Advancing Excellence in America's Nursing Homes

AE Safely Reduce Hospitalizations Tracking Tool

June 25, 2013

Advancing Excellence in America's Nursing Homes

Poll

Are you registered for the Advancing Excellence in America's Nursing Homes Campaign?

- Yes
- No

Advancing Excellence in America's Nursing Homes

About the Campaign

National, Voluntary, Aligned

Registered Participant

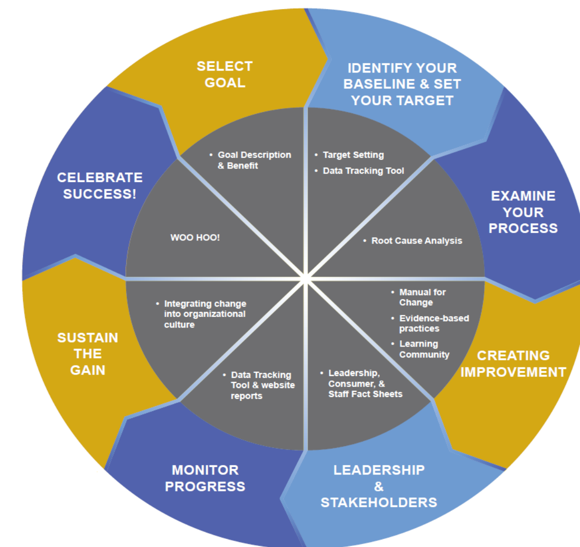
⇨ Register/Update Profile

⇨ Select Goals

Active Participant

⇨ Submit Data

www.nhqualitycampaign.org



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Quality Improvement Resources for NINE Goals

Hospitalizations	Staff Stability	Pressure Ulcers
Medications *Antipsychotics*	Consistent Assignment	Infections *C. difficile*
Mobility	Person-Centered Care	Pain Management

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Organizational Goals

Hospitalizations	Staff Stability	Pressure Ulcers
Medications *Antipsychotics*	Consistent Assignment	Infections *C. difficile*
Mobility	Person-Centered Care	Pain Management

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Today's Goal

Hospitalizations	Staff Stability	Pressure Ulcers
Medications *Antipsychotics*	Consistent Assignment	Infections *C. difficile*
Mobility	Person-Centered Care	Pain Management

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Poll

Are you using INTERACT Tools?

- Yes
- No

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INTERACT: Overview

Using the INTERACT Tools
In Every Day Care

New Resident Admission
Resident Re-Assessment

Advance Care Planning Tools

Medication Reconciliation Worksheet

Change in Resident Status Noted

CNA, Other Direct Care Staff, or Family Alerts LPN/RN

Stop and Watch Early Warning Tool

LPN/RN Evaluation

Care Paths

Acute Change in Condition File Cards

SBAR Form and Progress Note

MD/NP/PA Notified

Hospital Communication Tools

Acute Care Transfer

Transfer Checklist Envelope

Transfer Data List and Sample Forms

Hospitalization Rate Tracking Tool

Quality Improvement Tool for Review of Acute Care Transfers

Quality Improvement Program

Apply learning to improve care processes and education

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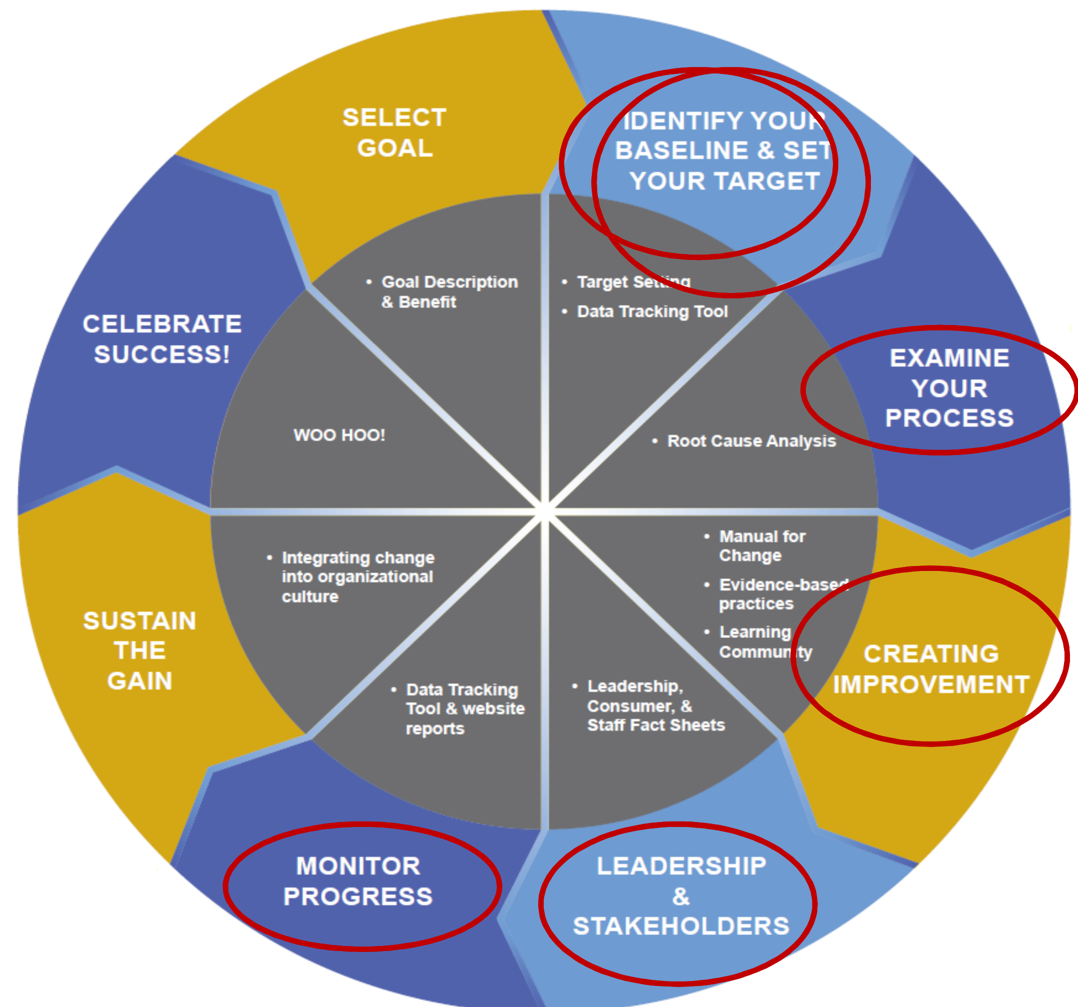
Data and the Quality Improvement Process

