National Nursing Home
QUALITY IMPROVEMENT CAMPAIGN

NNHQI Campaign

Safely Reduce Hospitalizations Tracking Tool

Getting Started!

This material was prepared by Telligen, National Nursing Home Quality Improvement Campaign Special Innovation Project contractor, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 11SOW-CO-NNHQIC-06/17-001

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

Telligen

Getting Started Hospitalizations Tracking Tool

This slide deck will help you:

1. Become familiar with the mechanics of the Hospitalizations Tracking Tool (Excel workbook), the specific data required to complete the tool, how to enter data, and how to check your data.

2. Know the kind of information produced by entering **required fields only** and how to use it.

www.nhQualityCampaign.org

Hospitalizations Tracking Tool Required Fields

DAILY: Only for residents admitted to your home within 30 days of a hospital discharge

Enter on the AdmittedWithRecentDischarge tab

1. Resident name
2. Date discharged from hospital
3. Date admitted to your nursing home
4. Status on admission to nursing home from hospital (Part A, Other)

DAILY: Only For Residents Transferred to Hospital *Enter on the TransferLog*

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

MONTHLY: For Your Home *Enter on the worksheet named "Census"*

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

Before You Start

Look at your daily report/census.

- How many of the required DAILY items does it already have?
- Could it be modified to include more?

Who could enter the data with the least impact on schedule?

Remember, this will only be a few items each day
Front desk/office staff? Medical records? Admissions staff?

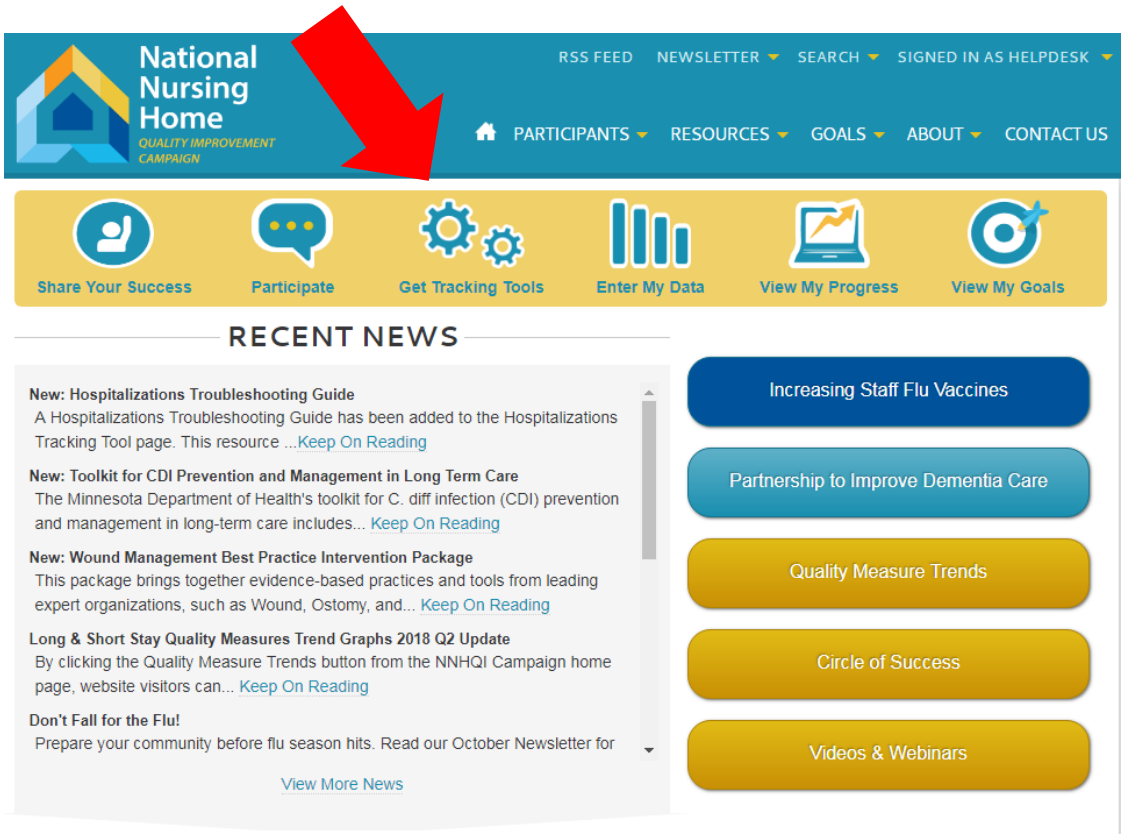
Get that daily report routed to the person entering the data daily.

