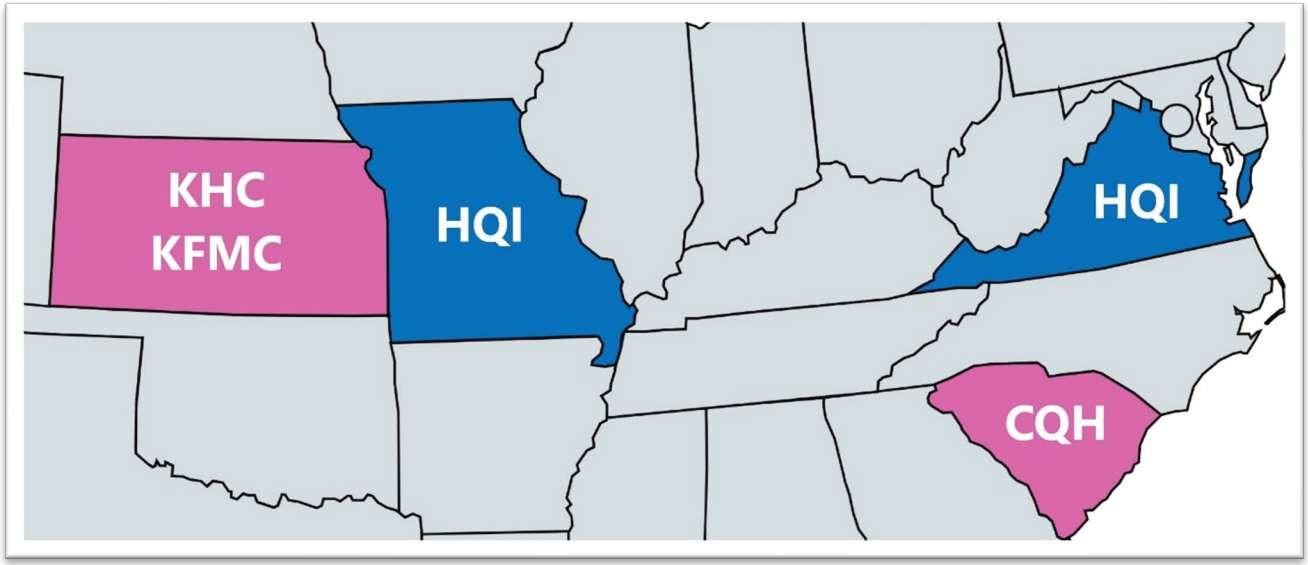
Health Quality Innovation Network



HQI
HEALTH QUALITY INNOVATORS

Constellation Quality Health

kfmc
HEALTH IMPROVEMENT PARTNERS

KC
Kansas Healthcare
COLLABORATIVE

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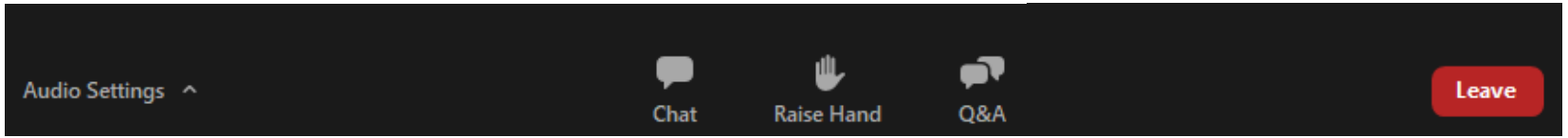
Logistics – Zoom Webinar



To ask a question, click on the **Q&A** icon.

Raise your hand if you want to verbally ask a question.

Resources from today's session will be posted in **Chat**.

You may adjust your audio by clicking **Audio Settings**.

You have been automatically muted with video turned off.

Your Team

Allison Spangler, BSN, RN, RAC-CT,QCP
Consulting Manager

Sibyl Goodwin, BSN, RN, DNS-CT, QCP
Senior Quality Improvement Advisor

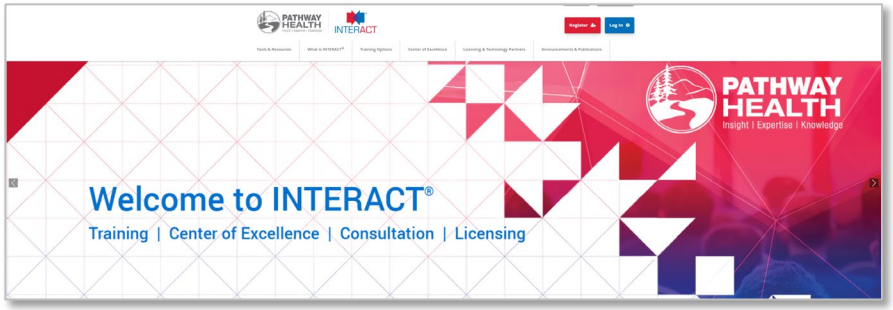
April Faulkner
Communications Specialist

Webinar Objectives

- Review the INTERACT® quality improvement tools
- Discuss how to use the INTERACT® QI tools for review of acute care transfers
- Implement QAPI strategies to reduce the frequency of potentially avoidable transfers

INTERACT® Tools

- Communication tools
- Decision support tools: Change in condition file cards and care paths
- Advanced care plan tools
- **Quality improvement tools**



Polling Question

Are you currently using, or have you used in the past, an INTERACT® QI tool to track acute care/hospitalization transfers?

A. Yes (Please enter which tool in chat)

B. INTERACT® Acute care transfer log (paper)

C. INTERACT® Hospitalization Rate Tracker (Excel)

D. No

E. Unsure

INTERACT® QI Tool Sets

Tracking Hospitalization Rates

- Acute Care Transfer Log-Worksheet
- Calculating Hospitalization Rates
- Hospitalization Rate Tracking Tool 2023
- Tracking Tool Instructions
- Tracking Tool Trouble Shooting

Quality Improvement Review-Root Cause Analysis

- Quality Improvement Tool for Review of Acute Care Transfers
- Quality Improvement Summary-Worksheet

Hospitalization Rates: Why They Matter

- Tracking, trending and benchmarking specific quality measures is fundamental to any quality improvement program
- Clearly and consistently defined measures must be used to benchmark and compare your measure to others
- The Centers for Medicare & Medicaid Services (CMS) is monitoring readmission and ED rates through various quality measure initiatives:
  - Skilled Nursing Facility Value-Based Purchasing Program
  - Five Star Nursing Home Care Compare

Acute Care Transfer Log

- Paper and pen tool
- Used to record all acute care transfers during a month
- Captures basic information

Acute Care Transfer Log

INTERACT
Version 4.5 Tool

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 National Nursing Home Quality Improvement Campaign at www.nhqualitycampaign.org