How do I know where I am?

Where do I want to be?

What processes are associated with my outcome?

When I change a process, how do I know it had the effect I wanted?



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QA and PI

Quality Assurance	Performance Improvement
Reactive	Proactive
Episode or event-based	Aggregate data & patterns
Prevent recurrence	Optimize process
Sometime anecdotal	Always measurable
Retrospective	Concurrent
Audit-based monitoring	Continuous monitoring
Sometimes punitive	Positive change

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Tracking Tools Support both QA and PI

- Easy view of individual records allows resident-level RCA of events
- Matrix of individual data allows scanning for patterns
- Summary information helps identify opportunities to improve communication and optimize processes at the system level

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The Tracking Tool

AE_SafelyReduceHospitalizationsTrackingTool.xls

www.NHQualityCampaign.org

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Required Fields

3 - For Residents Recently Discharged from Hospital

- Resident name
- Date discharged from hospital
- Status on admission to nursing home from hospital (Part A, Other)

4 - For Residents Transferred to Hospital

- Resident name
- Purpose of nursing home stay (PAC-type Care/Chronic Long Term Care)
- Date of transfer to hospital
- Outcome of transfer

1- For Your Home (or the group within your home you are tracking)

- ADC (or mid-month census) by purpose of stay

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Data Entry & Highlighted List of Residents in 30-day window

Home Insert Page Layout Formulas Data Review View Developer

Admitted with Recent Discharge

Today's Date: 05/15/2013

Step 3: List all admissions to your nursing home from hospital or who were discharged from a hospital within 30 days of admission to your nursing home. Fields with red asterisk * are required. This information will be used to calculate your 30-day rehospitalization rates.

Watch these residents. They are at risk of re-hospitalization within 30 days.

These residents were re-admitted to hospital within 30 days of admission to NH: RCA Indicated.

Which admissions should I record?

How to Use

Which admissions should I record?

	Automatic Resident Code to de-identify your file	Resident Name*	Hospital Discharge Date* Date resident discharged from hospital include discharges from acute care hospital, acute psychiatric hospital, and critical access hospital	Date Admitted to NH Date resident admitted to your nursing home include only residents who were admitted directly from hospital or who were discharged from hospital within 30 days of admission to your home	Automatic Day of Week no entry required	Status on Admission to Nursing Home*	Discharging Ho select from dropd use specific names ONLY hospitals
88	r57	Josefa Leite	03/10/13			Chronic Long-term Care (Not Medicare Part A)	
89	r195	Karan Maclachlan	03/09/13			Post-acute Care (Medicare Part A or managed care)	
90	r44	Kelvin Denmon	03/15/13			Post-acute Care (Medicare Part A or managed care)	
91	r117	Caleb Medley	04/01/13			Post-acute Care (Medicare Part A or managed care)	
92	r69	Cindi Ballantine	04/04/13			Post-acute Care (Medicare Part A or managed care)	
93	r23	Dale Gathers	04/22/13			Post-acute Care (Medicare Part A or managed care) / Chronic Long-term Care (Not Medicare Part A)	
94	r230	Devon Asmus	04/10/13			Post-acute Care (Medicare	
95	r166	Dulce Man	04/09/13			Post-acute Care (Medicare	
96	r68	Elinore Carmouche	04/15/13			Chronic Long-term Car	
97	r215	Ethan Peel	04/30/13			Chronic Long-term Car	
98	r45	Fred Houze	04/14/13			Chronic Long-term Car	
99	r206	Gerardo Matton	04/01/13			Chronic Long-term Car	
100	r134	Haley Hiler	04/04/13			Chronic Long-term Car	
101	r105	Janel Davila	04/22/13			Post-acute Care (Medicare	
102	r18	Jerald Rothschild	04/10/13			Chronic Long-term Care	
103	r239	Joseph Kindel	04/09/13			Chronic Long-term Care (Not Medicare Part A)	
104	r118	Kasey Kingston	04/15/13			Chronic Long-term Care (Not Medicare Part A)	
105	r47	Kenton Mcmillan	04/30/13			Post-acute Care (Medicare Part A or managed care)	
106	r162	Kurt Barragan	04/14/13			Chronic Long-term Care (Not Medicare Part A)	

Choose 'Post Acute Care' if the resident was admitted for post-acute or rehabilitative or medical care on the Medicare Part A skilled benefit or managed care.

