Session #: T32

Re-hospitalizations: Solutions Through Root-Cause Analysis

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Contact Information

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DISCLOSURE

- I have no financial relationships to disclose
- I have no conflicts of interests to disclose
- I will not promote any commercial products or services

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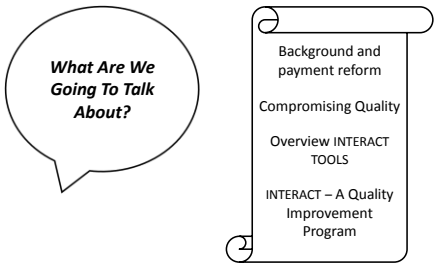
Objectives:

- *List three organizational bodies focusing on hospital readmissions*
- *Discuss the significance of the SBAR and its use in clinical practice*
- *Identify two risk factors for potential re-hospitalizations*



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Goal of INTERACT Program

- Reduce frequency of transfers to the acute hospital
- In the plans for health care reform, Medicare may financially reward facilities with lower hospitalization rates for certain conditions

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Health Care Reform

- The goal of the Affordable Care Act is:
  - Improving care
  - Improving health
  - Making care affordable
- Tremendous opportunities to improve care

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Background

Changes in Medicare and Health Care Financing

- **Pay-for-Performance**
  - No payment for certain complications
- **Bundling of Payments** for episodes of care
- **Accountable Care Organizations**
- **State Duals Programs and Medicaid Managed Care**

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Background Continued…

- Hospital transfers are common and can result in complications in older nursing home residents
- Many hospital transfers are preventable
- Care can be improved resulting in fewer hospitalizations and lower costs
- Financial and regulatory incentives are changing

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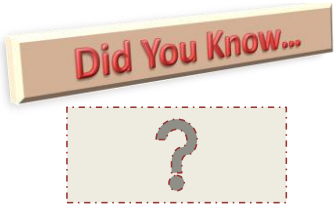

1 in 4 residents are re-admitted to acute care in 30 days

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A CMS Special Study revealed up to 68% of SNF hospital re-admissions were avoidable!

Dr. Joseph Ouslander
or
Dr. "O" or "Joe"

Ouslander et al: J Amer Ger Soc 58: 627-635, 2010

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CMS Pilot Study

Ouslander et al: J Amer Med Dir Assoc 9:644-652, 2009

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Significant **reduction in hospitalizations**

Significant **reduction in transfers rated as avoidable**

Ouslander et al: J Amer Med Dir Assoc 9:644-652, 2009

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Compromising Quality

- Traumatic to the resident and his or her family
- Can contribute to further complications
  - Delirium
  - Polypharmacy
  - Deconditioning
  - Falls
  - Immobility
  - Hospital Acquired Infections
  - Pressure Ulcers

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Environmental Changes

- Hospitals are feeling the effects of payment reforms (readmission penalties)
- Hospitals are putting pressure on nursing homes to reduce hospitalizations and basing referral patterns on readmission rates
- ACO's – financially incentivized to reduce hospital transfers

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What's Coming…

- Quality Measure for acute care transfers
  - 30 day readmissions for expanded diagnoses
    - d/c to hospital
    - d/c snf →home →hospital
    - Observation Status
    - ER visits without admission

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Interventions To Reduce Acute Care Transfers

- Quality improvement program designed to improve
  - Identification
  - Evaluation
  - Communication

  of nursing home residents with acute changes in condition
- Project supported by CMS and funded by a grant from the Commonwealth Fund

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INTERACT Quality Improvement Program

- ***Was*** a toolkit
- Version 3.0 Tool Nursing Homes
- **Version 4.0 Nursing Homes (*New)***
- Version 1.0 Assisted Living
- Version 1.0 Home Health

http://interact2.net

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Overview of INTERACT Quality Improvement Program

- Includes evidence and expert-recommended clinical practice tools, strategies to implement them, and related educational resources

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Overview of the INTERACT Quality Improvement Program

- Quality Improvement Tools
- Communication Tools
- Decision Support Tools
- Advance Care Planning Tools

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Acknowledgement

- The INTERACT Program and Tools were initially developed by Joseph G. Ouslander, MD and Mary Perloe, MS, GNP at the Georgia Medical Care Foundation with the support of a contract from the Center for Medicare and Medicaid Services.
- The current version of the INTERACT Program was developed by members of the INTERACT Team with input from many direct care providers and national experts in projects based at Florida Atlantic University (FAU) supported by The Commonwealth Fund

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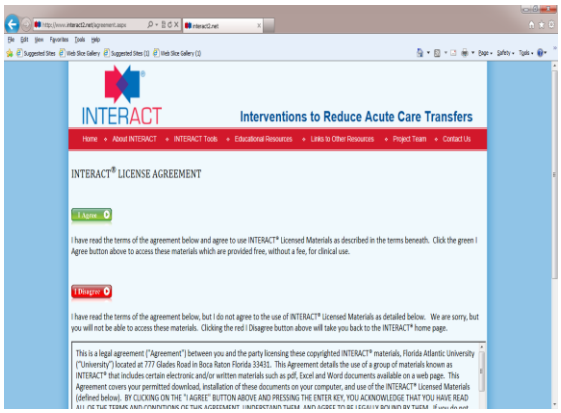

Overview of the INTERACT Quality Improvement Program

- Tools and resources are available on the internet and free of charge
- Documents may not be altered and labeled "INTERACT"
- The tools have a copyright statement at the bottom of the first page

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Quality Improvement

- Opportunity to:
  - Review transfers for trends
  - Identify patterns of assessment and/or needs for training and education
  - Evaluate and establish goals for improvement to decrease avoidable transfers
  - Improve overall resident and staff satisfaction leading to quality of care

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Who is involved?

