

Getting Started with the Advancing Excellence Hospitalization Goal

Session 3: Biting the Elephant

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August 1, 2013



**Click link while in 'slide show' mode OR copy
and paste the url into your browser.**

http://www.nhqualitycampaign.org/star_index.aspx?controls=HospitalizationsIdentifyBaseline

- Overview and introduction to the AE Safely Reduce Hospitalization Tracking Tool.
- Recordings of practicum webinars
- Slide decks
- Cumulative Q&A from first & second practicum

- Q&A Tips from Users
- For leadership and corporations

Progress report

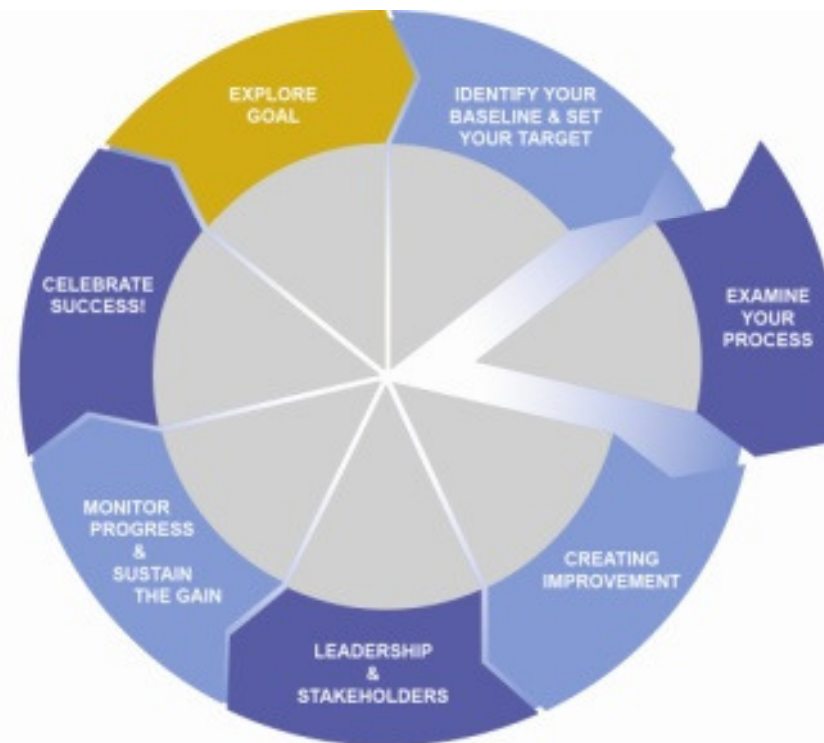
Select all that apply

- a) I have entered required fields for some transfers & admissions
- c) We have used the INTERACT QI Review Tool on one or more transfers.
- d) I have entered the 3 additional fields from the INTERACT QI Review Tool into the AE Hospitalization Tracking Tool (in addition to the required fields)
- e) I have accessed the Probing Questions from the AE website

How do I know where I am?



**What processes should we
target?**





This flight is headed for ...

Session 3: Getting started with the AE Hospitalization Goal: Time to Act (or ‘Biting the Elephant’)

Prioritizing AND starting with manageable bites are both important quality improvement principles. INTERACT is an entire program that includes many excellent tools to help standardize processes associated with changes in condition and optimize communications – but where to start? Data from the Tracking Tool helps us start small, but start smart.

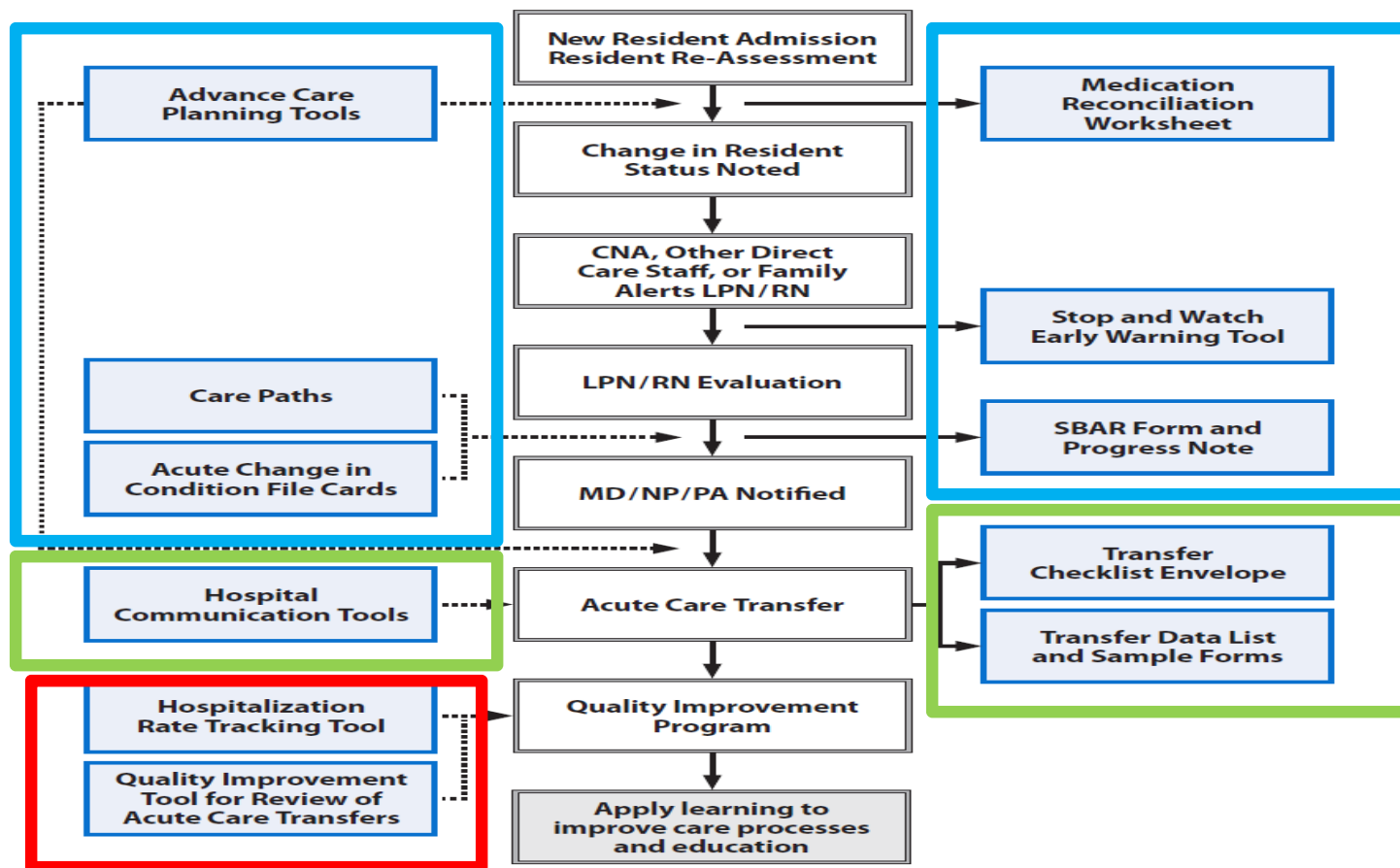
Biting the Elephant





INTERACT: Overview

Using the INTERACT Tools
In Every Day Care



- See the Common Q&A within your Excel workbook for a succinct discussion about Advance Care Planning and links to resources
- Advancing Excellence resources for Advance Care Planning
http://www.nhqualitycampaign.org/demo/star_index.aspx?controls=resByGoal
- INTERACT resources for Advance Care Planning
<http://www.interact2.net/tools.html>
- Advancing Excellence resources for resident and family education on the impact of hospital transfer
http://www.nhqualitycampaign.org/demo/star_index.aspx?controls=HospitalizationsLeadership



