National Nursing Home
QUALITY IMPROVEMENT CAMPAIGN

Look Inside!

Safely Reduce Hospitalizations Tracking Tool

This material was prepared by Telligen, National Nursing Home Quality Improvement Campaign contractor, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 11SOW-CO-NNHQIC-06/18-001

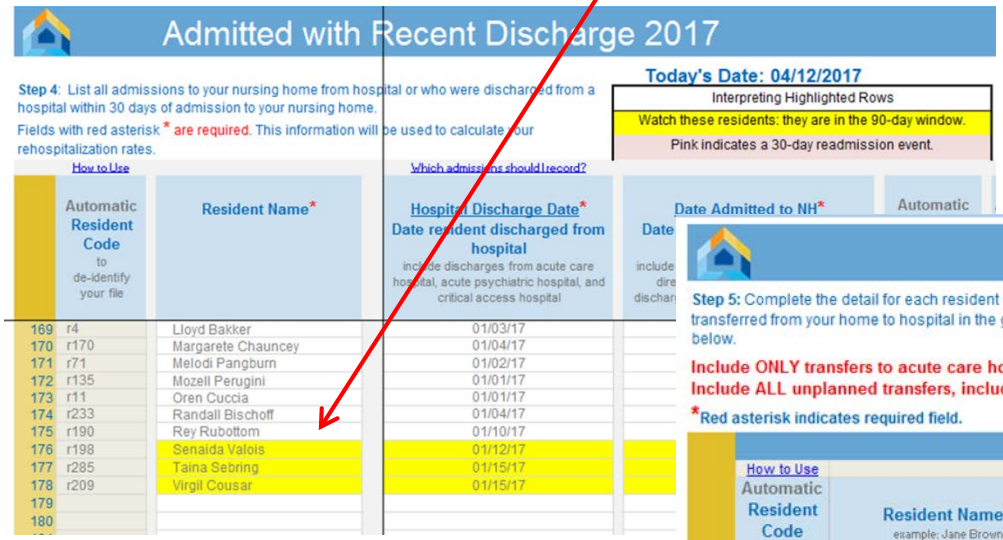
Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

Telligen

Even as you enter events the workbook provides actionable information.

As long as the date a resident was discharged from the hospital is within 90 days of the current date, their information will be highlighted yellow. This information can be used to prompt closer monitoring and early response to changes to avoid readmission.

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



Admitted with Recent Discharge 2017

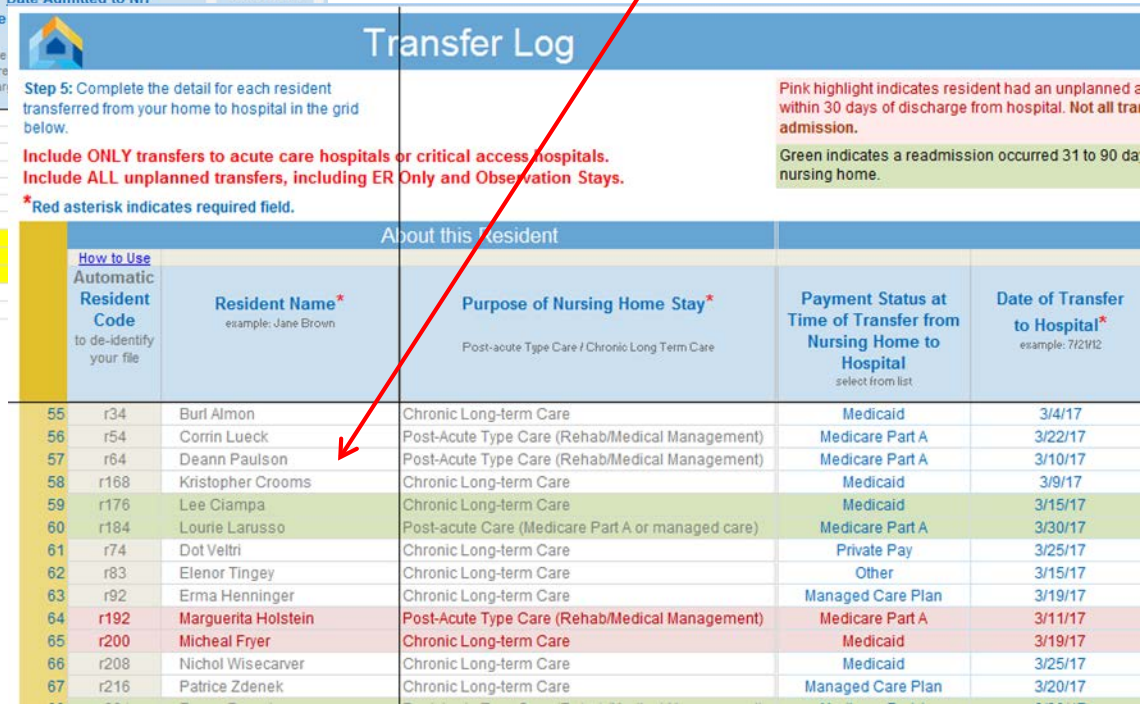
Step 4: List all admissions to your nursing home from hospital or who were discharged from a hospital within 30 days of admission to your nursing home.
Fields with red asterisk * are required. This information will be used to calculate your rehospitalization rates.

