NATIONAL RESEARCH
Corporation

PARTNERING FOR POST-ACUTE CARE: NURSING MODELS AND QUALITY METRICS

HCANJ 20-Hour Symposium

March 18, 2015 1-3pm

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Presentation Outline

- Articulate 5 criteria hospitals and other partners consider when choosing a post-acute provider with whom to contract.
- Learn effective change management strategies to achieve transition to a staffing model that employs an empowered, engaged workforce capable of reducing hospitalization.
- State how to properly assess for patient change in condition, use triage protocols and collaborate with medical practitioners to implement appropriate treatment regimen.
- Use a root cause analysis to examine rehospitalizations.

Why is this topic important to you?

Because Hospitals are Looking at YOU

Advice to Hospitals

Given:

- the implementation of federal- and state-operated health insurance exchanges,
- the pending expansion of bundled payment (including post-acute care models),
- penalties for readmissions,
- other payment reform initiatives

You must have a post-acute strategy

or suffer significant quality, financial performance, and patient experience consequences.

This is what they are saying

It is no longer possible to ignore the role of a post-acute strategy without suffering significant quality, financial performance and patient experience consequences.

- *BoardRoom Press*, Dec. 2013

Criterion to Evaluate the Post-Acute Partner Candidate

Compare yourself to other SNFs on these TEN Criterion

Lower **Comparable** **Higher**

1. Performance on Quality

- Track record in Quality
  - Clinical competency
  - Outcomes
- Cost
- Patient experience
  - Ambiance of the care delivery site
  - Responsiveness of staff to patient/caregiver needs
  - Satisfaction
- The partner has the ability to track and benchmark data that demonstrate performance

2. Readmission Rate and other indicators

- The track record for readmission rates to acute care facilities
- Length-of-stay relative to benchmarks specific to a particular clinical condition
- Other clinical indicators

- Medicare officials announced last year they would punish hospitals with hefty fines if they have too many readmissions within 30-days for **heart failure, heart attack and pneumonia** patients by reducing a portion of the hospital's payments by up to one percent.
- Under the health care law, the penalties gradually will rise until 3 percent of Medicare payments to hospitals are at risk and will also include hip and knee surgery and chronic obstructive pulmonary disease.

- Medicare is currently fining 2,225 hospitals for excess readmissions for heart failure, heart attack and pneumonia patients
- Some cities had particularly large numbers of high readmission hospitals.

3. Healthcare reform readiness

- A coordinated, formal care management process (led by on-site hospitalists, SNFists etc)
- Processes supporting performance improvement
- Use of Evidence-based care protocols
- IT infrastructure
  - Connectivity between acute and post-acute providers specific to EMR
  - Computerized physician order entry
- *These factor reveal how much the hospital will have to augment the post-acute care entity's infrastructure and care management processes.*

Care Transition Strategies

- Research shows a strong link between care transitions and lower readmission rates
- When patients move from the hospital to the next site of care, they benefit from
  - A clear treatment plan
  - Providers who are aware of and able to carry out the treatment plan
  - Access to the proper support services

4. Clinical Skills

- Registered Nurses VS Licensed Practical/Vocational Nurses
- Registered therapists VS techs.

5. The FIT with your organization's service line

- Culture
- Mission, Vision, Values
- Integrity
- Focus on patient-centered care
- Safety
- The ability of the post-acute entity to make a positive contribution to the value of the service line brand of the acute-care organization

6. Partner's Leadership

- The stability of the post-acute care organization's leadership team
- Can the post-acute leaders (administrative and clinical) implement a shared plan of action with the acute care hospital to achieve staff accountability
  - Adjusting role descriptions
  - Performance evaluation mechanisms
  - Incentive mechanisms

7. Synergy

- Does the breadth of services offered by the post-acute provider satisfy service line operational, financial, and/or strategic gaps?
- Does the breadth of services support the hospitals critical success factors?
- Do the services appeal to referring physicians, payers and patients?

8. Long-term viability

- Operating and cash-flow position
- Debt capacity
- Ownership structure
- Regulatory status (licensure and accreditation)
- Stability of clinical staff
- Condition of physical plant/resources

9. Accessibility

- The ability to admit/transfer patients to post-acute care 24 hours a day, seven days a week
- Limited/no wait time to achieve patient transfer from the acute to the post-acute setting
- Proximity of the location
- Ease of street access and parking
- Lack of barriers to entry based on payer contracts

10. Ease of forming the partnership

- Level of interest on the part of the post-acute provider
- Track record for prior affiliations, alliances and partnerships
- The time needed to complete due diligence
- The extent of the barriers, if any

Post-acute Care Provider Strategic Partner Evaluation Tool℠

Criterion to Evaluate Partner Candidate	Evaluation (circle one)		
Performance quality: competency, outcomes	Lower	Comparable	Higher
Performance on cost			
Performance on patient experience (satisfaction)			
Readmissions rate and other clinical indicators			
Healthcare reform readiness			
Clinical skills			
"Fit" with your organization's service line			
Partner's leadership: execute, manage integration			
Synergy			
Long-term viability			
Accessibility (location)			
Accessibility (scheduling)			
Ease of forming partnership			

Why is this important?

Care delivery is being redesigned in the hospital – what next?

Future Partners will look at your data

The Care Delivery Redesign

- At the core is payment reform where more profitability meant more services
- Providers are looking to reduce the cost of care as reimbursement pressures rise.
- CMS is no longer providing payments for unnecessary readmissions.
- BUT, did you also know……

Provider payments are also tied to…..

8 HCAHPS measures for Medicare patients

- Communication with nurses
- Communication with doctors
- Responsiveness of hospital staff
- Pain management
- Communication about medicines
- Hospital cleanliness and quiet
- Discharge information
- Overall rating of a hospital

The Good News

Effective Oct 1st, 2012

There are financial incentives for improving HCAHPS Scores!!

The Bad News…

There is no new money!

Effective Oct 1, 2013

Hospital's base DRG payments were

reduced by 1.25%

… to pay for VBP incentive payments

and there's more DRG payment

F2013: 1.0%

F2014: 1.25%

F2015: 1.5%

F2016: 1.75%

F2017: 2.0%

McKnights – October 3, 2014

- The latest round of readmission penalties began 10.1.14.
  - Hospitals that have the highest readmission rates may see their M'care slashed by up to 3%
  - 433 MORE hospitals in the coming year will be impacted than last year
- Investigate your local hospitals' readmissions rate and approach them with plans for lowering it .

McKnights – Emergency Room

- Hospitals are doing more follow-ups after patients are discharged from the emergency department
  - More than 1/3rd of respondents to a survey reported placing phone calls to patients within 24 hours of discharge up from 18% in 2011.

LESSON:

The more you can help a hospital reduce rehospitalizations, the more valuable a partner you become.

Meeting the Needs of the Changing Patient Population

Ellen Rychlik, RN, BSN
Director of Nursing

Defining the Population

- Population we serve has changed
  - Average age of our clientele has increased for both postacute and long term care
  - Older adults are often frailer and have multiple co-morbidities
  - Alternative levels of care results in increased care needs upon admission to SNF
  - Age related functional and physical changes, and family, social, and behavioral issues need to be considered
- Providers of postacute care and skilled nursing must respond to this population shift in order to remain viable

Defining the Change

- Acute care is governed by specific evidenced based care regimens making deviation close to impossible
- In the Postacute industry, care regimen has not yet been standardized
- Clinical providers capability and approach to care are variables
- Advanced directive tools (MOLST, Palliation parameters, etc.) are basis for care direction based on patient choice but not as means to reduce hospitalizations.

Where we need to be in today's Health Care Environment

- Many Health Care Organizations initially reacted by decreasing their utilization of registered nurses by substituting licensed practical nurses (LPNs) and CNA's.
- This situation has reversed in the acute care setting as hospitals soon found that shorter hospital stays—the key to financial health — required a greater intensity of services that was impossible to achieve without a sufficient numbers of RNs.
- Forward-thinking health care leaders will recognize the long-term financial benefit that good nurse staffing and supportive working environments can offer by avoiding complications, improving quality performance and reducing hospital readmissions.

Changing Philosophy Needed

- Little research focuses specifically on RN staffing in nursing homes, in part because nursing homes generally employ large numbers of LPNs and nurses aides and comparatively fewer RNs....Impossible in todays environment.
- The health care continuum is requiring the postacute care level to manage higher level acuity. Employing a 1980's nursing home philosophy as it pertains to staffing models and staff skill will not prepare for this requirement and provide safe, effective/efficient, quality care to the patient and reduced hospitalizations.

Our strategic approach

- SWOT Analysis on Care Delivery Model
  - Strength – Stable dedicated workforce
  - Weakness – Nursing staffing competency level to handle higher patient/resident acuity
  - Opportunity – Securing health care continuum partnerships by increasing nursing staff capabilities
  - Threat – Inadequacy of current staffing model
- Recognized need for paradigm shift in staffing model and staffing capabilities and maintain staffing stability

Keys to staffing stability

- Get the right people on the bus
  - Peer interviewing
- Welcome and engage new staff
  - Mentor program
- Keep staff engaged
  - Flexible scheduling when possible
  - Decisional participation
  - Autonomy
  - Appreciation

First: Effective Change Management

- People's reaction to change:
  - don't resist change
  - resist being changed
- Organizational change
  - normally involves some threat, real or perceived, of personal loss for those involved.
- Need to clearly define the change
  - reason for change
  - empowerment of the employee in decision making
  - personalize the change
- It is critical that people truly understand the vision/the reasoning behind the change for the change to be successful.

And Foremost: Sustainability

- Ability to embrace change is dependent on the organizations ability to engrain the process(s) in its culture, the way we function on a day to day basis.
- Always keep a finger on the pulse. Fine line between micro-management and crisis management.
- Never lose touch with the front-line staff.
- Key to success is to develop systems within a culture that promotes autonomy and ingenuity in line with the organizations vision that are not dependent on a single individuals presence.

Preparing for the Change

Typical LTC Staffing Model

- Primarily staffed by non-licensed/non-professional care givers
- Nurse:patient ratio's ranging from 1:20 – 1:40
- Lack of consistency in care giver.

Primarily Staffed by Registered Nurses

- Professional Nurses.
- Nurse/CNA:patient ratio varies dependent on patient/resident acuity with a max (sub-acute) ratio of 2:13 and a max (LT) ratio of 2:15.
- Staff are permanently assigned to their teams with the only variation occurring on PCUI (Medically Complex/Post-Surgical/Oncological rehab Unit).

Primary Permanent Nursing Care Model (Acuity Based Staffing)

- Model looks at (7) factors determining nursing time required:
  - number/complexity of medication administration
  - complexity of procedures
  - patient education
  - psychosocial issues
  - intravenous therapy needs
  - infection prevention protocols/needs
  - ADL's.

Primary Permanent Nursing Care Model (Acuity Based Staffing)

- Acuity assessments are done every shift and prn
- Adjustments are made to align needs of patients with necessary nursing staff levels
- Nurses help to decrease lengths of stay, prevent illness, errors, complications and readmissions, all of which saves money for providers and health plans and adds to overall productivity.
- Staffing models should be adjusted to reflect the true time required to meet the care needs of the patients based on their acuity level.

