


# Preventing Hospital Readmissions:


## The Long Term Care Perspective



MIDCOAST MAINE'S  
PREMIER EXTENDED CARE  
COMMUNITY FOR ADULTS 55+

# Learning Objectives

Participants in this session will:

- Explore the dynamics of reducing hospital readmissions—our LTC perspective
  - Become familiar with the INTERACT program and tools
- 

# Key Initiatives

- Physician Specialist Program
- Maine Health Falls Management Program
- UTI Prevention Program
- Continuity of Care Team—PBH
- INTERACT II

# Quarry Hill Retirement Community

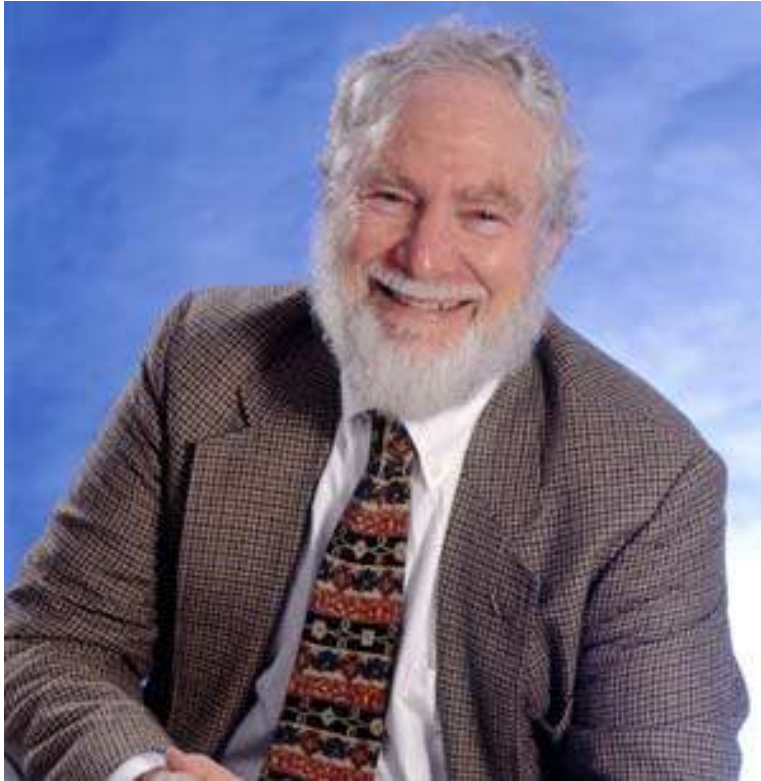
- Full spectrum retirement community located on 28 acres in Camden, Maine
- 45 Cottages
- Anderson Inn
  - 37 Independent Living Apartments
  - 60 Assisted Living Apartments
  - 24 AL Apartments—Memory Impairment
  - 39 Dually licensed SNF/NF Beds



- AMBULANCE
- OFFICE
- LABORATORY
- RESIDENTS



# Physician Specialist Program



## Dr. Richard Kahn

Respected, local internist

### Goals:

- +Improve Access
- +Convenience for Residents
- +Improved Communication
- +Reduce Avoidable Hospitalizations

= Overall Improved Quality and Resident Satisfaction

# MaineHealth Elder Care Services

## Falls Prevention Workgroup

### Goal

Implement a system wide fall prevention initiative across the long-term care continuum resulting in a decrease in falls and fall-related injuries.



# Falls Prevention Workgroup for Senior Living



Carmen Edwards, RN  
Pen Bay Healthcare- Quarry Hill

Elaine McMahon, RN  
MaineHealth Elder Care Services

Deborah French, RN  
Maine General Rehabilitation & Nursing at Glenridge

Jodi Mulholland, RN  
Maine General Rehabilitation & Nursing at Glenridge

Holly Harmon, RN  
LCHC-Cove's Edge

Kathleen Murphy, RN  
St Mary's d`Youville Pavilion

Michael Lee, MBA  
LCHC-St Andrews Village

Wendy Roberts, MPA  
LCHC-Cove's Edge

Rich Marino, MD  
MMC Div. of Geriatrics

Sue Sesto, PT  
HomeHealth Visiting Nurses of Southern Maine

Sherry McCormick, RN  
LCHC-Chase Point

Judy Sweeney, PT, MBA  
New England Rehabilitation Hospital

Cindy McCrum,  
LCHC-Chase Point


Judy Tierney  
MaineHealth Elder Care Services

Judy McGuire, MBA  
Lincoln County Healthcare (LCHC)