Get your Tracking Tool (Excel workbook) & Illustrated Instructions

From the website homepage www.nhQualityCampaign.org, click on the gear icon (Get Tracking Tools), and then Hospitalizations.

The workbook is posted on that page -- you'll download the zipped file, open it, and once you are looking at the "Welcome" page of the actual tracking tool, save it to your computer.

As you save it, change the name to include "2017" at the BEGINNING of the filename.



SafelyReduceHospitalizationsTrackingTool.xls

SafelyReduceHospitalizationsINSTRUCTIONS.pdf

Workbook Set Up
The DropDownLists tab

You'll want to begin by browsing through each of the worksheets, including the Common Qs & As. Note that on every worksheet where action is required there are instructions, such as "Step 1" and "Step 2" in the screenshot below. Be sure to read all instructions on the page before beginning to enter data.

DropDownLists

Step 1
Select Year for this Workbook

2017

These lists will create dropdown lists to use in subsequent sheets.
You may add to these lists at any time.

Step 2
In the columns below, type or paste lists of:

A) Hospitals from which you receive admissions
B) Clinicians who order transfers to hospital from your nursing home
C) Names of residents in your nursing home
D) Your residents' health care plans

Important: If there are gaps in your list, you may not see all names in your drop down lists on other tabs.

You may resolve this issue by sorting your lists at any time -- and alphabetizing makes them easier to use!

Click here for Sorting Instructions

Important: If you paste names from another source, it is important that you use the **'Paste Special'** option 'Values.' Please do no use a simple 'paste.'

Click here for **'Paste Special'** Instructions

	Admitted from Beginning at row a5, add the names of acute care hospitals from which you receive admissions.
a1	Home
a2	Assisted Living
a3	Other Nursing Home
a4	Other
a5	Community
a6	General
a7	Mercy

	Clinicians In the spaces below, list the clinicians who order transfers to hospital from your nursing home.
c1	Doolittle
c2	Faustus
c3	Frankenstein
c4	Jekyl
c5	Seuss
c6	Strangelove
c7	Watson

	Residents* In the spaces below, list the residents in your nursing home. This will ensure that their names appear consistently throughout this workbook.
r1	Abel Bova
r2	Abel Folmar
r3	Adelaide Steeves
r4	Adelle Lamm
r5	Adena Blann
r6	Adena Rohr
r7	Alejandra Jumper

	Medicare Insurance Plan regular fee-for-service vs. a managed care plan Beginning at row p2, list your residents' managed care plans. This will ensure that their names appear consistently throughout this workbook.
p1	Regular Medicare Fee-for-Service
p2	Blues
p3	Folk
p4	Jazz
p5	Pacifica
p6	R&B
p7	

Welcome | Common Qs&A | DropDownLists | Census | DataCollectionWorksheet | AdmittedwithRecentDischarge | TransferLog | ItemSummaries | ProcessTracking | CustomizedTracking

CRITICAL: Admitted with Recent Discharge

Admitted with Recent Discharge 2017

- "Admitted with Recent Discharge" means that the resident was admitted to your community with a recent discharge from an inpatient hospital stay.
- The resident may have come to you directly from the hospital. Or, they may come to you from another location, but had an inpatient hospital stay within 30 days prior to the date they are admitted to your home.
- It is VERY IMPORTANT that you *do not use* this sheet to record all admissions.

Information!

Admitted with Recent Discharge 2017

Step 4: 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 rehospitalization rates.