ElderWood at Hamburg

Clinical Acuity Intensity Level System

Level I <30 Minutes

- Foley Catheter Insertion
- Sequesntial Compressin Device
- Staple Removal
- PICC Dressing Change
- Accessing Mediport
- Cryocuff Applications
- CPM Placement and Maintenance
- Simple Treatments
- Simple Dressing Change
- Surgeon Protocols
- Range of Motion
- Nourishments
- Drain Care, i.e. JP, Penrose

Level II 30-60 Minutes

- Wound vac Dressing (uncomplicated)
- IV Insertion
- Basic Patient Education
- Soap Suds Enemas
- Moss Tube
- GT/JT
- Nephrostomy Tubes
- Nebulizers
- Med Pass <10 meds
- Moderate Confusion (BIMS=8-12)
- ADL's - Minimal Assistance

Level III 1-2 Hours

- Incontinant Cdiff Patients
- Patients on Diuretics/IV/UTI
- Care of Confused Patient without Complications
- Care of Patient in Precaution Rooms
- Wound Vac Dressing Complicated with Bridging
- IV Push Medications/ Monitoring
- Nursing Admission Assessment
- Vander Lifts
- Nurse Feed
- Med Pass 10-15 Meds
- Ostomy Care
- ADL's - Moderate Assistance

Level IV 2-4 Hours

- Behavioral Patient Physical and Verbal Agression/Wandering
- Increased Psychosocial Needs Related to Nature of Illness
- Care of the Confused Post Surgical Patient (with pins, cast, halo)
- Fresh Post-op without hospital stay
- Care of Confused Patient in Isolation Precautions
- Closed Head Injury
- Neutropenic Patients
- SMARTS ADMITS
- Complex IV Therapy
- Extensive Med Pass >15 meds
- Pending Discharge/Education
- **ADL's - Extensive Assistance**
- COPD/CHF Exacerbations
- TPN
- Nurse Feed
- Paliative Care
- Trach/Suctioning
- Severe Confusion (BIMS=1-7)
- Complex Treatments/Wound Care

Intensity Tool Staffing Requirements: Based on Number of Patient/Resident Encounters [1]

Intensity Levels [2]		Average Time/ Minutes[3]	1 Patient	2 Patients	3 Patients	4 Patients	5 Patients	6 Patients	7 Patients	8 Patients	9 Patients	10 Patients	11 Patients	12 Patients	13 Patients	14 Patients	15 Patients
			Staff Requirements														
I	< 30 min	20	0.04	0.09	0.13	0.18	0.22	0.27	0.31	0.36	0.40	0.44	0.49	0.53	0.58	0.62	0.67
II	30-60 min	45	0.10	0.20	0.30	0.40	0.50	0.60	0.70	0.80	0.90	1.00	1.10	1.20	1.30	1.40	1.50
III	1-2 hours	90	0.20	0.40	0.60	0.80	1.00	1.20	1.40	1.60	1.80	2.00	2.20	2.40	2.60	2.80	3.00
IV	2-4 hours	180	0.40	0.80	1.20	1.60	2.00	2.40	2.80	3.20	3.60	4.00	4.40	4.80	5.20	5.60	6.00

1 TL/Aide time required to see a patient/resident given intensity level, reflected as a fraction of 450 (minutes in an 7.5 hour shift)

2 Time(minutes) required to deliver nursing care

3 Average nursing time for each intensity level.

Ref. The Magnuson Model

*Staff Requirements = Average Nursing Time(Minutes)/450(minutes in 7.5 hour shift) x # of Patients

Determining Clinical Acuity (DART)

- Development of communication tools identifying specific acute concerns.
- Daily Acuity Reporting Tool (DART)
- PARED
  - Problem – any deviation from patient/resident baseline
  - Action – chosen in treatment of the problem identified
  - Response – patients response to the action chosen in treatment of the problem
  - Evaluation – is the plan effective….if not we need to go back and assess the problem and choose a new action in treatment of the problem.
  - Diagnostic Testing – Trending of pertinent lab values to ensure immediate intervention in prevention of acute exacerbation

Tools to Determine Staff Educational Opportunities for Quality Improvement/Assurance

- Thorough Case Review is conducted on every hospital transfer evaluating the symptoms and appropriateness of treatment leading up to acute exacerbation.
- Evaluation of Nurse Triage Process, assessment of patient condition/history, dialogue with provider, critical thinking skills, suggestions in treatment possibilities
- Attempted treatment and timeliness of intervention in attempt to prevent hospitalization.
- Prevalence of Admitting Diagnosis, CHF, Sepsis, Dehydration
- Identification of Particular Care Provider, Shift

elderwood
at HAMBURG

Hospitalization Tracking Record

Patient/Resident Name	Date of Admission to Facility	Date of Hospital Transfer	LOS Prior to Transfer	Level of Care	Time of Transfer	Transferring MD/NP	Symptoms Necessitating Transfer	Admitted to Hospital	Admitting Diagnosis	Payor Source	Hospital LOS
Adams, Janet	3/11/08	5/10/08	60	SA	1730	Dr. Andrews	Severe Hypotension and Tachycardia	Yes	MI	BC/BS	5days

Patient/Resident Name	Level of Care SA/LT	Date/Time of Transfer	Provider	Synopsis	Valid (Yes) or (No)	Rationale
Nancy *Pulmonary Embolism*	SA	11/1/12		71 year old female admitted from St. Francis for "further rehabilitation" as hospital diversion - exacerbation of lower back pain s/p I&D for surgical wound dehiscence post L3-5 Laminectomy with dural repair for significant lumbar stenosis. On 10/31 patient presents @ 1330 with new onset significant pain rated at 8 on scale of 1-10. Patient stating "it hurts when I breath". Lungs clear to auscultation. Resperations easy and regular. T = 99.8- P80-R18 BP=160/80. SPO2 RA = 95%. NP notified and in to assess patient. New orders = UA/C&S – CXR – Stat CBC/BMP – Rocephin IM – ECG. CXR resulted in No Acute Process. ECG = NSR with possible left atrial enlargement, ST abnormality possible. At 1845 T=101.3-90-18 BP 157/77. SPO2=91% on RA. Pain med administered with effect. On 11/1/12 at 0300 patient presents with T=102.4-118-28 BP=198/80. SPO2=89% RA. O2 applied with improvement to 92% on 2L. Patient c/o of pain in ribs. Call placed to NP with new order to transfer to ED for evaluation. Patient admitted with PE.	YES	**(Yes)Symptoms indicative of PE.**

Patient/Resident Name	Level of Care SA/LT	Date/Time of Transfer	Provider	Synopsis	Valid (Yes) or (No)	Rationale
	Mary Ann *GI Bleed*	12/8/12		88 year old female admitted to Hamburg 11/19/12 s/p hospitalization for Bradycardia. Medical history significant for DM, CKD, Ischemia BUE, HTN. Patient intake poor manifested in BUN of 60 (56). On 12/3 NP ordered IV of 0.9 NS to infuse over 5 days at a rate of 60cc/hr. On 12/7 Dr. in to examine patient with new orders to increase IV rate to 80cc/hr. VSS throughout stay. On 12/8 at 0230 patient presents with large amount of bloody emesis with clots. BP 82/39 AP126. New order to transfer for evaluation. Patient admitted with GI bleed.	YES	**(Yes) Patient in need of higher level of care with ProfoundHypotension and tachycardia resulting from gross bleeding avoiding potential shock.**
Betty A *Sepsis/UTI*	LTC	12/28/12		On 12/27 resident presents with T101.3. Lortab administered as scheduled which resulted in temp of 99.6. Remaining VSS. Resident denied any GU or Resp symptoms. Full System Assessment unremarkable. NP notified with new order to monitor. 12/28 resident consumed 100% of food and fluid for breakfast and 50%for lunch. Making generalized statements of not feeling well. 1630 Dr. in to see resident with new order to obtain influenza culture/Droplet Precautions – UA/UCS - CBC with diff/CMP – IV Hydration/ATB – CXR – Gut Prophy. CBC resulted in WBC = 30K. WBC on 12/21=7.0 and on 12/14=5.9. 1700 IV inserted and hydration initiated. 1800 Dr. in to assess resident and spoke with daughter/HCP agent who stated that she "would like to come in and evaluate her mom prior to making the determination over hospitalization. 1830 daughter arrived at facility and stated that she would like her mother transferred to ER for eval. Patient admitted with Sepsis.	Yes/ No	**(Yes) Family insisting on transfer and very confrontational.** **(No) WBC resulting at 1430 of 30k. IV ATB ordered to begin at 2200. No IM loading dose ordered.** ***The SSC - Surviving Sepsis Campaign: international guidelines for management of severe sepsis and septic shock: 2008. Crit Care Med 2008;36:296-327. recommends that intravenous antibiotics are begun within the first hour after diagnosis of severe sepsis and septic shock.***[1]

Patient/Resident Name	Level of Care SA/LT	Date/Time of Transfer	Provider	Synopsis	Valid (Yes) or (No)	Rationale
W. C. *CHF/AFib*	LTC	1/13/13 0315		Resident admitted to Lakewood on 3/16/12 SA from SBM s/thoracic Spine Compression Fracture – Sleep Apnea – BPH – HTN – Hypercholesterolemia – Osteopenia – AF – COPD – Hypothyroidism. On 4/25/13 resident was transitioned to LTC. On 11/29 resident was diagnosed with Atrial Fib via ECG performed for medical clearance prior to supra-pubic catheter placement. Resident on Coumadin. On 1/8/13 resident presented with a productive cough and congestion. Dr. in to assess resident with new orders to insert HT and begin infusion of Rocephin – Dounebs – Mucinex. Patient remained afebrile with remaining VS unremarkable up until 1/13 when patient presents with difficulty breathing, course audible rhales, SPO2 74% on RA which improved to 91% on 02 at 4L. VS as follows 98.3 – AP 110-130 – 19 BP=140/95. Call placed to provider with new order to transfer for evaluation. Resident admitted with CHF and AF.	NO	(No) Perhaps being the resident did have IV access an attempt could have been made to diurese the patient prior to transfer. His BP could have safely tolerated it. AFib was not a new diagnosis.
L. D. *AFib/CHF/RVR*	SA	1/28/13 2200	.	88 year old female patient admitted at 1925 s/p Respiratory Failure secondary to COPD Exacerbation – Pacemaker (Non-Functioning) - Bronchitis – History of Falls. Patient is a Full Code. Patients did have poor appetite. Was seen by NP on 1/14 with new orders to D/C Digoxin and begin Remeron. No Dig level was drawn. Vital signs = 98. – 72 – 18 BP136/80. Patient seen on 1/17 with new order to decrease Cardizem dosage. Patient seen on 1/21with Cardizem dose decreased. BP on 1/23 110/61 and AP = 87. 1/26 BP=108/86 with AP = 68. 1/27 BP = 130/98 with AP = 74. On 1/27 at 2120 patient presents with an AP = 140-170 and BP 92/50. Patient with history significant for AF. Call placed to provider with new order to transfer for evaluation. Patient admitted with diagnosis of Acute CHF related to diastolic dysfunction, AFib and RVR (D/C of Calcium Channel Blocker), Acute Hypoxic Respiratory Failure secondary to Pulmonary Edema due to acute CHF. Patient readmitted to Lakewood on Digoxin and Cardizem and placed on Palliative Care.	Yes/ No	Patient with significant medical history of AF and CHF managed on Digoxin and Cardizem. Digoxin and Cardizem discontinued prior to acute onset. Although patient did present with Anorexia, there was no Digoxin level drawn prior to discontinuation of medication. Patient was readmitted to Lakewood on Digoxin and Cardizem.