Choose 'Chronic Long Term Care' if the resident was admitted for LTC, not on Medicare Part A.

Welcome | Common Qs&As | DropDownLists | Census | AdmittedwithRecentDischarge | TransferLog | ProcessTracking | ItemSummaries | CustomizedTracking | CustomizedItemSu

Ready 80%

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Data Entry Step 3

Home Insert Page Layout Formulas Data Review View Developer

Transfer Log

Step 4: Complete the detail for each resident transferred from your nursing home to hospital in the grid below.

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

Include ONLY transfers to acute care hospitals or critical access hospitals

*Red asterisk indicates required field.

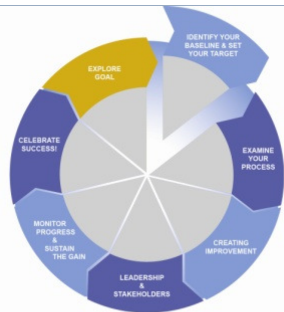
About this Resident

How to Use

	Automatic Resident Code to de-identify your file	Resident Name* example: Jane Brown	Purpose of Nursing Home Stay* Post-acute Type Care / Chronic Long Term Care	Payment Status at Time of Transfer from Nursing Home to Hospital select from list	Date of Transfer to Hospital* example: 7/21/12	Transfer: Time of D select from list
93	r108	Adena Blann	Post-Acute Type Care (Rehab/Medical Management)		4/25/13	
94	r173	Annabelle Solt	Chronic Long-term Care		4/6/13	
95	r236	Byron Centeno	Chronic Long-term Care		4/30/13	
96	r171	Nubia Arch	Chronic Long-term Care		4/30/13	
97	r48	Phil Laber	Chronic Long-term Care		4/23/13	
98	r253	Reba Swenson	Post-Acute Type Care (Rehab/Medical Management)		4/15/13	
99	r38	Roy Ringdahl	Chronic Long-term Care		4/11/13	
100	r220	Stewart Weatherall			4/30/13	
101	r111				4/25/13	
102	r201		ehab/Medical Management)		4/19/13	
103	r136				4/26/13	
104	r87		ehab/Medical Management)		4/18/13	
105	r205		Chronic Long-term Care		4/29/13	

Dropdown list:
- Korey Mauricio
- Ethan Peel
- Edwardo Hermanson
- Carey Linder
- Gaston Lenahan
- Elden Longshore
- Stewart Weatherall
- Wilford Mortensen

Resident's Name
Select from dropdown list or enter name exactly as it appears on the drop down list.



How do I know where I am? Identify Baseline

1. **30-Day Readmission Rate**
2. **Hospital Admission Rate**
3. **Rate of Transfers to ED Only**
4. **Rate of Transfers Resulting in Observation Stay**

February 2013

Data for Website Entry

You may use this sheet to view your monthly transfer rates as soon as you've entered all of your information through the end of the month.

IMPORTANT: Your 30-Day Readmission Rates for **February 2013** will not be final until you have completed your Transfer Log through:

Sunday, March 31, 2013

On or after 03/31/2013:
- Print this page.
- Log in to the Campaign https://www.nhqualitycampaign.org
- Select "Enter My Data." Under Safely Reduce Hospitalizations, click "Submit Data" and enter the numbers below in the corresponding fields.
- Click "Submit" and check the screen for the confirmation message.

Thank You!

February 2013			
Status at Time of Admission from Hospital			
	Post-Acute Care	Chronic Long Term Care (non-Medicare)	All Residents
Number of Residents with Date of Discharge from Hospital in This Month	13	17	30
30-Day Readmission Rate percent of those readmitted to hospital within 30 days of the date of discharge from hospital	30.8%	29.4%	30.0%
Purpose of Stay at Time of Transfer to Hospital			
	Post-Acute Care	Chronic Long Term Care	All Residents
Resident Days This Month Your ADC x the number of days in the month	1092	3080	4172
Hospital Admission Rate per 1000 resident days	2.7	4.5	4.1
Rate of Transfers to Emergency Department Only per 1000 resident days	2.7	2.3	2.4
Rate of Transfers Resulting in Observation Stay per 1000 resident days	2.7	1.6	1.9

Optional Fields

Patterns in Admissions *from* Hospital

- Day of week
- Hospital

Patterns in Transfers *to* Hospital

- Payment status at time of transfer
- Time of day
- Doctor ordering transfer
- Primary clinical reason for transfer
- Contributing