Today's Date: 04/12/2017

Interpreting Highlighted Rows
Watch these residents: they are in the 90-day window.
Pink indicates a 30-day readmission event.

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
169	r4	Lloyd Bakker	01/03/17	01/03/17
170	r170	Margarete Chauncey	01/04/17	01/04/17
171	r71	Melodi Pangburn	01/02/17	01/02/17
172	r135	Mozell Perugini	01/01/17	01/01/17
173	r11	Oren Cuccia	01/01/17	01/01/17
174	r233	Randall Bischoff	01/04/17	01/04/17
175	r190	Rey Rubottom	01/10/17	01/10/17
176	r198	Senaida Valois	01/12/17	01/12/17
177	r285	Taina Sebring	01/15/17	01/15/17
178	r209	Virgil Cousar	01/15/17	01/15/17
179				
180				

Enter data on a daily basis, and use this sheet to identify residents at risk for a 30 / 90 day readmission.

Residents highlighted yellow are on your "Daily Hospital Walking Rounds."

Information!

itted with Recent Discharge 2017

nursing home from hospital or who were discharged from a
to your nursing home.

are required. This information will be used to calculate your
spitalization rates.

Today's

Watch these

Pink in

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 Date resid include only re directly fro scharged fro admi	
169	r4	Lloyd Bakker	01/03/17		
170	r170	Margarete Chauncey	01/04/17		
171	r71	Melodi Pangburn	01/02/17		
172	r135	Mozell Perugini		01/01/17	Sunday
173	r11	Oren Guccia	01/01/17		Sunday
174	r233	Randall Bischoff	01/04/17	01/04/17	Wednesday
175	r190	Rey Rubottom	01/10/17	01/10/17	Tuesday
176	r198	Senaida Valois	01/12/17	01/12/17	Thursday
177	r285	Taina Sebring	01/15/17	01/15/17	Sunday
178	r209	Virgil Cousar	01/15/17	01/15/17	Sunday
179					
180					

The person entering the data is responsible for copying the list of residents whose names are highlighted yellow (along with the date of their hospital discharge), and bringing it to morning standup.

[Hint: Make a Word document with title and date. Then, each day, just copy and paste these three fields into your template.]

CRITICAL: TransferLog

- Record ALL unplanned transfers to the hospital, regardless of the outcome. You will be able to indicate whether the outcome is “Admitted, inpatient” or something else.
- Record unplanned transfers for ANY resident, not just those who had a recent hospital discharge.
- Unplanned transfers are transfers that weren’t previously scheduled. (Examples of planned transfers are planned surgical revisions, chemotherapy, dialysis, etc.)

Information!

Transfer Log

Step 5: Complete the detail for each resident transferred from your home to hospital in the grid below.

Include ONLY transfers to acute care hospitals or critical access hospitals.
Include ALL unplanned transfers, including ER Only and Observation Stays.

*Red asterisk indicates required field.