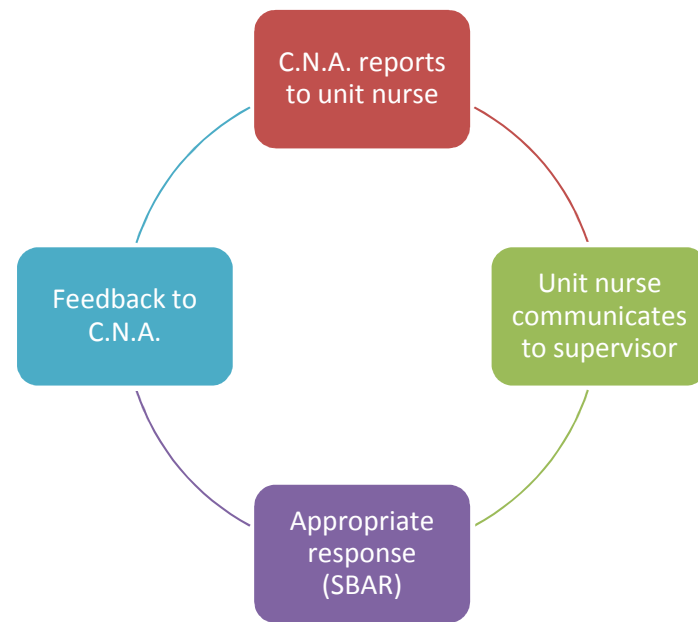
Stop and Watch The Early Warning Tool

Stop and Watch Early Warning Tool



If you have identified a change while caring for or observing a resident, please **circle** the change and notify a nurse. Either give the nurse a copy of this tool or review it with her/him as soon as you can.

S T O P a n d W A T C H	Seems different than usual
	Talks or communicates less
	Overall needs more help
	Pain – new or worsening; Participated less in activities
	Ate less
	No bowel movement in 3 days; or diarrhea
	Drank less
	Weight change
	Agitated or nervous more than usual
	Tired, weak, confused, or drowsy
	Change in skin color or condition
	Help with walking, transferring, toileting more than usual



Name of Resident

Your Name

Reported to

Date and Time (am/pm)

Nurse Response

Date and Time (am/pm)



Change in Condition File Cards

Change in Condition: *When to report to the MD/NP/PA*



Immediate Notification

Any symptom, sign or apparent discomfort that is:

- **Acute** or **Sudden** in onset, and:
 - **A Marked Change** (*i.e. more severe*) in relation to usual symptoms and signs, or
 - **Unrelieved** by measures already prescribed

Non-Immediate Notification

- **New or worsening symptoms that do not meet above criteria**

This guidance is adapted from: AMDA Clinical Practice Guideline – Acute Changes in Condition in the Long-Term Care Setting 2003; and Ouslander, J, Osterweil, D, Morley, J. *Medical Care in the Nursing Home*. McGraw-Hill, 1996



Change in Condition File Cards

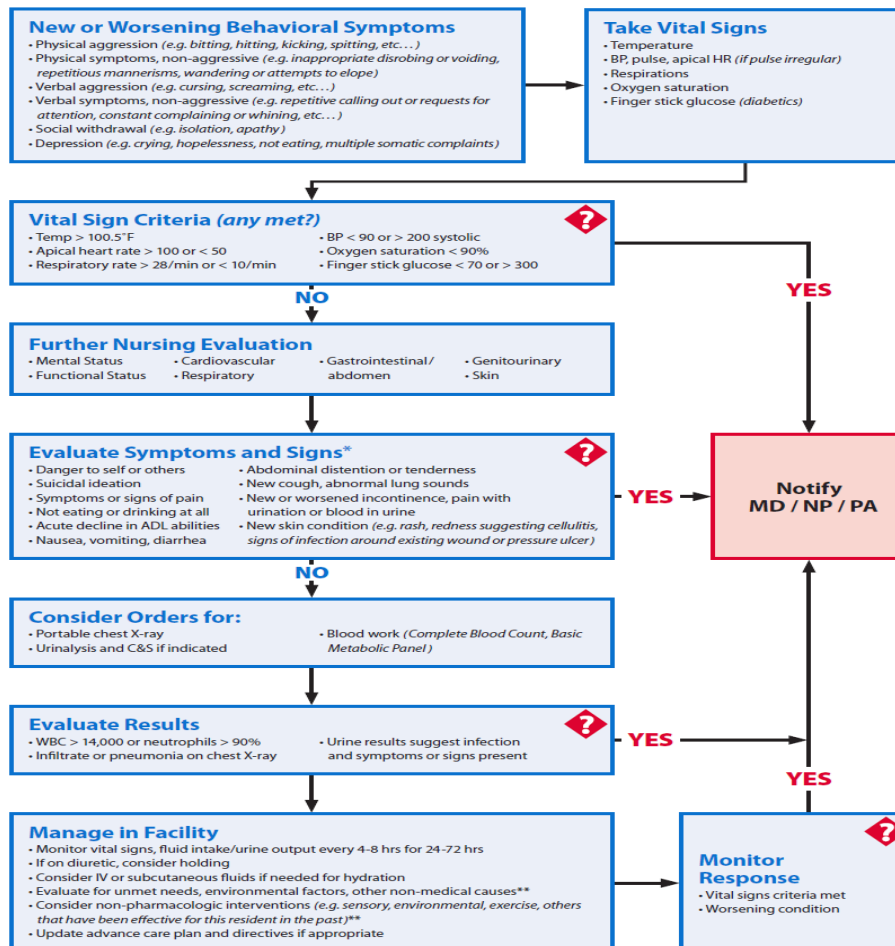


Signs and Symptoms S's

Symptom or Sign	Immediate	Non-Immediate
Seizure activity	Any new onset seizure activity, OR persistent seizure in someone with known intermittent seizure activity	Self-limited seizure in past 24 hours in a resident with known seizure activity who is already on an anticonvulsant
Shortness of breath (<i>dyspnea</i>) ¹	Abrupt onset of SOB with pain, fever, or respiratory distress	Recently progressive or persistent minor SOB without other symptoms, OR with progressive leg edema
Sleep disturbance		Difficulty sleeping
Sore throat	Accompanied by respiratory distress or inability to swallow	With mild to moderate symptoms of upper respiratory infection not responding to standard conservative treatments
Speech, abnormality ²	Abrupt change in speech, with or without other focal neurological findings	
Splinters/slivers	If unable to remove readily, with OR accompanied by considerable pain or bleeding	If area appears to be infected, with erythema or purulent drainage, OR if no tetanus shot within past ten years
Suicide potential	Makes a suicidal gesture, OR discusses a detailed plan for carrying out suicide	New onset of talking about wanting to die, but not making any specific suicidal threats
Swallowing difficulty	With new onset or progressive choking, aspiration	Decreased intake from dysphagia, with potential risk of dehydration malnutrition

¹ See INTERACT Shortness of Breath Care Path ² See INTERACT Acute Mental Status Change Care Path

CARE PATH *Change in Behavior* Evaluation of Medical Causes of New or Worsening Behavioral Symptoms





SBAR

SBAR Communication Form and Progress Note



Before Calling MD / NP / PA:

- Evaluate the Resident:** Complete relevant aspects of the SBAR form below
- Check Vital Signs:** BP, pulse, and/or apical heart rate, temperature, respiratory rate, oximetry, and finger stick glucose, if indicated
- Review Record:** Recent progress notes, labs, orders
- Review an INTERACT Care Path or Acute Change in Condition File Card,** if indicated
- Have Relevant Information Available when Reporting**
(i.e. medical record, vital signs, advance directives such as DNR and other care limiting orders, allergies, medication list)

SITUATION

The change in condition, symptoms, or signs I am calling about is/are _____

This started on ____/____/____ Since this started has it gotten: Worse Better Stayed the same

Things that make the condition or symptom **worse** are _____

Things that make the condition or symptom **better** are _____

This condition, symptom, or sign has occurred before: Yes No

Treatment for last episode *(if applicable)* _____

Other relevant information _____

BACKGROUND

Resident Description

This resident is in the NH for: Post-Acute Care Long-Term Care

Primary diagnoses _____

Other pertinent history *(e.g. medical diagnosis of CHF, DM, COPD)* _____

Medication Alerts

Changes in the last week *(describe below)* Resident is on warfarin/coumadin: Result of last INR _____ Date ____/____/____

Allergies _____

Vital Signs

BP _____ Pulse _____ Apical HR _____ RR _____ Temp _____ Weight _____ lbs *(date ____/____/____)*

For CHF, edema, or weight loss: last weight before the current one was _____ on ____/____/____

Oximetry % _____ on room air on O₂ *(liters/minute)* _____

Residents Name _____

ASSESSMENT (RN) OR APPEARANCE (LPN)

What do you think is going on with the resident?

For RNs: I think the problem may be *(e.g. cardiac, infection, respiratory, dehydration)* _____

For LPNs: The resident appears *(e.g. short of breath, in pain, more confused)* _____

REQUEST

I suggest or request *(check all that apply)*

- Monitor vital signs
- Lab work
- X-ray
- EKG
- Provider visit *(MD/NP/PA)*
- Transfer to the hospital *(send a copy of this form)*
- Other new orders *(specify)*

Nursing Notes *(for additional information on the Change In Condition)*

Name of Family/Health Care Agent Notified: _____ Date ____/____/____ Time (am/pm) _____

Reported to Primary Care Clinician (MD/NP/PA): _____ Date ____/____/____ Time (am/pm) _____



Transfer Form

Nursing Home to Hospital Transfer Form



Resident Name (last, first, middle initial) _____
 Language: English Other _____ Resident is: SNF/rehab Long-term
 Date Admitted (most recent) ____/____/____ DOB ____/____/____
 Primary diagnosis(es) for admission _____

Sent To (name of hospital) _____
 Date of transfer ____/____/____
Sent From (name of nursing home) _____ Unit _____

Contact Person _____
 Relationship (check all that apply)
 Relative Health care proxy Guardian Other
 Tel (_____) _____
 Notified of transfer? Yes No
 Aware of clinical situation? Yes No

Who to Call at the Nursing Home to Get Questions Answered
 Name/Title _____
 Tel (_____) _____

Primary Care Clinician in Nursing Home MD NP PA
 Name _____
 Tel (_____) _____

Code Status Full Code DNR DNI DNH Comfort Care Only Uncertain

Key Clinical Information

Reason(s) for transfer _____
 Is the primary reason for transfer for diagnostic testing, not admission? No Yes Tests: _____
 Relevant diagnoses CHF COPD CRF DM Ca (active treatment) Dementia Other _____
 Vital Signs BP _____ HR _____ RR _____ Temp _____ O2 Sat _____ Time taken (am/pm) _____
 Most recent pain level _____ (N/A) Pain location: _____
 Most recent pain med _____ Date given ____/____/____ Time (am/pm) _____



Transfer Form

Usual Mental Status:

- Alert, oriented, follows instructions
- Alert, disoriented, but can follow simple instructions
- Alert, disoriented, but cannot follow simple instructions
- Not Alert

Usual Functional Status:

- Ambulates independently
- Ambulates with assistive device
- Ambulates only with human assistance
- Not ambulatory

Additional Clinical Information:

- SBAR Acute Change in Condition Note included
 - Other clinical notes included
- For residents with lacerations or wounds:
Date of last tetanus vaccination (if known) ____/____/____

Devices and Treatments

- O2 at ____ L/min by Nasal canula Mask (Chronic New)
- Nebulizer therapy; (Chronic New)
- CPAP BiPAP Pacemaker IV PICC line
- Bladder (Foley) Catheter (Chronic New) Internal Defibrillator
- Enteral Feeding TPN Other _____

Isolation Precautions

- MRSA VRE
- Site _____
- C. difficile Norovirus
- Respiratory virus or flu
- Other _____

Allergies

Risk Alerts

- Anticoagulation Falls Pressure ulcer(s) Aspiration Seizures
- Harm to self or others Restraints Limited/non-weight bearing: (Left Right)
- May attempt to exit Swallowing precautions Needs meds crushed
- Other _____

Personal Belongings Sent with Resident

- Eyeglasses Hearing Aid
- Dental Appliance Jewelry
- Other _____

Nursing Home Would be able to Accept Resident Back Under the Following Conditions

- ER determines diagnoses, and treatment can be done in NH VS stabilized and follow up plan can be done in NH
- Other _____

Additional Transfer Information on a Second Page:

- Included Will be sent later

Form Completed By (name/title) _____ Signature _____
 Report Called in By (name/title) _____
 Report Called in To (name/title) _____ Date ____/____/____ Time (am/pm) _____



Nursing Home Capabilities List

Nursing Home Capabilities List



This list is for hospital emergency rooms, hospitalists, and case managers; and for physicians, NPs, and PAs who take off-hours call for the facility to assist with decisions about hospital admission or return to the facility.

Facility _____
 Address _____
 Tel (_____) _____ Key Contact _____

Circle 'Y' for yes or 'N' for no to indicate the availability of each item in your facility.

Capabilities	Yes	No
Primary Care Clinician Services		
At least one physician, NP, or PA in the facility three or more days per week	Y	N
At least one physician, NP, or PA in the facility five or more days per week	Y	N
Diagnostic Testing		
Stat lab tests with turnaround less than 8 hours	Y	N
Stat X-rays with turnaround less than 8 hours	Y	N
EKG	Y	N
Bladder Ultrasound	Y	N
Venous Doppler	Y	N
Cardiac Echo	Y	N
Swallow Studies	Y	N
Consultations		
Psychiatry	Y	N
Cardiology	Y	N
Pulmonary	Y	N
Wound Care	Y	N
Other Physician Specialty Consultations <i>specify:</i>	Y	N
Social and Psychology Services		
Licensed Social Worker	Y	N
Psychological Evaluation and Counseling by a Licensed Clinical Psychologist	Y	N
Therapies on Site		
Occupational	Y	N
Physical	Y	N
Respiratory	Y	N
Speech	Y	N

Capabilities	Yes	No
Nursing Services		
Frequent vital signs (e.g. every 2 hrs)	Y	N
Strict intake and output (I&O) monitoring	Y	N
Daily weights	Y	N
Accuchecks for glucose at least every shift	Y	N
INR	Y	N
O2 saturation	Y	N
Nebulizer treatments	Y	N
Incentive spirometry	Y	N
Interventions		
IV Fluids (initiation and maintenance)	Y	N
IV Antibiotics	Y	N
IV Meds – Other (e.g. furosemide)	Y	N
PICC Insertion	Y	N
PICC Management	Y	N
Total Parenteral Nutrition (TPN)	Y	N
Isolation (for MRSA, VRE, etc...)	Y	N
Surgical Drain Management	Y	N
Tracheostomy Management	Y	N
Analgesic Pumps	Y	N
Dialysis	Y	N
Advanced CPR (ACLS capability)	Y	N
Automatic Defibrillator	Y	N
Pharmacy Services		
Emergency kit with common medications for acute conditions available	Y	N
New medications filled within 8 hours	Y	N
Other Specialized Services (specify)		

Advancing Excellence

in America's Nursing Homes

INTERACT QI Review Tool

Quality Improvement Tool For Review of Acute Care Transfers



The INTERACT QI Tool is designed to help you analyze hospital transfers and identify opportunities to reduce transfers that might be preventable. Complete this tool for each or a representative sample of hospital transfers in order to conduct a root cause analysis and identify common reasons for transfers. Examining trends in these data with the INTERACT QI Summary Tool can help you focus educational and care process improvement activities.