- Interdisciplinary Team
  - Administrator
  - DON
  - Nursing Leadership (i.e. Supervisor, Charge Nurse etc.)
  - Activities, Social Services, Dietary
  - Medical Director
  - Nursing Assistants
  - Others as appropriate

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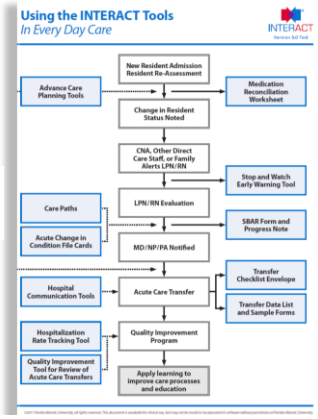
The INTERACT Version 3.0 Tools are meant to be used together in everyday care



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Beginning Steps of Implementation

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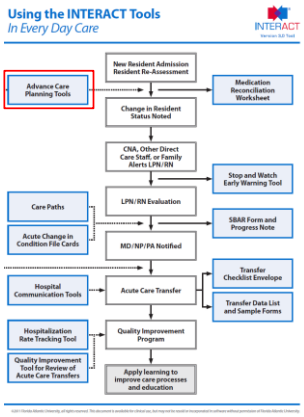

Advanced Care Planning

Advance Care Planning

A process of communication about anticipated medical choices throughout the adult lifespan, focused on patient goals and values

Advanced Care Planning

- Should occur shortly after admission
- Decisions should be reviewed regularly and at times of acute changes in condition

About Palliative Care

- Palliative care is specialized medical care for people with serious illnesses.
- It is focused on providing residents with relief from the symptoms, pain, and stress of a serious illness—whatever the diagnosis.
- The goal is to improve quality of life for both the resident and the family.

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Beginning

Identification

- Any resident who has a serious and perhaps terminal illness and wishes not to pursue curative treatments or efforts

Communication

- Starting the conversation can be tricky and requires language that is resident-centered
- Establishing a relationship of mutual trust and respect is a must
- Family is an integral part of this process

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Advanced Care Planning Tools

- ACP Tracking Tool
- ACP Communication Guide
- Identifying Residents Who May be Appropriate for Hospice or Palliative/Comfort Care Orders
- Comfort Care Order Set
- Deciding About Going To the Hospital
- Education On CPR
- Education On Tube Feeding

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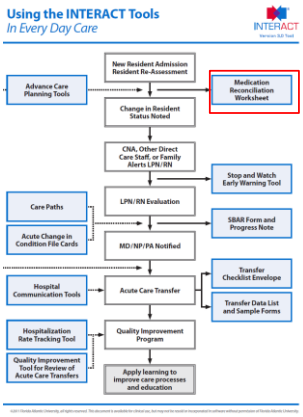

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Medication Reconciliation

Why does this matter?

- Patients admitted to the hospital receive new medications
- Poor access to complete medication list
- Upon discharge needed medications may be omitted
- Medication discrepancies occur in nearly 1/3 of patients admitted to the hospital
- F - 329

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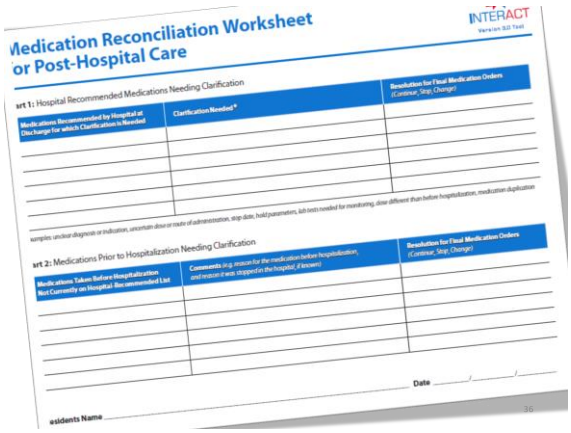

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Medication Reconciliation Example

Medications Recommended by Hospital at Discharge for which Clarification is Needed	Clarification
Cipro 500 mg BID	Need route and stop date
Coumadin 2 mg BID	Need route and PT/INR date
Lisinopril 10 mg BID	Need route and BP hold parameters
Lasix 20 mg daily	Need route and next BMP
Aricept 10 mg BID	Need route
Metoprolol 25 mg BID	Need route and BP hold parameters

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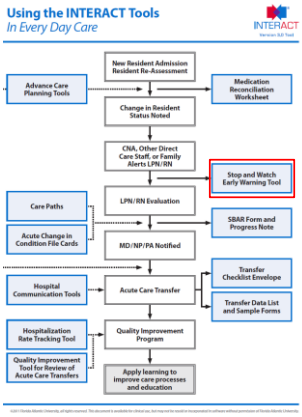

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Early Warning Signs

- Identifying clinical changes in a resident's condition early allows for assessment and interventions that can prevent a transfer
  - Identify changes in residents
  - Communicate changes to other staff members
  - Consider interventions to improve the change leading to quality care for residents

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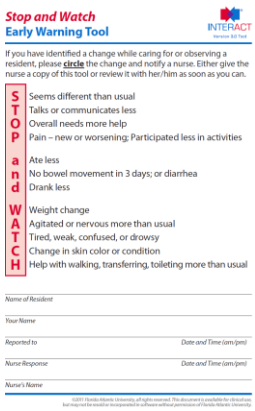

Stop and Watch
Early Warning Tool

INTERACT

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 Seems different than usual
T Talks or communicates less
O Overall needs more help
P Pain – new or worsening; Participated less in activities

a Ate less
n No bowel movement in 3 days; or diarrhea
d Drank less

W Weight change
A Agitated or nervous more than usual
T Tired, weak, confused, or drowsy
C Change in skin color or condition
H 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)*

Nurse's Name

- Changes in mental status
- Changes in physical status
- Changes in function
- Changes in behavior
- Changes in pain level

When in doubt, fill it out!

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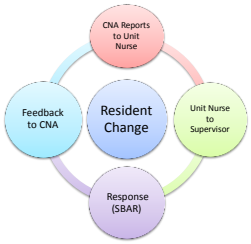
Close the Loop



INTERACT 4.0 Changes

- The **Stop and Watch** early warning tool has been revised to facilitate its use in routine monitoring of high risk residents by adding a checkbox for "no change".