Patient/Resident Name	Level of Care SA/LT	Date/Time of Transfer	Provider	Synopsis	Valid (Yes) or (No)	Rationale

Total Transfers: 3
Case Reviews: 3(Resulting Exclusion Determination, i.e. Appropriate Hospitalization – 2/3)
Admissions: 3
Exclusions (Direct Admits/Pre-plans/Trauma/Gross Bleeding/True Cardiac and Neurological Events/Inappropriate Hospital Discharge/Family Request, Case Review Determination of Patients Requiring a Higher Level of Care)
Pre-Plans/Direct Admits: 0
Family Request: 1
Cardiac: 1
Neurological Event: 0
Trauma: 0
Gross Bleeding: 1
Urology Consultation: 0

Unnecessary Hospitalization: 1

2012 Transfers: 56
Unnecessary Hospitalizations: 8

Continuing Education Requirements

- Clinical Education is driven off of case review determinations and efficacy of triage processes, diagnostics, documentation logistics, etc.
- Curriculum Development with “Test Out” determinations of competency both written and lab based demonstrations.
- Critical Thinking evaluation based on response to case review scenarios.
- All licensed nurses trained in phlebotomy.
- PICC Certified Nurses
- Infusion Therapy Education provided to all nursing staff on care/assessment of various VAD’s, lab value interpretation and treatment options, i.e. TPN, Crystalloids, Diuretics, Steroids, Antibiotics, etc.

Evaluating Capital Resource Investment

- Phlebotomy Supplies
- IV Pumps
- ECG Machine
- Dinamaps
- Bair Hugger
- SCD's
- Wound Vacs, etc.

Continual Focus

- Overcoming stigma of “nursing home”
- Educating health care continuum of our capabilities
- Demonstrating our competence
- Maintaining and enhancing staff skill levels
- Analyzing our environment for partnership opportunities

Facility Results

- My InnerView "Former Patient"
  - Recommendation to Others – 96%*
  - Overall Satisfaction – 95%*
  - Competency of staff – 98%*
  - RN/LPN Care – 99%*
  - CNA Care – 99%*
  - Quality of Medical Care – 97%*
  - *% excellent/good – ytd 2014
- Nursing Home Compare
  - 5-Star Overall Rating
- Staffing turnover
  - 20% or less consistently
- Hospitalization Rate
  - 4% or less consistently (unplanned)

Do you think satisfaction has any relationship with return to hospital?

Voice of Former Patient

Former Patient Response Rates

Former Patient Satisfaction

	2013	2012	2011
Response Rate	N/A	N/A	N/A
Communities Surveyed	2,483	2,501	2,476
Surveys Received	77,767	102,402	96,133

2013

Trending numbers for Discharge Surveys

Year		OverAllSat-%Excellent	OverAllSat-%Exc&Good	Recommendation-%Excellent	Recommendation-%Exc&Good
2008		39%	79%	41%	78%
2009		44%	83%	46%	82%
2010		48%	86%	50%	85%
2011		50%	87%	52%	87%
2012		52%	88%	53%	87%

2013

NATION'S FORMER PATIENTS SAY:

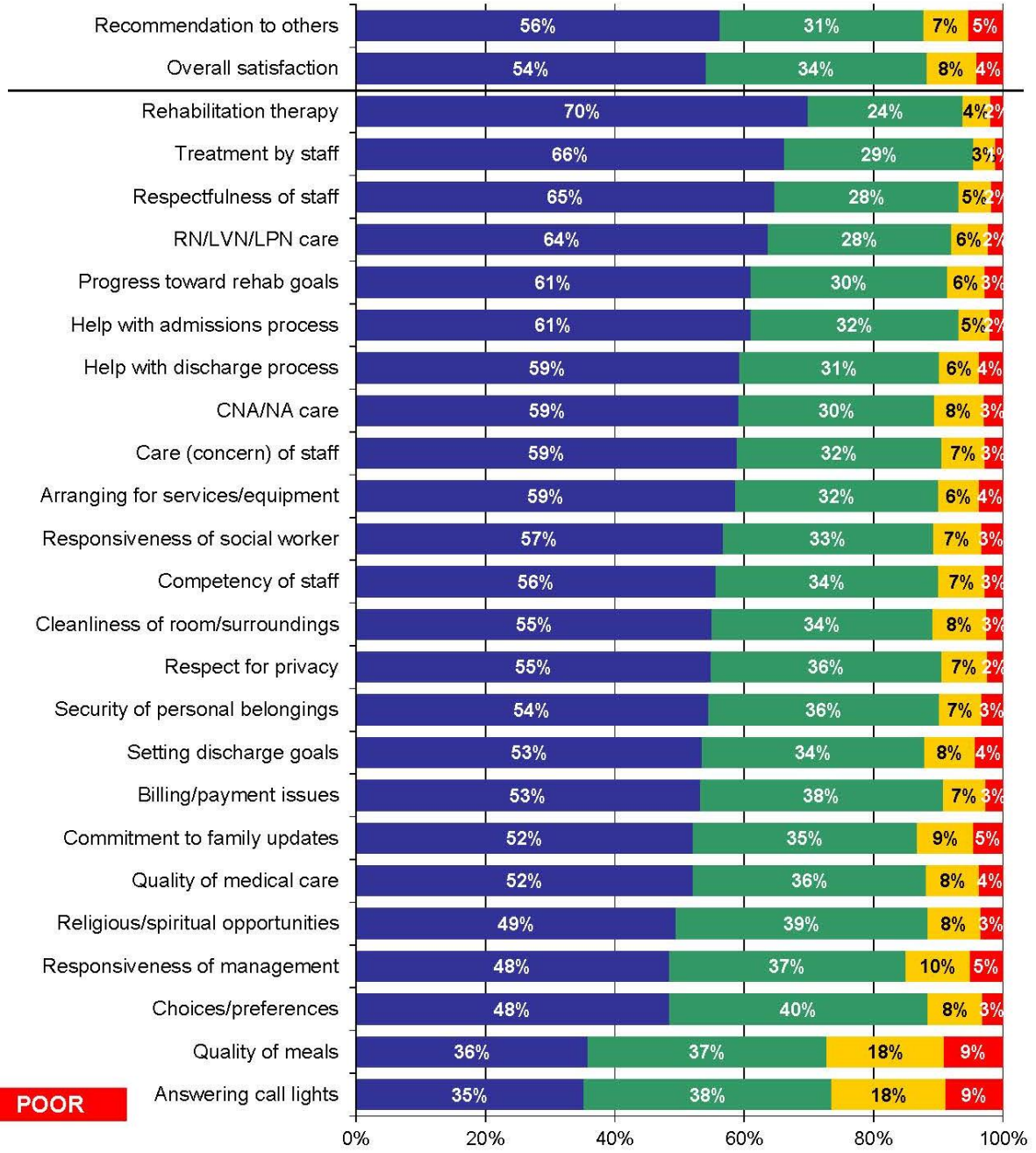
WHAT MATTERS MOST IN A NURSING HOME

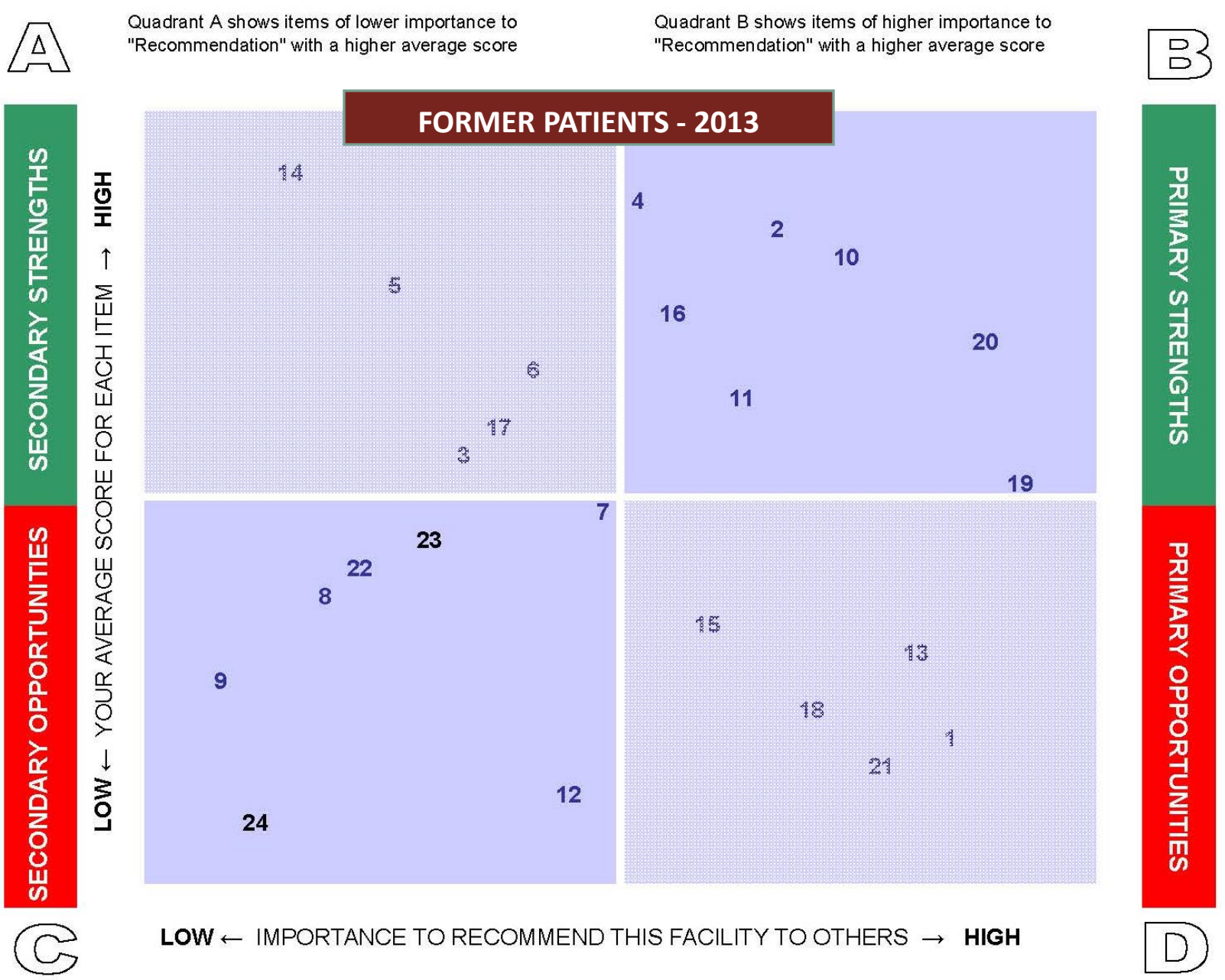
5 Responsiveness of Management
6 RN/LVN/LPN care
7 Commitment to family updates
8 Respectfulness of staff
9 CNA/NA care
10 Setting discharge goals

Being a **nurse** isn't about grades, it's about being who we are. No book can teach you how to **cry with a patient.** No class can teach you how to tell their family that their parents have died or are dying. No professor can teach you how to find dignity in giving someone a bed bath. A nurse is not about the pills or the charting. It's about being able to **love people** when they are at their weakest moments.