# Falls Prevention Workgroup

- Adapted *The Falls Management Program* (FMP)--Emory University with support from the Agency for Healthcare Research and Quality
- Interdisciplinary quality improvement initiative designed to assist nursing facilities in providing individualized, person-centered care, and improving their fall care processes and outcomes through educational and quality improvement tools.

# Falls Prevention Workgroup

- Education, Education, Education
  - Enhanced existing admission fall assessment
  - Created Multi-Disciplinary Falls Committee
  - Implemented Tracking Record for Improving Patient Safety (TRIPS) Form
- 

LABEL
-------

**TRIPS – Tracking Record for Improving Patient Safety**

Level of care:  Independent Living    Skilled Nursing    Assisted Living    Memory Impaired  
 Nursing Facility    Home Health    Rehabilitation    Hospice

**SECTION A**

**Date of Incident** \_\_\_\_\_

**Time of Incident** \_\_\_\_\_

**Day of Week**

- Sunday
- Monday
- Tuesday
- Wednesday
- Thursday
- Friday
- Saturday

**Severity Level (check highest level of injury)**

- 0. No injury
- 1. Minor injury (ex: bruise, abrasion, minor laceration) Injuries are minor in nature, and if they do require any medical intervention, they do not require a hospital stay except for observation or to obtain lab and/or radiology results.
- 2. Major injury (ex: fracture, brain injury) Injuries which requires hospital stay, or are disabling and/or disfiguring to a degree that the patient will have any degree of permanent lessened function.

**Location**

- Person's room
- Person's bathroom
- Another's room/bathroom
- Hallway
- Dining room/living room
- Kitchen
- Therapy room
- Activity room
- Shower/tub room
- Outside building
- Other (specify): \_\_\_\_\_

**Treatment –(If Severity Level 1 or 2 check all that apply)**

- First aid (ex. ice, ointment, bandage)
- Primary care provider for evaluation
- Transfer to Emergency Dept.
- Admit to hospital
- Neurological monitoring initiated
- Sutures
- X-ray
- Blood work
- Urinalysis
- Other (specify): \_\_\_\_\_

YES	NO		Date	Time
<input type="checkbox"/>	<input type="checkbox"/>	<b>Physician notified</b>		
		Physician name: _____		
<input type="checkbox"/>	<input type="checkbox"/>	<b>Family/POA notified</b>		
		Name of contact: _____		
<input type="checkbox"/>	<input type="checkbox"/>	<b>Pharmacist notified for medication review</b>		
		Pharmacist name: _____		
<input type="checkbox"/>	<input type="checkbox"/>	<b>Process for follow-up documentation initiated</b>		
<input type="checkbox"/>	<input type="checkbox"/>	<b>Plan of care reviewed</b>		

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**SECTION B Name:** \_\_\_\_\_



**1. Was the incident a:**

- Found on the floor (unwitnessed)
- Fall to the floor (witnessed)
- Near fall (resident lowered to floor by staff/volunteer or stabilized)
- Self-reported fall
- Reported by other person

**2. The activity during the incident was:**

- Ambulating
- Transferring in/out of bed
- Transferring on/off toilet
- Transferring in/out of chair/wheelchair
- Sliding out of wheelchair
- Changing clothes/other ADLs
- Transferring in/out of tub or shower
- Reaching for something
- Staff transport
- Other (specify): \_\_\_\_\_

**3. The footwear at the time of the incident was:**

- Shoes
- Slippers
- Plain socks only
- Non-skid socks
- TED/compression stockings
- Bare feet