SECTION 1: Describe Resident Characteristics

Resident ID _____ Age _____

Date of **most recent** admission to nursing home ____/____/____

a. Major diagnoses at admission _____

b. Conditions that put the resident at risk for hospital admission or readmission:

- Hospitalization within the last 6 months
- COPD
- Polypharmacy (e.g. 9 or more medications)
- Surgical complications
- Fracture
- CHF
- Cancer, on active chemo or radiation therapy
- Multiple co-morbidities (e.g. CHF, COPD and DM in the same patient; or multiple active diagnoses)
- Other (describe) _____

c. Resident hospitalized in the **past 30 days**? No Yes (list dates and reasons) _____

d. Resident hospitalized in the **past 12 months**? No Yes (list dates and reasons) _____

SECTION 2: Describe the Acute Change in Condition and Other Non-Clinical Factors that Contributed to the Transfer

a. Date the change in condition first noticed ____/____/____

b. Briefly describe the change, symptom, sign or other factor(s) that led to the transfer and then check each item below that applies

c. Were **advance care planning or advance directives** considered in evaluating/managing the change? (e.g. orders for Do Not Resuscitate (DNR), Do Not Intubate (DNI), palliative or hospice care): No Yes

If yes, were the relevant advance directives: Modified as a result of this change in clinical condition?
 Already in place and documented?
 New as a result of this change in clinical condition?

Describe _____

SECTION 4: Describe the Hospital Transfer

a. Date of transfer ____/____/____ Day _____ Time (am/pm) _____

b. Clinician authorizing transfer: Primary MD Covering MD NP or PA Other

c. Outcome of transfer: ED visit only Held for observation Admitted to hospital as inpatient

Hospital diagnosis(es) (if available) _____

d. Resident died in ED or hospital: No Yes Unknown

SECTION 5: Identify Opportunities for Improvement

a. In retrospect, does your team think this transfer might have been prevented? No Yes (check all that apply and describe below)

- The new sign, symptom, or other change might have been detected earlier
- Changes in the resident's condition might have been communicated better among NH staff, with MD/NP/PA, or with ER staff
- The condition might have been managed safely in the facility with available resources
- Resources were not available to manage the change in condition safely or effectively (check all that apply)
 - On-site primary care clinician
 - Staffing
 - Lab or other diagnostic tests
 - Pharmacy services
 - Other (describe) _____
- Resident and family preferences for hospitalization might have been discussed earlier
- Advance directives and/or palliative or hospice care might have been put in place earlier
- Other (describe) _____

b. In retrospect, does your team think this resident might have been transferred sooner? No Yes (if yes, describe) _____

c. After review of how this change in condition was evaluated and managed, has your team identified any opportunities for improvement? No Yes (describe specific changes your team can make in your care processes and related education as a result of this review)

Name of person completing form _____ Date of completion ____/____/____



Homework 2

RCA each transfer and record in Workbook

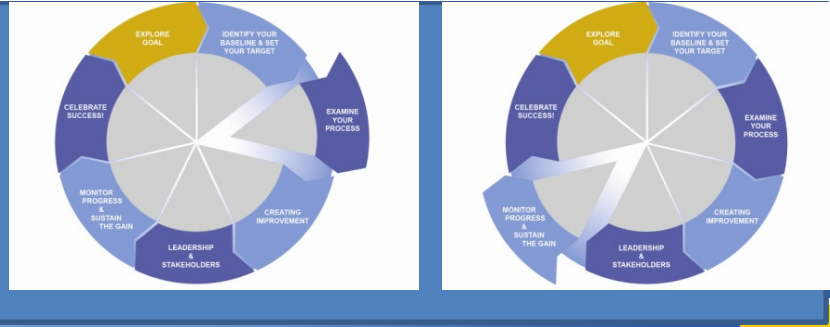
For EACH transfer to hospital, complete the INTERACT QI Review Tool, and record 3 additional items in your Tracking Tool:

Look for Patterns

- **Primary clinical reason for transfer**
- **Primary contributing reason for transfer**