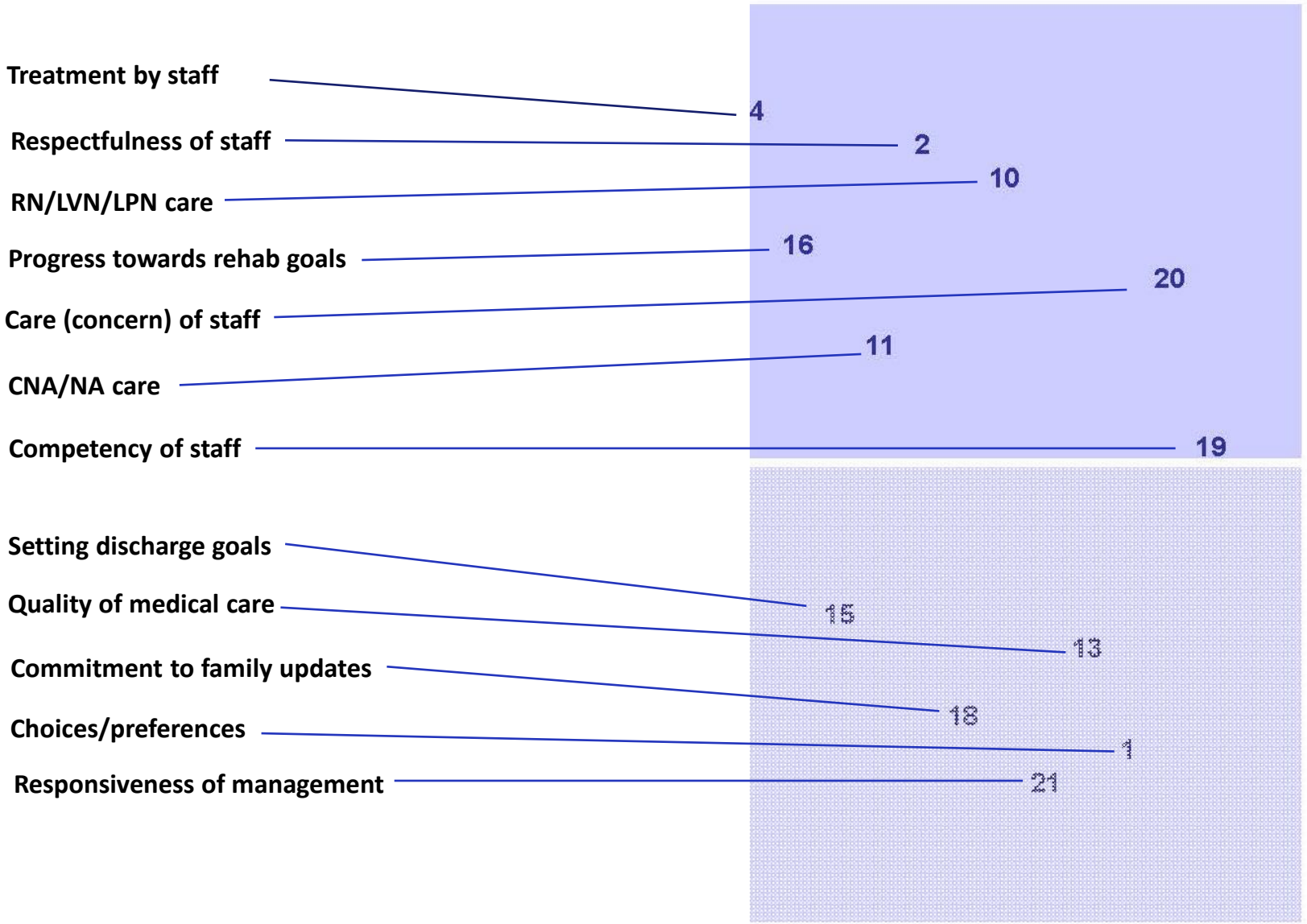
Items Ranked by Percent "Excellent"

2013




A
Quadrant A shows items of lower importance to "Recommendation" with a higher average score
Quadrant B shows items of higher importance to "Recommendation" with a higher average score
B
FORMER PATIENTS - 2013
SECONDARY STRENGTHS
PRIMARY STRENGTHS
SECONDARY OPPORTUNITIES
PRIMARY OPPORTUNITIES
LOW ← YOUR AVERAGE SCORE FOR EACH ITEM → HIGH
14
5
6
17
3
4
2
10
16
20
11
19
7
23
22
8
9
24
12
15
13
18
1
21
LOW ← IMPORTANCE TO RECOMMEND THIS FACILITY TO OTHERS → HIGH
C
D
Quadrant C shows items of lower importance to "Recommendation" with a lower average score
Quadrant D shows items of higher importance to "Recommendation" with a lower average score

FORMER PATIENTS - 2013



B

PRIMARY STRENGTHS

PRIMARY OPPORTUNITIES

D

National Aggregated Results for 2013

Length of Stay	
Less than 1 month	71%
1 to 3 months	25%
3 to 6 months	1%
6 months to 1 year	2%
1 to 3 years	0%
3 years or more	0%

Reason for Choosing	
Convenient location	38%
Good reputation	24%
Doctor or hospital	24%
Relative or friend	3%
Insurance requirement	4%
Other reason	6%

Person Visiting Most	
Spouse	44%
Child	31%
Brother or Sister	9%
Grandchild	0%
Friend	14%
Another person	3%

Gender of Resident	
Female	64%
Male	36%

National Aggregated Results for 2013

Age of Resident	
19 or under	0%
20 to 29	0%
30 to 39	1%
40 to 49	1%
50 to 59	11%
60 to 69	18%
70 to 79	29%
80 to 89	34%
90 or older	0%

Homes Visited	
None	69%
Only this one	3%
Two	18%
Three	6%
Four	3%
Five or more	1%

How Often Visited	
Less than once a year	0%
Once a year	0%
Once every 3 months	0%
Once a month or more	4%
Once a week or more	28%
Almost daily	68%

Current Living Arrangements	
Home alone	25%
Home with Family	55%
Assisted Living	11%
Hospital	0%
Independent Living Apartment	5%
Other	4%

How do I access my reports

From: <info@myinnerview.com>
Date: Fri, Aug 16, 2013 at 3:53 PM
Subject: MyInnerview Discharge Scheduled Reports
To: Client@clientemail.com

Your MyInnerview Discharge Dashboard report and full report are ready! Use the Dashboard report as a quick and effective way to get a pulse on how you are doing with a high-level view of areas of excellence and opportunities for improvement. Select the full report to view complete details. To access either report, click on the link and enter your username and password.

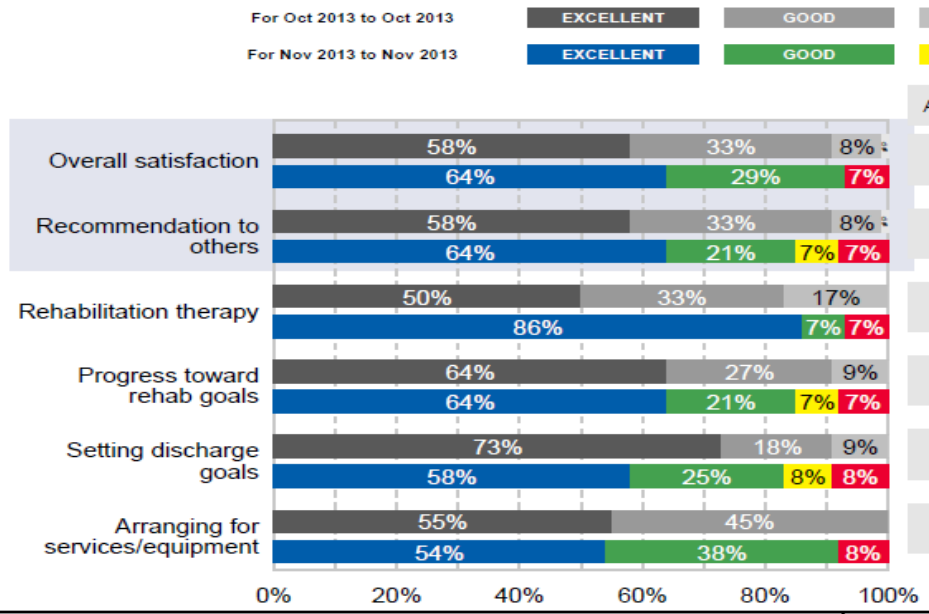
- Harlingen - Dashboard Full
- Silver Stream - Dashboard Full
- Lincolnton - Dashboard Full
- Berthoud - Dashboard Full
- Huntington - Dashboard Full
- Odin - Dashboard Full

Should you encounter any difficulties please reach a support specialist by dialing 1-800-601-3884 or emailing help@myinnerview.com.

Discharge Dashboard

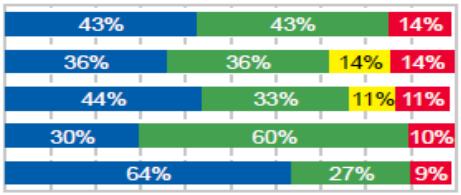
Prepared for: My Facility
Facility Type: Skilled Nursing Home
National Peer Group: 2168 facilities

Data Represents: Nov 2013 - Nov 2013
***Response Rate:** 42%
Surveys distributed: 33 **Returned:** 14
* If you utilize bulk mailing, the response rate cannot be calculated accurately

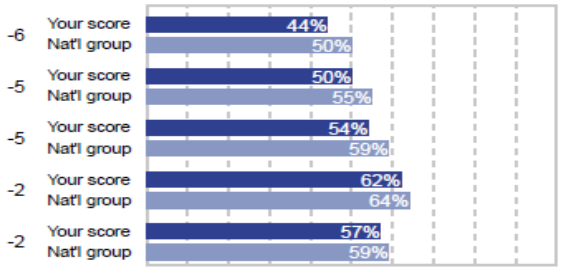


	Avg. Score	Nat'l Avg.	Percentile
Overall satisfaction	83	80	59
	83	80	59
Recommendation to others	83	80	58
	81	80	53
Rehabilitation therapy	78	87	19
	90	87	65
Progress toward rehab goals	85	83	58
	81	83	41
Setting discharge goals	88	79	79
	78	79	47
Arranging for services/equipment	85	82	63
	79	82	43

Internal Focus: 5 Items with highest percent "poor"