**4. Indicate mobility aid(s) in use at the time of the incident:**  None

- Cane
- Transfer/grab bar
- Wheelchair
- Walker
- Merry walker
- Slide board
- Crutches
- Motorized wheelchair
- Scooter
- Rollator
- Mechanical lift
- Other (specify): \_\_\_\_\_

**5. Indicate protective devices/strategies in use at time :**

- |  |  |
|--|--|
| <input type="checkbox"/> Hi/low bed in use     | <input type="checkbox"/> Lap buddy/lap tray      |
| <input type="checkbox"/> Bed against wall      | <input type="checkbox"/> Seat belt               |
| <input type="checkbox"/> Landing strip(s)      | <input type="checkbox"/> Anti- roll back device  |
| <input type="checkbox"/> Floor mat(s)          | <input type="checkbox"/> Anti-tip device         |
| <input type="checkbox"/> Hip protectors        | <input type="checkbox"/> Foot rests in use       |
| <input type="checkbox"/> Geri chair with table | <input type="checkbox"/> Bed assist/transfer bar |
| <input type="checkbox"/> Gait belt             | <input type="checkbox"/> Side rails              |

- Anti-slip/Dycem
- Other (specify): \_\_\_\_\_

**6. Was alarm present?(check all that apply)  Yes  No**

- Bed alarm sounded during event
- Bed alarm did not sound during event
- Chair alarm sounded during event
- Chair alarm did not sound during event
- Tab alarm sounded during event
- Tab alarm did not sound during event
- Motion alarm sounded during event
- Motion alarm did not sound during event

**7. Contributing factor (s) (check all that apply):**

- Lost balance
- Slipped (specify): \_\_\_\_\_
- Lost strength/weakness
- Tripped on \_\_\_\_\_
- Lost consciousness/seizure
- Poor vision
- Medication change in last 7 days
- Brakes unlocked
- Bed height
- Equipment malfunction (specify): \_\_\_\_\_
- Improper use of equipment or aid (specify): \_\_\_\_\_
- Environmental factor (i.e. clutter, inadeq. lighting) (specify): \_\_\_\_\_

**Inappropriate footwear**

- No tread or tread too high/thick
- High/narrow heel
- Poor fit/loose
- Other (specify): \_\_\_\_\_

**As a result of this incident:**

**8. Did mental status change?**

- Yes  No

**9. Did level of consciousness change?**

- Yes  No

**Vital Signs**

- 10. Blood pressure:** \_\_\_\_\_
- 11. Pulse:** \_\_\_\_\_
- 12. Temperature:** \_\_\_\_\_
- 13. O<sub>2</sub> saturation:** \_\_\_\_\_
- 14. Finger stick blood sugar:** \_\_\_\_\_

Name: \_\_\_\_\_

**15. Orthostatic vital signs:** (record values at 2 minute intervals)

Lying: Blood Pressure \_\_\_\_\_ / \_\_\_\_\_ Pulse: \_\_\_\_\_  
 Sitting: Blood Pressure \_\_\_\_\_ / \_\_\_\_\_ Pulse: \_\_\_\_\_  
 Standing: Blood Pressure \_\_\_\_\_ / \_\_\_\_\_ Pulse: \_\_\_\_\_

**16. Was there an injury as a result of the fall?**  Yes  No

If injury, indicate site(s) injured in first column, and the type of injury for each site checked ("X" all that apply):

INJURY SITE	Left	Right	Bruise, skin tear or abrasion, laceration without suture	Laceration w/ sutures	Fracture	Closed head injury
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Pain**

