March 21, 2013

To our Skilled Nursing Facility partners:

As you know, five Eastern Massachusetts health care organizations are participating in the Medicare Pioneer Accountable Care Organization model.* Under that model, ACOs work with CMS to provide Medicare beneficiaries with higher quality care, while reducing growth in Medicare expenditures through enhanced services, such as care coordination. For this population, skilled nursing facilities (SNF) are an essential part of the continuum of care.

In an effort to improve the quality of care that our mutual patients receive, the five Eastern Massachusetts Pioneer ACOs are releasing sets of aspirational quality standards and strategies for patients cared for in a skilled nursing facility – one set for skilled nursing facilities and another for the provider teams (e.g. MDs and advanced practice clinicians). The ultimate goal is to help support the "Triple Aim" of improved patient health, improved experience of care, and lower cost of care for the patients we serve. These common visions for enhanced care delivery in nursing homes are meant to eliminate the need for skilled nursing facilities and providers to respond to multiple sets of potentially conflicting expectations.

These strategies have been developed over many years of work and experience within our respective organizations and in collaboration with many SNF partners and provider organizations, such as Massachusetts Senior Care Association and LeadingAge Massachusetts.

We hope that these documents can serve as a shared blueprint for long-standing quality improvement efforts between our ACOs and nursing facilities and their provider teams, and we look forward to your feedback. We also hope to start a broader industry dialogue around strategies to increase quality throughout the continuum of care. We look forward to this work being the start of an ongoing conversation that can help best meet the needs of our community for years to come.

Sincerely,

Richard Lopez, MD
Chief Medical Officer
Atrius Health

Alan P. Abrams
Alan Abrams, MD
Assistant Medical Director, Pioneer ACO
Beth Israel Deaconess Care Organization LLC

Barbara Spivak, MD
President
Mount Auburn Cambridge –
Independent Practice Association

Timothy Ferris, MD
Vice President, Population Health
Partners Healthcare

Mark Girard, MD
President
Steward Healthcare Network, Inc.

* The five Pioneer ACOs represented in this effort are: Atrius Health, Beth Israel Deaconess Care Organization LLC (BIDCO), Mount Auburn Cambridge Independent Practice Association (MACIPA), Partners Healthcare, and Steward Health Care System.

**STRATEGIES FOR SKILLED NURSING FACILITIES**

March 2013

**Background:**

As Accountable Care Organizations (ACOs), our primary objective is to provide the highest quality care possible for our patients. We are also responsible for the entire continuum of care that our patients receive – even when that care is provided outside of our facilities. Patients that require skilled nursing care are some of the most complex and frail patients under our care. The responsibility to ensure safe, high quality, efficient care is shared amongst the ACOs, referring hospitals, our skilled nursing facility (SNF) partners, and the SNF provider teams (e.g. doctors and advanced practice clinicians), along with the patients themselves and their families and communities.

The document below lays out a set of strategies for SNFs that we believe, through years of collective effort with skilled nursing facilities, contribute to high quality care for our patients. Delivering on these is a shared responsibility. This is also seen as a living document. As evidence proves any particular strategy superior to any other, these will be revised. The goal is to achieve the "Triple Aim" – improved patient health, improved experience of care, and lower cost of care for our patients. However, since we all share in the collective responsibility for our patients – we hope that this document (and those that will likely follow) provides a common starting point for discussion and collaboration.

Of note, measuring the implementation of these strategies is a critical component of ensuring quality and supporting ongoing improvement. As such, a column has been included below which will be filled in overtime as we work to establish the most accurate, consistent, meaningful and least burdensome ways to measure performance.

| STANDARDS OF POST ACUTE CARE | PERFORMANCE EXPECTATIONS/ ASPIRATIONS | MEASUREMENT OPTIONS TO BE DEVELOPED |
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| **GENERAL** | | |
| ***1. Staffing*** | a. Low staff turnover.<br>b. Minimal use of agency nursing/nurse's aides.<br>c. A nursing supervisor on all shifts (far preferably on-site).<br>d. A primary care RN/LPN on-site 24/7 for short-stay units.<br>e. Facility has a primary nursing (RN | |

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| | or LPN) model with consistent assignment for nurses and CNAs.<br>f. Facility has access to adequate interpreter services. | |
| ***2. System Continuity*** | a. Facility will offer the group's preferred providers to all of the group's patients at discharge (e.g. DME, VNA, specialists). | |
| ***3. Quality Improvement Efforts*** | a. Facility will participate in collaborative QI work with the group (e.g. STAAR Cross-Continuum meetings, monthly case reviews, receive warm hand-offs, etc.).<br>b. Facility will 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. Facility will provide patient screens and determination of bed offer within 2 hours of referral.<br>b. Facility is willing to collaborate with group on late evening admissions.<br>c. Facility will both screen and accept patients seven days per week.<br>d. Facility will accept direct admits for qualified patients from home/ER/clinician office.<br>e. Facility will identify the patient's as group patients when bed offer is made, as reported by the ACO to the facility. | |