External Comparision: 5 Items with greatest difference in % "Excellent" Score



Long-term focus: Quadrant Analysis

Includes last 6 months of response if total >= 30

Primary Strengths

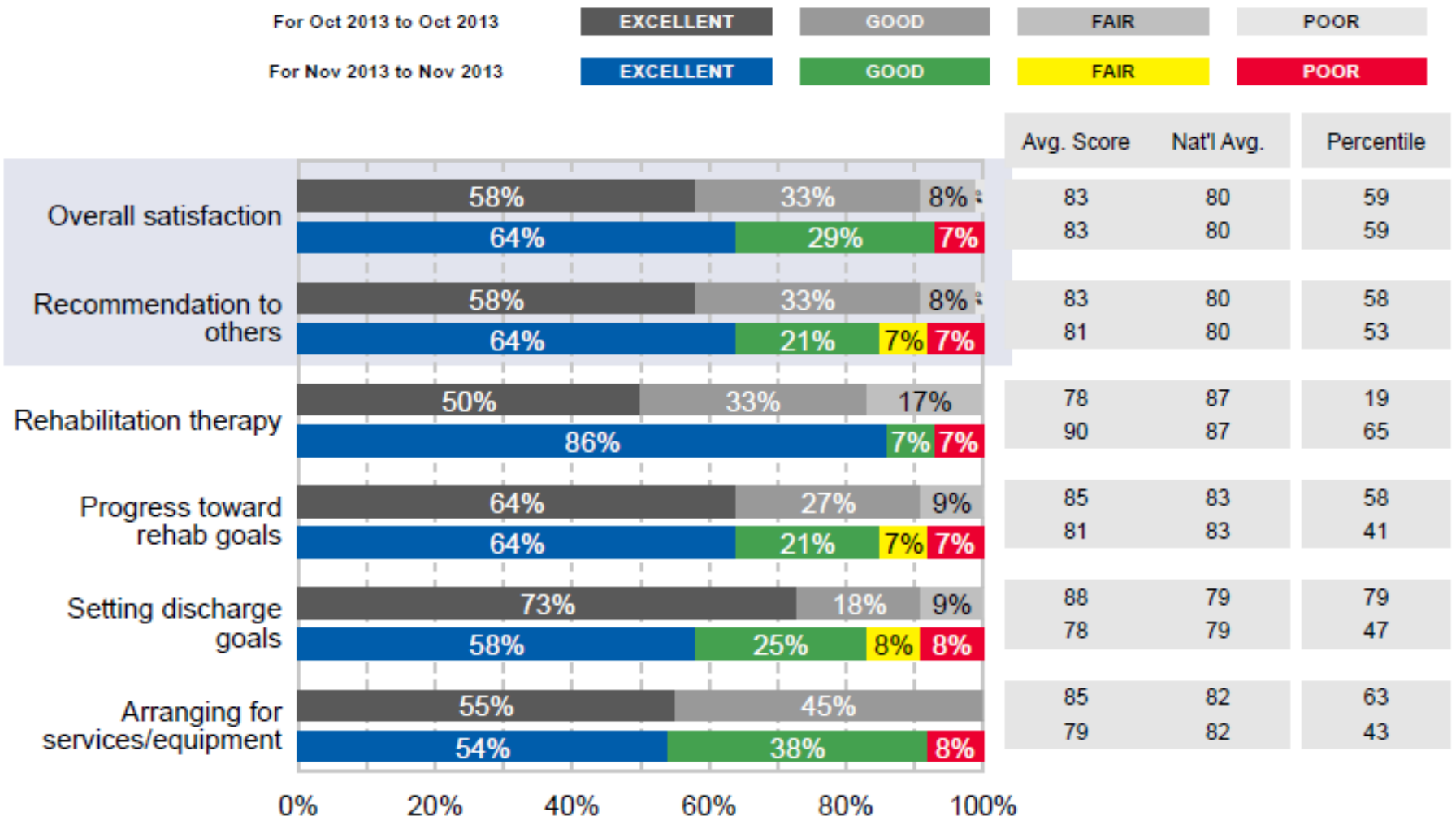
Quadrant B shows items of higher importance to "Recommendation" with a higher average score

- 19 Competency of staff
- 22 Security of personal belongings
- 10 RN/LVN/LPN care
- 16 Progress toward rehab goals
- 3 Respect for privacy

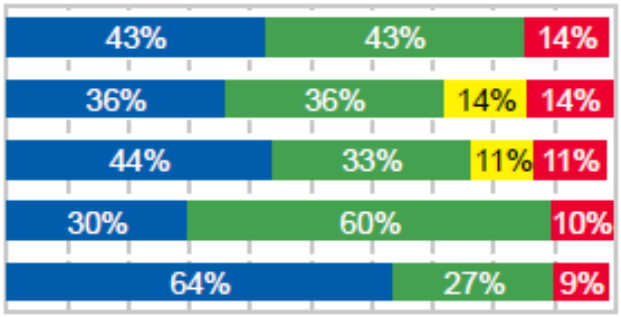
Primary Opportunities

Quadrant D shows items of higher importance to "Recommendation" with a lower average score

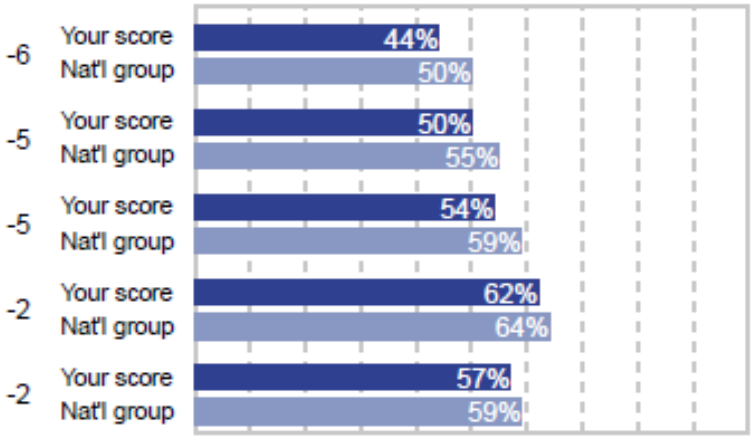
- C1 Meaningfulness of activities
- 1 Choices/preferences
- 21 Responsiveness of management
- 13 Quality of medical care
- 20 Care (concern) of staff


For Oct 2013 to Oct 2013
EXCELLENT
GOOD
FAIR
POOR
For Nov 2013 to Nov 2013
EXCELLENT
GOOD
FAIR
POOR
Avg. Score
Nat'l Avg.
Percentile
Overall satisfaction
58%
33%
8%
64%
29%
7%
83
80
59
83
80
59
Recommendation to others
58%
33%
8%
64%
21%
7%
7%
83
80
58
81
80
53
Rehabilitation therapy
50%
33%
17%
86%
7%
7%
78
87
19
90
87
65
Progress toward rehab goals
64%
27%
9%
64%
21%
7%
7%
85
83
58
81
83
41
Setting discharge goals
73%
18%
9%
58%
25%
8%
8%
88
79
79
78
79
47
Arranging for services/equipment
55%
45%
54%
38%
8%
85
82
63
79
82
43
0%
20%
40%
60%
80%
100%

Internal Focus: 5 Items with highest percent "poor"



External Comparision: 5 Items with greatest difference in % "Excellent" Score



Long-term focus: Quadrant Analysis

Includes last 6 months of response if total >= 30

Primary Strengths

Quadrant B shows items of higher importance to "Recommendation" with a higher average score

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22	Security of personal belongings
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Quadrant D shows items of higher importance to "Recommendation" with a lower average score

C1	Meaningfulness of activities
1	Choices/preferences
21	Responsiveness of management
13	Quality of medical care
20	Care (concern) of staff

“What gets measured, gets improved.”

Peter Drucker

Why is this important?

QAPI is here
Future Partners will look at your data

Toyota's Five Important Questions

Just Ask Why

The nurse made a medication error

The wrong medication was in the drawer

The pharmacy tech put it in the drawer

The tech read it off the computer that way

The nurse put it in the computer that way

The nurse misread the doctor's writing as the medication was only one letter different from the one she thought was correct.

The nurse misread the doctor's handwriting and entered the wrong medication on the order sheet

The 5 Elements of QAPI

1. Design and Scope
2. Governance and Leadership
3. Feedback, Data Systems, Monitoring
4. Performance Improvement Projects
5. Systematic Analysis and Action

Feedback, Data Systems, Monitoring

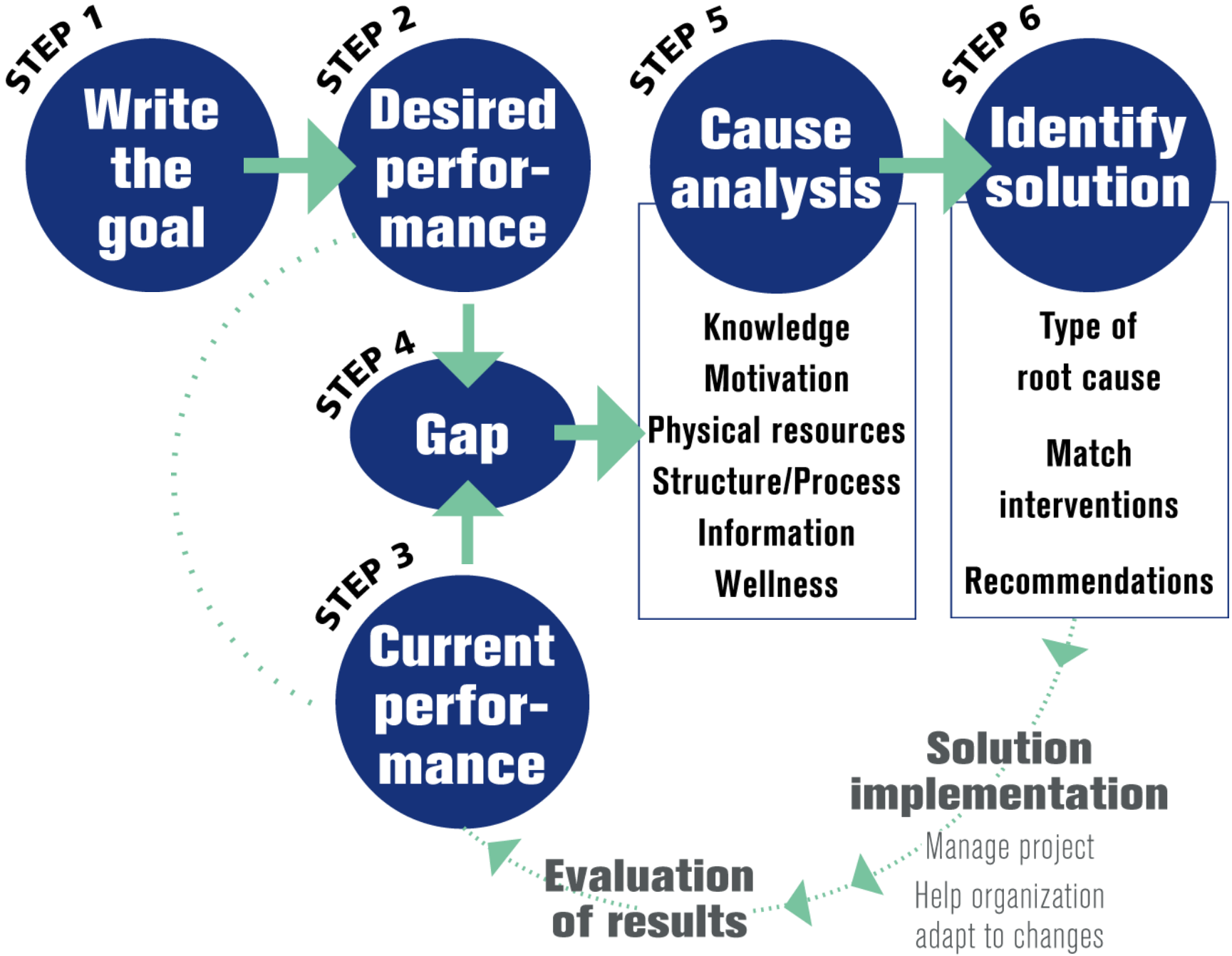
- Systems are in place to monitor care and services
- Feedback systems receive input from staff, residents, families and others
- Performance indicators monitor a wide range of care processes
- Findings are benchmarked
- Targets are established

Systematic Analysis and Action

- Homes use a systematic approach to determine when in-depth analysis is needed to fully understand the issue
- A highly structure approach is to be used
- Homes will be expected to be proficient in the use of ROOT CAUSE ANALYSIS
- There is a focus on continual learning and continuous improvement.