SBAR

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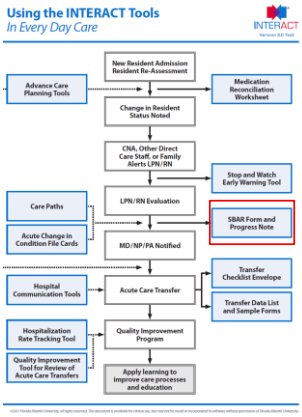

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SBAR and Progress Note

S – Situation

B – Background

A – Assessment

R – Request

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SBAR: Change in Condition Tool

Change in Condition Process

- **CNA/staff concern about resident status**
- **RN assess resident**
- **Take Action**
  - **Monitor**
  - **Nursing interventions**
  - **Contact Practitioner to review and develop plan**
  - **Send resident to ER/hospital**

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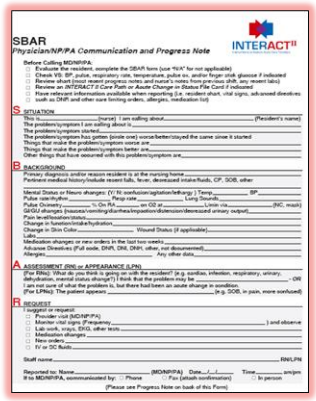

SBAR
Physician/NP/PA Communication and Progress Note

INTERACT II

Before Calling MD/NP/PA:
- Evaluate the resident, complete the SBAR form (use "N/A" for not applicable)
- Check VS: BP, pulse, respiratory rate, temperature, pulse ox, and/or finger stick glucose if indicated
- Review chart (most recent progress notes and nurse's notes from previous shift, any recent labs)
- Review an *INTERACT II Care Path or Acute Change in Status File Card* if indicated
- Have relevant information available when reporting (i.e. resident chart, vital signs, advanced directives such as DNR and other care limiting orders, allergies, medication list)

S SITUATION

This is _____ (nurse). I am calling about _____ (Resident's name)
The problem/symptom I am calling about is _____
The problem/symptom started _____
The problem/symptom has gotten (circle one) worse/better/stayed the same since it started
Things that make the problem/symptom worse are _____
Things that make the problem/symptom better are _____
Other things that have occurred with this problem/symptom are _____

B BACKGROUND

Primary diagnosis and/or reason resident is at the nursing home _____
Pertinent medical history/include recent falls, fever, decreased intake/fluids, CP, SOB, other _____
_____
Mental Status or Neuro changes: (Y/ N/ confusion/agitation/lethargy) Temp _____ BP _____
Pulse rate/rhythm _____ Resp rate _____ Lung Sounds _____
Pulse Oximetry _____ % On RA _____ on O2 at _____ Limits via _____ (NC, mask)
GI/GU changes (nausea/vomiting/diarrhea/impaction/distension/decreased urinary output) _____
Pain/sedation/status _____
Change in hydration/intake/hydration _____
Change in Skin Color _____ Wound Status (if applicable) _____
Labs _____
Medication changes or new orders in the last two weeks _____
Advance Directives (Full code, DNR, DNI, DNH, other, not documented) _____
Allergies _____ Any other data _____

A ASSESSMENT (ENS) or APPEARANCE (LPN) _____
(For RNs): What do you think is going on with the resident? (e.g. sepsis, infection, respiratory, urinary, dehydration, mental status change?) I think that the problem may be _____ OR
I am not sure of what the problem is, but there had been an acute change in condition.
(For LPNs): The patient appears _____ (e.g. SOB, in pain, more confused)

R REQUEST

I suggest or request:
- Provider visit (MD/NP/PA)
- Monitor vital signs (Frequency _____) and observe
- Labs, chest x-rays, EKG, other tests _____
- Medication changes _____
- New orders _____
- IV or SC fluids _____

Staff name _____ RN/LPN

Reported to: Name _____ (MD/NP/PA) Date ___/___/___ Time _____ am/pm
If to MD/NP/PA, communicated by: ☐ Phone ☐ Fax (attach confirmation) ☐ In person
(Please use Progress Note on back of this Form)

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SBAR is More…

- Communication Tool
  - Script for contacting MD/NP
  - Change of shift report
  - Morning Stand-Up
  - Warm hand off between settings
- Documentation Tool
  - Progress note
  - Transfer note to send to ER
- Education Tool

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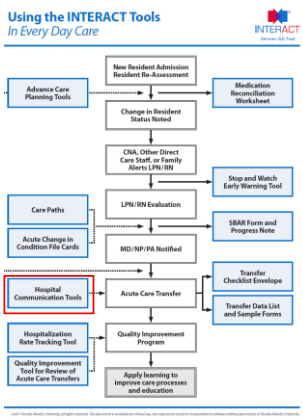
INTERACT 4.0 Changes

- The **SBAR Communication Form and Progress Note** has been substantially revised to make it a more comprehensive and user-friendly nursing evaluation that helps guide and document critical thinking in an efficient way. Changes have been made to several areas of terminology in response to user concerns and suggestions.

