

*Eastern Massachusetts Pioneer Accountable Care Organization (ACO) Quality Standards*

**COMMON EXPECTATIONS FOR SKILLED NURSING FACILITIES**

Draft – 12-5-12

**General:**

1. Staffing:
  - a. Low staff turnover rate.
  - b. Minimal use of agency nursing/nurse's aides.
  - c. The facility has a nursing supervisor on all shifts (far preferably on-site).
  - d. The facility has a primary nursing (RN or LPN) model.
  - e. High patient continuity for CNAs.
2. System Continuity:
  - a. Facility agrees to offer to all patients the group's<sup>1</sup> preferred providers (DME, VNA, specialists).
3. Quality Improvement Efforts:
  - a. Will participate in collaborative QI work with the group (e.g. STAAR Cross-Continuum mtgs, monthly case reviews, receive warm hand-offs, etc.).
  - b. Also willing to participate in meetings with the group on an as needed basis to cover related topics (e.g. customer service, etc.).

**Pre-Admission:**

1. Screening/Admission:
  - a. Same day patient screens (determination of bed offer).
  - b. Willing to collaborate with group on late evening admissions.
  - c. Accepts patients seven days per week.
  - d. Able to accept direct admits from home/ER/clinician office.
  - e. Patients are identified as group patients when bed offer is made.
2. Medical Coverage:
  - a. Patients are assigned to the appropriate attending physician (as selected in collaboration with the group) at time of bed offer.
3. Ability to receive a "warm hand-off" from nursing staff on hospital floor (processes in place to facilitate)

**During stay:**

1. Facility Environment:
  - a. Suitable work space available for MD and APCs as well as computer/printer access.
  - b. Wireless internet access made available to both patients and to MD/APCs.

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- c. Facility meets patient expectations regarding food, cleanliness and environment.
  - d. DME is in the patient's room prior to their arrival when appropriate.
2. Care Systems:
- a. INTERACT tool (or comparable tool) use is standard of care and is appropriately documented and communicated.
  - b. High quality mental health coverage:
    - i. At a minimum for emergent needs – continuous 24/7 telephonic coverage until resolution of emergency.
    - ii. All other – telephonic coverage, as well as face-to-face consultation within 2 to 3 days.
  - c. High quality palliative care coverage;
  - d. STAT Radiology, Laboratory obtained and resulted within 4 hours.
  - e. STAT prescriptions delivered within 6 hours.
  - f. PT/OT are provided as ordered at least six days per week; if patient arrives before 2 pm, assessment and initial evaluation must be completed and documented on the day of admission. If admitted after 2 pm, evaluation must be completed and documented by the end of the next day. Therapies are available seven days per week.
3. Care Planning/Coordination:
- a. Care planning meetings within three days of admissions. Patients, families, and legal representatives are notified at least 48 hours prior the family meeting and are encouraged to participate.
  - b. At this first care planning meeting:
    - i. Establish and document the functional goal required for patient to be transferred safely home.
    - ii. Establish and communicate to both patient and care team the estimated discharge date.
  - c. Establish a day-of-week and time-of-day (e.g. every Tuesday at 9am) for the interdisciplinary team meetings for the group's patients.
  - d. Facility case managers are responsible for:
    - i. Assessment, creation, implementation and documentation of a discharge plan that begins at admission.
      - 1. The discharge plan is revised as appropriate, documents functional status, delivers notification of discharge/termination of benefits letters, etc.
    - ii. Timely collaboration with the group's Case Management staff (e.g. Care Coaches and Case Managers) or their designee with any significant change in status or plan.
  - e. A "point person" is identified by the SNF who will be responsible for providing both rehabilitation and clinical updates (could be case manager or alternate with easy availability and access to coordinate with group's staff or SNF provider team), including tele-rounding with the group case manager.