Human Performance Improvement Model

American Society of
Training and Development


STEP 1
Write the goal
STEP 2
Desired performance
STEP 3
Current performance
STEP 4
Gap
STEP 5
Cause analysis
Knowledge
Motivation
Physical resources
Structure/Process
Information
Wellness
STEP 6
Identify solution
Type of root cause
Match interventions
Recommendations
Solution implementation
Manage project
Help organization adapt to changes
Evaluation of results

Narrow the focus

STEP 1	WRITE THE GOAL: Clearly state what outcome you would like to accomplish.
PRIMARY BUSINESS INITIATIVE:	Decrease hospital readmissions
GOAL:	

Narrow the focus

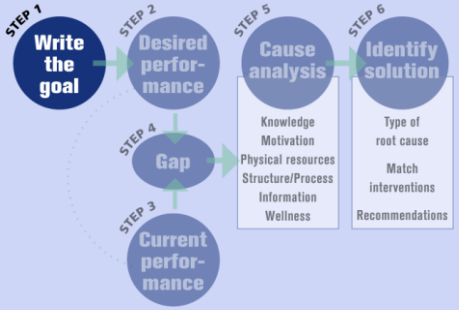
Decrease hospital readmissions

OPPORTUNITIES

- Understand your current rate of rehospitalizations
- Know the current rate in your state/city/region.
- Know the rate for managed care patients as well as traditional M'care patients
- Improve communications using INTERACT

STEP 1

Write the goal



- What do we want to accomplish?
- Clearly state intended outcome
- Be clear about whose performance is at issue
- In goal, stay away from “process” words like “develop,” “grow,” “come to see”

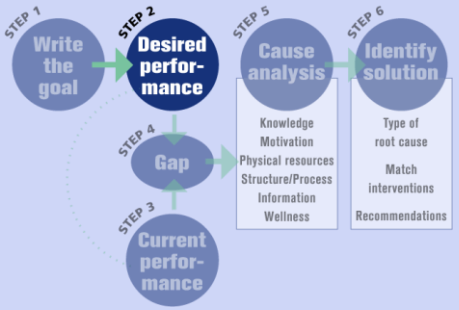
GOALS ARE ABOUT ENDS, NOT MEANS TO ENDS

Narrow the focus

STEP 1	WRITE THE GOAL: Clearly state what outcome you would like to accomplish.
PRIMARY BUSINESS INITIATIVE:	Decrease hospital readmissions
GOAL:	We will reduce the number of patients that return to the hospital in 30 days by 10% (that is, from xxxx to xxxx) within the next 6 months.

STEP 2

Desired performance



The Performance Guide

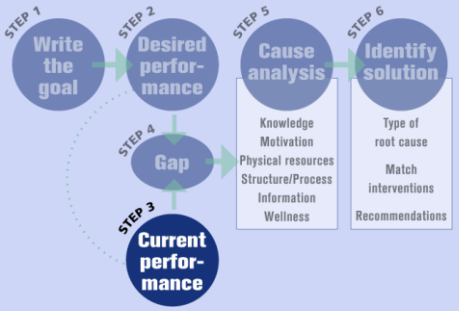
- Personal experience
- Evidence-based practice guidelines
- Professional experience
- **Look at what key performers are doing**
- Look at worst practice and turn it around
- **Ask employees**

STEP 2	STEP 3	STEP 4	
DESIRED PERFORMANCE: What, in a perfect world, employees should be doing if the goal were accomplished.	CURRENT PERFORMANCE: The way things *really* are now.	GAP: The performance gap is a difference, a mismatch, between *what is* and *what should be*.	
All frontline caregivers are using Stop and Watch			
CARE PATH Maps are used to ensure the patient is receiving proper care when they are exhibiting symptoms			
All nurses complete the SBAR form before contacting a physician			
The resident transfer forms accompanies the patient to the ER – it includes the capabilities of the NH to receive the patient back			

STEP 2	STEP 3	STEP 4	
DESIRED PERFORMANCE: What, in a perfect world, employees should be doing if the goal were accomplished.	CURRENT PERFORMANCE: The way things *really* are now.	GAP: The performance gap is a difference, a mismatch, between *what is* and *what should be*.	
Complete the Acute Transfer Form if not an emergency – ensure proper information is transferred to the hospital/ER			
Advanced Care Planning helps to ensure that the desires and wishes of the patient are known and carried out.			
The Quality Improvement Tool is completed after the transfer			

STEP 3

Current performance



- **Go to the source!**
- **What are standard performers doing?**
  - Direct observation
  - Interviews
  - Focus groups
  - P&P Review
  - Medical Records and TARs
  - Check Braden to determine at risk residents
  - Observe care of those at risk

STEP 2	STEP 3
DESIRED PERFORMANCE: What, in a perfect world, employees should be doing if the goal were accomplished.	CURRENT PERFORMANCE: The way things *really* are now.
All frontline caregivers are using Stop and Watch	*Some caregivers use Stop and Watch, others do not. Several of the caregivers give the slip to the charge nurse but the charge nurse does nothing with it.*

STEP 2	STEP 3
DESIRED PERFORMANCE: What, in a perfect world, employees should be doing if the goal were accomplished.	CURRENT PERFORMANCE: The way things *really* are now.
CARE PATH Maps are used to ensure the patient is receiving proper care when they are exhibiting symptoms	*While the Care Path Maps are found at each nursing station, not all of the nurses use them – rotating nurses, agency nurses, and new nurses do not appear to have been instructed on their use.*

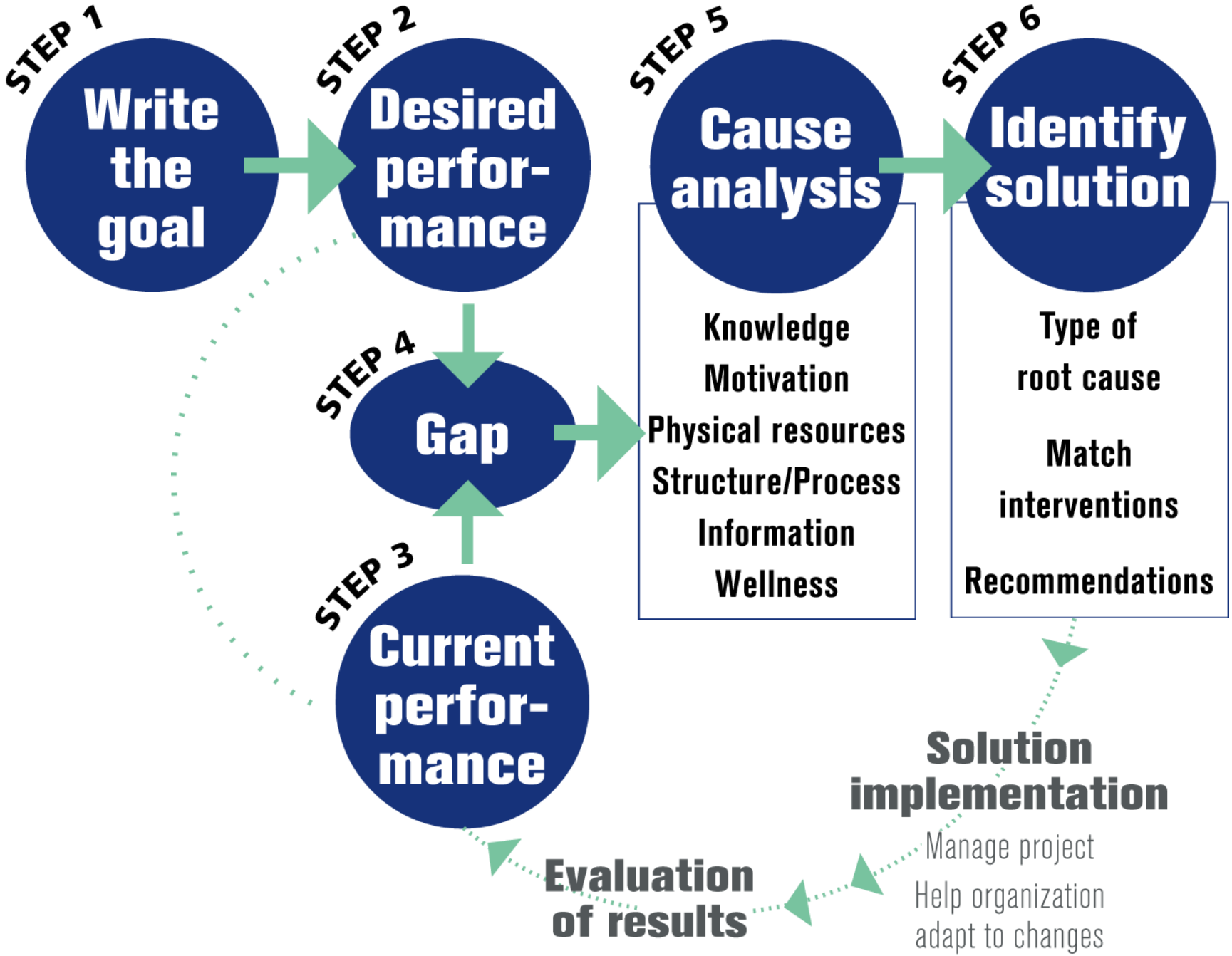
STEP 2	STEP 3
DESIRED PERFORMANCE: What, in a perfect world, employees should be doing if the goal were accomplished.	CURRENT PERFORMANCE: The way things *really* are now.
All nurses complete the SBAR form before contacting a physician	*The SBAR form is not universally completed before the physician is notified.*

STEP 2	STEP 3
DESIRED PERFORMANCE: What, in a perfect world, employees should be doing if the goal were accomplished.	CURRENT PERFORMANCE: The way things *really* are now.
The resident transfer forms accompanies the patient to the ER – it includes the capabilities of the NH to receive the patient back	*while this form is typically filled out and sent with the patient, the section which describes the organization's capabilities to take the patient back is left blank.*

STEP 2	STEP 3
DESIRED PERFORMANCE: What, in a perfect world, employees should be doing if the goal were accomplished.	CURRENT PERFORMANCE: The way things *really* are now.
Complete the Acute Transfer Form if not an emergency – ensure proper information is transferred to the hospital/ER	*Typically all of the information listed on the Acute Transfer Form are sent to the hospital with the patient.*

STEP 2	STEP 3
DESIRED PERFORMANCE: What, in a perfect world, employees should be doing if the goal were accomplished.	CURRENT PERFORMANCE: The way things *really* are now.
Advanced Care Planning helps to ensure that the desires and wishes of the patient are known and carried out.	*Only a small % of patients have Advanced Care Planning completed for them and typically they were admitted with this paperwork as there doesn't seem to be a systematic approach to getting it done after admission.*

STEP 2	STEP 3
DESIRED PERFORMANCE: What, in a perfect world, employees should be doing if the goal were accomplished.	CURRENT PERFORMANCE: The way things *really* are now.
The Quality Improvement Tool is completed after the transfer.	*The QI tool is completed on some units but not all.*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Solution implementation
Manage project
Help organization adapt to changes
Evaluation of results

STEP 2	STEP 3	STEP 4
DESIRED PERFORMANCE: What, in a perfect world, employees should be doing if the goal were accomplished.	CURRENT PERFORMANCE: The way things *really* are now.	GAP: The performance gap is a difference, a mismatch, between *what is* and *what should be*.
All frontline caregivers are using Stop and Watch.	*Some caregivers use Stop and Watch, others do not. Several of the caregivers give the slip to the charge nurse but the charge nurse does nothing with it.*	*While some CNA's are using Stop and Watch, it is not a universal practice. It has been noticed that some of the charge nurses are not treating the observations of the CNA's seriously and are not acting on them.*

