Getting Started with the Advancing Excellence Hospitalization Goal

Session 3: Biting the Elephant

Mary Perloe RN, MS, GNP & Adrienne Mihelic PhD

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

b) 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?
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
Using the INTERACT Tools
In Every Day Care

New Resident Admission
Resident Re-Assessment

Change in Resident
Status Noted

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

LPN/RN Evaluation

MD/NP/PA Notified

Acute Care Transfer

Quality Improvement
Program

Apply learning to
improve care processes
and education

Medication
Reconciliation
Worksheet

Stop and Watch
Early Warning Tool

SBAR Form and
Progress Note

Transfer
Checklist Envelope

Transfer Data List
and Sample Forms

Advance Care
Planning Tools

Care Paths

Acute Change in
Condition File Cards

Hospital
Communication Tools

Hospitalization
Rate Tracking Tool

Quality Improvement
Tool for Review of
Acute Care Transfers

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• 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
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.

- 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: *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

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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

<table>
<thead>
<tr>
<th>Symptom or Sign</th>
<th>Immediate</th>
<th>Non-Immediate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seizure activity</td>
<td>Any new onset seizure activity, OR persistent seizure in someone with known intermittent seizure activity</td>
<td>Self-limited seizure in past 24 hours in a resident with known seizure activity who is already on an anticonvulsant</td>
</tr>
<tr>
<td>Shortness of breath (dyspnea)¹</td>
<td>Abrupt onset of SOB with pain, fever, or respiratory distress</td>
<td>Recently progressive or persistent minor SOB without other symptoms, OR with progressive leg edema</td>
</tr>
<tr>
<td>Sleep disturbance</td>
<td></td>
<td>Difficulty sleeping</td>
</tr>
<tr>
<td>Sore throat</td>
<td>Accompanied by respiratory distress or inability to swallow</td>
<td>With mild to moderate symptoms of upper respiratory infection not responding to standard conservative treatments</td>
</tr>
<tr>
<td>Speech, abnormality²</td>
<td>Abrupt change in speech, with or without other focal neurological findings</td>
<td>If area appears to be infected, with erythema or purulent drainage, OR if no tetanus shot within past ten years</td>
</tr>
<tr>
<td>Splinters/slivers</td>
<td>If unable to remove readily, with OR accompanied by considerable pain or bleeding</td>
<td></td>
</tr>
<tr>
<td>Suicide potential</td>
<td>Makes a suicidal gesture, OR discusses a detailed plan for carrying out suicide</td>
<td>New onset of talking about wanting to die, but not making any specific suicidal threats</td>
</tr>
<tr>
<td>Swallowing difficulty</td>
<td>With new onset or progressive choking, aspiration</td>
<td>Decreased intake from dysphagia, with potential risk of dehydration malnutrition</td>
</tr>
</tbody>
</table>

¹ See INTERACT Shortness of Breath Care Path  ² See INTERACT Acute Mental Status Change Care Path
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, oxygenation, and finger stick glucose, if indicated
- Review Records: Recent progress notes, lab, orders
- Review an INTERACT Care Path or Acute Change in Condition: File Card, if indicated
- Have Recent Information Available when Reporting
  (e.g., 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, it has 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 COPD, DM, COP: ________________________________________________________________

Medication Alerts: □ Changes in the last week, describe below; □ Resident is on warfarin, heparin, Result of last INR: _______ Date ____/____/______

Allergies: ________________________________________________________________

Vital Signs: BP _______ Pulse _______ Apical HR _______ RR _______ Temp _______ Weight _______ Lbs platelet _______ Date _______ _______ _______

For COPD, asthma, or weight loss: Last weight before the current one was: ____________________________ Date _______ _______ _______

Respiratory rate: □ on room air □ on CPAP (liters/min) ____________________________ Date _______ _______ _______

Residents Name: ________________________________________________________________

ASSESSMENT (RN) OR APPEARANCE (LPN)
What do you think is going on with the resident?
For RN: I think the problem may be (e.g., cardiac, infection, respiratory, dehydration) ________________________________________________________________

For LPN: 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) _______
# 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) ________
# 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:**

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

## Key Contact

### Capabilities

<table>
<thead>
<tr>
<th>Capabilities</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Care Clinician Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>At least one physician, NP, or PA in the facility three or more days per week</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>At least one physician, NP, or PA in the facility five or more days per week</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td><strong>Diagnostic Testing</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stat lab tests with turnaround less than 8 hours</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Stat X-rays with turnaround less than 8 hours</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>EKG</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Bladder Ultrasound</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Venous Doppler</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Cardiac Echo</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Swallow Studies</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td><strong>Consultations</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatry</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Cardiology</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Pulmonary</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Wound Care</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Other Physician Specialty Consultations specify</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td><strong>Social and Psychology Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Licensed Social Worker</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Psychological Evaluation and Counseling by a Licensed Clinical Psychologist</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td><strong>Therapies on Site</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupational</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Physical</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Respiratory</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Speech</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td><strong>Nursing Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequent vital signs (e.g., every 2 hrs)</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Electrolyte and acid therapy (IV) administration</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Daily weights</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Accucheck for glucose at least every shift</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>INR</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>O2 saturation</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Nebulizer treatments</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Incentive spirometry</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td><strong>Interventions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IV Fluids (initiation and maintenance)</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>IV Antibiotics</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>IV Meds - Other (e.g., furosemide)</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>PICC Insertion</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>PICC Management</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Total Parenteral Nutrition (TPN)</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Isolation (for MRSA, VRE, etc...)</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Surgical Drain Management</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Tracheostomy Management</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Analgesic Pumps</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Dialysis</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Advanced CPR (ACLS capability)</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Automatic Defibrillator</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td><strong>Pharmacy Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency kit with common medications for acute conditions available</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>New medications filled within 8 hours</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td><strong>Other Specialized Services (specify)</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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 ______________

