Safely Reducing Potentially Preventable Hospitalizations

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The Commonwealth Fund
www.commonwealthfund.org
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• Allows residents with acute changes in medical condition to remain in nursing home with staff who know them and can safely care for them without compromising residents’ well-being or wishes.

• Avoids trauma and other risks associated with hospitalization.

• Increases communication between hospital and nursing home to ensure continuity of care and improve care transitions.
Hospitalizations - Measures

• 30-day Readmission Rate as percent of those admitted from a hospital during the month

• Hospital Admission Rate per 1000 resident days this month

• Rate of Transfers to ER Only per 1000 resident days this month

• Rate of Transfers Resulting in Observation Stay per 1000 resident days this month

• Includes “process measures” to help with root cause analysis, e.g. asks “Was a structured communication tool used?”
List of work-group participants

Mary Jane Koren: (workgroup Chair), Immediate Past Chair, Advancing Excellence in Long-Term Care Collaborative; VP - Long-Term Care Quality Improvement Program, The Commonwealth Fund

Carol Benner: former Executive Director, Advancing Excellence in Long-Term Care Collaborative

Selena Bolotin: Director WA Patient Safety & Care Transitions, Qualis Health

Jane Brock: Medical Officer, Colorado Foundation for Medical Care

Chris Condeelis: former Sr. Director of Quality, American Health Care Association

Sandra Fitzler: Senior Director of Clinical Services, American Health Care Association

Jennie Harvell: Senior Policy Analyst, Dept. HHS, Assistant Secretary for Planning and Evaluation

Alice Hedt: State Long Term Care Ombudsman, Maryland Department of Aging

Joseph Isaacs: Executive Director, Advancing Excellence in Long-Term Care Collaborative

Ruta Kadonoff: Vice President, Quality & Regulatory Affairs, American Health Care Association

Katie Maslow: Scholar-in-Residence, Institute of Medicine

Kris Mattivi: Manager, Analytic Services, Project Manager, Advancing Excellence, Colorado Foundation for Medical Care

Adrienne Mihelic: Biostatistician, Analytic Services, Colorado Foundation for Medical Care

Victor Orija: State Long-Term Care Ombudsman, DE Department of Health and Social Services, Office of The Secretary

Joe Ouslander: Professor and Senior Associate Dean for Geriatric Programs, Florida Atlantic University

Carol Scott: Field Operations Manager, Advancing Excellence in Long-Term Care Collaborative

Urvi Shah: Manager, Quality Improvement, AHCA/NCAL National Quality Award Program, American Health Care Association

Diana Sturdevant: Gerontological Clinical Nurse Specialist, Director of Nursing Services, Mitchell Manor Convalescent Home, Inc.
Circle of Success

- **Explore Goal**
  - Goal Description & Benefit

- **Identify Your Baseline & Set Your Target**
  - Target Setting
  - Data Tracking Tool

- **Examine Your Process**
  - Root Cause Analysis
  - Manual for Change
  - Evidence-based practices
  - Learning Community

- **Creating Improvement**
  - Leadership, Consumer, & Staff Fact Sheets

- **Monitor Progress & Sustain the Gain**
  - Data Tracking Tool & website reports
  - Integrating change into organizational culture

- **Celebrate Success!**
  - WOO HOO!

- **Leadership & Stakeholders**
Explore Goal

Deciding what you want to change is the first step of the quality improvement cycle. These goal descriptions provide general information about the goal and its benefits to share with your team.

Nursing home residents are often transferred to hospitals when they have an acute change in their clinical condition. Many such changes in condition can be managed safely without transfer, avoiding the trauma and risks associated with hospitalization. In order to achieve this goal, nursing home staff must be prepared and have the necessary resources available. Working on this goal will assist nursing home staff to safely care for residents on-site using evidence-based and expert recommended tools and practices to reduce rates of hospitalization without compromising residents’ well-being or wishes.

How does reducing hospitalizations safely benefit residents?
How does reducing hospitalizations safely benefit staff?
How does reducing hospitalizations safely benefit nursing homes?
Welcome to the Advancing Excellence Safely Reduce Hospitalizations Tracking Tool!