SNF/NF 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	
	/ /	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	
	/ /	Hosp H O	PAC LTC	/ /	AM PM	IP OBS ER	
	/ /	Hosp H O	PAC LTC	/ /	AM PM	IP OBS ER	

1 **Hosp** = acute care hospital; **H** = home; **O** = Other location
2 **PAC** = post-acute care *(most often Medicare Part A skilled care)* for rehabilitation and/or management of medical or post-surgical conditions; **LTC** = long-term care
3 **IP** = admitted as an inpatient; **OBS** = admitted on observation status; **ER** = emergency room visit only with return to the facility *(includes residents who die in the ambulance or ER)* **4**
Examples of options on the above referenced Tracking Tools: Bleeding, Cellulitis, Chest Pain, HF, COPD, Dehydration /Electrolyte Imbalance, Fall, GI *(vomiting, diarrhea, pain)*, Pneumonia/Respiratory Infection, Seizure, Sepsis, Shortness of Breath, UTI, Other

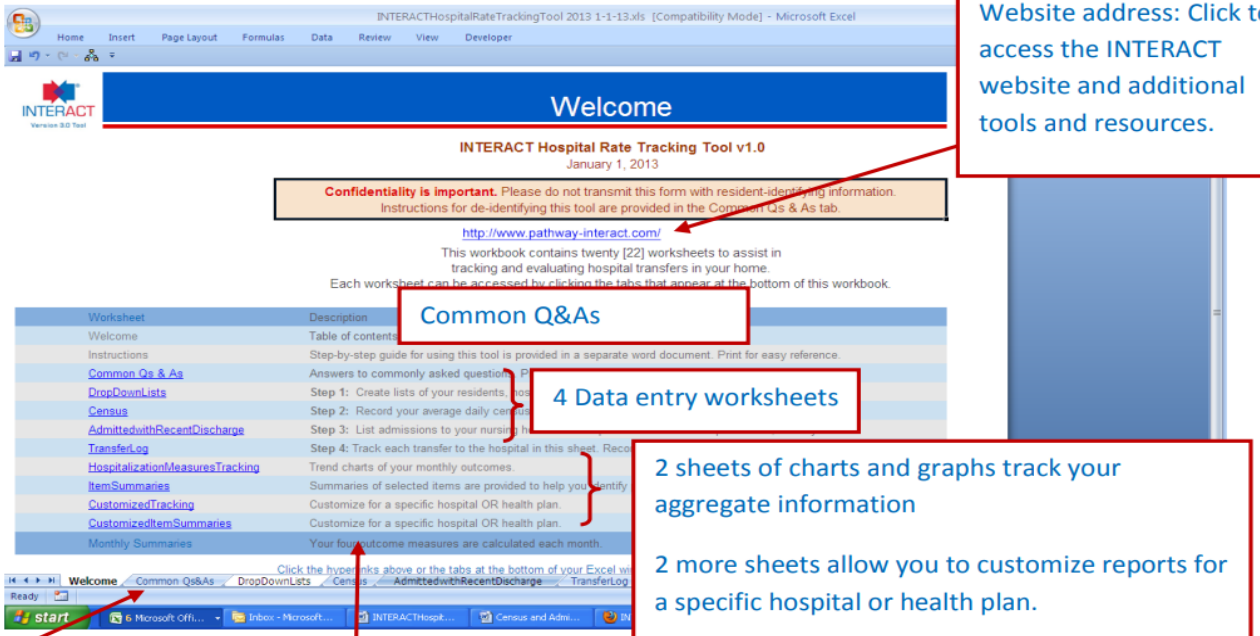
[Acute Care Transfer Log]

The Hospitalization Rate Tracking Tool

- Excel workbook with embedded formulas that calculate and trend rates for key measures
- Allows entry of census data and information on transfers to generate a variety of summary reports

Hospitalization Rate Tracking Tool

Welcome Page



Website address: Click to access the INTERACT website and additional tools and resources.

Common Q&As

4 Data entry worksheets

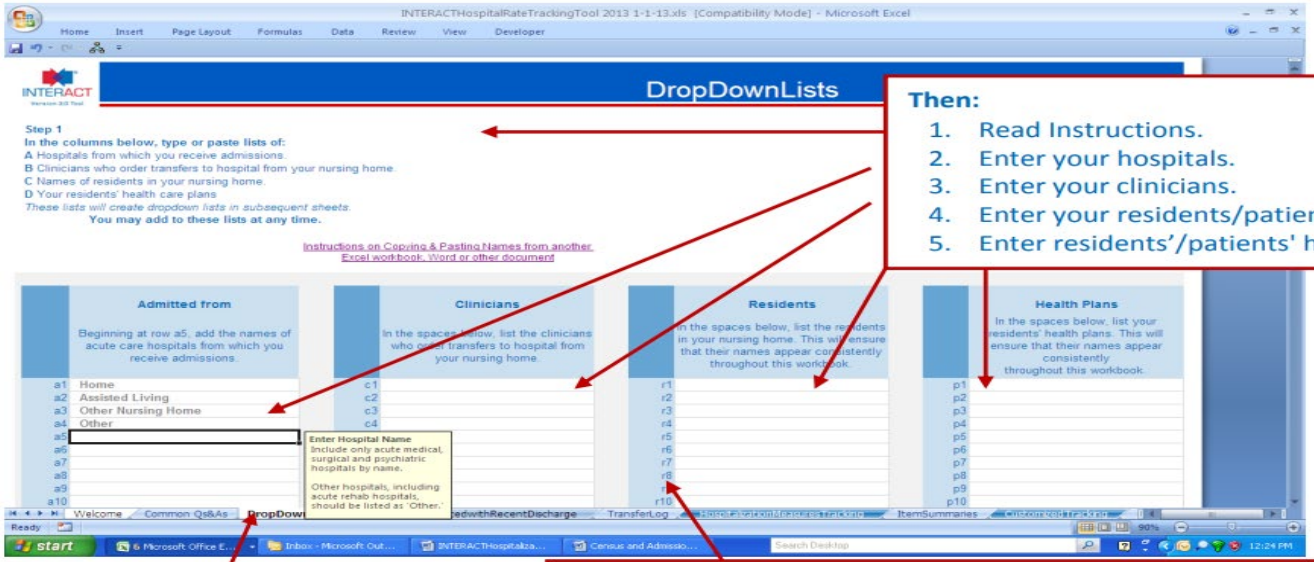
2 sheets of charts and graphs track your aggregate information

2 more sheets allow you to customize reports for a specific hospital or health plan.

Click on the named tabs to move between worksheets.

Monthly outcome summaries for website entry.