Hospital Communication

The INTERACT Version 3.0 Tools are meant to be used together in everyday care in the nursing home



Hospital Communication

- ***Ask*** the hospital to be an active partner in your INTERACT improvements
  - Post INTERACT AL Capabilities List in ED department and Case Management office
  - Educate ER and other hospital staff on the INTERACT tools you are using
  - Improve hand-off communication between hospital and AL using "Warm Hand Offs" (in person communication)

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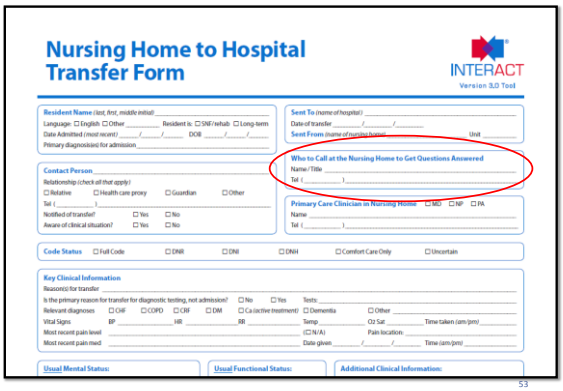

Nursing Home to Hospital Transfer Form

INTERACT Version 3.0 Tool

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

Who to Call at the Nursing Home to Get Questions Answered

Name / Title

Tel ( )

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

Primary Care Clinician on 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 ☐ CVF ☐ DM ☐ Ca (active treatment) ☐ Dementia ☐ Other

Vital Signs BP HR RR Temp (☐ N/A) O2 Sat Time taken (am/pm)

Most recent pain level Pain location:

Most recent pain med Date given ____/____/____ Time (am/pm)

Usual Mental Status:

Usual Functional Status:

Additional Clinical Information:

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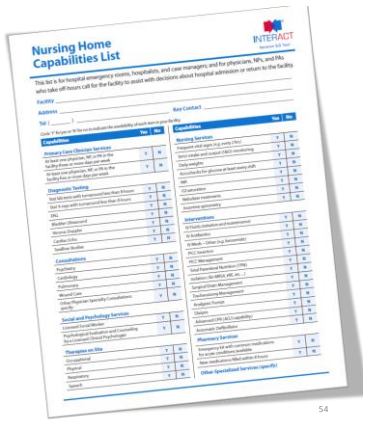

Nursing Home Capabilities List

INTERACT Version 3.0 Tool

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

Check "Y" for yes or "N" for no to indicate the availability of each item or type for this facility.

Capabilities | Yes | No

Primary Care Clinicians Services

At least one physician, NP, or PA on site

At least one physician, NP, or PA on the facility front or home-like site

At least one physician, NP, or PA on the facility front or home-like site

Diagnostic Testing

Stat X-ray with turnaround less than 4 hours

Stat X-ray with turnaround less than 24 hours

EKG

Bladder Ultrasound

Venous Doppler

Cardiac Echo

Swallow Studies

Consultations

Psychiatry

Cardiology

Pulmonary

Wound Care

Other Physician Specialty Consultations (specify)

Social and Psychology Services

Licensed Social Worker

Psychological Evaluation and Counseling

Psychological Clinical Psychologist

Therapists on Site

Occupational

Physical

Respiratory

Speech

Capabilities | Yes | No

Nursing Services

Frequent vital signs (e.g. every 1hr)

Strict intake and output (I&O) monitoring

Daily weights

Accurate checks for glucose at least every shift

IVF

O2 saturation

Subcutaneous insulin

Insulin sliding scale

Interventions

IV Fluids (initiation and maintenance)

IV Antibiotics

IV Meds – Other (e.g. Aminophyllin)

PICC Insertion

PICC Management

Total Parenteral Nutrition (TPN)

Isolation (for MRSA, VRE, etc.)

Tube Feeding Management

Tracheostomy Management

Analgesia Pumps

Dialysis

Advanced CPR (ACLS capability)

Automatic Defibrillator

Pharmacy Services

Emergency kit with commonly used medications for acute conditions available

Non-medication filled within 8 hours

Other Specialized Services (specify)

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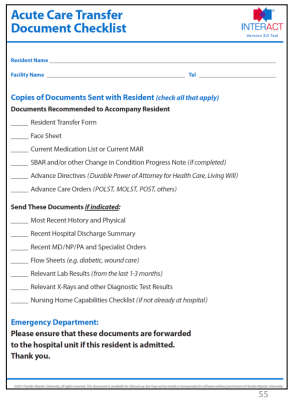
Communication NH→ Hosp re: capabilities

This **Transfer Checklist** can be printed or taped onto an envelope, and is meant to compliment the Transfer Form by indicating which documents are included with the Form



Acute Care Transfer Document Checklist

INTERACT Version 3.0 Tool

Resident Name _____

Facility Name _____ Tel _____

Copies of Documents Sent with Resident *(check all that apply)*

Documents Recommended to Accompany Resident

_____ Resident Transfer Form
_____ Face Sheet
_____ Current Medication List or Current MAR
_____ SBAR and/or other Change in Condition Progress Note *(if completed)*
_____ Advance Directives *(Durable Power of Attorney for Health Care, Living Will)*
_____ Advance Care Orders *(POLST, MOLST, POST, others)*

Send These Documents *(if indicated)*:

_____ Most Recent History and Physical
_____ Recent Hospital Discharge Summary
_____ Recent MD/NP/PA and Specialist Orders
_____ Flow Sheets *(e.g. diabetic, wound care)*
_____ Relevant Lab Results *(from the last 1-3 months)*
_____ Relevant X-Rays and other Diagnostic Test Results
_____ Nursing Home Capabilities Checklist *(if not already at hospital)*

Emergency Department:
Please ensure that these documents are forwarded to the hospital unit if this resident is admitted.
Thank you.

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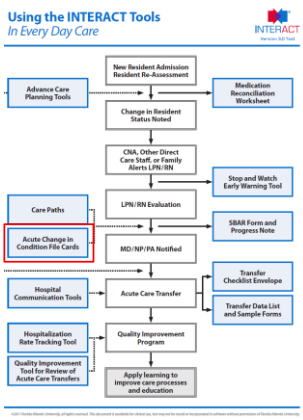
Decision Support Tools: Change in Condition File Cards And Care Paths

The INTERACT Version 3.0 Tools are meant to be used together in everyday care in the nursing home



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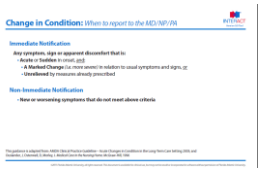
Change In Condition File Cards and Care Paths