Process when Admitting *from* Hospital

- Structured communication tool used
- Information adequate to care for resident

Process when Transferring t*o* Hospital

- Structured communication tool used when transferring *to* hospital
- RCA of transfer completed
- Documented ACP discussion in past quarter
- ACP reviewed at time of transfer
- Structured communication tool used at nursing home to evaluate acute condition

Optional Fields Help Identify Next Steps

Patterns in Admissions *from* Hospital

- Day of week
- Hospital

Patterns in Transfers *to* Hospital

- Payment status at time of transfer
- Time of day
- Clinician ordering transfer
- **Primary clinical reason for transfer**
- **Primary contributing reason for transfer**

Process when Admitting *from* Hospital

- Structured communication tool used
- Information adequate to care for resident

Process when Transferring *to* Hospital

- Structured communication tool used when transferring *to* hospital
- **RCA of transfer completed**
- Documented ACP discussion in past quarter
- ACP reviewed at time of transfer
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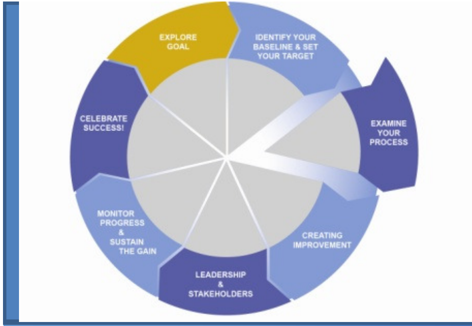
Use Data to Track Process Measures

Transfer Related Processes

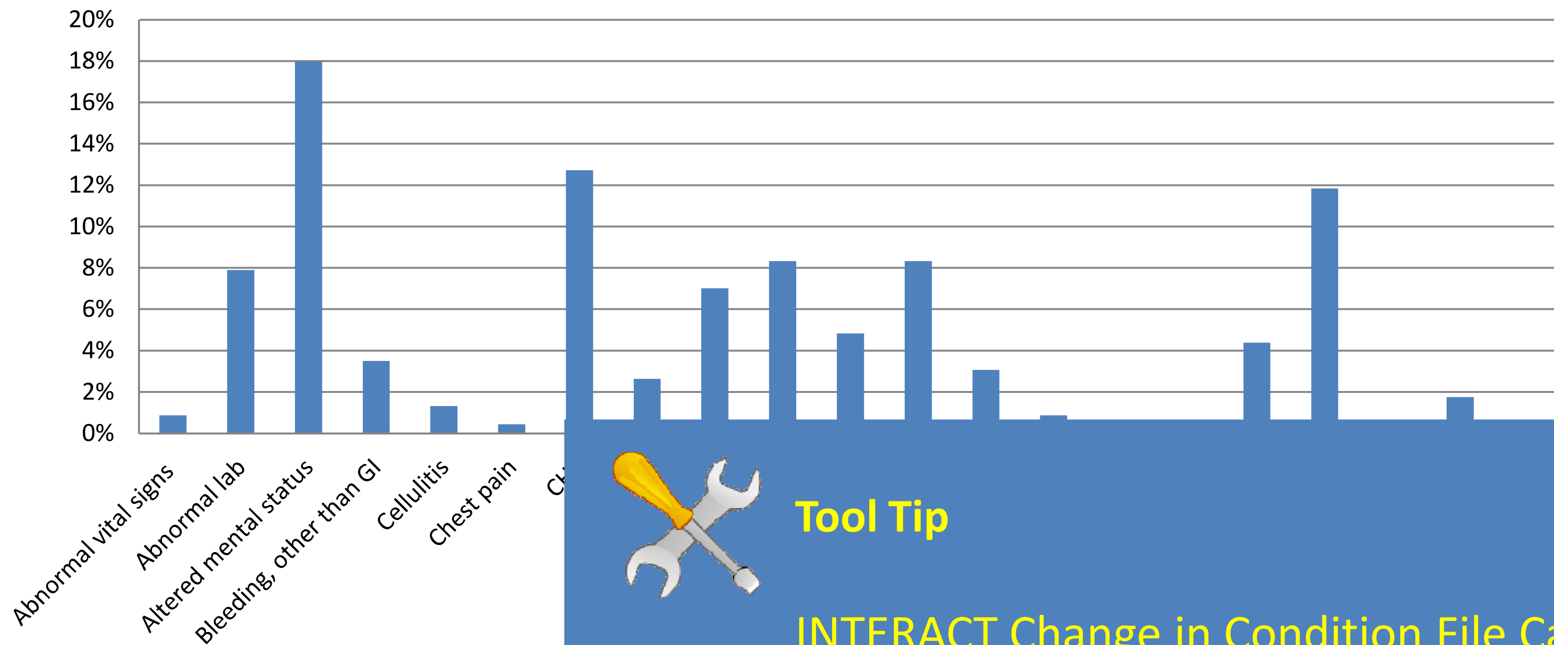
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%

January 2013 February 2013 March 2013 April 2013 May 2013 June 2013 July 2013 August 2013 September 2013 October 2013 November 2013 December 2013