How to Use | Which admissions should I record?

Today's Date: 04/12/2017

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

	Automatic Resident Code (to de-identify your file)	Resident Name*	Hospital Discharge Date* Date resident discharged from hospital (include discharges from acute care hospital, acute psychiatric hospital, and critical access hospital)	Date Admitted to NH*	Automatic
169	r4	Lloyd Bakker	01/03/17		
170	r170	Margarete Chauncey	01/04/17		
171	r71	Melodi Pangburn	01/02/17		
172	r135	Mozell Perugini	01/01/17		
173	r11	Oren Cuccia	01/01/17		
174	r233	Randall Bischoff	01/04/17		
175	r190	Rey Rubottom	01/10/17		
176	r198	Senaida Valois	01/12/17		
177	r285	Taina Sebring	01/15/17		
178	r209	Virgil Cousar	01/15/17		
179					
180					



Transfer Log

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

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

*Red asterisk indicates required field.

Pink highlight indicates resident had an unplanned a within 30 days of discharge from hospital. Not all tra admission.

Green indicates a readmission occurred 31 to 90 da nursing home.

About this Resident

How to Use

	Automatic Resident Code (to de-identify your file)	Resident Name* (example: Jane Brown)	Purpose of Nursing Home Stay* (Post-acute Type Care / Chronic Long Term Care)	Payment Status at Time of Transfer from Nursing Home to Hospital (select from list)	Date of Transfer to Hospital* (example: 7/21/12)
55	r34	Burl Almon	Chronic Long-term Care	Medicaid	3/4/17
56	r54	Corrin Lueck	Post-Acute Type Care (Rehab/Medical Management)	Medicare Part A	3/22/17
57	r64	Deann Paulson	Post-Acute Type Care (Rehab/Medical Management)	Medicare Part A	3/10/17
58	r168	Kristopher Crooms	Chronic Long-term Care	Medicaid	3/9/17
59	r176	Lee Ciampa	Chronic Long-term Care	Medicaid	3/15/17
60	r184	Lourie Larusso	Post-acute Care (Medicare Part A or managed care)	Medicare Part A	3/30/17
61	r74	Dot Veltri	Chronic Long-term Care	Private Pay	3/25/17
62	r83	Elenor Tingey	Chronic Long-term Care	Other	3/15/17
63	r92	Erma Henninger	Chronic Long-term Care	Managed Care Plan	3/19/17
64	r192	Marguerita Holstein	Post-Acute Type Care (Rehab/Medical Management)	Medicare Part A	3/11/17
65	r200	Micheal Fryer	Chronic Long-term Care	Medicaid	3/19/17
66	r208	Nichol Wisecarver	Chronic Long-term Care	Medicaid	3/25/17
67	r216	Patrice Zdenek	Chronic Long-term Care	Managed Care Plan	3/20/17