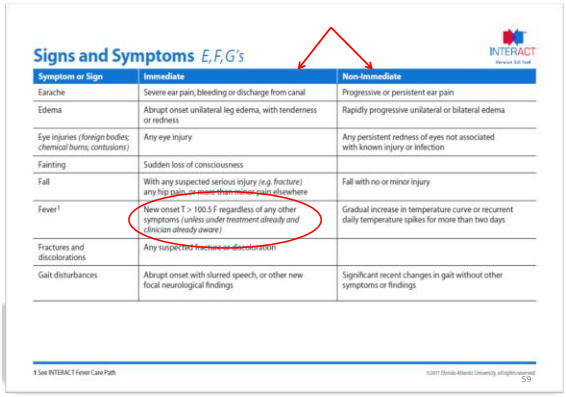
- The INTERACT Change in Condition File Cards are meant to be visible and sit next to the phone for quick reference
- Originated at the LA JHA, published in a letter to JAGS, then in Medical Care in the Nursing Home
- New version based on AMDA Clinical Practice Guideline


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


Signs and Symptoms *E, F, G's*

INTERACT Version 3.0 Tool

Symptom or Sign	Immediate	Non-Immediate
Earache	Severe ear pain, bleeding or discharge from canal	Progressive or persistent ear pain
Edema	Abrupt onset unilateral leg edema, with tenderness or redness	Rapidly progressive unilateral or bilateral edema
Eye injuries *(foreign bodies; chemical burns; contusions)*	Any eye injury	Any persistent redness of eyes not associated with known injury or infection
Fainting	Sudden loss of consciousness	
Fall	With any suspected serious injury *(e.g. fracture)* any hip pain, or more than minor pain elsewhere	Fall with no or minor injury
Fever[1]	New onset T > 100.5 F regardless of any other symptoms *(unless under treatment already and clinician already aware)*	Gradual increase in temperature curve or recurrent daily temperature spikes for more than two days
Fractures and discolorations	Any suspected fracture or discoloration	
Gait disturbances	Abrupt onset with slurred speech, or other new focal neurological findings	Significant recent changes in gait without other symptoms or findings

1 See INTERACT Fever Care Path

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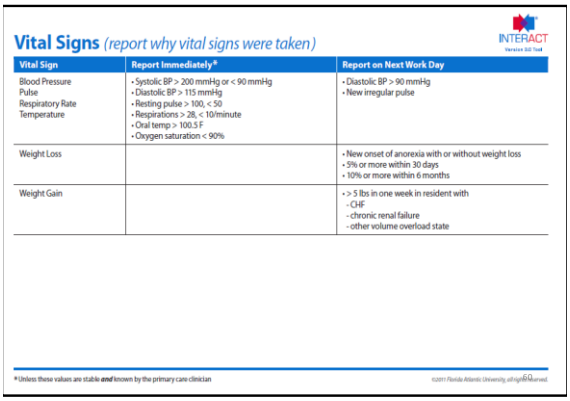
Vital Signs *(report why vital signs were taken)*

INTERACT Version 3.0 Tool

Vital Sign	Report Immediately*	Report on Next Work Day
Blood Pressure Pulse Respiratory Rate Temperature	• Systolic BP > 200 mmHg or < 90 mmHg • Diastolic BP > 115 mmHg • Resting pulse > 100, < 50 • Respirations > 28, < 10/minute • Oral temp > 100.5 F • Oxygen saturation < 90%	• Diastolic BP > 90 mmHg • New irregular pulse
Weight Loss		• New onset of anorexia with or without weight loss • 5% or more within 30 days • 10% or more within 6 months
Weight Gain		• > 5 lbs in one week in resident with - CHF - chronic renal failure - other volume overload state

*Unless these values are stable ***and*** known by the primary care clinician

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Laboratory Tests / Diagnostic Procedures

(report why the test or procedure was done)

INTERACT

Test/Procedure	Report Immediately*	Report on Next Work Day
Complete Blood Count	• WBC > 14,000 • Hematocrit < 24 • Hemoglobin (Hb) < 8 • Platelets < 50,000	WBC > 10,000 without symptoms of fever
Chemistry	• Blood/urea/nitrogen (BUN) > 60 mg/dl • Calcium (Ca) > 12.5 mg/dl • Potassium (K) < 3.0, > 6.0 mg/dl • Sodium (Na) < 125, > 155 mg/dl • Blood glucose > 300 mg/dl or < 70 mg/dl *(diabetic)*	• Glucose consistently > 200 mg/dl • Hb A1c *(any value)* • Albumin *(any value)* • Bilirubin *(any value)* • Cholesterol *(any value)* • Triglycerides *(any value)* • Other chemistry values
Consult Reports	Consultant report recommending immediate action or changes in management	Routine consultant report recommending routine action or changes in patient's management
Drug Levels	Levels above therapeutic range of any drug *(hold next dose)*	Any therapeutic or low level
INR *(International Normalized Ratio)*	• INR > 6 IUs *(hold warfarin)*	• INR 3-6 IUs *(hold warfarin)* • PT *(in seconds)* 2x control *(hold warfarin)*
Urinalysis	Abnormal result in resident with signs and symptoms possibly related to urinary tract infection or urosepsis *(e.g. fever, burning sensation, pain in suprapubic or flank area)*	Abnormal result in resident with no signs or symptoms
Urine Culture	>100,000 colony count with a urinary pathogen with symptoms	Any growth with no symptoms
X-ray	New or unsuspected finding *(e.g. fracture, pneumonia, CHF)*	Old or long-standing finding, no change

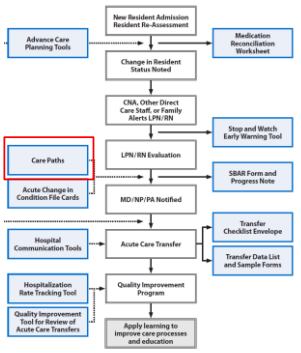
* Unless these values are stable ***and*** known by the primary care clinician

The INTERACT Version 3.0 Tools are meant to be used together in everyday care in the nursing home