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| ***2. Medical Coverage*** | a. Facility will assign patients to the group's selected attending physician at time of bed offer (unless patient expresses alternative request). | |
| ***3. Care Transition*** | a. Facility will develop and maintain a process for the nursing staff to receive a "warm hand-off" from any referral site. | |
| **DURING STAY** | | |
| ***1. Facility Environment*** | a. The Facility will provide:<br>i. An environment (e.g. food, cleanliness, noise, comfort, etc.) that meets patient expectations.<br>ii. Critical medications (e.g. pain, antibiotics, anticoagulation, cardiac, etc.) are available at patient's arrival.<br>iii. DME that is in the patient's room prior to their arrival when appropriate.<br>iv. Suitable work space available for MD and APCs as well as computer/printer access.<br>v. Wireless internet access made available to both patients and to MD/APCs. | |
| ***2. Care Systems*** | a. Facility will train staff and implement the INTERACT program.<br>i. If alternative protocols/tools are in place, facility to make available to group.<br>b. Facility will provide high quality mental health coverage:<br>i. At a minimum for emergent needs – continuous 24/7 telephonic coverage until resolution of emergency.<br>ii. All other – telephonic coverage, as well as face-to-face consultation within 2 to 3 days. | |

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| | c. Facility will provide high-quality palliative care consultations.<br>d. Facility will assure STAT Radiology, Laboratory obtained and resulted within 4 hours.<br>e. Facility will assure STAT prescriptions delivered within 6 hours.<br>f. Facility will assure PT/OT are provided as ordered at least six days per week; if patient arrives before 2 pm, assessment and initial evaluation will 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. | |
| ***2. Care Planning/Coordination*** | a. Facility will implement care planning meetings that occur within three days of admissions. Patients, families, legal representatives and PCP's care manager are to be notified at least 48 hours prior the family meeting and are encouraged to participate.<br><br>b. Outcomes of this first care planning meeting include:<br><br>i. Establishing and documenting the functional goal required for patient to be transferred safely home.<br><br>ii. Establishing and communicating to patient, care team and group designee the estimated discharge date.<br><br>c. Facility will establish a consistent day-of-week and time-of-day (e.g. every Tuesday at 9am) for the interdisciplinary team meetings for the | |

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| | group's patients.<br><br>d. Facility case managers are responsible for:<br><br>i. Assessment, creation, implementation and documentation of a discharge plan that begins at admission. The discharge plan is revised as appropriate, documents functional status, delivers notification of discharge/termination of benefits letters, etc.<br><br>ii. Timely collaboration with the group's Case/Care Management staff (e.g. Care Coaches and Case Managers) or their designee with any significant change in status or plan, including, discharge date.<br><br>e. The facility will identify a "point person" 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. Medication Reconciliation and Education*** | a. The facility with assure that patients are given a typed list - in large font - of current medications upon discharge from SNF; medication changes are highlighted and explained; the list is fully reconciled with the home and hospital discharge summary medication lists. | |

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| ***2. Advance Directive Documentation*** | a. The facility will assure that:<br><br>i. If patient does not arrive to facility with advance directives documented, these will be discussed and documented prior to discharge.<br>ii. Any Advance Care directives, health care proxy or activation form will also be sent with the patient and faxed to the group and/or PCP office.<br>iii. Of note, 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 (including outpatient appointments). | |
| ***3. Communication of Discharge Paperwork to the Group*** | a. The facility 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.<br>b. Will fax falls assessment to group's designee upon discharge. | |
| ***4. Standard discharge planning checklist*** | The facility will use a standard discharge planning checklist that includes at least the following:<br>a. Identify family/caregiver availability<br>b. Discharge medication list:<br>i. Determine patient's ability to acquire needed medications including cost and transportation.<br>ii. Patient will receive appropriate | |

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| | education on medications.<br>iii. Prescriptions for medications.<br>iv. Technique review for example, for inhaler use.<br>c. Discharge instructions.<br>d. Ensure patient can "teach back" using consistent teaching tools. | |
| ***54. Selection of Transfer Facility*** | a. If patient requires transfer to acute care facility, patients are to be transferred to original referring acute care facility unless medically contraindicated or due to patient preference. | |
| **REPORTING EXPECTATIONS**<br>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): | | |
| | ***Bed Screen Outcomes***<br>1. Bed screen outcomes:<br>a. Bed offer made and bed accepted;<br>b. Reason why bed not offered. | |
| | ***INTERACT QI Review Summary*** | |
| | ***Clinical Programs***<br>a. Provide list of specific clinical programs (e.g. cardiac, pulmonary, behavioral); | |
| | ***Patient satisfaction results***<br>a. The facility will survey patients regarding their satisfaction (at least two questions in the survey are from the CAHPS surveys and includes at least and "willingness to recommend") and share the results quarterly with the group. | |
| | ***Staffing***<br>a. Staff turn-over rate by staff type (e.g. RN, LPN, CNA, etc.);<br>b. Nurse staffing ratios by staff type (e.g. RN, LPN, CNA, etc.) for both short- | |