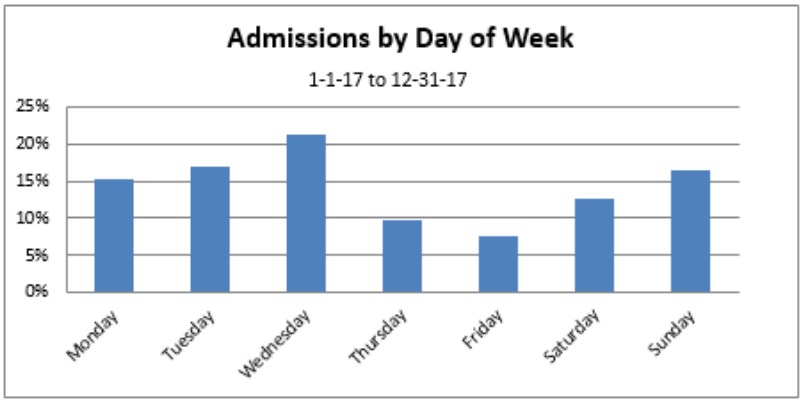
Item Summaries

Adjust dates for your Admissions report by editing the dates in the cells to the right.

Enter dates in the format mm/dd/yyyy

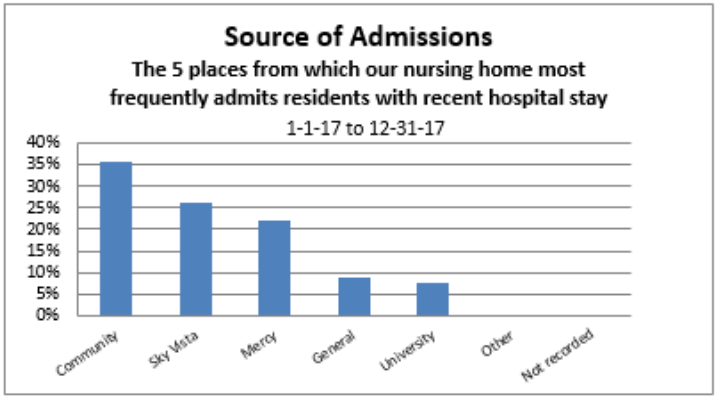
Admissions Detail		
	From	1/1/2017
	To	12/31/2017

Total Admissions in the Selected Timeframe	183



Admissions by Day of Week

	Number of Admissions	Percent of all Admissions
Monday	28	15.3%
Tuesday	31	16.9%
Wednesday	39	21.3%
Thursday	18	9.8%
Friday	14	7.7%
Saturday	23	12.6%
Sunday	30	16.4%



Source of Admissions
for the five places from which our nursing home most frequently admits residents with recent hospital stay