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

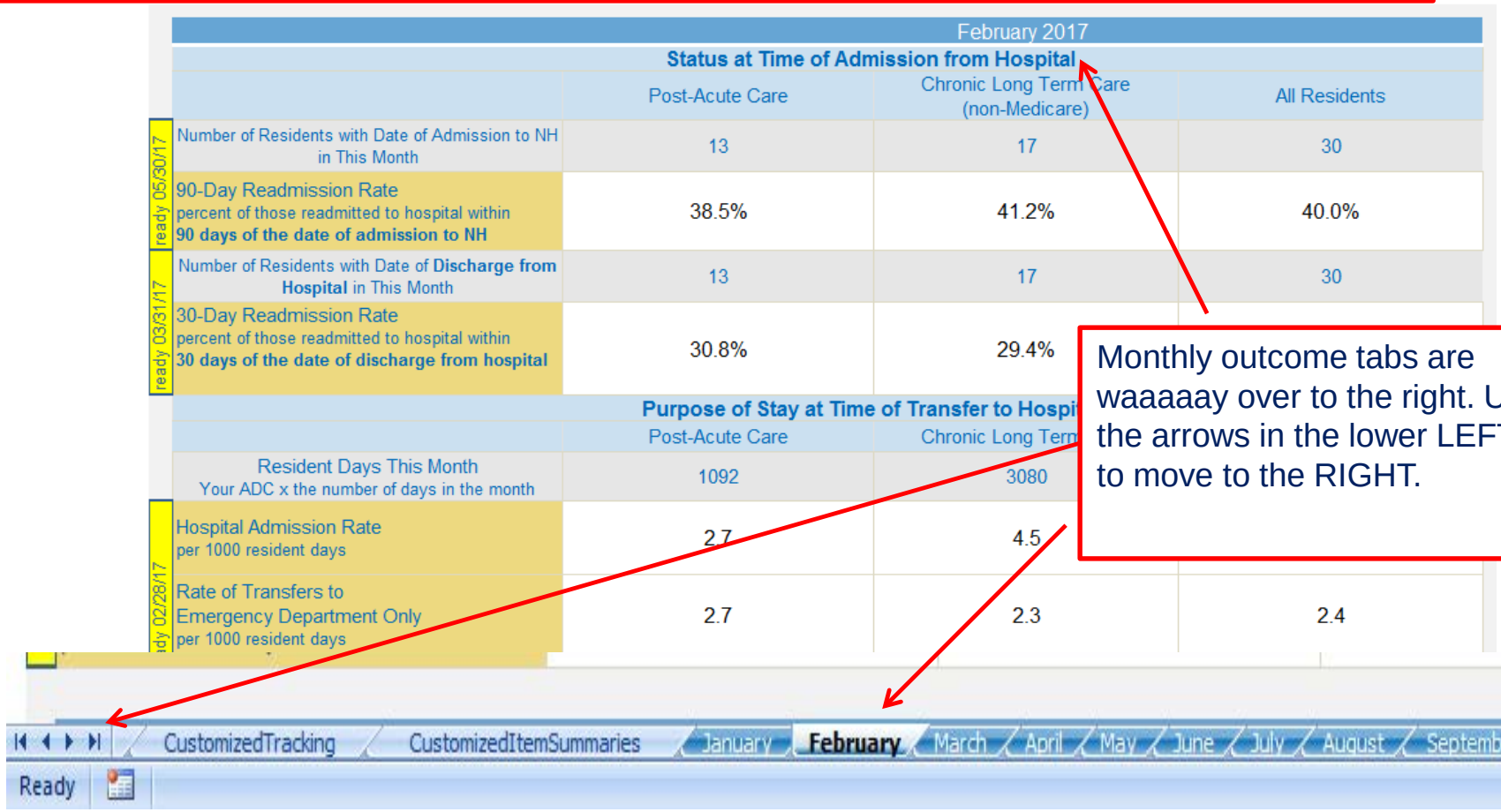
Green indicates a readmission occurred 31 to 90 days following admission to nursing home.

30-day readmissions are highlighted RED are. 90-day readmissions are highlighted GREEN. These deserve a special look.