Drop Down Lists



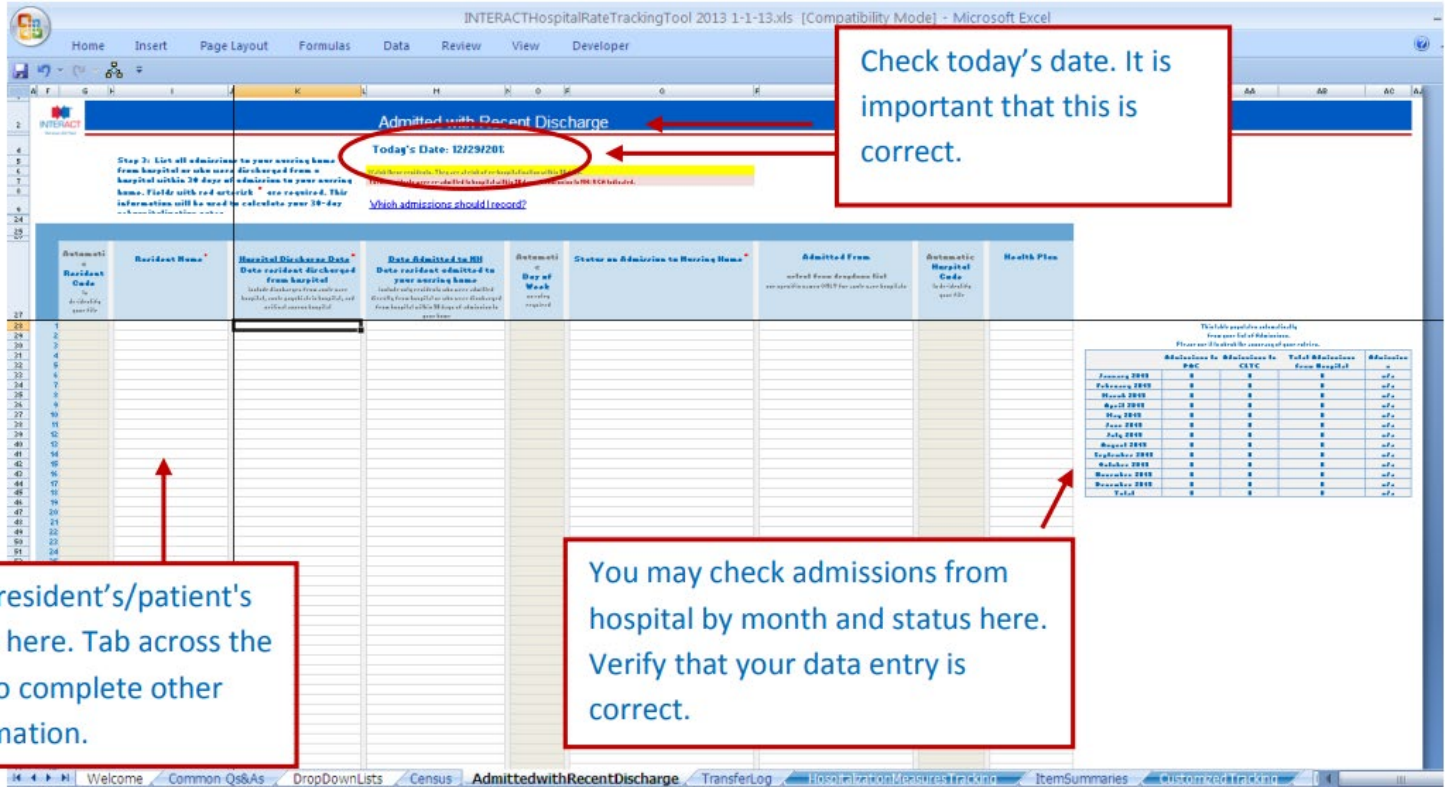
Then:

1. Read Instructions.
2. Enter your hospitals.
3. Enter your clinicians.
4. Enter your residents/patients.
5. Enter residents'/patients' health plans.

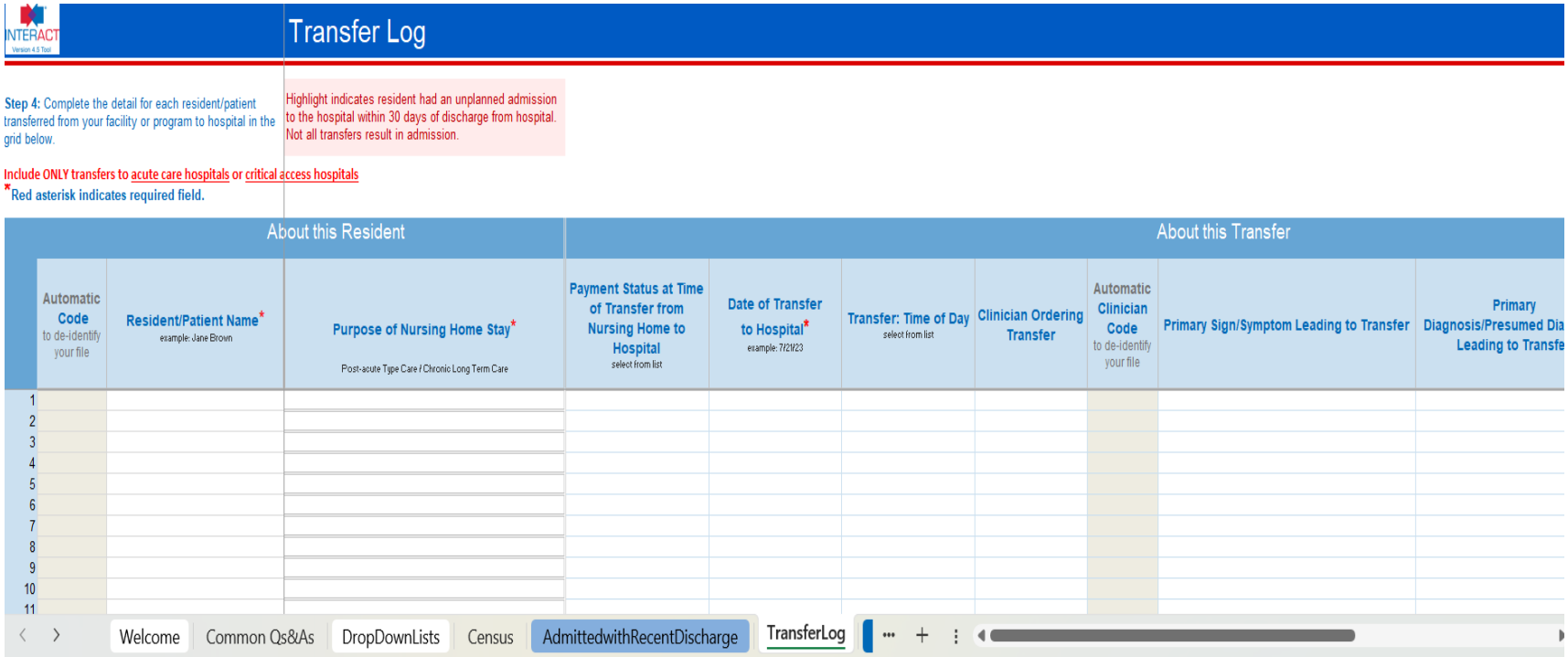
First: Go to the DropDownLists sheet.

