

# REDUCING HOSPITAL TRANSFERS: APPLYING MOQI FINDINGS

## NEWPATH HEALTH SOLUTIONS, LLC

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## OBJECTIVES <sup>OF</sup> THIS SESSION

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- 1) Describe components of the Missouri Quality Initiative (MOQI) model designed to help reduce avoidable hospitalizations in long-term care
- 2) Identify key outcomes achieved by MOQI including reduced hospitalizations, reduced ED visits, improved quality measures, and cost savings
- 3) Describe implementation strategies for the MOQI as facilitated by NewPath Health Solutions



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# MOQI PROJECT GOALS

Reduce avoidable hospital transfers via FOUR aspects of APRN Care Coordination:

1. CONDITION MANAGEMENT
2. EARLY ILLNESS DETECTION
3. INTERACT® IMPLEMENTATION
4. ADVANCE CARE PLANNING/END-OF-LIFE CARE

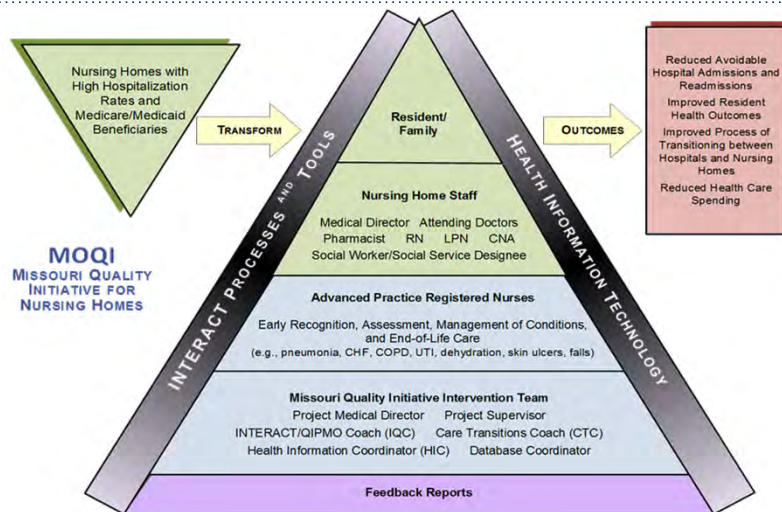


AND integrate HEALTH INFORMATION TECHNOLOGY into resident care processes



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# OUR PROVEN MODEL



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## APRN ROLE <sup>IN</sup> RESIDENT CARE MANAGEMENT



Basics of care delivery

Early illness detection and chronic illness management



Medication reviews



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## POLLING/DISCUSSION QUESTIONS

- Does your home have an Advanced Practice Nurse (APRN) who visits residents in your facility?
  - Yes
  - No
  - Unsure
  
- What is their main role?
  - Primary care
  - Specialty provider
  - Managed care provider
  - Unsure
  - N/A (don't have an APRN)



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# EARLY ILLNESS RECOGNITION



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## EARLY ILLNESS RECOGNITION: ENGAGING FRONTLINE STAFF

- *Communication*
- *Empower Frontline Staff*
- *Improve Staff Clinical Reasoning*
  - Hone Assessment skills
  - Consideration of Resident wishes and goals
  - Use of In-house experts (peers, managers, APRNs)

Great leadership isn't about control. It's about **empowering people.**

-Brigette Hyacinth



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## COMMUNICATION

- Good communication with all individuals...
  - Residents, family, staff, and providers
- Skills of customer service
- Role model behaviors you would like to see
- Staff: learn to present 'the story' of the change to providers and family (SBAR)
- Communicate what resources the facility has to manage residents (NH Capabilities List)



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## SET THE TONE



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## COACHING AND MENTORING STAFF

Promote collaboration

Boost clinical reasoning and skills

Educate on best practices



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## POLLING/DISCUSSION QUESTIONS