This tool is an Excel workbook that you can use to support your quality improvement project using data on your acute hospital admissions, readmissions, and transfers.

You will enter information for all residents admitted from an acute care hospital, and for all residents transferred to the hospital for any reason. Entering these items will produce monthly summary statistics that will allow you to track your outcomes and progress over time.

There are also options to record additional information that will help you examine your care processes to discover what is working well and where there are opportunities for improvement. You will be able to identify some areas of improvement by recording items such as specific hospitals you receive residents from and transfer to, doctors requesting transfers, days of week and time of day that transfers occur, and whether structured communication tools were used to receive and send information about your resident during transfers to or from your nursing home.
Click on the named tabs at the bottom of the window to move between worksheets. Or click the hyperlinked name in the directory.

Sometimes there are so many worksheets in your workbook that you can’t see them all. Use the scroll bar on the LEFT side of the window to see all tabs.

Note: If you can’t see the tabs at the bottom of the Excel window, make sure your window is maximized.
This set of probing questions will help you evaluate your current processes and provide guidance for ways to make improvements.

**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?

**Which groups are most affected?**
- What proportion of our transfers has dementia?
- Is there a pattern of clinical causes for transfer to the hospital?
- Of the individuals that were admitted to the hospital,
  - How many of them died?
  - How soon after the transfer did they die?
  - Is this primarily a problem of:
    - Readmissions to the hospital,
    - Primary hospitalizations, or
    - Both?
  - Are most of the decisions for hospital admission made by the Medical Director, a covering physician, or by the individual’s physician?
<table>
<thead>
<tr>
<th>Title</th>
<th>Description</th>
<th>Hyperlink</th>
<th>RCA Question Answered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognition Tool</td>
<td>INTERACT Stop and Watch, designed for use by all staff and family members provides a way recognize early warning signs of changes in resident condition that need clinical follow-up.</td>
<td><a href="http://interact2.net/tools.html">http://interact2.net/tools.html</a></td>
<td>Recognition</td>
</tr>
<tr>
<td>Making Clinical Judgments</td>
<td>INTERACT Care Paths and Change in Condition File Cards assist nurses in making judgments about changes in resident condition and what issues need immediate and non-immediate intervention by the physician.</td>
<td><a href="http://interact2.net/tools.html">http://interact2.net/tools.html</a></td>
<td>Recognition</td>
</tr>
<tr>
<td>Transfer to the Hospital</td>
<td>INTERACT Acute Care Document Checklist identifies and organizes the information that needs to be sent to the hospital when a hospital transfer is needed.</td>
<td><a href="http://interact2.net/tools.html">http://interact2.net/tools.html</a></td>
<td>Hospital Communication</td>
</tr>
<tr>
<td>Interdisciplinary Communication Approach</td>
<td>Pioneer Network Shift Huddle Tip Sheet describes how to set up and conduct Shift Huddles to communicate change in condition information across shifts.</td>
<td><a href="https://b12prd0711.outlook.com/owa/attachment.asmx?attach=1&amp;id=RgAAAAABsILeCrmZQJoYexZ4tDmBdBwCtHZgrtlyvSKnFytmOxhsEAAAYygEKAAChHZgtrlyvSKnFYtmOxhsEAAACsD7MAAAJ&amp;attid0=BAABAAAAAattcnt=1">https://b12prd0711.outlook.com/owa/attachment.asmx?attach=1&amp;id=RgAAAAABsILeCrmZQJoYexZ4tDmBdBwCtHZgrtlyvSKnFytmOxhsEAAAYygEKAAChHZgtrlyvSKnFYtmOxhsEAAACsD7MAAAJ&amp;attid0=BAABAAAAAattcnt=1</a></td>
<td>Communication</td>
</tr>
</tbody>
</table>
Leadership fact sheet

**Why is safely reducing preventable hospitalizations important?**
Nursing homes have the immediate and urgent opportunity to improve care, lower healthcare costs and share in savings to support further care improvements. When safe and feasible, managing acute changes in condition in the nursing home is better for residents, family and staff. Due to changes in Medicare reimbursement, nursing homes that do not prepare and act now could lose substantial revenue from hospital partners who are seeking to collaborate with facilities that have lower hospital transfer and rehospitalization rates.