Notice the combination letter and number codes that appear next to each name.
These codes will follow the names throughout the workbook, no matter what order the names are listed in other sheets. They may be used to de-identify this workbook for sharing. Detailed instructions are provided in Common Q&As.

Admitted with Recent Discharge



Transfer Log



Transfer Log

Step 4: Complete the detail for each resident/patient transferred from your facility or program to hospital in the grid below.

Highlight indicates resident had an unplanned admission to the hospital within 30 days of discharge from hospital. Not all transfers result in admission.

Include ONLY transfers to acute care hospitals or critical access hospitals

*Red asterisk indicates required field.

	About this Resident			About this Transfer						
	Automatic Code to de-identify your file	Resident/Patient Name* example: Jane Brown	Purpose of Nursing Home Stay* Post-acute Type Care / Chronic Long Term Care	Payment Status at Time of Transfer from Nursing Home to Hospital select from list	Date of Transfer to Hospital* example: 7/21/23	Transfer: Time of Day select from list	Clinician Ordering Transfer	Automatic Clinician Code to de-identify your file	Primary Sign/Symptom Leading to Transfer	Primary Diagnosis/Presumed Dia Leading to Transfe
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										

Welcome | Common Qs&As | DropDownLists | Census | AdmittedwithRecentDischarge | TransferLog

Census

Census

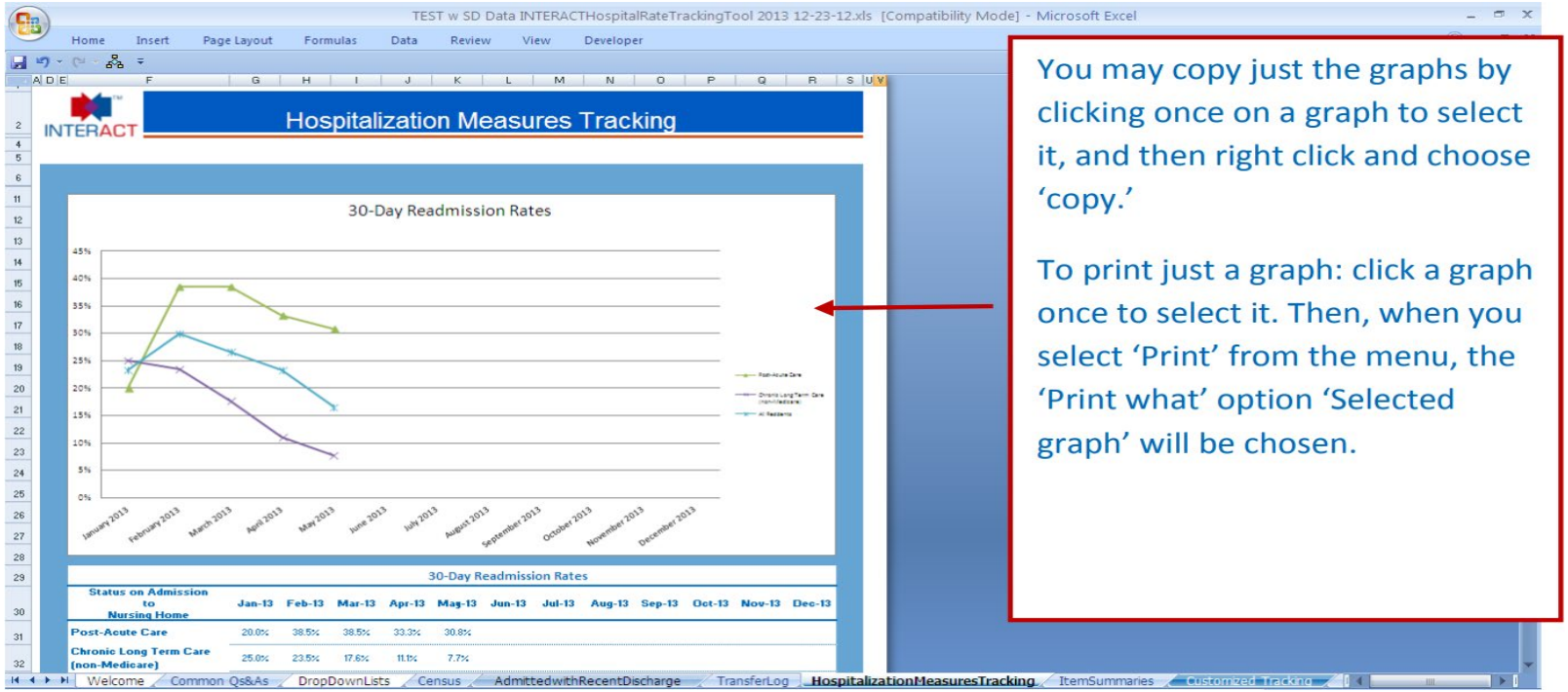
Step 2

- At the **end** of each month, enter your average daily census (ADC) for the month.
- If you are tracking transfers for only part of your facilty or program and/or do not have your ADC by stay type, you may use your census on the 15th day of the month.

NOTE: Whether you use ADC or census, this number should reflect the number of residents in the specified type of care during the month. It is not the same as 'paid beds.'