Using the INTERACT Tools

In Every Day Care

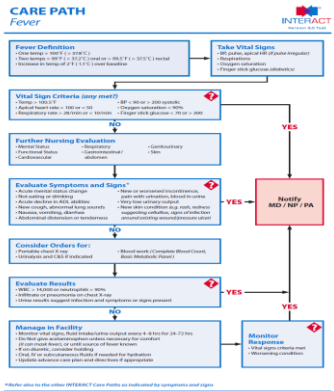
INTERACT



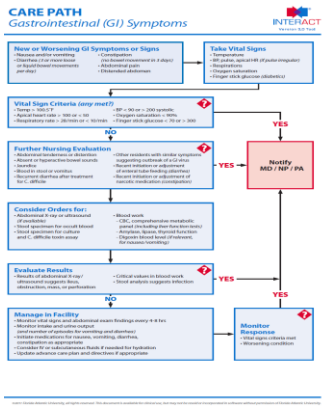
CARE PATH

Fever

INTERACT



*Refer also to the other INTERACT Care Paths as indicated by symptoms and signs



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Care Paths

Also…

- Acute Mental Status Change
- Change in Behavior: New or Worsening Behavioral Symptoms
- Dehydration
- Shortness of Breath
- Symptoms of CHF
- Symptoms of Lower Respiratory Illness
- Symptoms of UTI

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INTERACT 4.0 Changes

- The criteria for notifying the clinician have been made more consistent between the **Decision Support Tools (Change in Condition File Cards and Care Paths)**, and these criteria are now included in the revised SBAR.

Quality Improvement Through Root-Cause Analysis

RCA Using INTERACT Quality Improvement Tool

- Track and trend transfer data
- Look for common causes and patterns in transfers
- Focus on improvement opportunities

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Quality Improvement Tool
For Review of Acute Care Transfers
INTERACT
Version 3.0 Tool
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: ____/____/____
Major diagnoses at admission: _____
Conditions that put the resident at risk for hospital admission or readmission:
☐ Hospitalizations within the last 6 months
☐ CHF
☐ COPD
☐ Polypharmacy (e.g. 9 or more medications)
☐ Cancer, on active chemo or radiation therapy
☐ Multiple co-morbidities (e.g. CHF, COPD and DM in the same person)
☐ Other (describe): _____
☐ Terminal complications
☐ Fracture
Resident hospitalized in the past 30 days? ☐ No ☐ Yes (list dates and reasons): _____
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
Does the change in condition first noticed: ____/____/____
Briefly describe the change, symptom, sign or other factor(s) that led to the transfer and then check each item below that applies:
(continued on reverse side)

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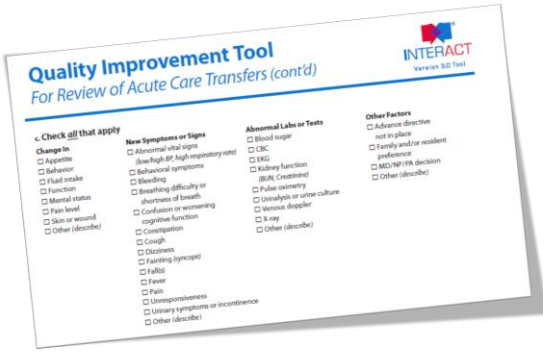

Quality Improvement Tool
For Review of Acute Care Transfers (cont'd)

INTERACT Version 3.0 Tool

c. Check *all* that apply

Change in
- ☐ Appetite
- ☐ Behavior
- ☐ Fluid intake
- ☐ Function
- ☐ Mental status
- ☐ Pain level
- ☐ Skin or wound
- ☐ Other (describe)

New Symptoms or Signs
- ☐ Abnormal vital signs (low/high BP, high respiratory rate)
- ☐ Behavioral symptoms
- ☐ Bleeding
- ☐ Breathing difficulty or shortness of breath
- ☐ Confusion or worsening cognitive function
- ☐ Constipation
- ☐ Cough
- ☐ Dizziness
- ☐ Fainting (syncope)
- ☐ Fall(s)
- ☐ Fever
- ☐ Pain
- ☐ Unresponsiveness
- ☐ Urinary symptoms or incontinence
- ☐ Other (describe)

Abnormal Labs or Tests
- ☐ Blood sugar
- ☐ CBC
- ☐ EKG
- ☐ Kidney function (BUN, Creatinine)
- ☐ Pulse oximetry
- ☐ Urinalysis or urine culture
- ☐ Venous doppler
- ☐ X-ray
- ☐ Other (describe)

Other Factors
- ☐ Advance directive not in place
- ☐ Family and/or resident preference
- ☐ MD/NP/PA decision
- ☐ Other (describe)

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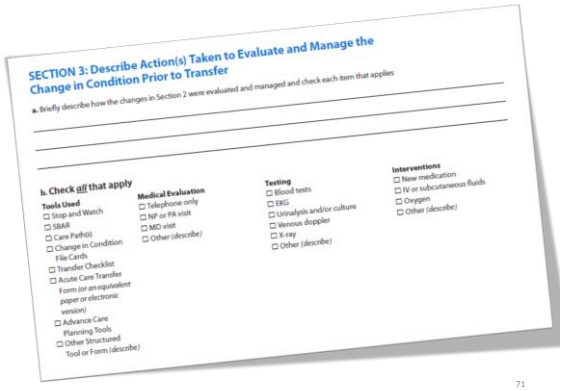

SECTION 3: Describe Action(s) Taken to Evaluate and Manage the Change in Condition Prior to Transfer

a. Briefly describe how the changes in Section 2 were evaluated and managed and check each item that applies

b. Check *all* that apply

Tools Used
- ☐ Stop and Watch
- ☐ SBAR
- ☐ Care Path(s)
- ☐ Change in Condition File Cards
- ☐ Transfer Checklist
- ☐ Acute Care Transfer Form (or an equivalent paper or electronic version)
- ☐ Advance Care Planning Tools
- ☐ Other Structured Tool or Form (describe)