**How does safely reducing preventable hospitalizations benefit nursing homes?**
- As hospitals are being penalized for excess readmissions, they are turning to nursing homes with a reputation for high performance and a track record of lowering hospitalization rates via clinical readiness and enhanced capabilities to become preferred providers.
- Nursing homes that are prepared and have experience treating residents with an acute change of condition will be ready to take advantage of future incentives and payment reform, such as partnering with Accountable Care Organizations, bundled payments and value based purchasing.
- Penalties for readmissions and value based purchasing are a reality for hospitals now. It is likely that nursing home care settings will follow in the future.
- Being a participant in this Advancing Excellence goal, tracking your data and uploading it monthly on the website will give your nursing home a head start on meeting Quality Assurance Performance Improvement (QAPI) requirements for systematic implementation of a quality improvement culture.
- Resident and family satisfaction will increase as their preferences for care are accommodated and their advanced care plans are respected.

Nursing homes will realize cost savings from greater efficiencies associated with transferring and readmitting residents. Staff satisfaction will increase as well since they will be better prepared and less stressed.

**How can nursing home leadership help reduce preventable hospitalizations?**
- Commit to a goal of safely reducing potentially preventable hospitalizations: Join Advancing Excellence and select this goal.
- Bring your multi-disciplinary QI team together look at your current data, discuss the issue and set an achievement target.
- Assess your home’s capacity to safely manage acute changes in condition.
Staff fact sheet

Understanding this goal:
Nursing home residents are often sent to the hospital when they get sick or have a change in condition. If the NH is well prepared it may not be necessary to send the resident to the hospital. Working on this goal will teach you what you can do to be sure residents get the best care. It will also remind you to respect the resident’s wishes about health care decisions. Working as a team with other staff, the number of times residents have to be sent to the hospital can be safely reduced.

Why is the goal to safely reduce hospitalizations important for residents?
Research shows that sending a resident to the hospital is upsetting. It can even cause physical harm, like new pressure ulcers or infections. A home must be prepared to care for sicker residents. Staff also must be trained on what to do. If the home is prepared, not sending the resident to the hospital has benefits:
• Staff can meet the resident’s care preferences because they know them well.
• Staying in a familiar place can be comforting;
• Riding in an ambulance is uncomfortable. There can be long waits in a noisy emergency room. This can frighten or confuse an older person, especially someone with dementia.
• Important information isn’t lost between the hospital and the nursing home.
• Nursing homes know what medicines the resident is taking so mistakes are less common
• Residents are not exposed to serious hospital infections.

How can nursing assistants help to safely manage acute changes in condition?
• You, as the CNA, know the resident best. You may notice that the resident seems different than usual. That may mean the resident is getting sick. Tell the nurse if you are worried.
• Write your observations down in the chart. Other staff need to know what you saw even if you’re off-duty.
• Find out if the nursing home has a tool to make it easier to share information. If not, maybe suggest they try a tool called STOP and WATCH.
Consumer fact sheet

Why is this goal important?
Often when nursing home residents get sick or have a medical problem they are immediately sent to the hospital. While a transfer to the hospital may be the right decision, it does carry considerable risk for very frail older people. For this and other reasons, hospitals as well as nursing homes are trying to see if they can reduce hospitalizations and rehospitalizations by improving care. Research has shown that if the NH is well prepared it may not be necessary to send the resident to the hospital. Therefore, nursing homes working on this goal will do three important things. They will:

- Give residents the best care possible when they become ill;
- Ensure that the resident’s wishes about care are respected; and
- Safely reduce the number of preventable transfers to emergency rooms and hospitals