### **At Discharge and Post-Discharge:**

1. Patient Satisfaction:
  - a. Patients are surveyed regarding their satisfaction (at least two questions in the survey are from the CAPHS surveys – “overall satisfaction” and “willingness to recommend”).
2. Medication Reconciliation/Education:
  - a. In accordance with NQF standards, patients are given a typed list of current medications upon discharge; medication changes are highlighted and explained; the list is in agreement with discharge summary medication list.
3. Advanced Directive Documentation:
  - a. If the patient is DNR or a completed MOLST form is available, the form will be sent with the patient upon any transfer and through every area of care; any Advance Care directives, health care proxy or activation form will also be sent with the patient.
  - b. DNR forms and health care proxies will also be faxed to the group and/or PCP office.
4. Communication of Discharge Paperwork to the Group:
  - a. Will comply with the standard for completion of page 1, 2, 3 referrals and will include a typed discharge medication list to be faxed to the appropriate group and/or PCP fax number for scanning into electronic medical record.
5. Use recommended Discharge Planning Checklist or a standard checklist that includes at least the following:
  - a. Identify family/caregiver availability
  - b. Discharge medication list
    - i. Determine patient’s ability to acquire needed medications including cost and transportation
    - ii. Patient will receive appropriate education on medications.
    - iii. Prescriptions for medications
    - iv. Technique review for example, for inhaler use
  - c. Discharge instructions.
  - d. Ensure patient can “teach back” using consistent teaching tools

### **Reporting Expectations:**

During relationship with the group, facilities are expected to have the following data updated on at least a monthly basis (or quarterly if specifically noted below) to be made available in regular reports to the group (or on request):

1. Readmission rates and average LOS:
  - a. For group patients;
  - b. For all facility sub-acute patients;
2. Bed screen outcomes:
  - a. Bed offer made and bed accepted;
  - b. Reason why bed not offered.
3. INTERACT quarterly reports;
4. Clinical Programs:
  - a. Provide list of specific clinical programs (e.g. cardiac, pulmonary, behavioral);
5. Patient satisfaction results (per above):

- a. Goal to be in the >90<sup>th</sup> percentile.
- 6. Staffing:
  - a. Staff turn-over rate;
  - b. Nurse staffing ratios;
  - c. Flu vaccination rate;
- 7. DPH/Joint Commission Results:
  - a. Namely, details of any survey deficiencies.
- 8. QI process measures (as established w/ group):
  - a. For example, number of admissions w/ completed warm hand-offs.

The following information is expected to be reported to the group in real-time without prompting:

- 1. Change in Director of Nursing;
- 2. Change in any “point person” per above, including admission director, case manager, etc.
- 3. If not already employed by the group, any change in staffing of medical coverage or any concern that coverage group may not be able to accept additional patient volume.

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**COMMON EXPECTATIONS FOR SKILLED NURSING FACILITY PROVIDER TEAMS**

Draft – 12-10-12

SNF providers (MDs and APCs) will either be employed by “the group”<sup>1</sup> or will be an outside clinician identified as a “preferred” attending clinician. All SNF providers, both employed and preferred, will be asked to comply with a set of minimum expectations. A draft of the expectations includes:

**General:**

1. Comply with all payer minimum requirements.
2. 24 hour/7 day coverage by clinicians who have experience managing patients in the SNF setting and who are able to respond in a timely manner to changes in clinical status – including either same day if made aware during business day, or, if alerted after-hours, phone coverage with next day visit.
3. Be part of a larger physician organization with performance oversight and provide the group with contact information for the organization’s peer review manager.

**During the Stay:**

1. Newly admitted patients are seen at least within 48 hours of admission by physician (or sooner if medically necessary based on the stability of the patient).
2. Within 48 hours of admission, provider is to contact the group and/or PCP to confirm their awareness of the patient’s admission (and to exchange any other clinically relevant information at that time).
3. Provider will participate in team meetings at least weekly and in family meetings as necessary.
4. Should work with facility to follow specific care pathways/protocols of the group (e.g. orthopedics care pathway).
5. Timely communication to PCP if there is an unexpected change in the patient’s status.
6. Provider will participate in quality and INTERACT or other related readmissions reviews.
7. Effort made to provide in-facility care as appropriate; when patient does require transfer to emergency department, effort is made to contact ED (and be available to ED) for care coordination and shared care planning (including examining appropriateness of patient return to facility). If requiring acute admission, work with ED to return patient to appropriate group Hospital (even if ED-to-ED transfer is required).

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8. The patient or decision maker's Advance Care Directives will be independently documented in the chart by the SNF clinician.

**Discharge Planning:**

1. A legible discharge summary will be completed within 24 hours of discharge (preferably on the day of discharge) and sent to the group's designated fax number and/or the patient's PCP for scanning into the electronic health record.
2. The discharge summary will preferably follow the attached template, but should at a minimum include: a complete discharge medication list (including pertinent changes and reason, past three Coumadin doses and INR); pertinent physical exam changes on discharge, pending lab results, code status, advance directive status and follow up plan.
3. Provider will review the patients discharge/follow up needs and ensure that follow up care is appropriate and that the patient is returned to their PCP.