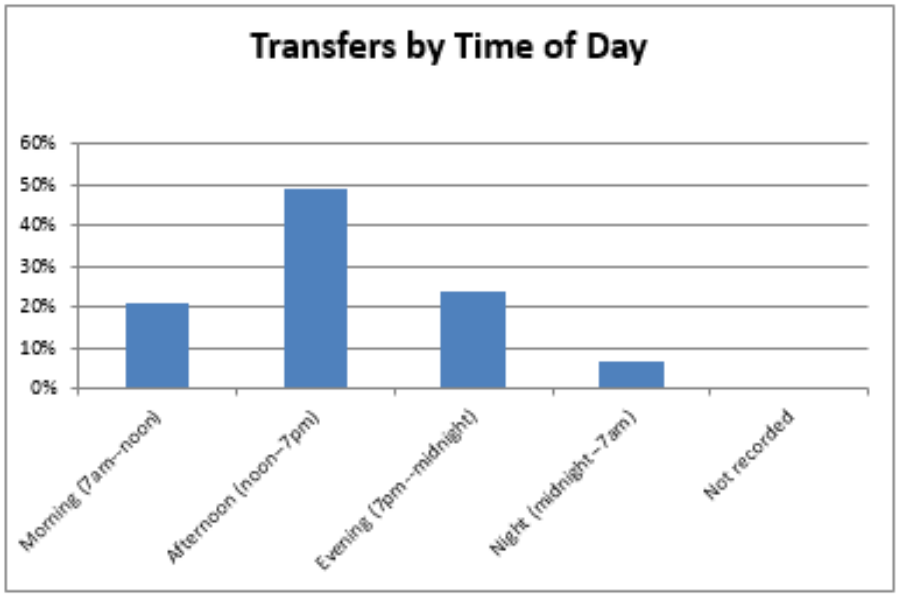
	Number of Admissions	Percent of all Admissions
Community	65	35.5%
Sky Vista	48	26.2%
Mercy	40	21.9%
General	16	8.7%
University	14	7.7%
Other	0	0.0%
Not recorded	0	0.0%

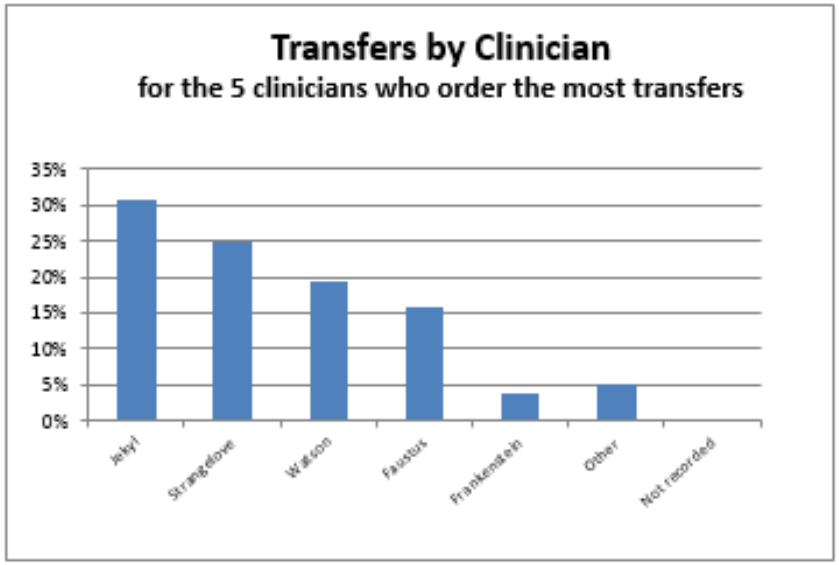
A variety of charts and graphs are provided *within* the workbook to make the most of the information you are entering. Each of these graphs provides potentially actionable information.