WHAT ARE THE BENEFITS FOR RESIDENTS OF NOT BEING TRANSFERRED?
Nursing home residents are very vulnerable. They are physically frail, chronically ill and many have dementia. A hospitalization, or even a visit to the emergency room, can cause many complications. Nursing homes that are prepared to care for residents when they have a change in condition may actually do a better job than a hospital. Some of the benefits of being treated at the nursing home include:

- Staff know the resident. They know the resident’s personal preferences and are able to meet their needs. This is especially important for those with dementia;
- Nursing homes know the importance of mobility and socialization to well-being. Residents are not left lying in beds for long hours as they are in hospitals;
- The familiar place is comforting. It can reduce confusion, delirium and depression; ambulance is uncomfortable. There can be long waits in a noisy emergency room. This can frighten or terrify the family. This can improve communication and help with decision making;

Information isn’t lost between the hospital and the nursing home.
- We know what medicines the resident is taking so mistakes are less common;
- Is managed with toileting programs rather than urinary catheters;
- Not exposed to serious hospital infections. They are less likely to get pressure ulcers.
COST INFORMATION FOR NURSING HOME RESIDENTS WHO FACE HOSPITALIZATION

GOAL:
This information is aimed at explaining to nursing home residents and their families two cost related issues they may want to ask about if the resident has to go to the hospital.

1. What is the nursing home’s “bed hold” policy?
2. What kind of stay will the resident have in the hospital? Is it an “inpatient admission” or an “observational stay”?

BED HOLD POLICY

Sometimes a resident has to leave the nursing home for a day or two to be treated at a hospital. It’s important to ask whether or not the resident’s nursing home bed will be saved for his or her return. This answer may vary depending on how the resident is paying for his/her care. If the stay in the nursing home is being paid for by...

• Medicaid: State and Federal laws give the resident the right to return to the first available nursing home bed after hospitalization. Many states specify how many days a nursing home must hold a bed for the resident and for those covered by Medicaid, the number of days cannot be less than the state requirement. Before a resident on Medicaid is hospitalized, the nursing home must give the resident and a family member or legal representative written information describing its bed hold policy and the resident’s right to return to the first available bed. IF THE RESIDENT EXCEEDS THE TIME SPECIFIED IN THE “BED HOLD” POLICY AND DOESN’T PAY THE HOME FOR ADDITIONAL DAYS OUT-OF-POCKET, the resident may be temporarily admitted to another nursing home. They are able to then get the first available bed at the original nursing home if they so choose.

Insurance: Check the insurance policy to see what it will pay for. Each policy is different. Some may not pay to hold the nursing home bed for the resident. In that case, the resident or his/her family may have to hold the bed if the resident wants to return to a particular nursing home.

Pay (or out-of-pocket): If the resident or his or her family is paying directly for the resident’s care and wants to stay at that same nursing home after going to the hospital, they will most likely have to continue to pay the home its daily rate while the resident is in the hospital. Ask the nursing home what its specific policies are.
What health related services can my nursing home provide?
A questionnaire to help families and residents talk to nursing homes

When a resident of a nursing home suddenly gets sick they may need certain types of care or services not routinely provided in the nursing home. Following are questions consumers can ask about services a nursing home might offer in these situations. Don’t wait for an emergency – know in advance what the NH can provide because not all nursing homes will have everything listed here. Once you know, it will be easier to decide whether or not the resident can be safely cared for without going to the hospital.

- Is there someone on site at all times who has been trained and is certified to perform basic cardio-pulmonary resuscitation (CPR)? Are automatic defibrillators present? Not all residents may want to have resuscitation. But for those that do, it should only be given by people who have completed the required training course.
- What tests can be done in the nursing home? Within what time frame should results be available? Examples include:
  - Electrocardiogram (EKG) – should be within 4-6 hours
  - Chest X-ray (CXR) – should be within 4-6 hours
  - Laboratory tests, such as blood work – should be within 4-6 hours
  - Bladder ultrasound to determine if urine is being retained
  - Venous Doppler test to detect blood clots in the leg
- How often is a doctor, nurse practitioner, or physician assistant present on site? (should be at least once or twice a week)
- What kind of specialty consultants come to the nursing home?
  - Psychiatry?
  - Wound care specialists?
  - Other medical or surgical specialists?
- When a new medicine is ordered, how long is it before it can be given to the resident? For example, if a resident has pneumonia and the doctor orders an antibiotic can it be started within 4 hours?
Item Summaries