	Enter Average Daily Census for PAC-type Care*	Enter Average Daily Census for Chronic LTC-type Care*	Combined Average Daily Census for the Month	Days in this Month	Resident Days this Month ADC x The Number of Days in the Month
January 2023	0.0	0.0	0.0	31	0.0
February 2023	0.0	0.0	0.0	28	0.0
March 2023	0.0	0.0	0.0	31	0.0
April 2023	0.0	0.0	0.0	30	0.0
May 2023	0.0	0.0	0.0	31	0.0
June 2023	0.0	0.0	0.0	30	0.0
July 2023	0.0	0.0	0.0	31	0.0
August 2023	0.0	0.0	0.0	31	0.0
September 2023	0.0	0.0	0.0	30	0.0
October 2023	0.0	0.0	0.0	31	0.0
November 2023	0.0	0.0	0.0	30	0.0
December 2023	0.0	0.0	0.0	31	0.0

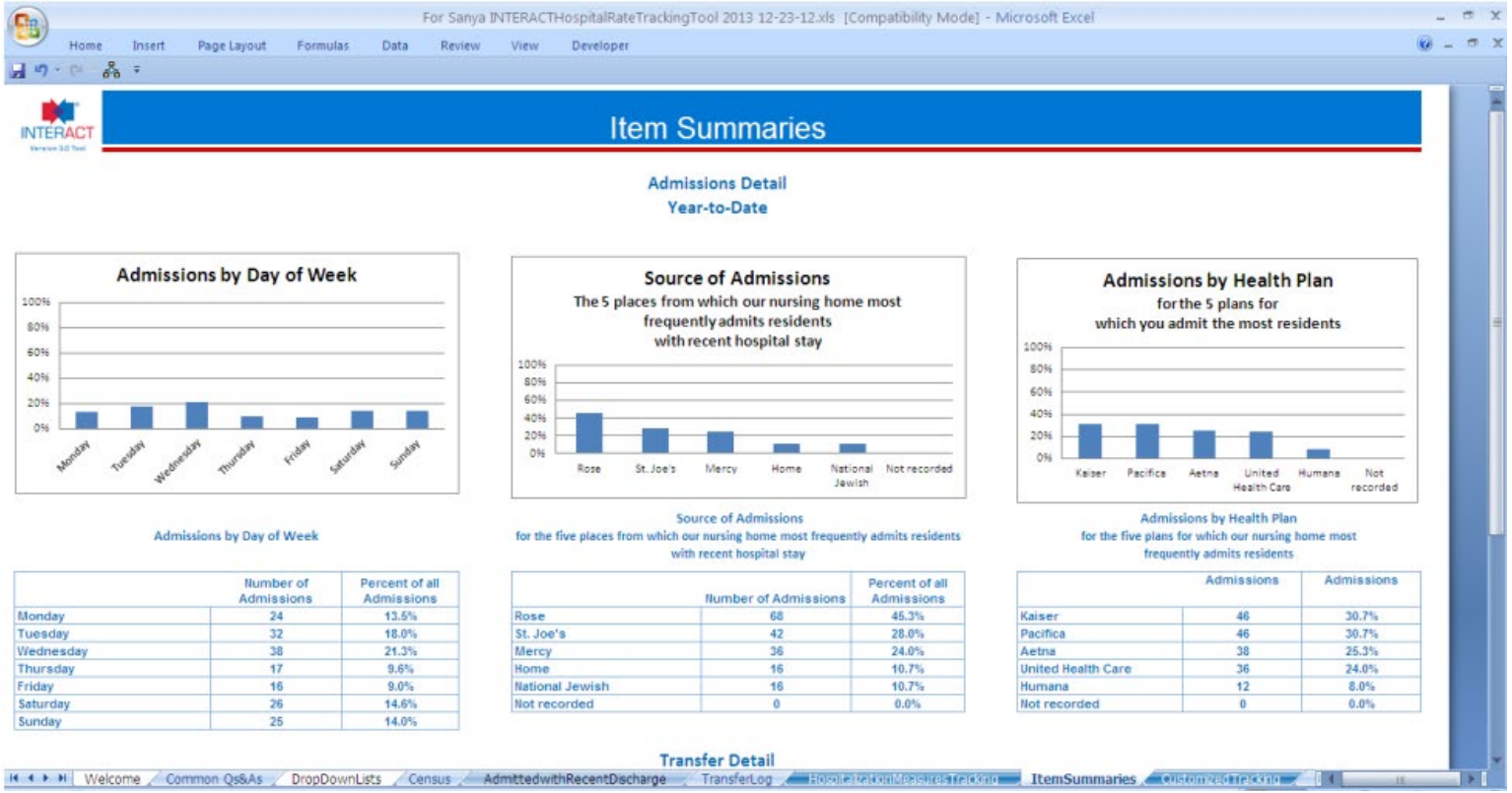
Hospitalization Measures Tracking



You may copy just the graphs by clicking once on a graph to select it, and then right click and choose 'copy.'

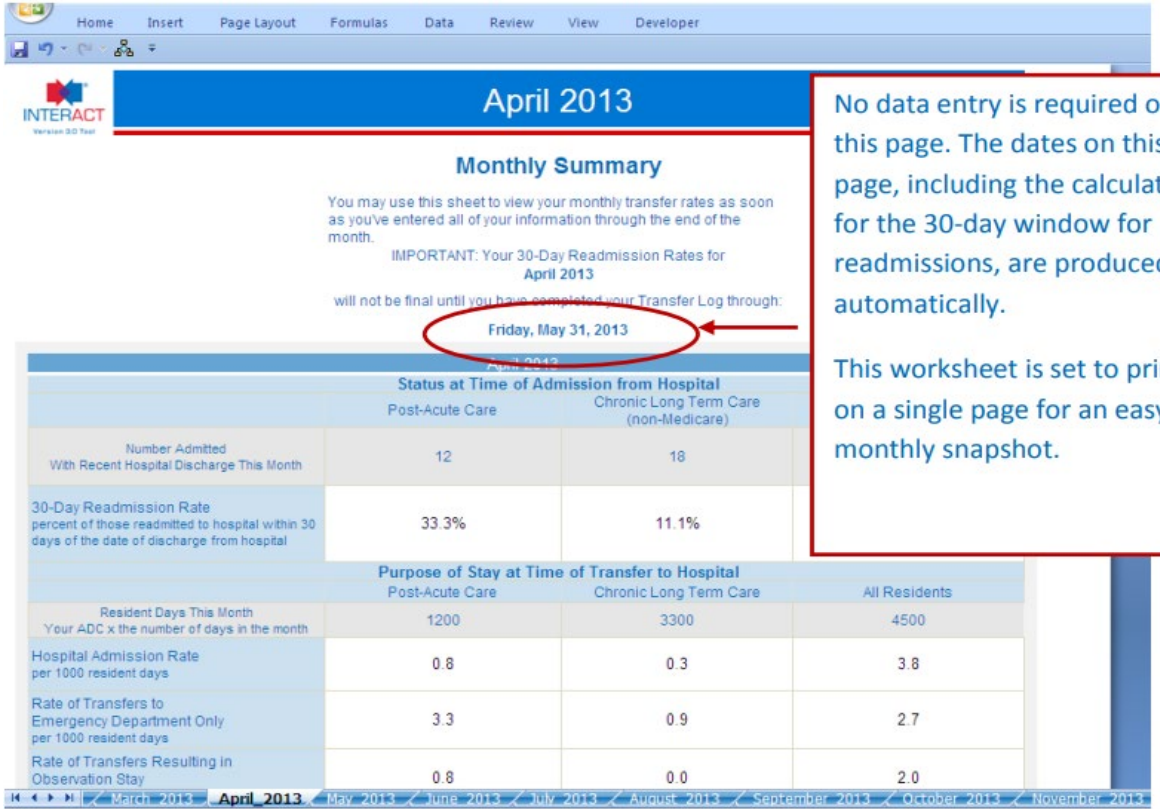
To print just a graph: click a graph once to select it. Then, when you select 'Print' from the menu, the 'Print what' option 'Selected graph' will be chosen.