Transfers

Transfer Detail		
	From	1/1/2017
	To	12/31/2017

Total Transfers in the Selected Timeframe	228





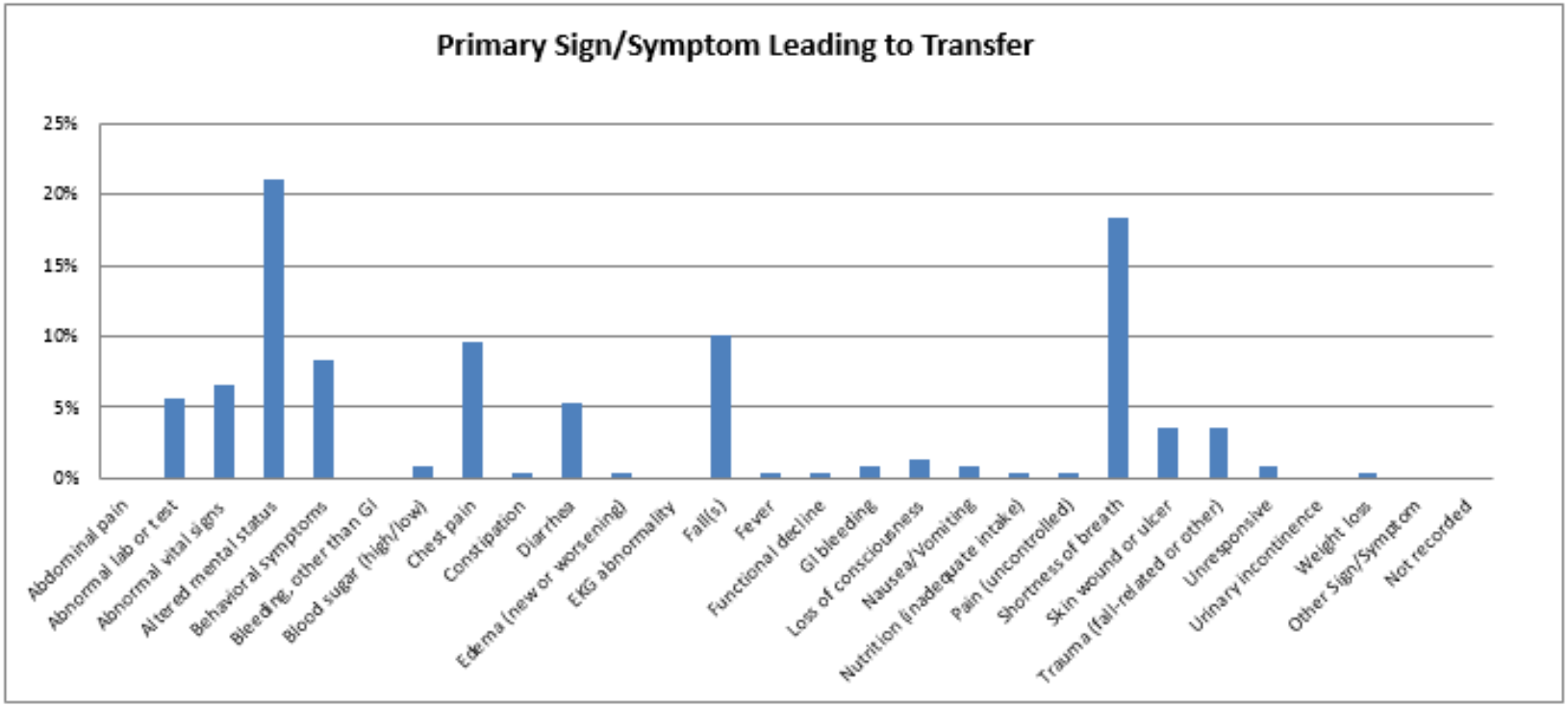
Transfers by Time of Day

	Number of Transfers	Percent of all Transfers
Morning (7am--noon)	48	21.1%
Afternoon (noon--7pm)	111	48.7%
Evening (7pm--midnight)	54	23.7%
Night (midnight--7am)	15	6.6%
Not recorded	0	0.0%

Transfers by Clinician
for the five clinicians who most frequently order transfer of residents to hospital

	Number of Transfers	all Transfers
Jekyl	70	30.7%
Strangelove	57	25.0%
Watson	44	19.3%
Faustus	36	15.8%
Frankenstein	9	3.9%
Other	12	5.3%
Not recorded	0	0.0%

Aggregate data on processes and patterns in hospital transfers can prompt questions about processes, help plan for good transfers, and identify potential change champions.