	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 Day select from list		What is an unplanned transfer?
							Outcome of Transfer*	Planned or Unplanned* prepopulated: Only record unplanned transfers
55	r34	Burl Almon	Chronic Long-term Care	Medicaid	3/4/17	Evening (7pm--midnight)	W	ED visit only / Unplanned
56	r54	Corrin Lueck	Post-Acute Type Care (Rehab/Medical Management)	Medicare Part A	3/22/17	Afternoon (noon--7pm)	J	ED visit only / Unplanned
57	r64	Deann Paulson	Post-Acute Type Care (Rehab/Medical Management)	Medicare Part A	3/[illegible]/17	Afternoon (noon--7pm)	Strai	ED visit only / Unplanned
58	r168	Kristopher Crooms	Chronic Long-term Care	Medicaid	3/9/17	Evening (7pm--midnight)	Fa	Admitted, observation / Unplanned
59	r176	Lee Ciampa	Chronic Long-term Care	Medicaid	3/15/17	Morning (7am--noon)	W	Admitted, inpatient / Unplanned
60	r184	Lourie Larusso	Post-acute Care (Medicare Part A or managed care)	Medicare Part A	3/30/17	Afternoon (noon--7pm)	Franl	Admitted, inpatient / Unplanned
61	r74	Dot Veltri	Chronic Long-term Care	Private Pay	3/25/17	Afternoon (noon--7pm)	Strai	Admitted, inpatient / Unplanned
62	r83	Elenor Tingey	Chronic Long-term Care	Othe	3/15/17	Evening (7pm--midnight)	Fa	Admitted, observation / Unplanned
63	r92	Erma Henninger	Chronic Long-term Care	Managed Care Plan	3/19/17	Afternoon (noon--7pm)	W	Admitted, inpatient / Unplanned
64	r192	Marguerita Holstein	Post-Acute Type Care (Rehab/Medical Management)	Medicare Part A	3/11/17	Evening (7pm--midnight)	J	Admitted, inpatient / Unplanned
65	r200	Micheal Fryer	Chronic Long-term Care	Medicaid	3/19/17	Afternoon (noon--7pm)	Strai	ED visit only / Unplanned
66	r208	Nichol Wisecarver	Chronic Long-term Care	Medicaid	3/25/17	Afternoon (noon--7pm)	Fa	Admitted, observation / Unplanned
67	r216	Patrice Zdenek	Chronic Long-term Care	Managed Care Plan	3/20/17	Morning (7am--noon)	W	Admitted, inpatient / Unplanned
68	r224	Rayna Peranio	Post-Acute Type Care (Rehab/Medical Management)	Medicare Part A	3/30/17	Afternoon (noon--7pm)	J	Admitted, inpatient / Unplanned
69	r101	Franklin Hildebrand	Chronic Long-term Care	Medicaid	3/11/17	Evening (7pm--midnight)	Strai	ED visit only / Unplanned
								Admitted, observation / Unplanned
								Admitted, inpatient / Unplanned
								Admitted, inpatient / Unplanned
								ED visit only / Unplanned
								Admitted, observation / Unplanned
								Admitted, inpatient / Unplanned

Monthly Outcome Data

Five outcomes are calculated for you each month. Each month's outcomes are displayed on a separate tab.



February 2017

	Status at Time of Admission from Hospital		
	Post-Acute Care	Chronic Long Term Care (non-Medicare)	All Residents
ready 05/30/17 — Number of Residents with Date of Admission to NH in This Month	13	17	30
ready 05/30/17 — 90-Day Readmission Rate percent of those readmitted to hospital within **90 days of the date of admission to NH**	38.5%	41.2%	40.0%
ready 03/31/17 — Number of Residents with Date of **Discharge from Hospital** in This Month	13	17	30
ready 03/31/17 — 30-Day Readmission Rate percent of those readmitted to hospital within **30 days of the date of discharge from hospital**	30.8%	29.4%	