- Percent of All Transfers for which Resident had a Documented Advance Care Planning Discussion in the Past Quarter
- Percent of All Transfers in which Resident's Advance Care Plan was Reviewed at Time of Transfer
- Percent of All Transfers in which a Structured Communication Tool was Used at Nursing Home to Evaluate Acute Condition
- Percent of All Transfers for which a Structured Communication Tool was Used to Receive Information from Hospital when Resident was Last Admitted to Nursing Home
- Percent of All Transfers for which a Root Cause Analysis was Completed



Use Data to Explore Patterns



Tool Tip

INTERACT Change in Condition File Cards
INTERACT Care Paths
AE Goal Packages and Tracking Tools

Use Data to Explore Processes

Primary Contributing Reasons for Transfers

35%
30%
25%
20%
15%
10%
5%
0%

Advance care plan not in place
Practitioner unable to provide face-to-face…
Supplies/Resources
Medication management
Equipment not av
Problems w/n

Tool Tip

AE & INTERACT Advance Care Planning
INTERACT SBAR
INTERACT NH Capabilities Checklist

Optional Fields Help *Monitor Implementation*

Patterns in Admissions *from* Hospital

- Day of week
- Hospital

Patterns in Transfers *to* Hospital

- Payment status at time of transfer
- Time of day
- Clinician ordering transfer
- Primary clinical reason for transfer
- Primary contributing reason for transfer

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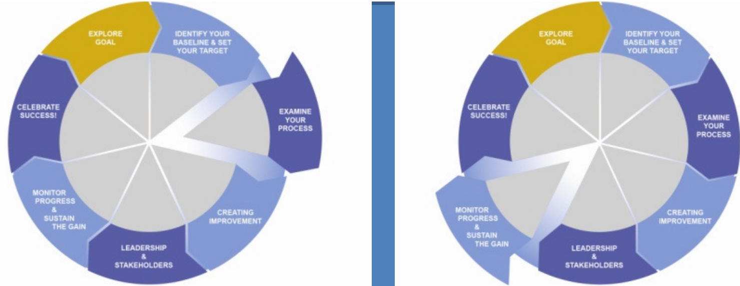

Use Data to Track Process Measures

Transfer Related Processes

100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%

January 2013, February 2013, March 2013, April 2013, May 2013, June 2013, July 2013, August 2013, September 2013, October 2013, November 2013, December 2013

- Percent of All Transfers for which Resident had a Documented Advance Care Planning Discussion in the Past Quarter
- Percent of All Transfers in which Resident's Advance Care Plan was Reviewed at Time of Transfer

Optional Fields Help *Identify Patterns*

Patterns in Admissions *from* Hospital

- Day of week
- **Hospital**

Patterns in Transfers *to* Hospital

- Payment status at time of transfer
- Time of day
- **Clinician ordering transfer**
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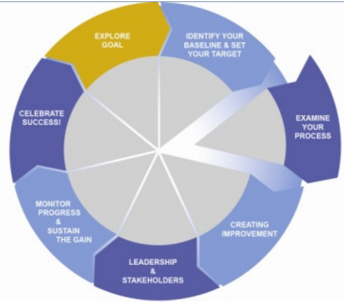
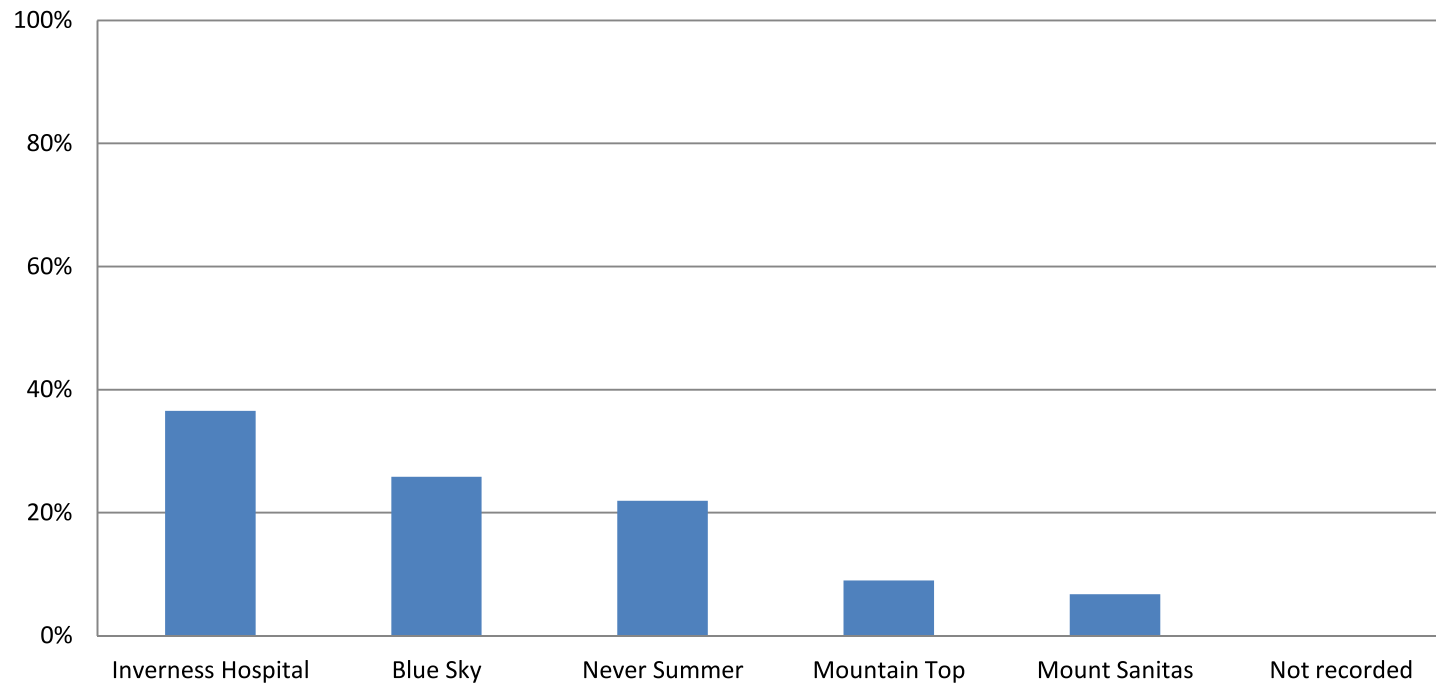