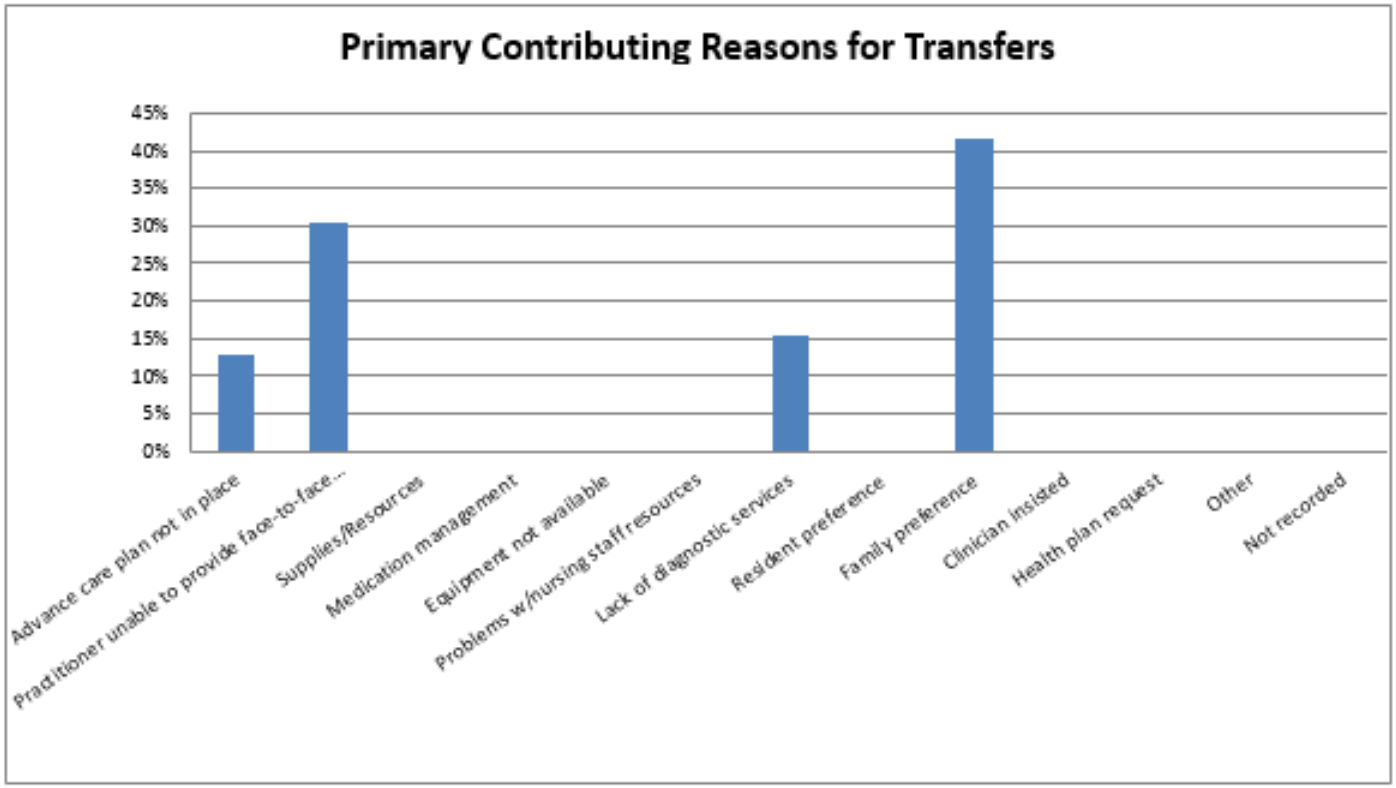


Primary Sign/Symptom Leading to Transfer

	Number of Transfers	Percent of all Transfers
Abdominal pain	0	0.0%
Abnormal lab or test	13	5.7%
Abnormal vital signs	15	6.6%
Altered mental status	48	21.1%
Behavioral symptoms	19	8.3%
Bleeding, other than GI	0	0.0%
Blood sugar (high/low)	2	0.9%
Chest pain	22	9.6%
Constipation	1	0.4%
Diarrhea	12	5.3%
Edema (new or worsening)	1	0.4%
EKG abnormality	0	0.0%
Fall(s)	23	10.1%
Fever	1	0.4%

Summary data on reasons for transfer may point to opportunities to improve staff competence or confidence in addressing changes in condition.