- Do you use INTERACT tools such as Stop & Watch (S&W) and SBAR to report and document condition change?
  - Yes
  - No
  - Unsure
- What in-house resource is primarily used by staff nurses in managing a condition change?
  - SBAR
  - Stop & Watch (S&W)
  - Other communication/documentation tool
  - We don't use any
  - Unsure



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## ADVANCE CARE PLANNING: SERIOUS ILLNESS CONVERSATIONS

- Provide opportunity for **ONGOING** conversations about goals of care **BEFORE** a crisis
- Improve **TRUST** among the facility and families
- Honor resident's **WISHES**



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## ADVANCE CARE PLANNING AND END-OF-LIFE CARE

Quality of Life vs Quantity of Life

Recognize Care Planning Opportunities

Develop Communication Processes

Timely Palliative Care and Hospice Referrals



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## HEALTH INFORMATION TECHNOLOGY/HEALTH INFORMATION EXCHANGE

Maximize HIT/HIE use in each nursing home

- Reports
- Alerts
- Quality Improvement

Use secure process – *avoid workarounds*

Communication with hospitals and other agencies



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## QUALITY IMPROVEMENT

- Track progress
  - Transfers
  - Quality Measures
  - Infections
  - Falls
  - Antipsychotic meds
- Celebrate successes...



**... even small ones**



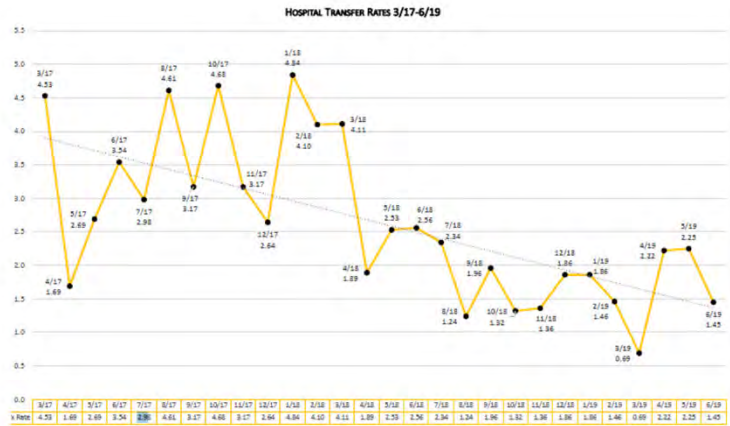
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# USING DATA TO DRIVE CHANGE



## SAMPLE TRANSFER FEEDBACK REPORT



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# POLLING/DISCUSSION QUESTIONS

- How many reports do you review weekly? (I.e., transfers, quality measures, falls, depression, etc.)
  - 1-3
  - 4-6
  - 7-10
  - 10+
  - Unsure or none
- Are reports shared with frontline staff?
  - Yes
  - No
  - Unsure



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# REVIEWING TRANSFERS



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## ROOT CAUSE ANALYSIS

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- RCA conducted on *every* hospital transfer
- *No shame, no blame* environment
- Focus on identifying underlying causes of:
  - Resident specific issues
  - System specific issues
- Work with facility staff, families and physicians to influence change



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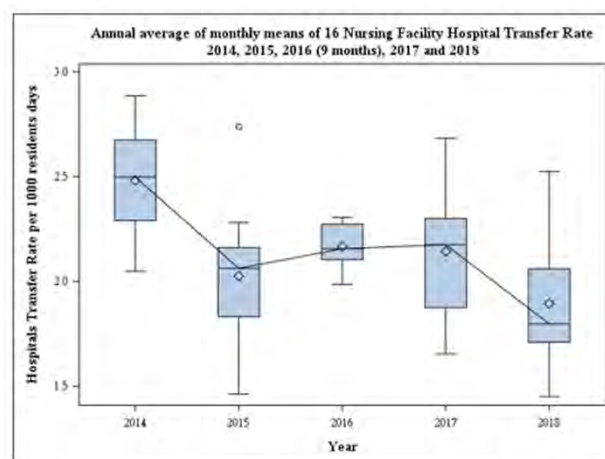
## MOQI FINDINGS