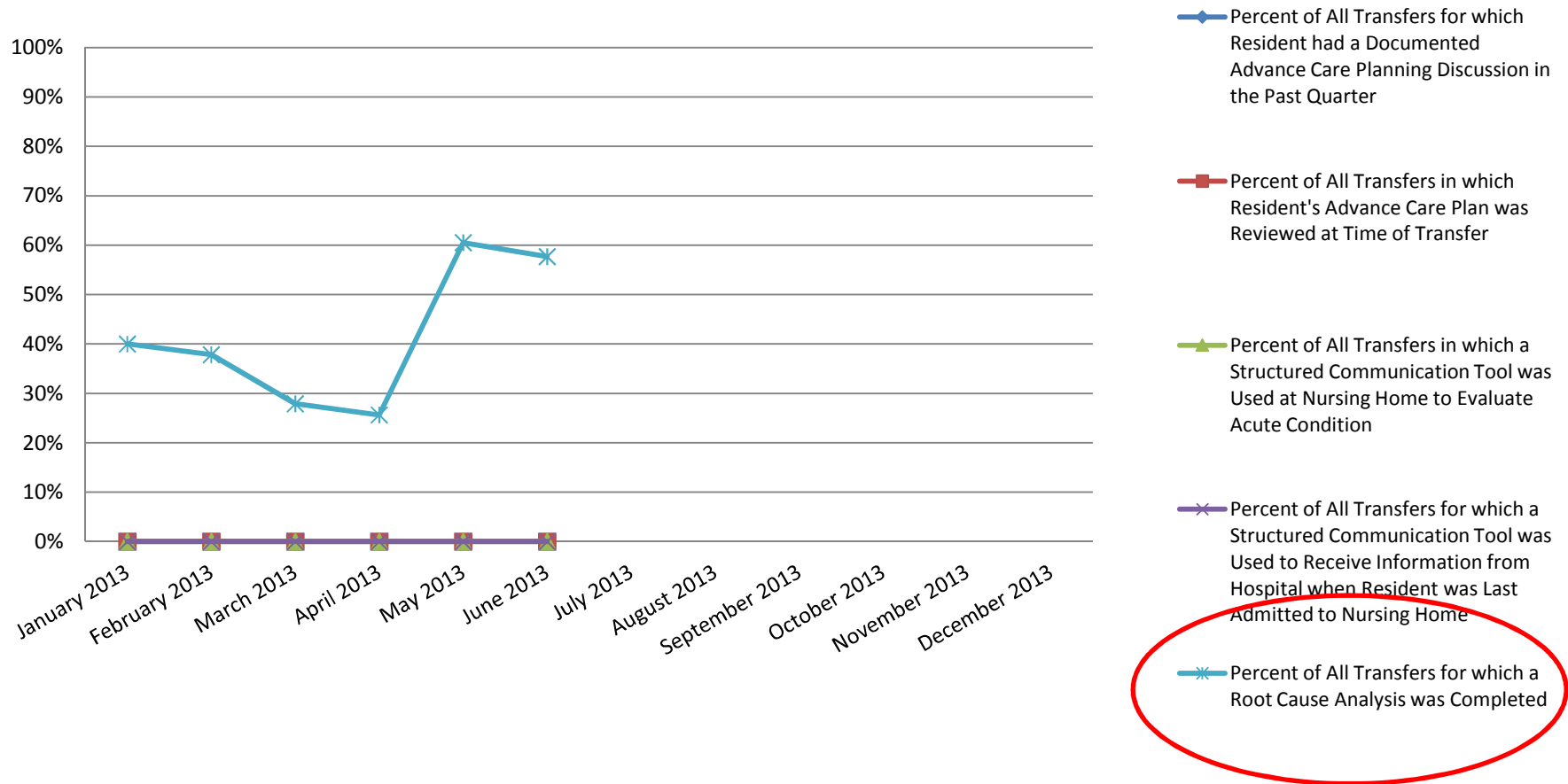
Track Implementation of the Process

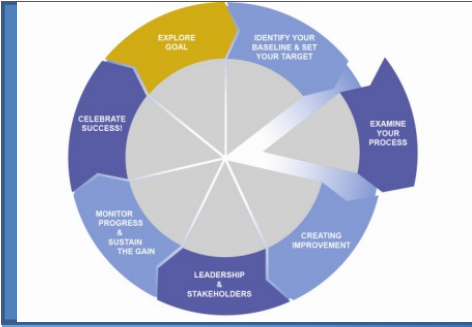
- **RCA of transfer completed**



Use Data to Track Process Measures

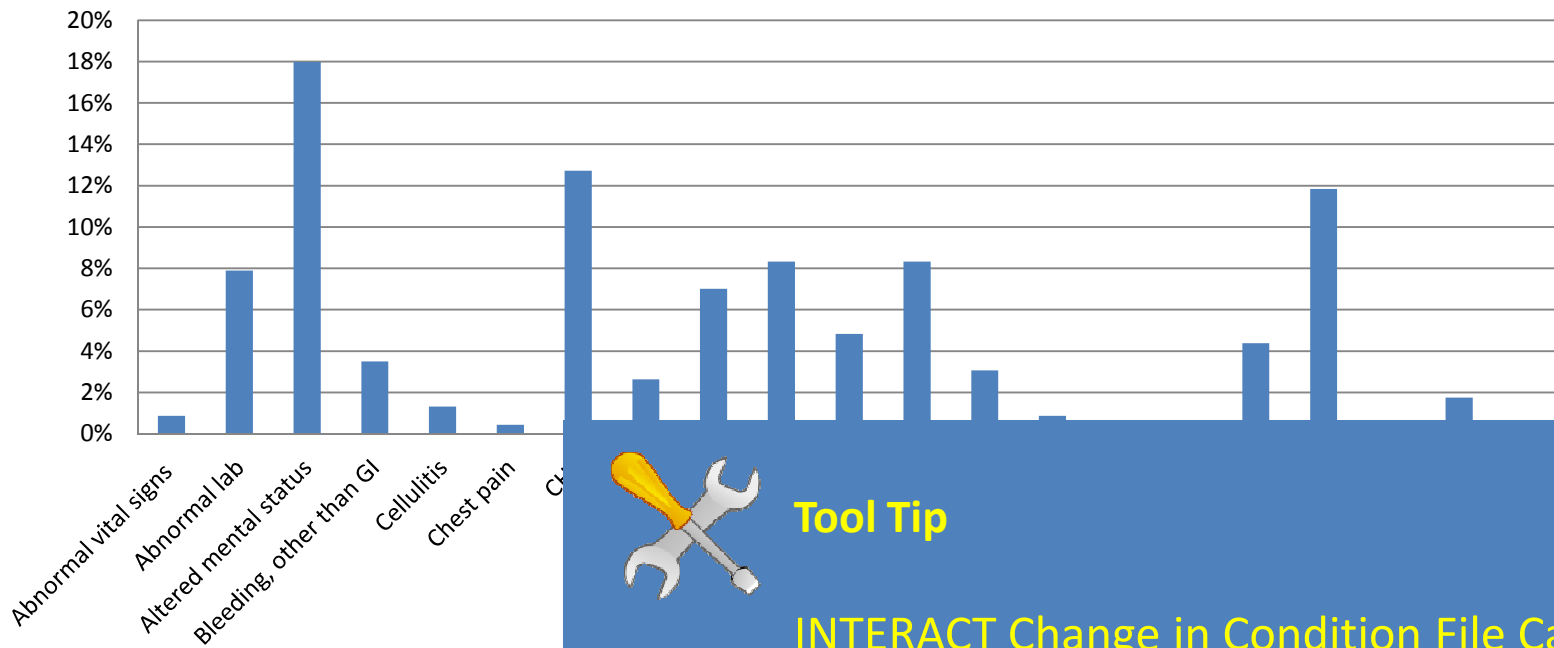
Transfer Related Processes





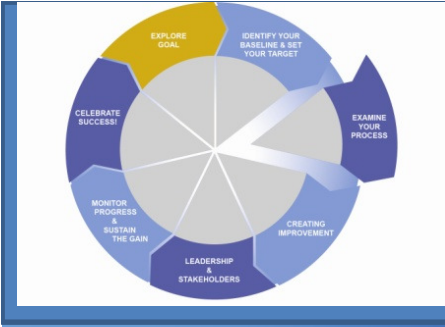
Use Data to Explore Patterns

Primary Clinical Reasons for Transfers



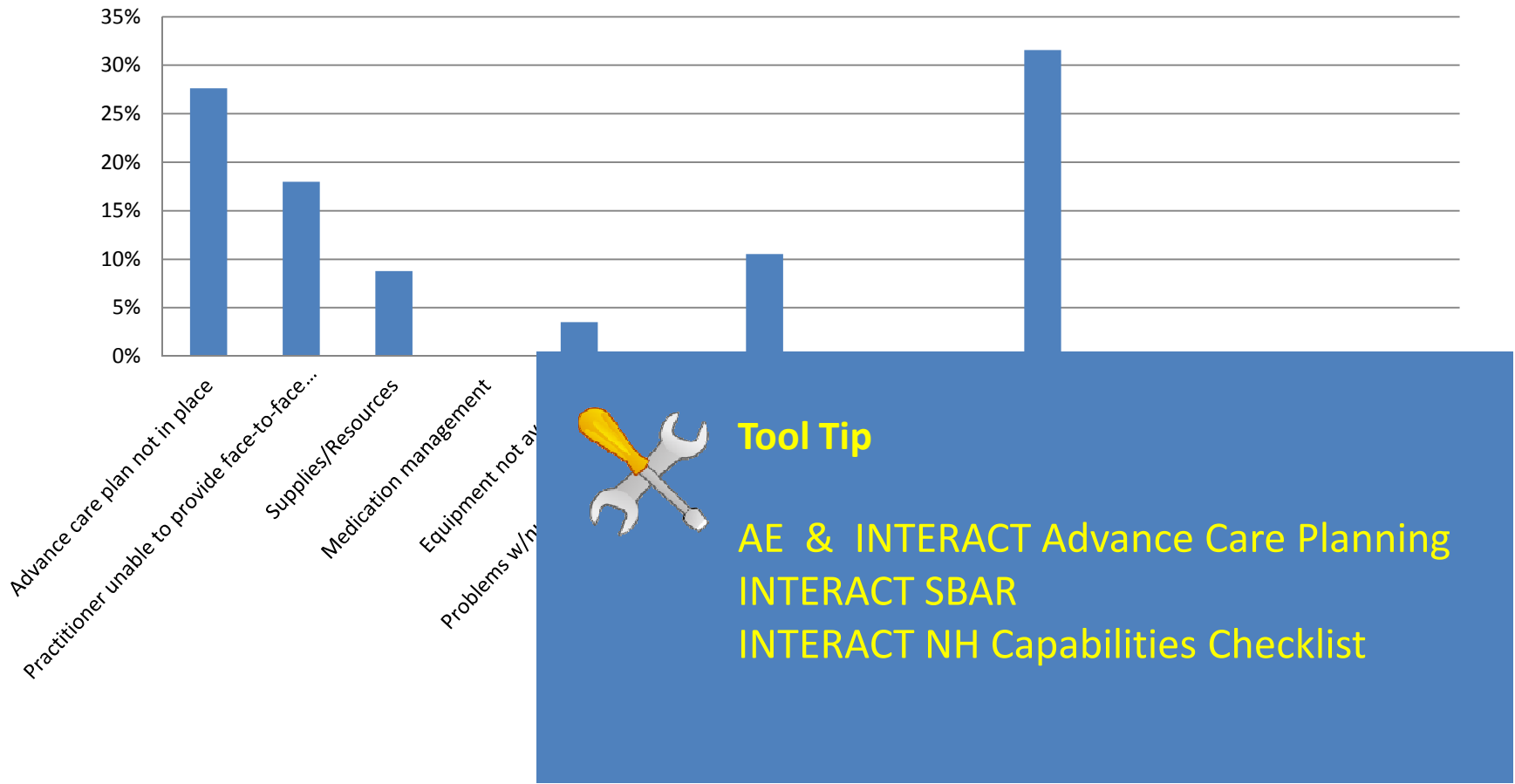
Tool Tip

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

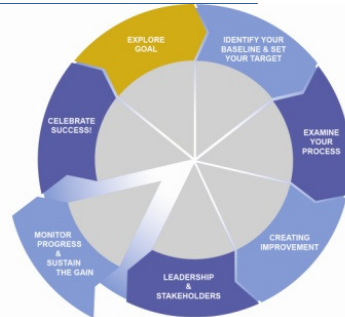
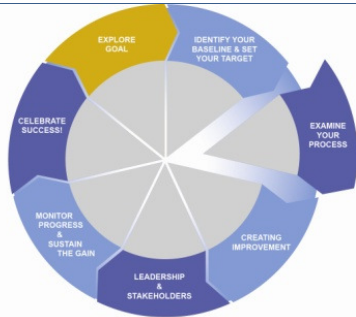


1. Continue to:

- a. Enter required fields for all transfers to hospital and all admissions to your home with a recent hospital discharge.
- b. RCA each transfer to hospital using the QI Review Tool
- c. Summarize your RCA on the RCA Summary Form
- d. Enter the 3 additional pieces of information into your AE Hospitalization Tracking Tool for each transfer (Primary Clinical Reason for Transfer, Primary Contributing Reason for Transfer, Root Cause Analysis Complete (“Yes,” if you did QI Review Tool and Summary sheet))