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| | stay and long-term patients;<br>c. Flu vaccination rate; | |
| | ***DPH/Joint Commission Results***<br>a. Namely, details of any survey deficiencies. | |
| | ***QI process measures (as established w/ group)***<br>a. For example, number of admissions w/ completed warm hand-offs. | |
| | ***Functional Improvement Scores***<br>a. Use of MDS measures acceptable. | |
| The following information is expected to be reported to the group in real-time without prompting:<br>1) Change in Director of Nursing, Administrator or other senior leadership.<br>2) Change in any "point person" per above, including admission director, case manager, etc.<br>3) If not already employed by the group, any change in staffing of medical coverage or any concerns regarding the ability of the medical coverage provider team of meeting the needs of existing or new patients.<br>4) If facility is closed for admission (e.g. flu outbreak or other unforeseen event). | | |

## STRATEGIES FOR SKILLED NURSING FACILITY PROVIDER TEAMS

March 2013

**Background:**

As Accountable Care Organizations (ACOs), our primary objective is to provide the highest quality care possible for our patients. We are also responsible for the entire continuum of care that our patients receive – even when that care is provided outside of our facilities. Patients that require skilled nursing care are some of the most complex and frail patients under our care. The responsibility to ensure safe, high quality, efficient care is shared amongst the ACOs, referring hospitals, our skilled nursing facility (SNF) partners, and the SNF provider teams (e.g. doctors and advanced practice clinicians), along with the patients themselves and their families and communities.

The document below lays out a set of strategies for SNF provider teams that we believe, through years of collective effort with skilled nursing facilities and their provider teams, contribute to high quality care for our patients. Delivering on these is a shared responsibility. This is also seen as a living document. As evidence proves any particular strategy superior to any other, these will be revised. The goal is to achieve the "Triple Aim" – improved patient health, improved experience of care, and lower costs for our patients. However, since we all share in the collective responsibility for our patients we hope that this document (and those that will likely follow) provides a common starting point for discussion and collaboration.

Of note, measuring the implementation of these strategies is a critical component of ensuring quality and supporting ongoing improvement. As such, a column has been included below which will be filled in overtime as we work to establish the most accurate, consistent, meaningful and least burdensome ways to measure performance.

| MD AND APC STANDARDS OF POST ACUTE CARE | PERFORMANCE STRATEGIES/ ASPIRATIONS | MEASUREMENT OPTIONS TO BE DETERMINED |
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| | **GENERAL** | |
| | 1. SNF providers (MDs and advanced practice clinicians) will either be employed by "the group" or will be an outside clinician identified as a "preferred" clinician/team. | |

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| | 2. Providers will comply with all payer minimum requirements and state/federal regulations. | |
| | 3. Providers will offer 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 a next-day visit, seven days a week. | |
| | 4. Be part of a larger physician organization with performance oversight and provide the group with information about the oversight process as well as contact information for the organization's peer review manager. | |
| | 5. Clinical team will alert its affiliate group and facility in advance of any change in staffing of medical coverage or any concern that coverage group may not be able to accept additional patient volume. | |
| **DURING THE STAY** | | |
| **Admission Timeliness** | 1. Newly admitted patients will be seen within 48 hours of admission by MD or APC (or sooner if medically necessary based on the stability of the patient). | |
| | 2. Within 48 hours of admission, provider will 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). | |

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| **Care Planning/ Communication** | 3. Providers will participate in inter-disciplinary team meetings at least weekly and in family meetings as necessary. | |
| | 4. Providers will communicate to the PCP in a timely fashion when there is an unexpected change in the patient's status. | |
| **Collaborative Care Delivery** | 5. Providers will work with the group case manager as well as facility team to meet discharge goals (including functional attainment and length-of-stay). | |
| | 6. Providers will provide in-facility care as appropriate; when patient does require transfer to emergency department, the provider will contact the 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). | |
| | 7. Providers will work with facility to follow specific care pathways/protocols of the group (e.g. orthopedics care pathway). | |
| **Quality Improvement Activities** | 8. Providers will participate in quality improvement projects, including INTERACT or other related readmissions reviews. | |

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| **Advance Care Planning** | 9. The patient or decision maker's Advance Care Directives will be independently documented in the chart by the provider (either confirmed with patient/family if present on admission or discussed anew if not available upon admission). | |
| **DISCHARGE PLANNING** | | |
| | 1. Providers will complete a legible discharge summary 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 a common template, but should at a minimum include: a complete discharge medication list (including pertinent changes and reason, and, if applicable, the past three Coumadin doses and INRs, indication, INR goal, duration of treatment and clinician who will prescribe the next dose); pertinent physical exam changes on discharge; pending lab results; code status and advance directives; and follow-up plan (including instructions to home care team when applicable). | |
| | 3. Providers will review the patient's discharge/follow up needs and ensure that follow up care is appropriate and that the patient is returned to their PCP. | |