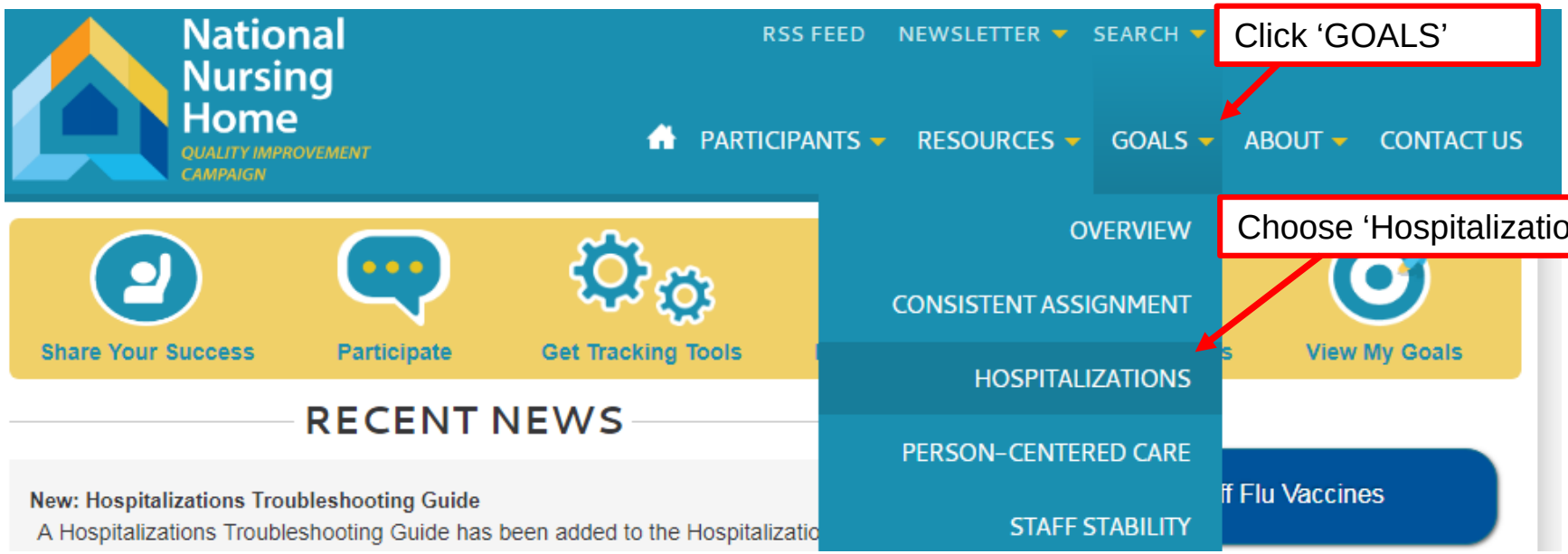
	Purpose of Stay at Time of Transfer to Hospi	
	Post-Acute Care	Chronic Long Term
Resident Days This Month Your ADC x the number of days in the month	1092	3080
dy 02/28/17 — Hospital Admission Rate per 1000 resident days	2.7	4.5
dy 02/28/17 — Rate of Transfers to Emergency Department Only per 1000 resident days	2.7	2.3

CustomizedTracking | CustomizedItemSummaries | January | **February** | March | April | May | June | July | August | Septemb