Item Summaries



Customized Reports

Monthly Summary Sheets



No data entry is required on this page. The dates on this page, including the calculation for the 30-day window for readmissions, are produced automatically.

This worksheet is set to print on a single page for an easy monthly snapshot.

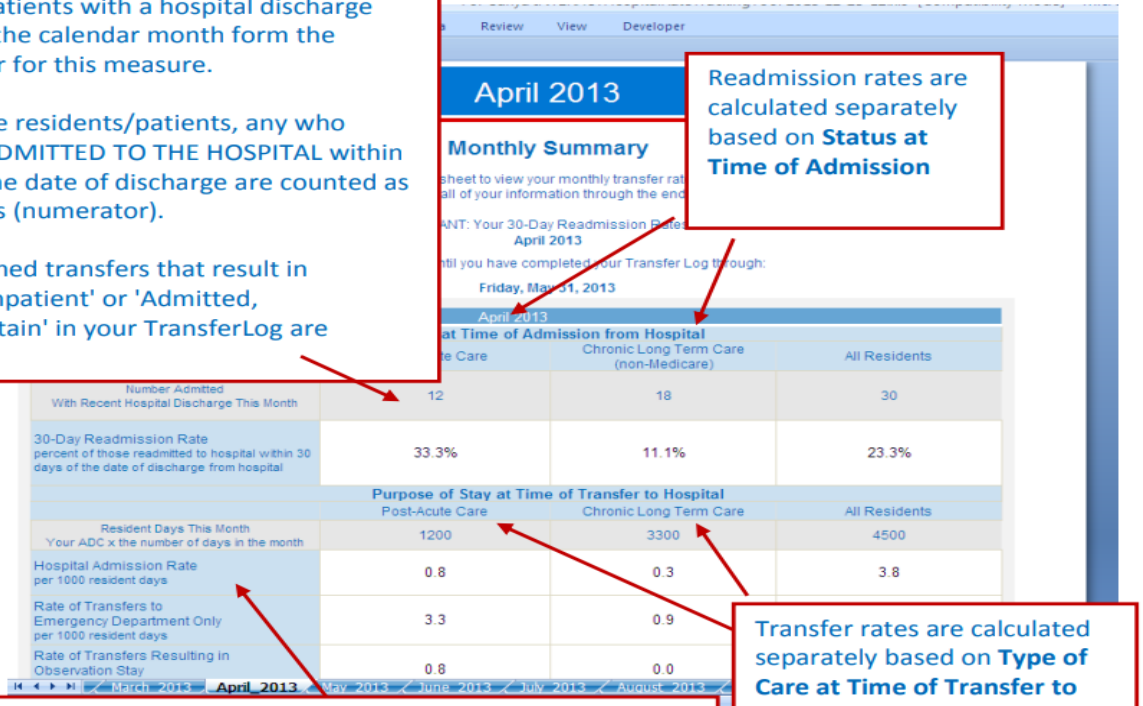
About the Outcomes [QuickLinks]

A complete and detailed discussion is provided in the last tab of your workbook: "CalculatingHospitalizationRates. "

30-Day Readmission Rate:
Residents/patients with a hospital discharge date within the calendar month form the denominator for this measure.

Among those residents/patients, any who were then ADMITTED TO THE HOSPITAL within 30 days of the date of discharge are counted as readmissions (numerator).

Only unplanned transfers that result in 'Admitted, inpatient' or 'Admitted, status uncertain' in your TransferLog are counted.

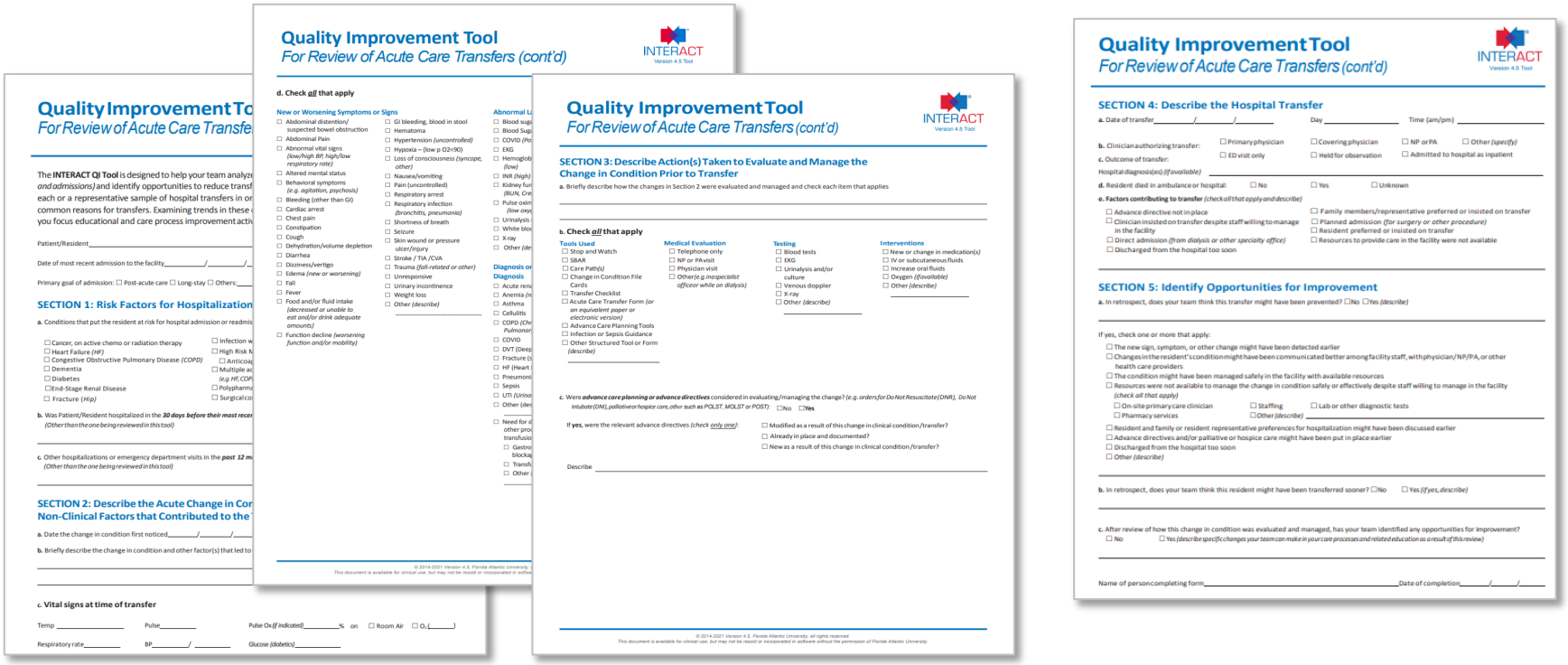


Readmission rates are calculated separately based on **Status at Time of Admission**