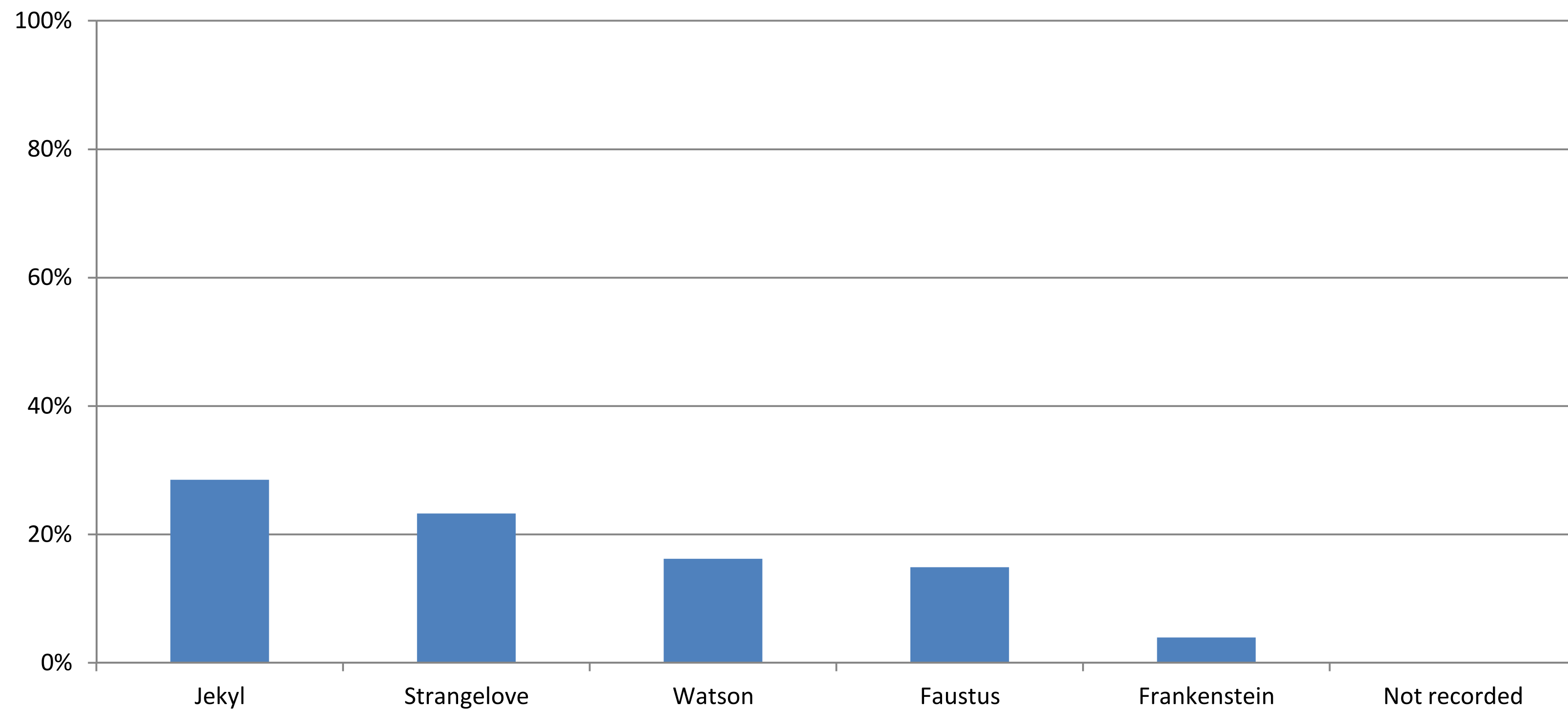
Use Data to Explore Patterns

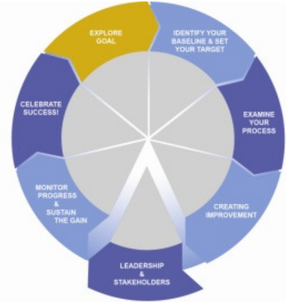
Source of Admissions

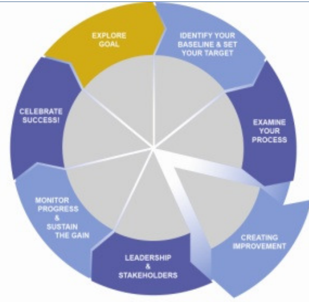
The 5 places from which our nursing home most frequently admits residents with recent hospital stay