2. With your team:

- a. Look at your bar charts for primary clinical and primary contributing reasons
- b. Review the AE Probing Questions:
http://www.nhqualitycampaign.org/star_index.aspx?controls=HospitalizationsExamineProcess
- c. Choose one or two processes to focus on, including implementing the corresponding INTERACT Tools and materials
- d. Track implementation of the process change/tool with in your AE Hospitalization Tracking Tool



Optional Fields Help Identify Next Steps & Monitor Process

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

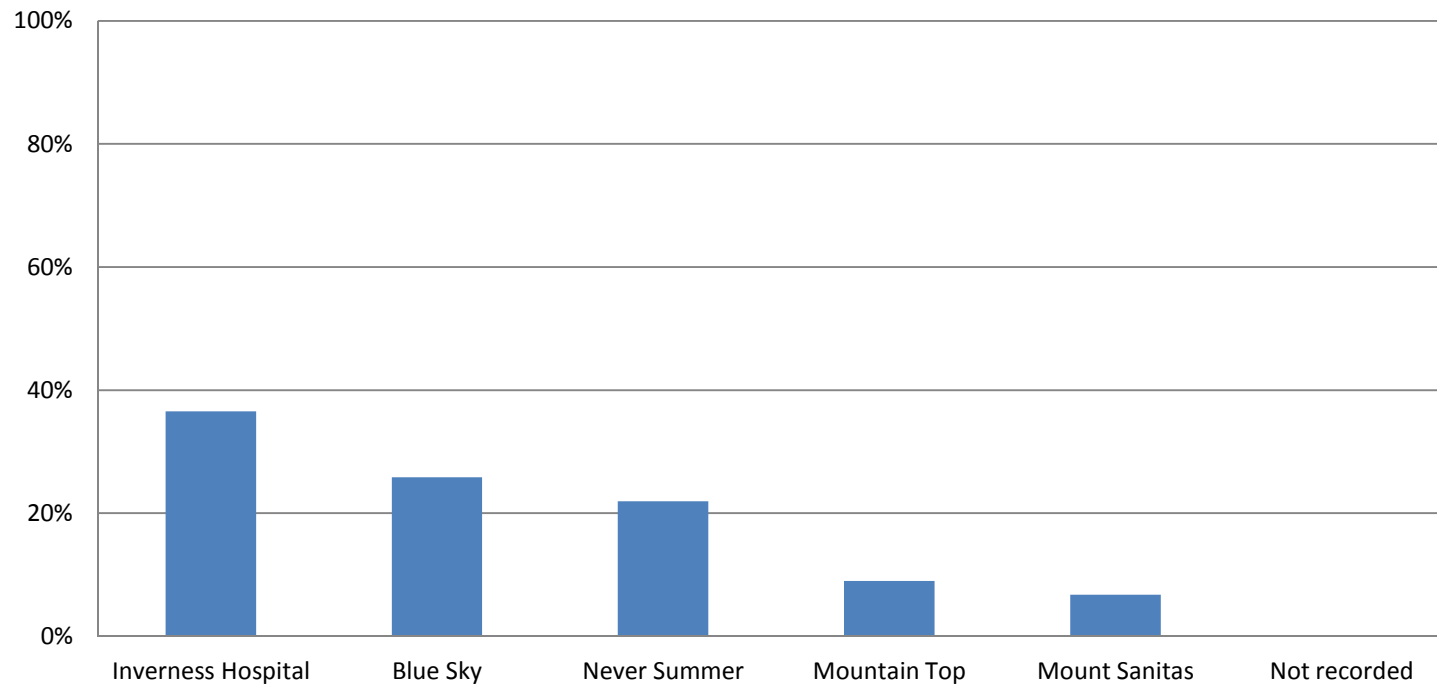
- Structured communication tool used when transferring *to* hospital
- RCA of transfer completed
- Documented ACP discussion in past quarter
- ACP reviewed at time of transfer
- Structured communication tool used at nursing home to evaluate acute condition