Transfer rates are calculated separately based on **Type of Care at Time of Transfer to Hospital**

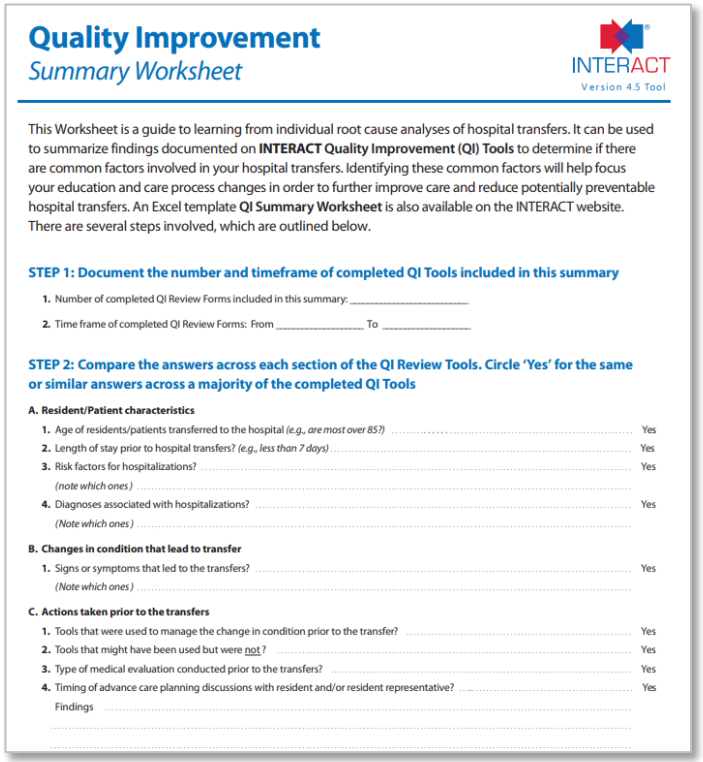
Hospital Admission Rate:
When you record the outcome of a transfer as being either 'Admission, inpatient,' or 'Admission, uncertain,' it will be counted in the Hospital Admission rate.

QI Reviews-Root Cause Analysis



[Quality Improvement Tool for Review of Acute Care Transfers]

QI Summary Worksheet



Quality Improvement
Summary Worksheet

INTERACT
Version 4.5 Tool

This Worksheet is a guide to learning from individual root cause analyses of hospital transfers. It can be used to summarize findings documented on **INTERACT Quality Improvement (QI) Tools** to determine if there are common factors involved in your hospital transfers. Identifying these common factors will help focus your education and care process changes in order to further improve care and reduce potentially preventable hospital transfers. An Excel template **QI Summary Worksheet** is also available on the INTERACT website. There are several steps involved, which are outlined below.

STEP 1: Document the number and timeframe of completed QI Tools included in this summary

1. Number of completed QI Review Forms included in this summary: _____
2. Time frame of completed QI Review Forms: From _____ To _____

STEP 2: Compare the answers across each section of the QI Review Tools. Circle 'Yes' for the same or similar answers across a majority of the completed QI Tools

A. Resident/Patient characteristics

1. Age of residents/patients transferred to the hospital *(e.g., are most over 85?)* ..... Yes
2. Length of stay prior to hospital transfers? *(e.g., less than 7 days)* ..... Yes
3. Risk factors for hospitalizations? ..... Yes
   (note which ones) .....
4. Diagnoses associated with hospitalizations? ..... Yes
   (Note which ones) .....

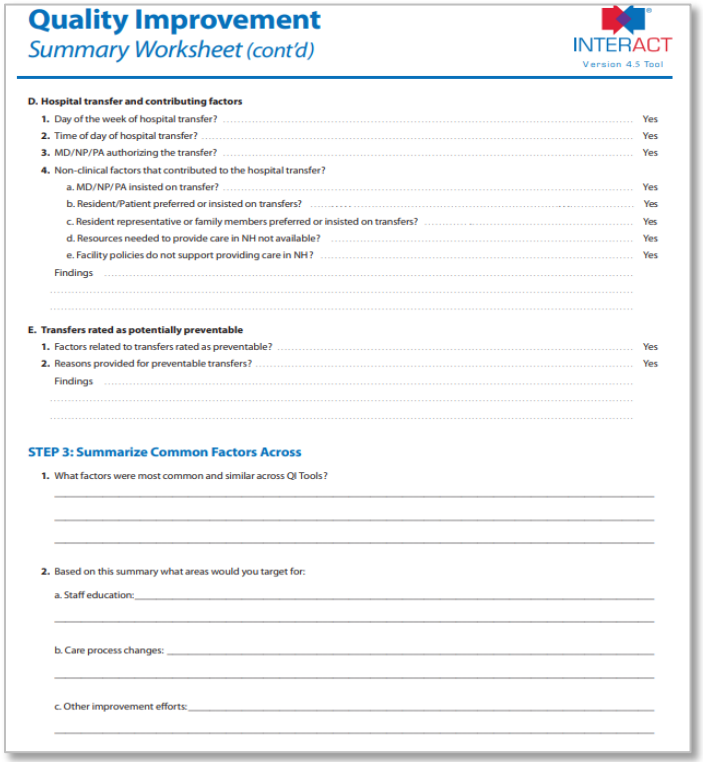
B. Changes in condition that lead to transfer

1. Signs or symptoms that led to the transfers? ..... Yes
   (Note which ones) .....

C. Actions taken prior to the transfers

1. Tools that were used to manage the change in condition prior to the transfer? ..... Yes
2. Tools that might have been used but were not? ..... Yes
3. Type of medical evaluation conducted prior to the transfers? ..... Yes
4. Timing of advance care planning discussions with resident and/or resident representative? ..... Yes

   Findings .....



Quality Improvement
Summary Worksheet (cont'd)

INTERACT
Version 4.5 Tool

D. Hospital transfer and contributing factors

1. Day of the week of hospital transfer? ..... Yes
2. Time of day of hospital transfer? ..... Yes
3. MD/NP/PA authorizing the transfer? ..... Yes
4. Non-clinical factors that contributed to the hospital transfer?
   a. MD/NP/PA insisted on transfer? ..... Yes
   b. Resident/Patient preferred or insisted on transfers? ..... Yes
   c. Resident representative or family members preferred or insisted on transfers? ..... Yes
   d. Resources needed to provide care in NH not available? ..... Yes
   e. Facility policies do not support providing care in NH? ..... Yes

   Findings .....