STEP 2	STEP 3	STEP 4
DESIRED PERFORMANCE: What, in a perfect world, employees should be doing if the goal were accomplished.	CURRENT PERFORMANCE: The way things *really* are now.	GAP: The performance gap is a difference, a mismatch, between *what is* and *what should be*.
CARE PATH Maps are used to ensure the patient is receiving proper care when they are exhibiting symptoms.	*While the Care Path Maps are found at each nursing station, not all of the nurses use them – rotating nurses, agency nurses, and new nurses do not appear to have been instructed on their use.*	*The use of Care Path Maps for dealing with new symptoms has been taught and reinforced with the nurses, it has been noticed that rotating nurses as well as agency nurses are not using the Care Path Maps and may not know about them.*

STEP 2	STEP 3	STEP 4
DESIRED PERFORMANCE: What, in a perfect world, employees should be doing if the goal were accomplished.	CURRENT PERFORMANCE: The way things *really* are now.	GAP: The performance gap is a difference, a mismatch, between *what is* and *what should be*.
All nurses complete the SBAR form before contacting a physician .	*The SBAR form is not universally completed before the physician is notified.*	*While many of the nurses do complete the SBAR form before calling a physician, it is noted that this is not consistently done on nights and weekends.*

STEP 2	STEP 3	STEP 4
DESIRED PERFORMANCE: What, in a perfect world, employees should be doing if the goal were accomplished.	CURRENT PERFORMANCE: The way things *really* are now.	GAP: The performance gap is a difference, a mismatch, between *what is* and *what should be*.
The resident transfer forms accompanies the patient to the ER – it includes the capabilities of the NH to receive the patient back.	*while this form is typically filled out and sent with the patient, the section which describes the organization's capabilities to take the patient back is left blank.*	*While it is important that the hospital/ER be aware of the capability of the nursing home to receive the patient back, this part of the Transfer Form is typically left blank.*

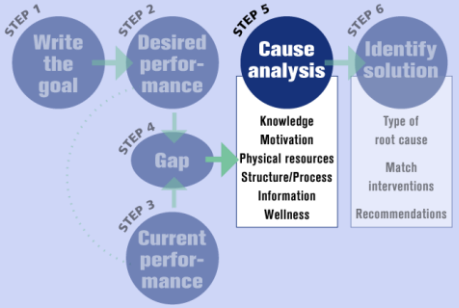
STEP 2	STEP 3	STEP 4
DESIRED PERFORMANCE: What, in a perfect world, employees should be doing if the goal were accomplished.	CURRENT PERFORMANCE: The way things *really* are now.	GAP: The performance gap is a difference, a mismatch, between *what is* and *what should be*.
Complete the Acute Transfer Form if not an emergency – ensure proper information is transferred to the hospital/ER.	*Typically all of the forms listed on the Acute Transfer Form are sent to the hospital with the patient.*	*This is no gap noticed in this area but for the lack of information about facility capabilities to receive the patient back.*

STEP 2	STEP 3	STEP 4
DESIRED PERFORMANCE: What, in a perfect world, employees should be doing if the goal were accomplished.	CURRENT PERFORMANCE: The way things *really* are now.	GAP: The performance gap is a difference, a mismatch, between *what is* and *what should be*.
Advanced Care Planning helps to ensure that the desires and wishes of the patient are known and carried out.	*Only a small % of patients have Advanced Care Planning completed for them and typically they were admitted with this paperwork as there doesn't seem to be a systematic approach to getting it done after admission.*	*There is no system in place to discuss Advanced Care Planning during or after the admission process into this organization.*

STEP 2	STEP 3	STEP 4
DESIRED PERFORMANCE: What, in a perfect world, employees should be doing if the goal were accomplished.	CURRENT PERFORMANCE: The way things *really* are now.	GAP: The performance gap is a difference, a mismatch, between *what is* and *what should be*.
The Quality Improvement Tool is completed after the transfer.	*The QI tool is completed on some units but not all.*	*Utilization of the QI Tool is essential for determining the root causes of return to hospitals – the completion of this tool on all units for all transfer patients is essential to our success in reducing return hospitalizations.*

STEP 5

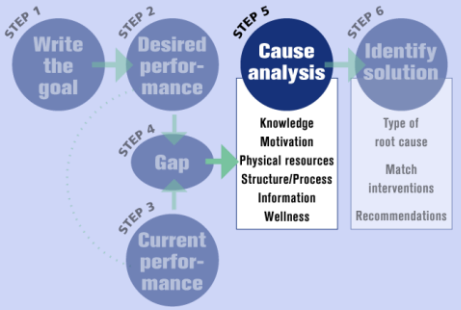
Cause analysis



- Do staff know what to do? (Information)
- Do staff know how to do it? (Knowledge)
- Do staff want to do it? (Motivation)
- Are staff allowed to do it? (Structure/ Process)
- Do staff have what they need to do it? (Physical resources)
- Wellness

STEP 5

Cause analysis



STEP 2	STEP 3	STEP 4	STEP 5	STEP 6
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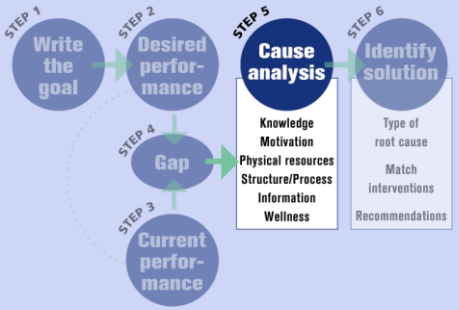
			Information:	
			Knowledge:	
			Motivation:	
			Structure/Process:	
			Physical resources:	
			Wellness:	

STEP 5

Cause analysis



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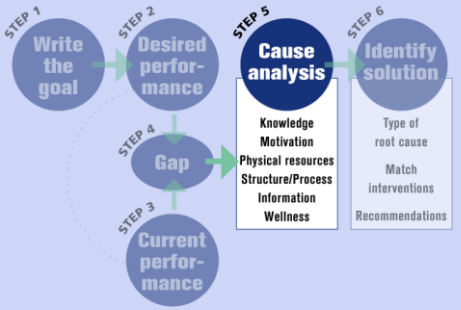

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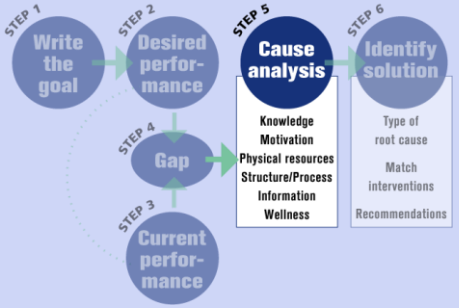
			Knowledge:	
			Motivation:	
			Structure/Process:	
			Physical resources:	
			Wellness:	

INFORMATION – All frontline caregivers are using Stop and Watch

STEP 5

Cause analysis



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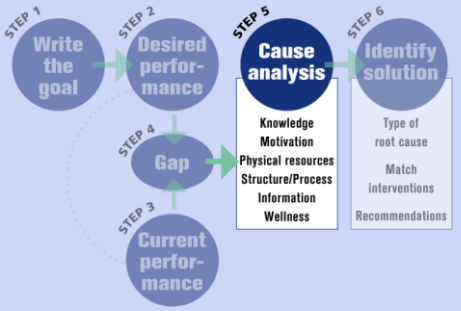
STEP 5 Cause analysis



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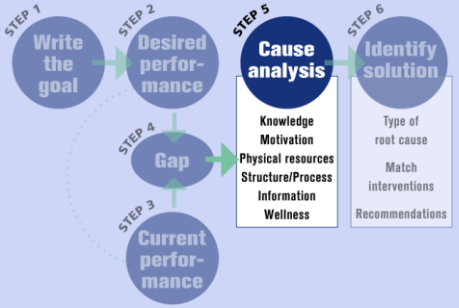
			Information:	
			Knowledge:	
			Motivation:	
			Structure/Process:	
			Physical resources:	
			Wellness:	

KNOWLEDGE – CNA's do not realize the importance of providing the information from the Stop and Watch form to the charge nurse.

STEP 5

Cause analysis



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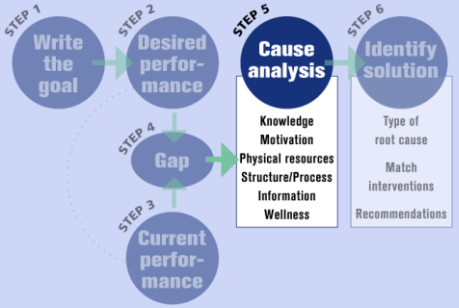
STEP 5 Cause analysis



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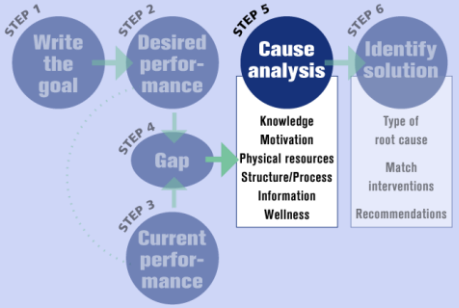
STEP 5

Cause analysis



- Do staff know what to do? (Information)
- Do staff know how to do it? (Knowledge)
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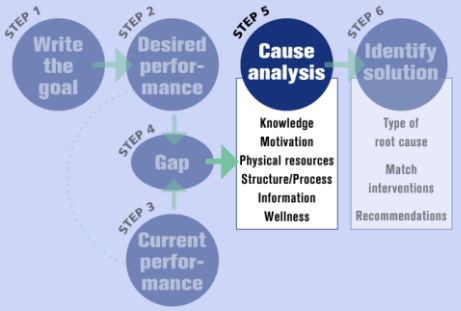
- Are staff allowed to do it? (Structure/ Process)
- Do staff have what they need to do it? (Physical resources)
- Wellness

STEP 5 Cause analysis



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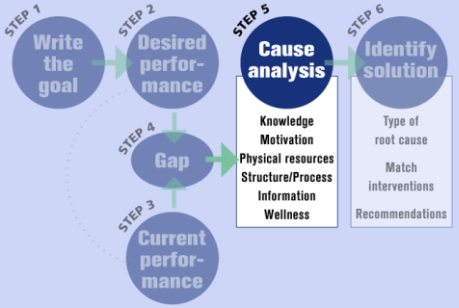

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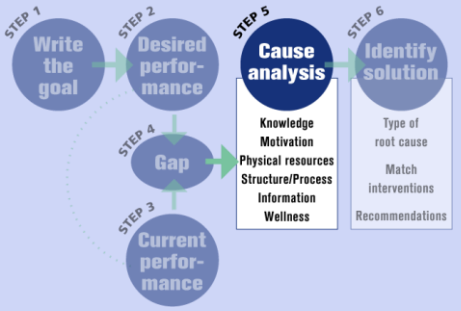

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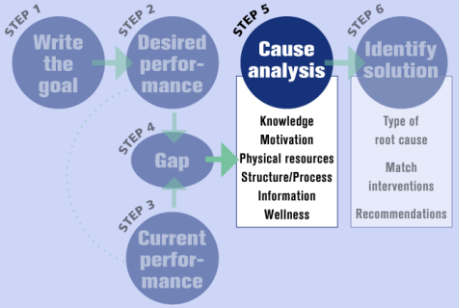

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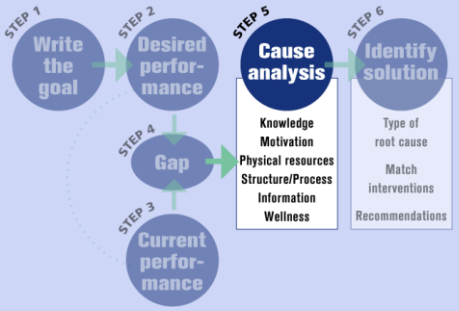

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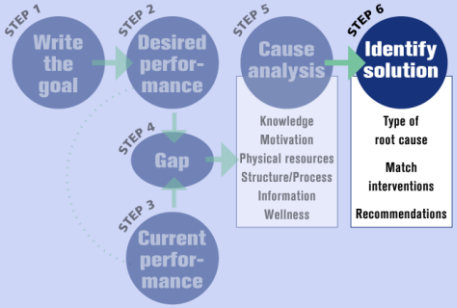
WELLNESS – If/when CNA's are put down by charge nurses for reporting information, they may be unsure of themselves and reluctant to continue to complete the Stop and Watch.