Medical Evaluation
- ☐ Telephone only
- ☐ NP or PA visit
- ☐ MD visit
- ☐ Other (describe)

Testing
- ☐ Blood tests
- ☐ EKG
- ☐ Urinalysis and/or culture
- ☐ Venous doppler
- ☐ X-ray
- ☐ Other (describe)

Interventions
- ☐ New medication
- ☐ IV or subcutaneous fluids
- ☐ Oxygen
- ☐ Other (describe)

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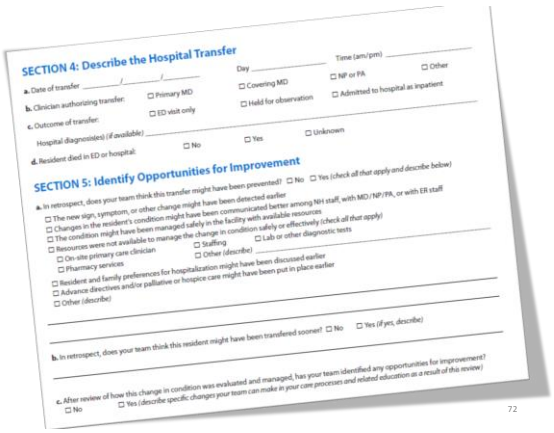

SECTION 4: Describe the Hospital Transfer

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
  - ☐ Pharmacy services
  - ☐ Stuffing
  - ☐ Other (describe) _____
  - ☐ Lab or other diagnostic tests
- ☐ 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)

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Quality Improvement
Summary Worksheet (cont'd)
INTERACT
Version 3.0 Tool
D. Hospital transfer and contributing factors
1. Day of the week of hospital transfer? Yes
2. Time of day of hospital transfer? Yes
3. MD/NP/PA authorizing the transfer? Yes
4. Non-clinical factors that contributed to the hospital transfer? Yes
a. MD/NP/PA insisted on transfer? Yes
b. Resident preferred or insisted on transfers? Yes
c. Family members preferred or insisted on transfers? Yes
d. Resources needed to provide care in NH not available? Yes
e. Facility policies do not support providing care in NH? Yes
Findings
E. Transfers rated as potentially preventable
1. Factors related to transfers rated as preventable? Yes
2. Reasons provided for preventable transfers? Yes
Findings
STEP 3: Summarize Common Factors Across
1. What factors were most common and similar across QI Tools?
2. Based on this summary what areas would you target for:
a. Staff education:
b. Care process changes:
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Quality Improvement
Summary Worksheet (cont'd)
INTERACT
Version 3.0 Tool
D. Hospital transfer and contributing factors
1. Day of the week of hospital transfer? Yes
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1. What factors were most common and similar across QI Tools?
2. Based on this summary what areas would you target for:
a. Staff education:
b. Care process changes:
c. Other improvement efforts:
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Quality Improvement

- Opportunities to improve care and decrease potentially avoidable hospital transfers
  - Population level – look at trends and patterns in order to improve performance
  - Individual case level – more reactive and aimed at identifying specific system/process breakdowns in order to improve performance

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Hospitalization Rate Tracking Tool

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

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Hospitalization Rate Tracking Tool

- Same as Advancing Excellence Safely Reduce Hospitalizations Tracking Tool except:
  - AE has high-level process measures captured in the same tool as associated outcomes
  - INTERACT has detailed process information recorded separately in the companion QI Tool

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Acute Care Transfer Log

INTERACT
Version 3.0 Tool

You can use this tool as a worksheet for recording all acute care transfers during a month. Print more pages as needed. This tool is not necessary if you use the **INTERACT Hospitalization Rate Tracking Tool**, which allows you to enter the data directly into an Excel spreadsheet, and calculates rates and generates reports. A similar tracking tool is available through the Advancing Excellence Campaign in America's Nursing Homes at www.nhqualitycampaign.org

Facility Name ______________________ **Month/Year** ________ / ________

Resident ID	Date of Most Recent Admission to Facility	Admitted to Facility from[1] *(circle)*	Status on Admission[2] *(circle)*	Date of Acute Care Transfer	Time of Transfer *(circle AM or PM)*	Outcome of Transfer[3] *(circle)*	Reason for Transfer[4]
	/ /	Hosp H O	PAC LTC	/ /	AM PM	IP OBS ER	
	/ /	Hosp H O	PAC LTC	/ /	AM PM	IP OBS ER	
	/ /	Hosp H O	PAC LTC	/ /	AM PM	IP OBS ER	
	/ /	Hosp H O	PAC LTC	/ /	AM PM	IP OBS ER	
	/ /	Hosp H O	PAC LTC	/ /	AM PM	IP OBS ER	
	/ /	Hosp H O	PAC LTC	/ /	AM PM	IP OBS ER	
	/ /	Hosp H O	PAC LTC	/ /	AM PM	IP OBS ER	
	/ /	Hosp H O	PAC LTC	/ /	AM PM	IP OBS ER	
	/ /	Hosp H O	PAC LTC	/ /	AM PM	IP OBS ER	
	/ /	Hosp H O	PAC LTC	/ /	AM PM	IP OBS ER	

1 **Hosp** = acute care hospital; **H** = home; **O** = Other location
2 **PAC** = post-acute care *(most often Medicare Part A skilled care)* for rehabilitation and/or management of medical or post-surgical conditions; **LTC** = long-term care
3 **IP** = admitted as an inpatient; **OBS** = admitted on observation status; **ER** = emergency room visit only with return to the facility *(includes residents who die in the ambulance or ER)*
4 Examples of options on the above referenced Tracking Tools: Bleeding, Cellulitis, Chest Pain, CHF, COPD, Dehydration/Electrolyte Imbalance, Fall, GI *(vomiting, diarrhea, pain)*, Pneumonia/Respiratory Infection, Seizure, Sepsis, Shortness of Breath, UTI, Other