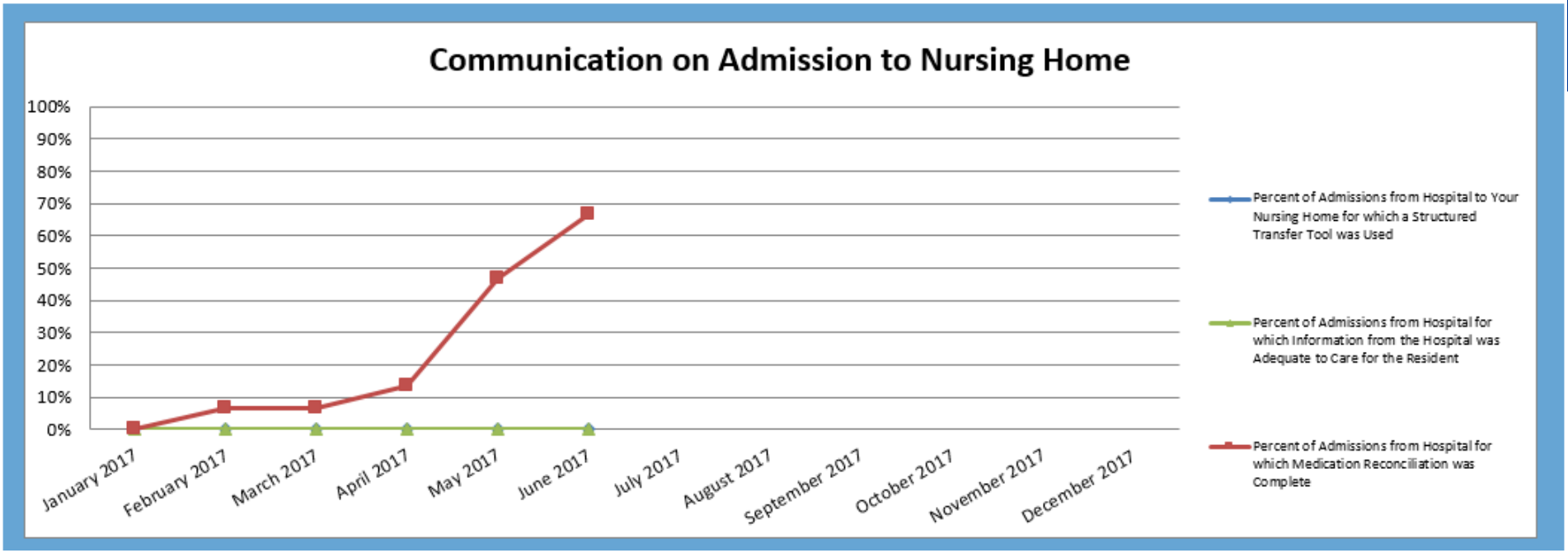
Knowing which symptoms most frequently trigger transfers can help prioritize trainings or new processes, like care pathways or Change in Condition File Cards from INTERACT.



Non-clinical reasons for transfer may point to opportunities for process improvement, education, and human or material resource availability.

The Campaign has identified specific resources that can help you leverage this information for improvement.