Ready

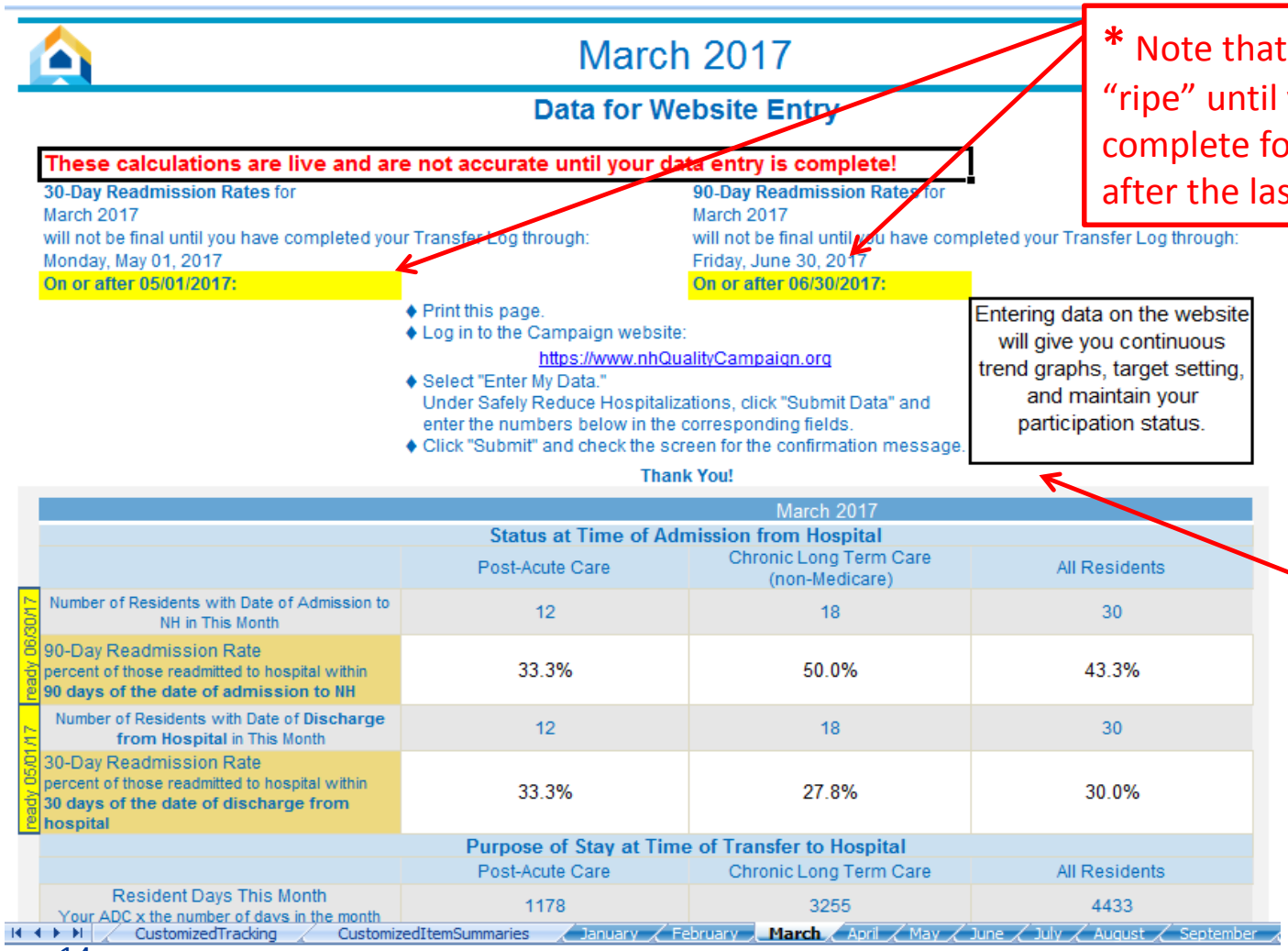
Monthly outcome tabs are waaaaay over to the right. Use the arrows in the lower LEFT to move to the RIGHT.

Find Tracking Tool



The Tracking Tool is on the Tracking Tool page, but don't forget the other pages as well!

Transfer Summary Data to the Website Each Month*



March 2017

Data for Website Entry

These calculations are live and are not accurate until your data entry is complete!

30-Day Readmission Rates for March 2017 will not be final until you have completed your Transfer Log through: Monday, May 01, 2017

On or after 05/01/2017:

90-Day Readmission Rates for March 2017 will not be final until you have completed your Transfer Log through: Friday, June 30, 2017

On or after 06/30/2017:

- Print this page.
- Log in to the Campaign website: 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!

Entering data on the website will give you continuous trend graphs, target setting, and maintain your participation status.

March 2017			
Status at Time of Admission from Hospital			
	Post-Acute Care	Chronic Long Term Care (non-Medicare)	All Residents
Number of Residents with Date of Admission to NH in This Month	12	18	30
ready 06/30/17 — 90-Day Readmission Rate percent of those readmitted to hospital within **90 days of the date of admission to NH**	33.3%	50.0%	43.3%
Number of Residents with Date of **Discharge from Hospital** in This Month	12	18	30
ready 05/01/17 — 30-Day Readmission Rate percent of those readmitted to hospital within **30 days of the date of discharge from hospital**	33.3%	27.8%	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	1178	3255	4433