Use Data to Explore Patterns

Source of Admissions

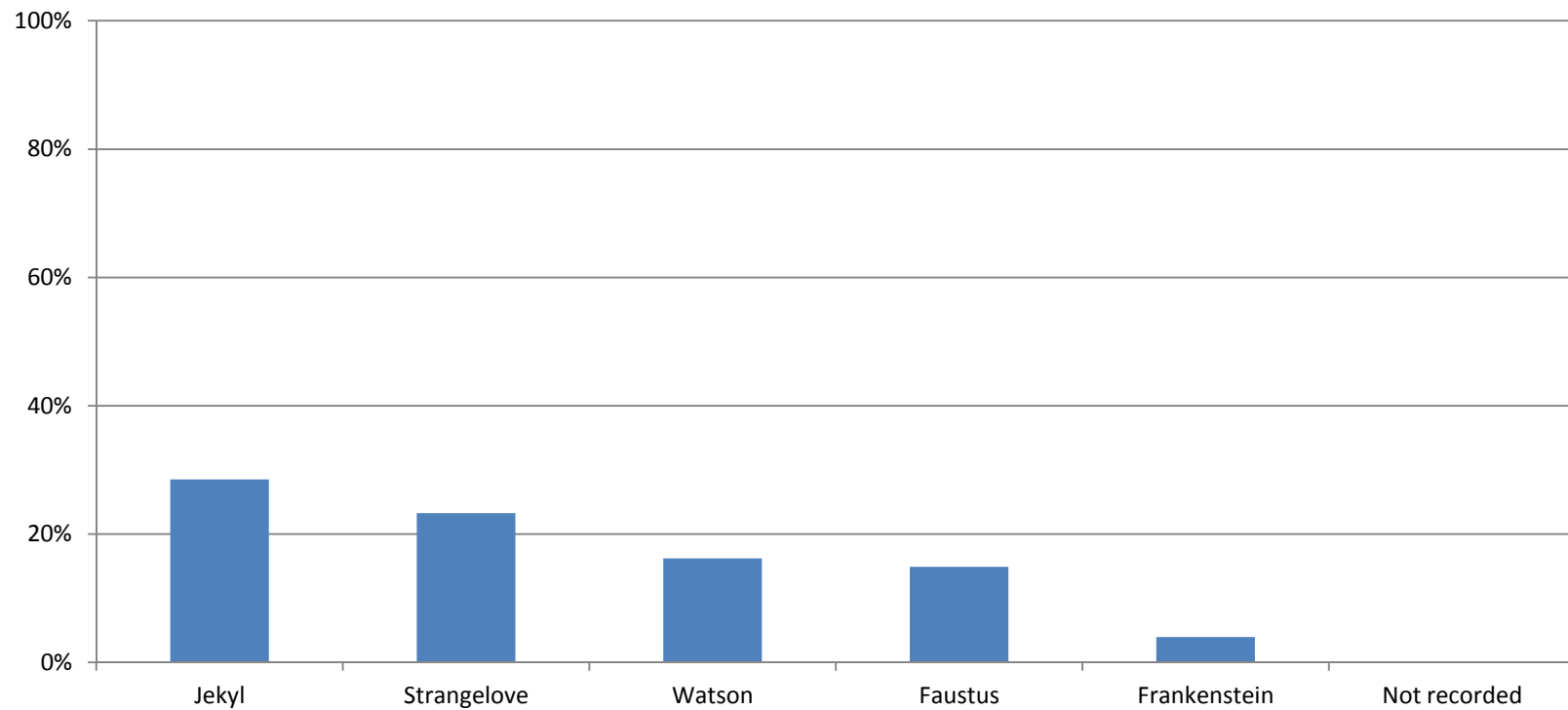
The 5 places from which our nursing home most frequently admits residents with recent hospital stay