E. Transfers rated as potentially preventable

1. Factors related to transfers rated as preventable? ..... Yes
2. Reasons provided for preventable transfers? ..... Yes

   Findings .....

STEP 3: Summarize Common Factors Across

1. What factors were most common and similar across QI Tools?

2. Based on this summary what areas would you target for:

   a. Staff education: _____

   b. Care process changes: _____

   c. Other improvement efforts: _____

QI Summary Worksheet

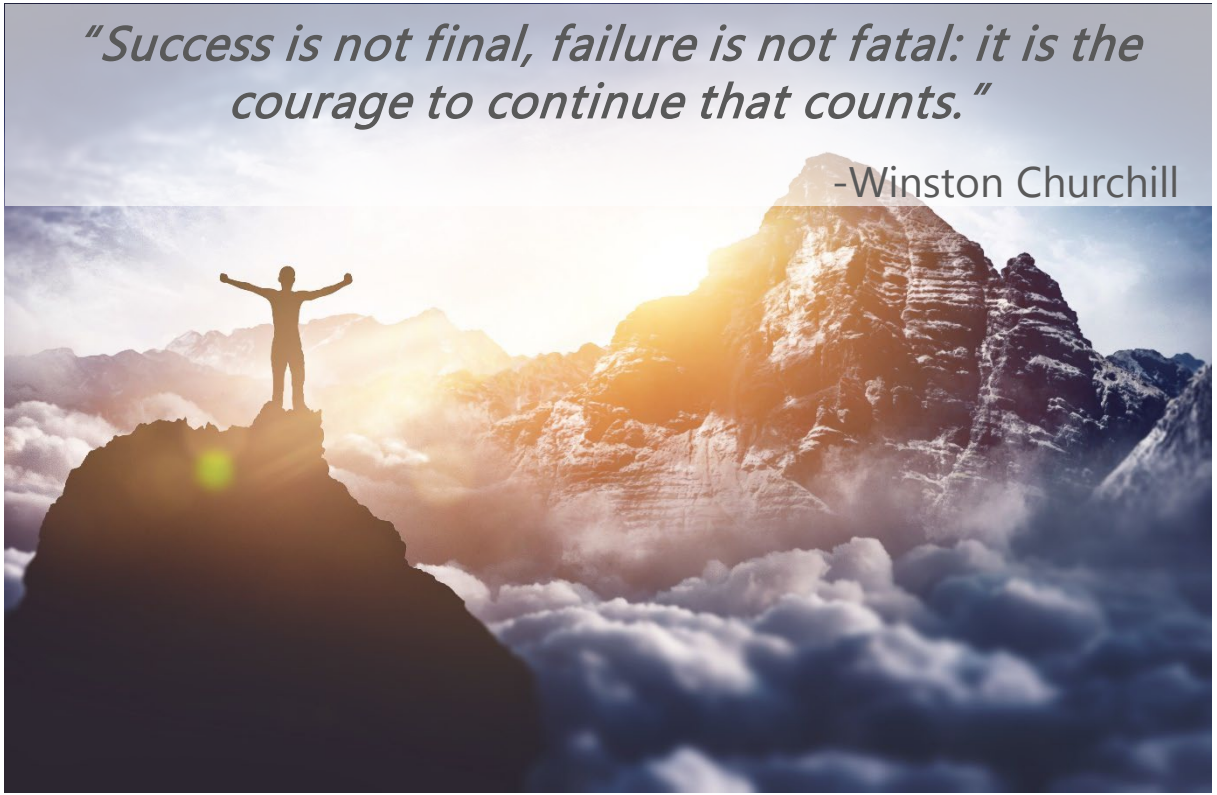
Tips for QAPI

- Evaluate your tracking method/tools and make changes as needed
- Analyze your transfer and hospitalization data to identify areas of focus
- Identify gaps in the system and areas for improvement
- Know your hospitalization and ED visit rate and what factors are driving it

QAPI At a Glance: A Step by Step Guide to Implementing Quality Assurance and Performance Improvement (QAPI) in Your Nursing Home

Helpful Reminders

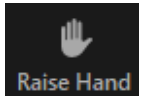
- Not all ED transfers and rehospitalizations should be prevented
  - Acute care may be medically necessary in many situations
  - Accurate assessment of care needs is critical
- Watch for premature hospital discharges and ensure your facility can provide the necessary care
- Know your facility's capabilities and scope of services


"Success is not final, failure is not fatal: it is the courage to continue that counts."
-Winston Churchill

Recognize and Respond Collaborative Learning Sessions

- Learning Session 1: September 12, 2023
  - Advance Care Planning/Resident and Family Engagement
- Learning Session 2: September 26, 2023
  - Communication Strategies
- Learning Session 3: October 10, 2023
  - INTERACT® Care Paths
- Learning Session 4: October 24, 2023
  - INTERACT® QI Tools
- **Collaborative Outcomes: November 14, 2023**
  - **Pulling it all Together and Sustainability**

Questions? Comments? Share What is Working or What is Difficult for Your Team!



Raise your hand to verbally ask a question

Type a question by clicking the **Q&A** icon

Don't hesitate to ask a question after the webinar is over.
Email **LTC@hqi.solutions** *or your HQIN Quality Improvement Advisor.*

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The Center of Excellence focuses on increasing the knowledge, competency and confidence of nursing facility staff to care for residents with behavioral health conditions.

- Provides mental health and substance use trainings, customized technical assistance and resources at no cost
- Services are available to all CMS certified nursing facilities throughout United States
- Established by the Substance Abuse and Mental Health Services Administration (SAMHSA) in collaboration with the Centers for Medicare and Medicaid Services

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For assistance, submit a request at nursinghomebehavioralhealth.org

Contact us:
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Email: coeinfo@allianthealth.org

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Visit the COE-NF website & Online Resource Hub:
nursinghomebehavioralhealth.org

National Call Center: 1-844-314-1433
For more information or to request assistance.

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FOR MORE INFORMATION

Call 877.731.4746 or visit www.hqin.org

LTC@hqi.solutions

Kansas
Brenda Groves
Quality Improvement Advisor
bgroves@kfmc.org
785.271.4150

Virginia and Missouri
Allison Spangler
Quality Improvement Advisor
aspangler@hqi.solutions
804.289.5342

South Carolina
Kristine Williamson
Quality Specialist
kwilliamson@constellationqh.org
919.461.5525

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