- 40% reduction in all-cause hospitalizations
- 57.7% potentially avoidable hospitalizations reduced (p=.001)
- 54.1% all-cause Emergency Department (ED) visits reduction
- 65.3% potentially avoidable ED visits reduced (p=.001)
- 33.6% Medicare expenditures in all-cause hospitalizations reduced
- 50.2% Medicare expenditures in all-cause ED visits reduced



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## MAKING A DIFFERENCE



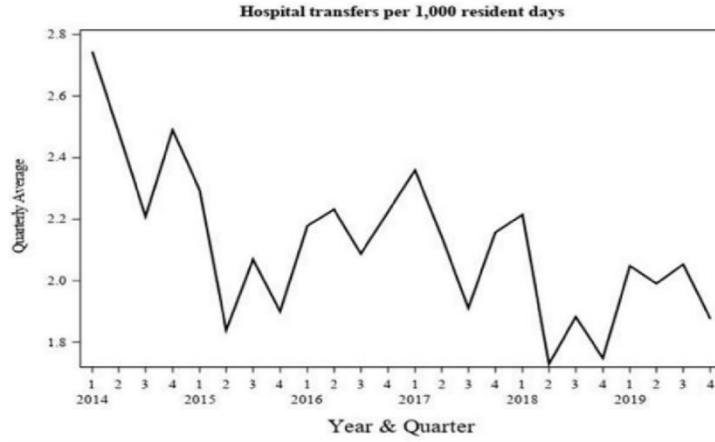
Note: Inside each box "square" symbol refers to mean, and horizontal across line refers to median.



Difference from 2014 through 2018 is statistically significant

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## MAKING A DIFFERENCE



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AND THEN THERE'S THE MONEY!

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**EVERY TIME** a resident goes to the hospital, there is revenue sneaking out the backdoor...



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In addition to the better care and early illness detection, reducing hospitalizations recaptures lost revenue for your nursing home to **use**, not lose!



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## AVERAGE REVENUE LOST EACH YEAR

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Even though MOQI homes reduced hospitalizations, there were still empty bed days that resulted in revenue sneaking out the back door.

As a group, MOQI NHs still had more than **\$32.5 million** that **could have been recaptured and used in the homes** during the 6 years (2014-2019).

On average, about **\$500,000** *each* year per 200 beds that could have been recaptured by further reducing hospitalizations.



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## POLLING/DISCUSSION QUESTIONS

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- In your facility have discussions regarding quality changed over the course of the pandemic?
  - Yes
  - No
  - Unsure



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## WHAT IS **NEWPATH** HEALTH SOLUTIONS?

Support nursing home leaders and staff to improve care processes that can reduce avoidable hospitalizations and ED use.

Using a team-based approach, the NewPath team helps develop and support a comprehensive plan that is implemented by leaders and staff within each facility.



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## IS YOUR NURSING HOME READY FOR A **NEWPATH**?

- Maximize systems of care to improve resident outcomes
- Improve **QUALITY MEASURE** performance
- Implement strategies to maximize use of available data
- Customizes an approach for your unique situation



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## WHAT IS YOUR NEWPATH JOURNEY?

Receive facility-level assessment

Guided implementation to:

- \* Improve early illness detection and acute condition management
- \* Coach and mentor staff to use enhanced clinical skills
- \* Increase nursing home capacity by improved care delivery systems

Assistance with designing tailored solutions to systems problems

Receive ongoing support via face-to-face and on-site visits

Access to education materials, clinical resources, and practice experts



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## IT STARTS WITH A CONVERSATION

What are the TOP 3 THINGS you would improve for your facility?

What keeps you AWAKE at night?



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## START <sup>THE</sup> CONVERSATION...

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