Use Data to Explore Patterns







Involving Partners with Data

Share data with staff

Share data with hospitals

Involving Partners with Data

Home Insert Page Layout Formulas Data Review View Developer

Use this sheet to create a readmissions report for a specific hospital or health plan.

Select the hospital OR health plan you would like the report created for:

Inverness Hospital

OR

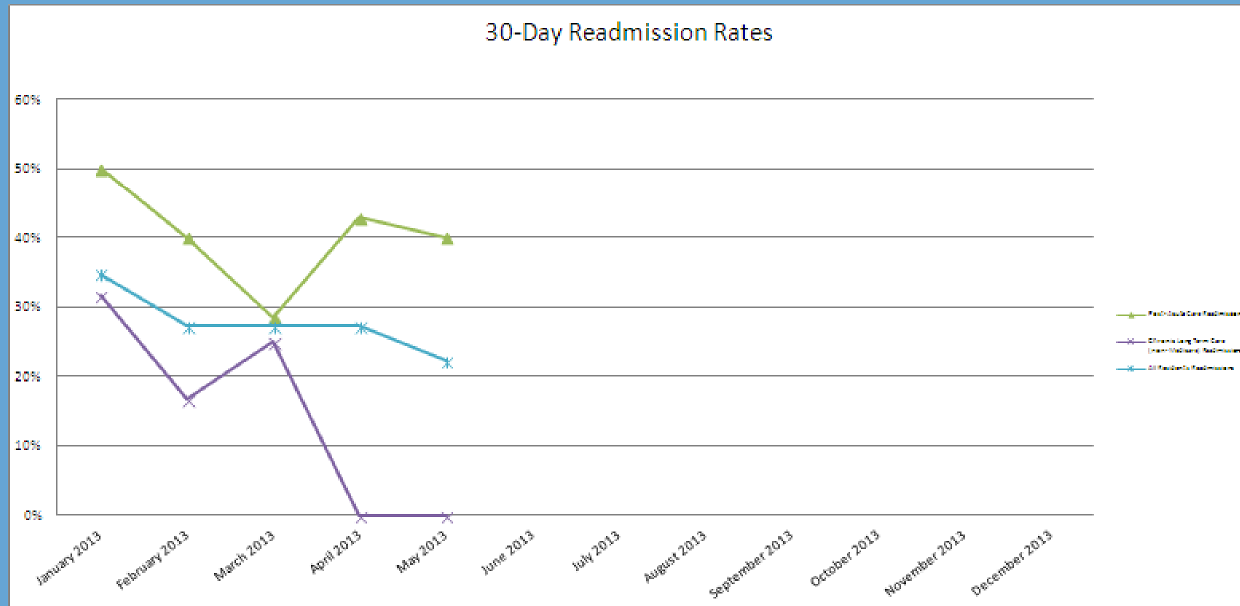
All Plans

Important!

For specific health plan rates, you must set the first option to "All Sources."

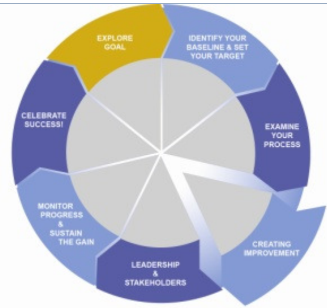
Advancing Excellence

Inverness Hospital



30-Day Readmission Rates

Status on Admission to Nursing Home	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13
Post-Acute Care Readmissions	50.0%	40.0%	28.6%	42.9%	40.0%							
Chronic Long Term Care (non-Medicare) Readmissions	31.6%	16.7%	25.0%	0.0%	0.0%							



Creating Change
Involving Partners with Data

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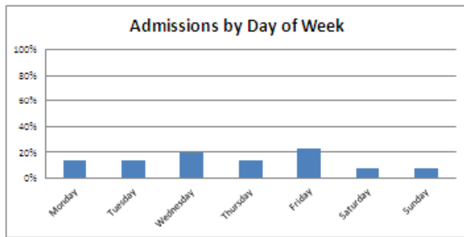
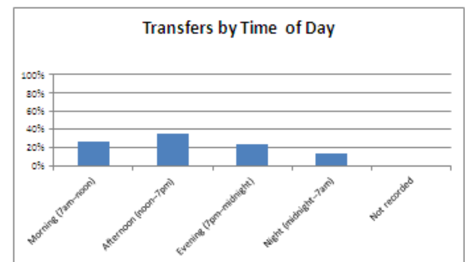
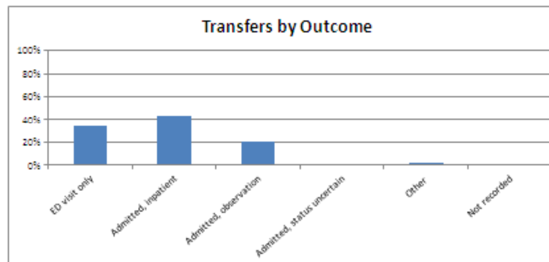