Process Tracking

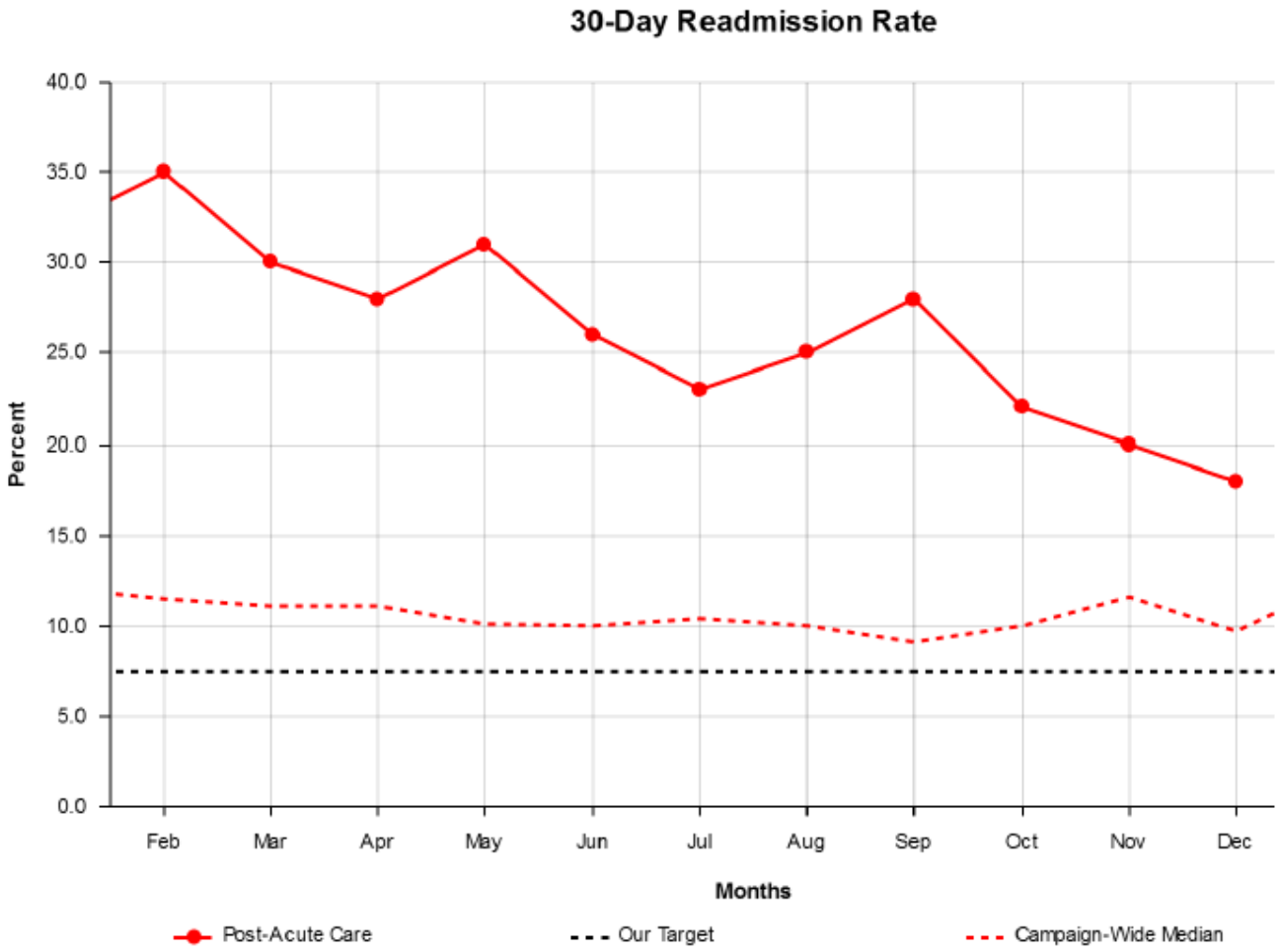


There are options to track your progress implementing new processes, both as you are admitting residents transferred from hospital and as you are transferring.

Examples include:

- Using a structured transfer tool
- Performing a systematic medication reconciliation
- Reviewing Advance Care Plan prior to transfer
- Implementing the Transfer SBAR

Website Data Displays



Transfer your monthly outcomes to the website for continuous trend graphs of each outcome. Great for sharing with your Quality Council, Staff, and community.

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

Next Steps

From the Campaign home page www.nhQualityCampaign.org

- Choose “Goals” then “Hospitalizations”
- Click on the second tab within Hospitalizations for the Tracking Tool page.
- Scroll down and get the “Tips for Getting Started”
- Download the Excel workbook. It’s hiding inside a Zip folder for faster download.

Please let us hear from you!

Our HelpDesk is available weekdays and can help with project design, data collection, interpreting results and exploring next steps.

www.nhQualityCampaign.org