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) ________________________________

   Hospital diagnosis(es) (if available) ________________________________

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

   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

   ______________________________________________________________

   ______________________________________________________________

   ______________________________________________________________

   ______________________________________________________________

   ______________________________________________________________

   ______________________________________________________________

   ______________________________________________________________

   ______________________________________________________________

SECTION 4: Describe the Hospital Transfer

   a. Date of transfer ___________/__________/_________  Day  [ ] Monday  [ ] Tuesday  [ ] Wednesday  [ ] Thursday  [ ] Friday  [ ] Saturday  [ ] Sunday

   b. Time (am/pm) ___________

   c. Clinician authorizing transfer:  [ ] Primary MD  [ ] Covering MD  [ ] NP or PA  [ ] Other

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

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)

   b. The new sign, symptom, or other change might have been detected earlier

   c. Changes in the resident’s condition might have been communicated better among NH staff, with MD/NP/PA, or with ER/ICU staff

   d. The condition might have been managed safely in the facility with available resources

   e. Resources were not available to manage the change in condition safely or effectively (check all that apply)

   f. On-site primary care clinician

   g. Staffing

   h. Lab or other diagnostic tests

   i. Pharmacy services

   j. Other (describe) ________________________________

   k. Resident and family preferences for hospitalization might have been discussed earlier

   l. Advance directives and/or palliative or hospice care might have been put in place earlier

   m. Other (describe) ________________________________

NAME OF PERSON COMPLETING FORM ________________________________ DATE OF COMPLETION ___________/__________/_________
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

- 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

Primary Clinical Reasons for Transfers

Tool Tip
INTERACT Change in Condition File Cards
INTERACT Care Paths
AE Goal Packages and Tracking Tools
Homework 3

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


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

- Inverness Hospital: 40%
- Blue Sky: 20%
- Never Summer: 20%
- Mountain Top: 10%
- Mount Sanitas: 10%
- Not recorded: 0%

Use Data to Explore Patterns
Transfers by Clinician
for the 5 clinicians who order the most transfers
Involving Partners with Data

Share data with staff

Share data with hospitals
Involving Partners with Data

30-Day Readmission Rates

Table: 30-Day Readmission Rates

<table>
<thead>
<tr>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Post-Acute Care Readmissions</td>
<td>50.0%</td>
<td>49.0%</td>
<td>28.5%</td>
<td>42.5%</td>
<td>40.0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic Long Term Care (non-Medicare) Readmissions</td>
<td>33.1%</td>
<td>6.7%</td>
<td>25.2%</td>
<td>6.0%</td>
<td>8.6%</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
Creating Change
Involving Partners with Data
### 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.

- Print this page
- Log in to the Campaign [https://www.nhqualitycampaign.org](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

<table>
<thead>
<tr>
<th>Status at Time of Admission from Hospital</th>
<th>Post-Acute Care</th>
<th>Chronic Long Term Care (non-Medicare)</th>
<th>All Residents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Residents with Date of Discharge from Hospital in This Month</td>
<td>13</td>
<td>17</td>
<td>30</td>
</tr>
<tr>
<td>30-Day Readmission Rate</td>
<td>39.8%</td>
<td>29.4%</td>
<td>30.0%</td>
</tr>
<tr>
<td>percent of those admitted to hospital within 30 days of the date of discharge from hospital</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Purpose of Stay at Time of Transfer to Hospital

<table>
<thead>
<tr>
<th>Resident Days This Month</th>
<th>Post-Acute Care</th>
<th>Chronic Long Term Care</th>
<th>All Residents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your ADC x the number of days in the month</td>
<td>1092</td>
<td>3000</td>
<td>4172</td>
</tr>
<tr>
<td>Hospital Admission Rate per 1000 resident days</td>
<td>2.7</td>
<td>4.6</td>
<td>4.1</td>
</tr>
<tr>
<td>Rate of Transfers to Emergency Department Only per 1000 resident days</td>
<td>2.7</td>
<td>2.3</td>
<td>2.4</td>
</tr>
<tr>
<td>Rate of Transfers Resulting in Observation Stay per 1000 resident days</td>
<td>2.7</td>
<td>1.6</td>
<td>1.9</td>
</tr>
</tbody>
</table>
Enter Summary Data on the AE Website

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.

### Status at Time of Admission from Hospital

<table>
<thead>
<tr>
<th>Month</th>
<th>Post-Acute Care</th>
<th>Chronic Long Term Care</th>
<th>All Residents</th>
</tr>
</thead>
<tbody>
<tr>
<td>February</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>March</td>
<td></td>
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<tr>
<td>April</td>
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<td>May</td>
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<td>June</td>
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<tr>
<td>July</td>
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<td>August</td>
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<tr>
<td>September</td>
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<tr>
<td>October</td>
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<td></td>
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<tr>
<td>November</td>
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<td></td>
</tr>
<tr>
<td>December</td>
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</tbody>
</table>

### Reason of Stay at Time of Transfer to Hospital

<table>
<thead>
<tr>
<th></th>
<th>Post-Acute Care</th>
<th>Chronic Long Term Care</th>
<th>All Residents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident Days This Month</td>
<td></td>
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</tr>
<tr>
<td>Unplanned Hospital Admission Rate</td>
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<tr>
<td>Rate of Transfers to Emergency Department Only</td>
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</tr>
<tr>
<td>Rate of Transfers Resulting in Observation Stay</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Submit  Clear
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!

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