Admissions by Day of Week

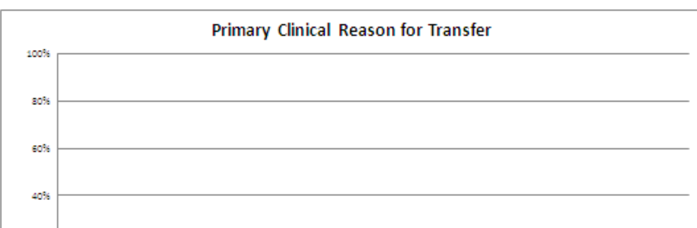
	Number of Admissions	Percent of all Admissions
Monday	9	13.8%
Tuesday	9	13.8%
Wednesday	13	20.0%
Thursday	9	13.8%
Friday	15	23.1%
Saturday	5	7.7%
Sunday	5	7.7%

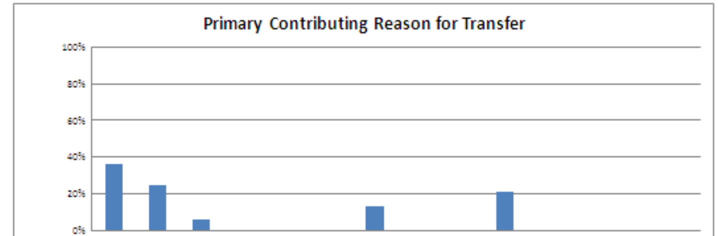
Transfers by Time of Day

	Number of Transfers	Percent of all Transfers
Morning (7am--noon)	14	26.4%
Afternoon (noon--7pm)	19	35.8%
Evening (7pm--midnight)	13	24.5%
Night (midnight--7am)	7	13.2%
Not recorded	0	0.0%

Transfers by Outcome

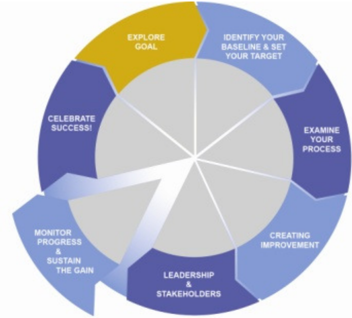
	Number of Transfers	Percent of all Transfers
ED visit only	18	34.0%
Admitted, inpatient	23	43.4%
Admitted, observation	11	20.8%
Admitted, status uncertain	0	0.0%
Other	1	1.9%
Not recorded	0	0.0%





DropDownLists Census AdmittedwithRecentDischarge TransferLog ProcessTracking ItemSummaries CustomizedTracking CustomizedItemSummaries January 2013

Ready 60%



How am I doing? Monitor Progress

February 2013

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Number of Residents with Date of Discharge from Hospital in This Month	13	17	30
30-Day Readmission Rate percent of those readmitted to hospital within 30 days of the date of discharge from hospital	30.8%	29.4%	30.0%
Purpose of Stay at Time of Transfer to Hospital			
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Hospital Admission Rate per 1000 resident days	2.7	4.5	4.1
Rate of Transfers to Emergency Department Only per 1000 resident days	2.7	2.3	2.4
Rate of Transfers Resulting in Observation Stay per 1000 resident days	2.7	1.6	1.9

Enter Summary Data on the AE Website

Advancing Excellence in America's Nursing Homes

- Hospitalizations
- Person Centered Care
- Staff Stability

Clinical Outcome Goals:

- Infections
- Medications
- Mobility
- Pain
- Pressure Ulcers

Select a month and year from the list to load any previously entered data for that year and enable data entry in the table. After entering data for a month, click the Submit button to save your data.

Select a month ▾ Select a year ▾

Select a month
January
February
March
April
May
June
July
August
September
October
November
December

...atus at Time of Admission from Hospital			
	Post-Acute Care	Chronic Long Term Care	All Residents
...Month			
...ate			

...ose of Stay at Time of Transfer to Hospital			
	Post-Acute Care	Chronic Long Term Care	All Residents
Resident Days This Month			
Unplanned Hospital Admission Rate			
Rate of Transfers to Emergency Department Only			
Rate of Transfers Resulting in Observation Stay			

Submit Clear

Advancing Excellence in America's Nursing Homes

Getting Started with the Advancing Excellence Hospitalization Goal

Join us for a series of 3 webinars

June 27 * July 18 * August 1

1:00-2:00pm MT

This FREE series of 3 practicums is hosted by AE and is open for anyone who would like to participate.

Each practicum will include presentation/demonstration, open space for questions and discussion, and homework

Advancing Excellence in America's Nursing Homes

Thank You

For making our nursing homes better places to live, work, and visit!

Adrienne Mihelic
amihelic@cfmc.org
help@nhqualitycampaign.org
303-931-0027