STEP 6 Identify solution



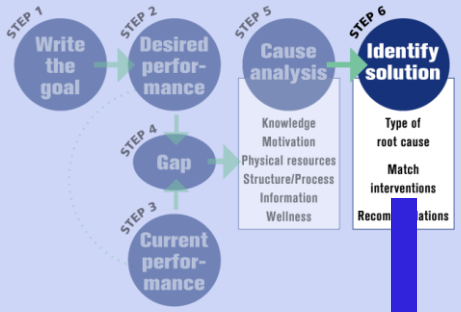
The solutions you select must match the causes

That is why we work not to jump to conclusions.

When we pin down the correct *causes*, we can select the right *solutions*

STEP 6

Identify solution



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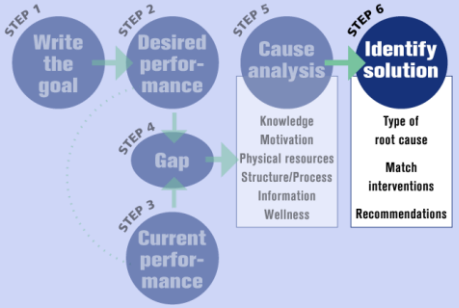

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			Knowledge:	
			Me…	
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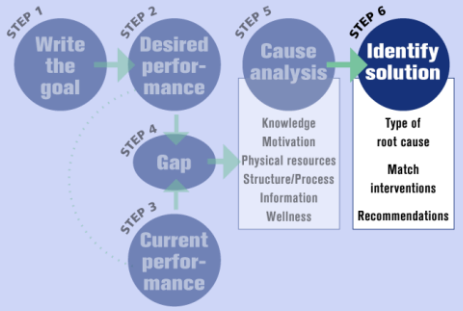
			Wellness:	

INFORMATION – Not all CNA's have been trained on how to use Stop and Watch

SOLUTION – As part of orientation, information about the Stop and Watch will be provided to all new CNA's. In addition, inservices will be held as needed and one on one training provided to ensure that CNA" s have clarity regarding the use and importance of the form.

STEP 6

Identify solution



KNOWLEDGE – CNA's do not realize the importance of providing the information from the Stop and Watch form to the charge nurse.

SOLUTION – Information from the QA activities regarding return to hospitals is shared with CNA's during inservices to ensure they have knowledge regarding the role Stop and Watch plays in reducing rehospitalizations.

STEP 4	STEP 5	STEP 6
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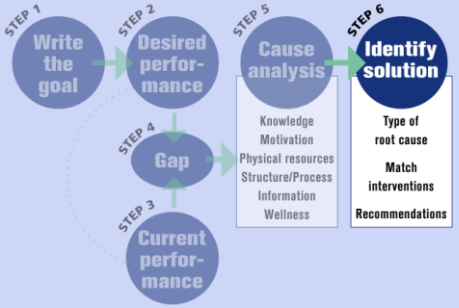

MOTIVATION – No positive reinforcement is ever given to CNA's for the proper use of Stop and Watch – in fact, some charge nurses do not treat the observations from Stop and Watch seriously.

SOLUTION – Supervisors note CNA's completing the Stop and Watch forms and compliment them. Charge nurses are taught the importance of this information in reducing hospitalizations and are evaluated on how well they encourage/reinforce information provided to them by the CNA's.

	STEP 5	STEP 6
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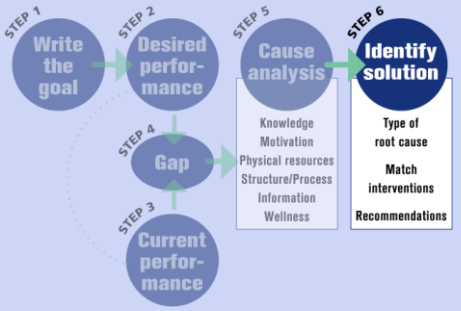

STRUCTURE/PROCESS – There also is no process in place for the CNA to share the information from Stop and Watch with the charge nurse. In fact, often the charge nurse says "this isn't the right time" when the CNA is trying to report to her.

SOLUTION – The nursing dpt creates a P&P which includes the use of the Stop and Watch form. Charge nurses are included in the development of this P&P. A focus of the P&P is "when", during the shift, should the CNA report the Stop and Watch information to the charge nurse.

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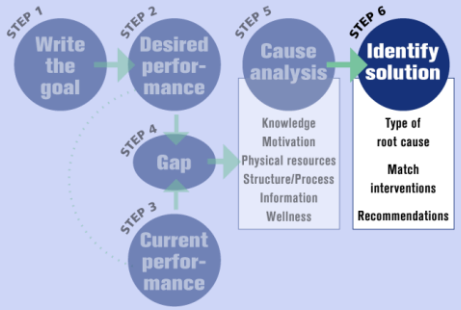

PHYSICAL RESOURCES – While there are forms available to collect the data (the Stop and Watch Form), some CNA's do not know where to obtain them. It does not appear that any one person has the responsibility for replenishing the forms at the nursing station.

SOLUTION – The organization identifies one person who is responsible for copying and replenishing the Stop and Watch forms at each nursing station. CNA's and charge nurses are shown where to find the forms and what to do when the supply runs low.

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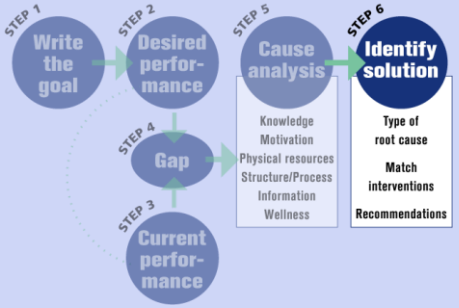

WELLNESS – If/when CNA's are put down by charge nurses for reporting information, they may be unsure of themselves and reluctant to continue to complete the Stop and Watch.

SOLUTION – Charge nurses are taught the importance of receiving this information and provided positive feedback when the CNA's feel free and confident in providing this information. CNA's are instructed on the importance of collecting this information and instructed what to do if/when their charge nurse is uninterested in receiving it.

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ACCOUNTABLE CARE NETWORKS

5 Steps to Get in and Stay in

Considerations for partnering with ACO's

- Accountable care is about delivering
  - The right service to the patient
  - At the right time
  - At the right cost
  - With the right outcome
- Outcomes of episodes impact
  - Your business performance
  - How providers are compensated
- Are you prepared to make investments necessary for post-acute services?
  - Technology
  - Processes
  - Infrastructure

1. Developing the Unit

- Separate and distinct – you don't need to renovate the whole building
- Separate entrance – an extension of the med-surg unit
  - A "hospital-like" setting
  - Similar amenities
- Systems and processes on how to transition patients (*not discharge)*
  - *Transitioning the patients to a more cost-effective level of service as soon as possible*

2. Approaching potential partners

- ACO's are paring down their list of post-acute options
- Don't just look at hospitals
  - Of the 88 pioneer ACO's all were driven by large physician groups
  - Don't ignore your independent physician practitioners
- Managed care plans – in the future they won't be an option

2. Approaching potential partners

- Connect with corporate-level management
- Focus on being someone they can trust
- Come armed with data that shows your potential to be a partner
- Get smart about the key metrics they are looking for you to produce and deliver

Key Metrics for Accountable Care

- Clinical outcomes
- Customer satisfaction
- Readmission rates
- Length of stay
- Patient/resident costs
- NHPPDs/ratios
- Turnover rates
- Performance improvement initiatives/results
- Physician performance metrics

3. Make smart technology investment

- What is the technology the hospitals and physicians are using and will need
- Consider these
  - Care management
  - Telemedicine
  - Electronic MAR (eMAR)
  - Electronic health records (EHR)
  - Staffing and labor management tools

"YOU HAVE TO DEMONSTRATE TO THEM THAT YOU UNDERSTAND WHAT ACCOUNTABLE CARE IS, AND YOU NEED TO DO THAT BEFORE THEY ASK"
ZALETEL

You must develop a culture of accountability and transparency. If your organization is not measuring outcomes and keeping customer satisfaction results, you're not positioning your group to partner with networks.

4. Prioritize Staffing

- You must manage both patients and staff
- "Transitional care nurse"
  - Dedicated to working with family, resident, staff in transitioning the patient throughout the in-patient stay
  - The point of contact from day one to transition
- Success is having the right staff with the right tools, systems and processes necessary to manage the business daily
- A culture of accountability is critical to retain partnerships
- Must be able to control overtime

4. Prioritize Staffing

- Proper staffing ratios and staffing mix
  - This unit will be much more dynamic than the traditional LTC
  - You must prove you can handle the volume and activity
- Finding the best caregivers is a challenge
  - Hire the right people the first time
  - Invest in training
  - Give them the technology and systems to work with

5. What decision-makers need to hear

- That you can admit patients 24/7
- Share clinical staff
  - Utilize part-time staff from the hospital
  - Collaborative training with the hospital
- Rather than engaging discharge planners/case management directors, focus on corporate-level management
  - They want partners they can trust who are top-tier performers.

5. What decision-makers need to hear

"The best way to prove you're top tier is to share your data and prove that you can generate consistent outcomes and prevent unnecessary readmissions"

» *Dale Zaletel*

5. What decision-makers need to hear

- Hospitals want their partners to use their ancillary services.
  - Take every opportunity to position your facility in-network
- Form a clinical advisory council
  - Hospital key clinical staff (CMO, CNO)
  - DON, post-acute unit manager, care manager
  - Medical director and NP of facility
  - *Consider: allowing hospitals to select your physicians and medical director*
    - *This provides a direct tie-back to the hospital*
    - *The hospital knows where to look if you're not achieving the established outcomes*

WHILE IT'S CRITICAL FOR YOUR ORGANIZATION TO BE A TOP-TIER PROVIDER, IT ALL REALLY COMES DOWN TO BEING A TRUE PARTNER THAT IS TRANSPARENT AND ACCOUNTABLE TO MAKE THESE RELATIONSHIPS WORK

We did the best we could,
with what we knew,

And when we knew better,
we did better.

Maya Angelou

Now you know better so …

… what do you do?

QUESTIONS?

info@nationalresearch.com
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