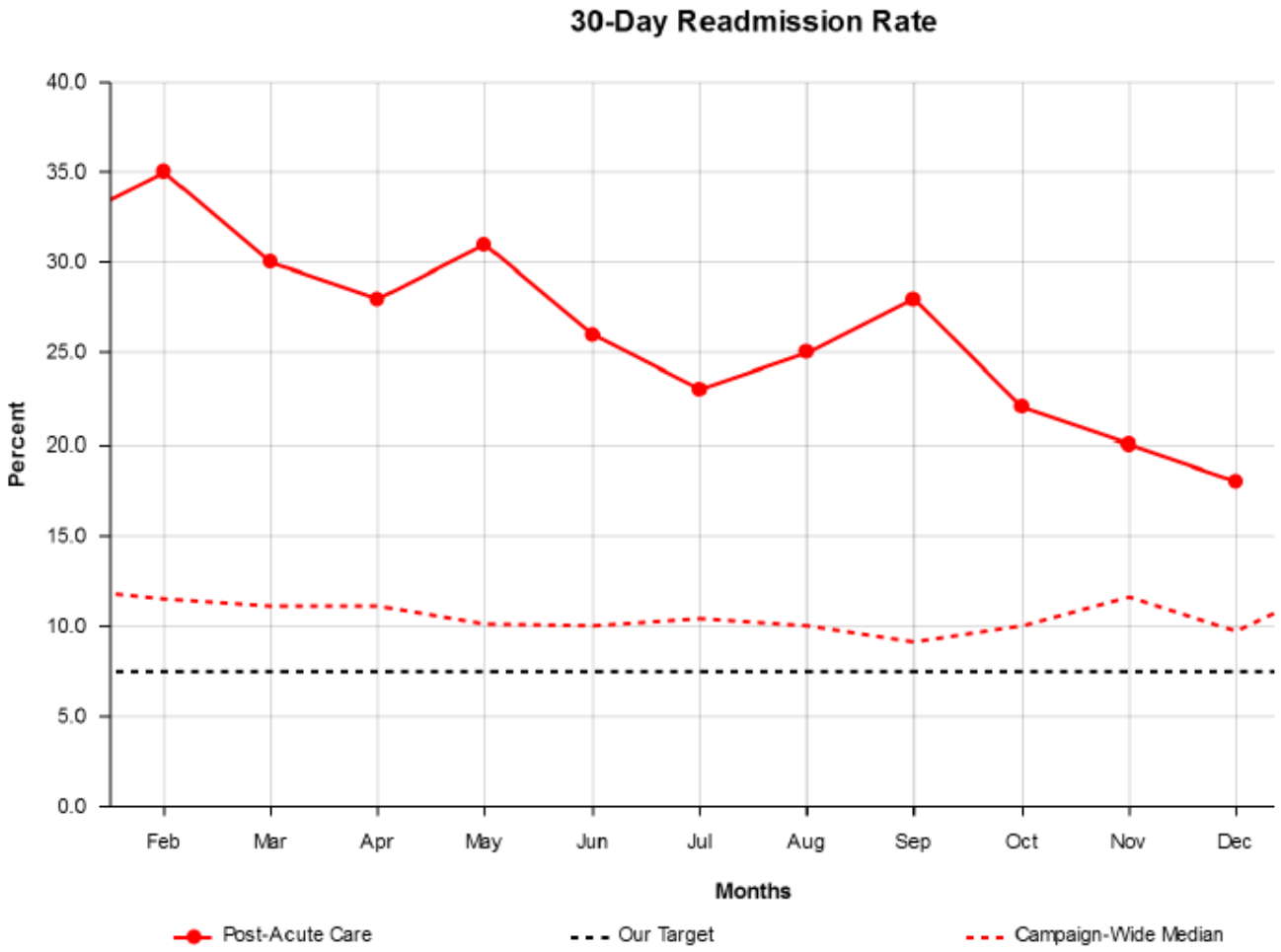
CustomizedTracking | CustomizedItemSummaries | January | February | **March** | April | May | June | July | August | September

* Note that your data are not "ripe" until your TransferLog is complete for 30 (and 90) days after the last day of the month.

This step takes about 2 minutes. Just follow the directions on the worksheet.

For more help, return to the Tools page, and get the document "Submitting Data Instructions"

Website Data Displays



When you transfer your monthly outcomes to the website, you can get trend graphs that look like this -- Great for sharing with your Quality Council, Staff, and community.

You can customize to choose the date range, add a target line, and compare your progress with other communities working on this goal.

We’re here to help!

help@nhQualityCampaign.org

Thank You

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