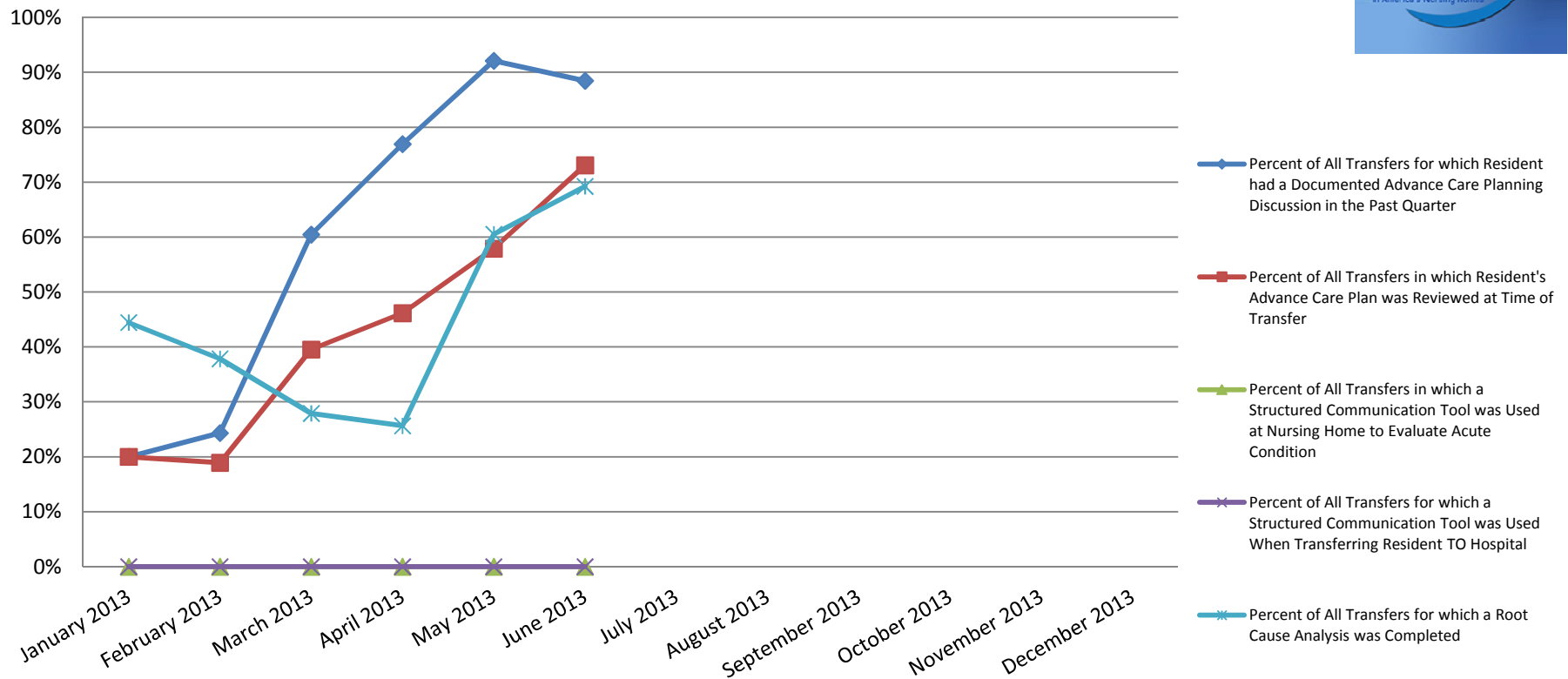
Use Data to Explore Patterns

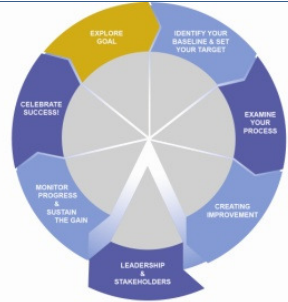


Transfers by Clinician
for the 5 clinicians who order the most transfers



Transfer Related Processes





Involving Partners with Data

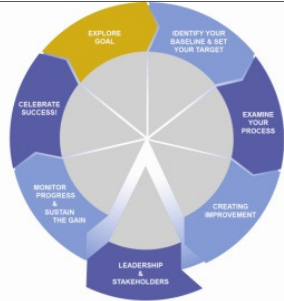


Share data with staff



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

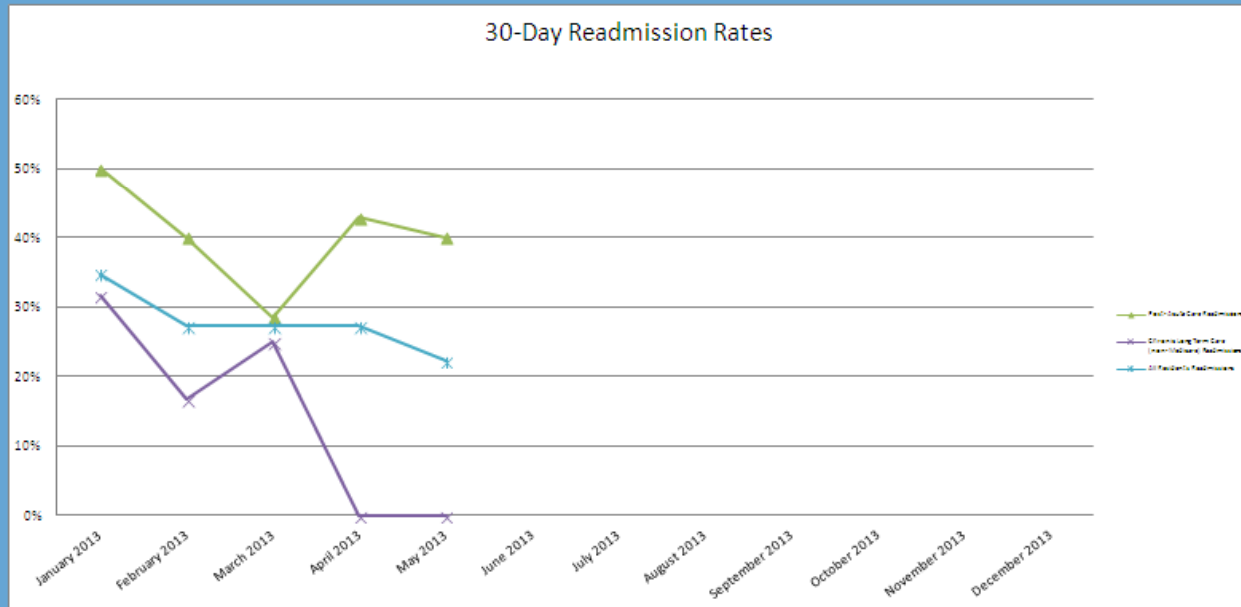
OR

All Plans

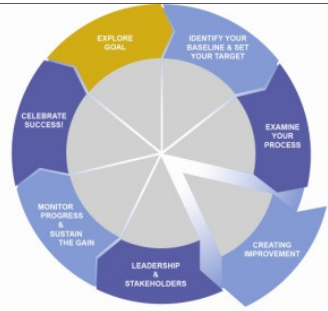
Important!
For specific health plan rates, you must set the first option to "All Sources."



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	31.8%	16.7%	25.0%	0.0%	0.0%							



Creating Change Involving Partners with Data

Home Insert Page Layout Formulas Data Review View Developer

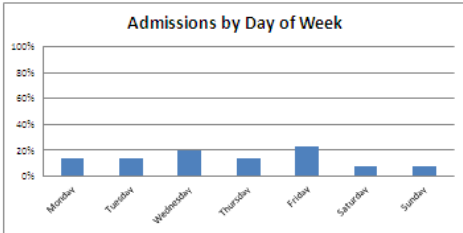
Use this sheet to create a readmissions report for a specific hospital or health plan.

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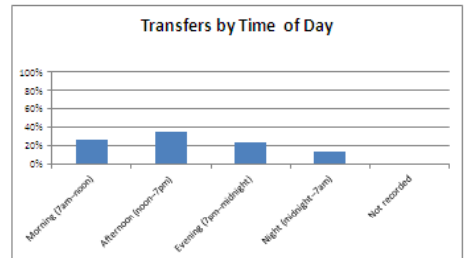
OR

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



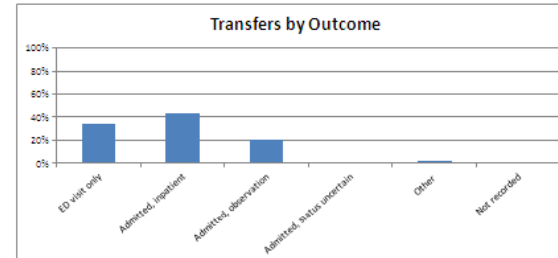
Admissions by Day of Week

	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%



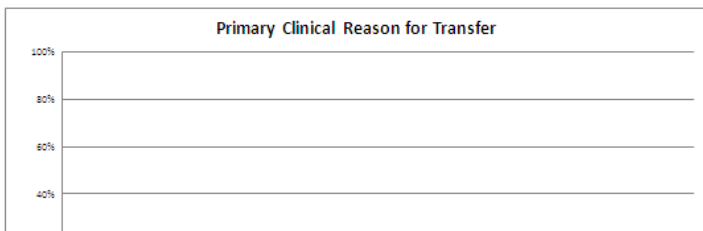
Transfers by Time of Day

	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%

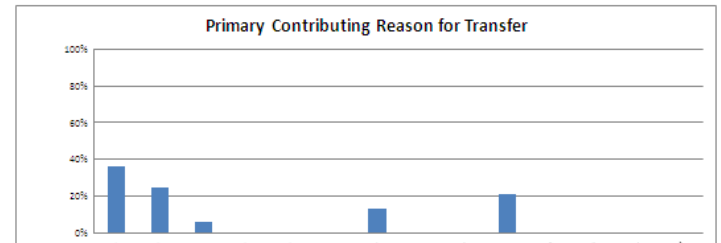


Transfers by Outcome

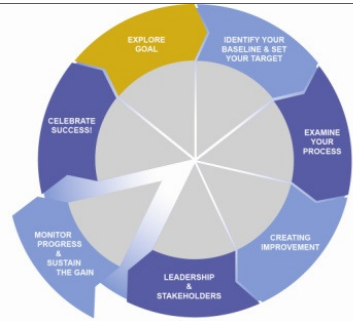
	Number of Transfers	Percent of all Transfers
ED visit only	18	34.0%
Admitted, inpatient	23	43.4%
Admitted, observation	11	20.8%
Admitted, status uncertain	0	0.0%
Other	1	1.9%
Not recorded	0	0.0%



Primary Clinical Reason for Transfer



Primary Contributing Reason for Transfer



How am I doing? Monitor Progress



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

[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

Status at Time of Admission from Hospital			
	Post-Acute Care	Chronic Long Term Care	All Residents
January			
February			
March			
April			
May			
June			
July			
August			
September			
October			
November			
December			

Cause 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			

How Can We Help?

Select all that apply

- a) Extend this series? (If yes, send us a chat with ideas of what that would cover.)

- b) Weekly office hours to discuss progress on the project, perhaps including brief demos of useful functions and tricks?

Thank You

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

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