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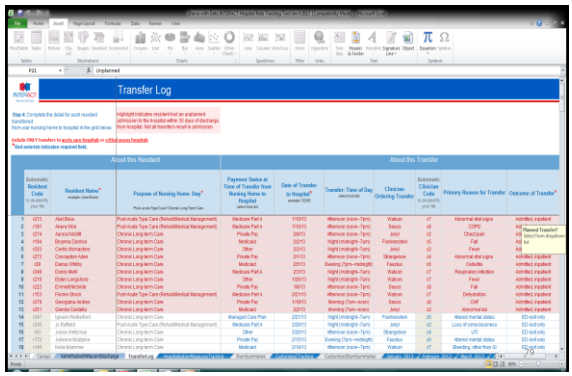
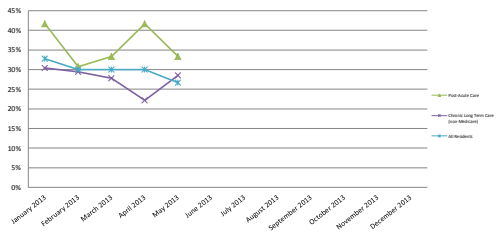


30-Day Readmission Rates



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	41.7%	30.8%	33.3%	41.7%	33.3%	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A
Chronic Long Term Care (non-Medicare)	30.4%	29.4%	27.8%	22.2%	28.6%	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A
All Residents	32.8%	30.0%	30.0%	30.0%	26.7%	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A

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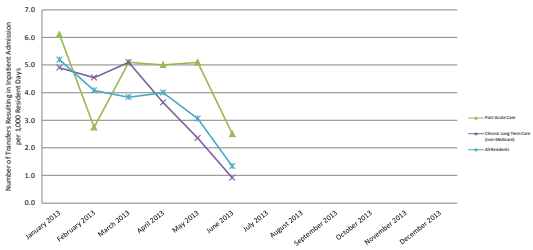
Transfers Resulting in Admission to Hospital as an Inpatient



Status on Admission to Nursing Home	In-patient Stays per 1,000 Resident Days											
	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	6.1	2.7	5.1	5.0	5.1	2.5	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A
Chronic Long Term Care (non-Medicare)	4.9	4.5	5.1	3.6	2.3	0.9	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A
All Residents	5.2	4.1	3.8	4.0	3.1	1.3	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A

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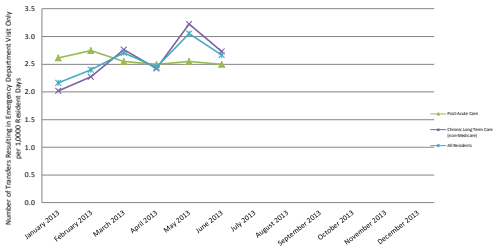
Transfers Resulting in Emergency Department Visit Only



Emergency Department Visits per 1,000 Resident Days

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	2.6	2.7	2.5	2.5	2.5	2.5						
Chronic Long Term Care (non-Medicare)	2.0	2.3	2.8	2.4	3.2	2.7						
All Residents	2.2	2.4	2.7	2.4	3.1	2.7						

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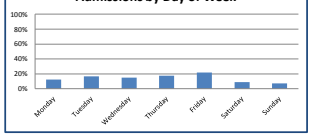
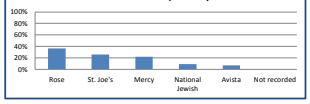
Admissions by Day of Week



Source of Admissions

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



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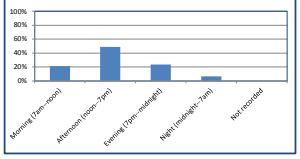
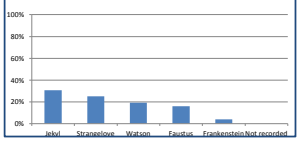
Transfers by Time of Day



Transfers by Doctor

for the 5 doctors who order the most transfers



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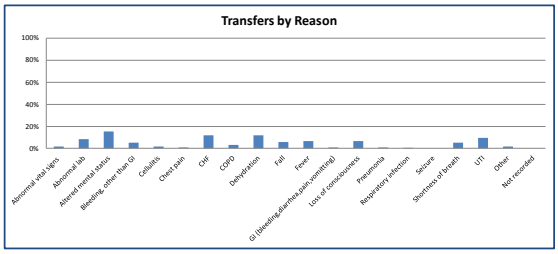

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Probing Questions

- What patterns do we see in our hospitalizations rates?
- Is there a particular day that has a high frequency of hospitalizations?
- What time of day are most of our admissions from the hospital occurring?
- What time of day are most of our discharges to the hospital occurring?
- What day of the week are most of our admissions from the hospital occurring?
- What day of the week are most of our discharges to the hospital occurring?

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Transfers by Primary Reason for Transfer

	Number of Transfers	Percent of all Transfers
Abnormal vital signs	4	1.8%
Abnormal lab	10	4.3%
Altered mental status	35	15.4%
Bleeding, other than GI	12	5.3%
Cellulitis	4	1.8%
Chest pain	2	0.9%
CHF	27	11.8%
COPD	7	3.1%
Dehydration	27	11.8%
Fall	13	5.7%
Fever	15	6.6%
GI (bleeding,diarrhea,pain,vomitting)	2	0.9%
Loss of consciousness	15	6.6%
Pneumonia	2	0.9%
Respiratory infection	1	0.4%
Seizure	0	0.0%
Shortness of breath	12	5.3%
UTI	22	9.6%
Other	4	1.8%
Not recorded	0	0.0%

Delirium?

Edema, lungs?

Intakes, labs?

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Commonly Overlooked Clinical Changes

- Decreased intakes
- Slight change in ADL's
- Mood and behavior changes dismissed as dementia
- Decreased activity due to pain
- Changes in blood pressure (especially systolic)
- ***Shift Huddles Tip Sheet*** (Pioneer Network)

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A Word on leadership

- Trickles from the top
- "Buy in" is key
- Team approach from the beginning
- Training
  - ✓ All key staff – consider small groups
  - ✓ New employees
  - ✓ Periodic "re-training"

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