Admissions Detail

**Admissions by Day of Week**

<table>
<thead>
<tr>
<th>Day</th>
<th>Number of Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td>0</td>
</tr>
<tr>
<td>Tuesday</td>
<td>0</td>
</tr>
<tr>
<td>Wednesday</td>
<td>0</td>
</tr>
<tr>
<td>Thursday</td>
<td>0</td>
</tr>
<tr>
<td>Friday</td>
<td>0</td>
</tr>
<tr>
<td>Saturday</td>
<td>0</td>
</tr>
<tr>
<td>Sunday</td>
<td>0</td>
</tr>
</tbody>
</table>

**Admissions by Hospital for the 5 hospitals from which you admit the most residents**

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Number of Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital A</td>
<td>Not recorded</td>
</tr>
<tr>
<td>Hospital B</td>
<td>0</td>
</tr>
</tbody>
</table>

**Admissions by Day of Week**

<table>
<thead>
<tr>
<th>Day</th>
<th>Percent of all Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td>n/a</td>
</tr>
<tr>
<td>Tuesday</td>
<td>n/a</td>
</tr>
<tr>
<td>Wednesday</td>
<td>n/a</td>
</tr>
<tr>
<td>Thursday</td>
<td>n/a</td>
</tr>
<tr>
<td>Friday</td>
<td>n/a</td>
</tr>
<tr>
<td>Saturday</td>
<td>n/a</td>
</tr>
<tr>
<td>Sunday</td>
<td>n/a</td>
</tr>
</tbody>
</table>

**Admissions by Hospital for the five hospitals from which our nursing home most frequently admits residents**

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Number of Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital C</td>
<td>0</td>
</tr>
</tbody>
</table>

Transfer Detail

**Transfers by Time of Day**

<table>
<thead>
<tr>
<th>Time of Day</th>
<th>Number of Transfers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morning</td>
<td></td>
</tr>
<tr>
<td>Afternoon</td>
<td></td>
</tr>
<tr>
<td>Evening</td>
<td></td>
</tr>
<tr>
<td>Night</td>
<td></td>
</tr>
</tbody>
</table>

**Transfers by Doctor for the 5 doctors who order the most transfers**

<table>
<thead>
<tr>
<th>Doctor</th>
<th>Number of Transfers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. A</td>
<td></td>
</tr>
<tr>
<td>Dr. B</td>
<td></td>
</tr>
<tr>
<td>Dr. C</td>
<td></td>
</tr>
<tr>
<td>Dr. D</td>
<td></td>
</tr>
<tr>
<td>Dr. E</td>
<td></td>
</tr>
</tbody>
</table>

**Transfers by Outcome**

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Number of Transfers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exit</td>
<td></td>
</tr>
<tr>
<td>Death</td>
<td></td>
</tr>
<tr>
<td>Transfer</td>
<td></td>
</tr>
</tbody>
</table>
### 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 June 2012 will not be final until you have completed your Transfer Log through:

**Tuesday, July 31, 2012**

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

#### Status at Time of Admission from Hospital

<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 Admitted This Month</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Purpose of Stay at Time of Transfer to Hospital</th>
<th>Post-Acute Type Care</th>
<th>Chronic Long Term Care</th>
<th>All Residents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Resident Days This Month</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Unplanned Hospital Admission Rate per 1000 resident days</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Rate of Transfers to Emergency Department Only per 1000 resident days</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Rate of Transfers Resulting in Observation Stay per 1000 resident days</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
</tbody>
</table>
Celebrate Your Success!
Thank you for helping us to help nursing homes become good places to live, work and visit

Mary Jane Koren, M.D., M.P.H.
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