**17. Was pain present prior to the fall?**  Yes  No  
 If yes, location: \_\_\_\_\_

**18. Was an analgesic given prior to fall?**  Yes  No

**19. Was there an increase or change in pain as a result of the incident?**  Yes  No  
 If yes, explain: \_\_\_\_\_

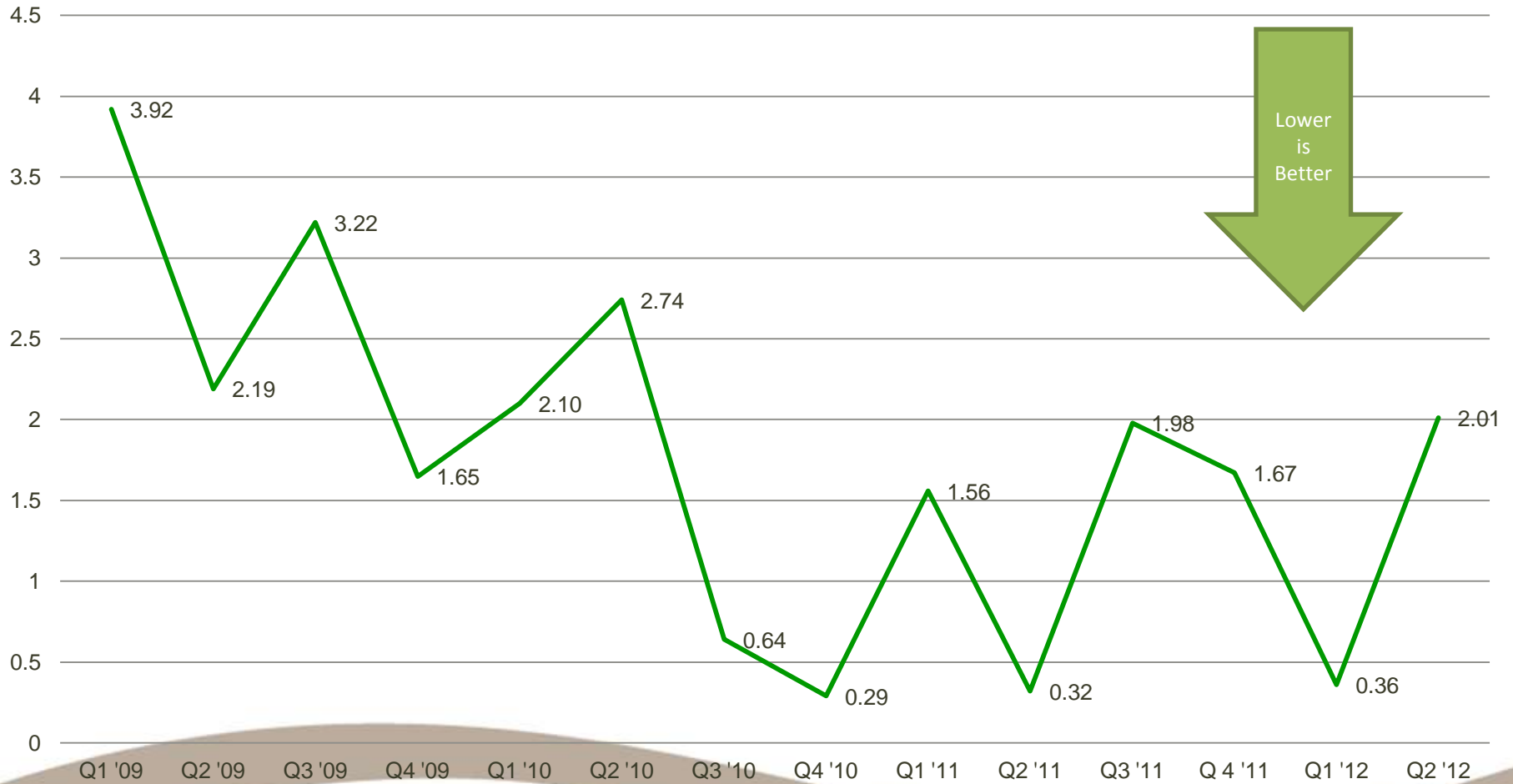
**20.  Plan of care updated** Date: \_\_\_\_\_

**21. Was this person in *The Falls Management Program* at the time of the fall?**  
 N/A (not applicable)  
 Yes If yes, send fax alert to physician and enter date in FMP Entry Log  
 No If no, enroll in *The Falls Management Program* and enter name and date in FMP Entry Log

If necessary, please provide a brief narrative of this incident:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

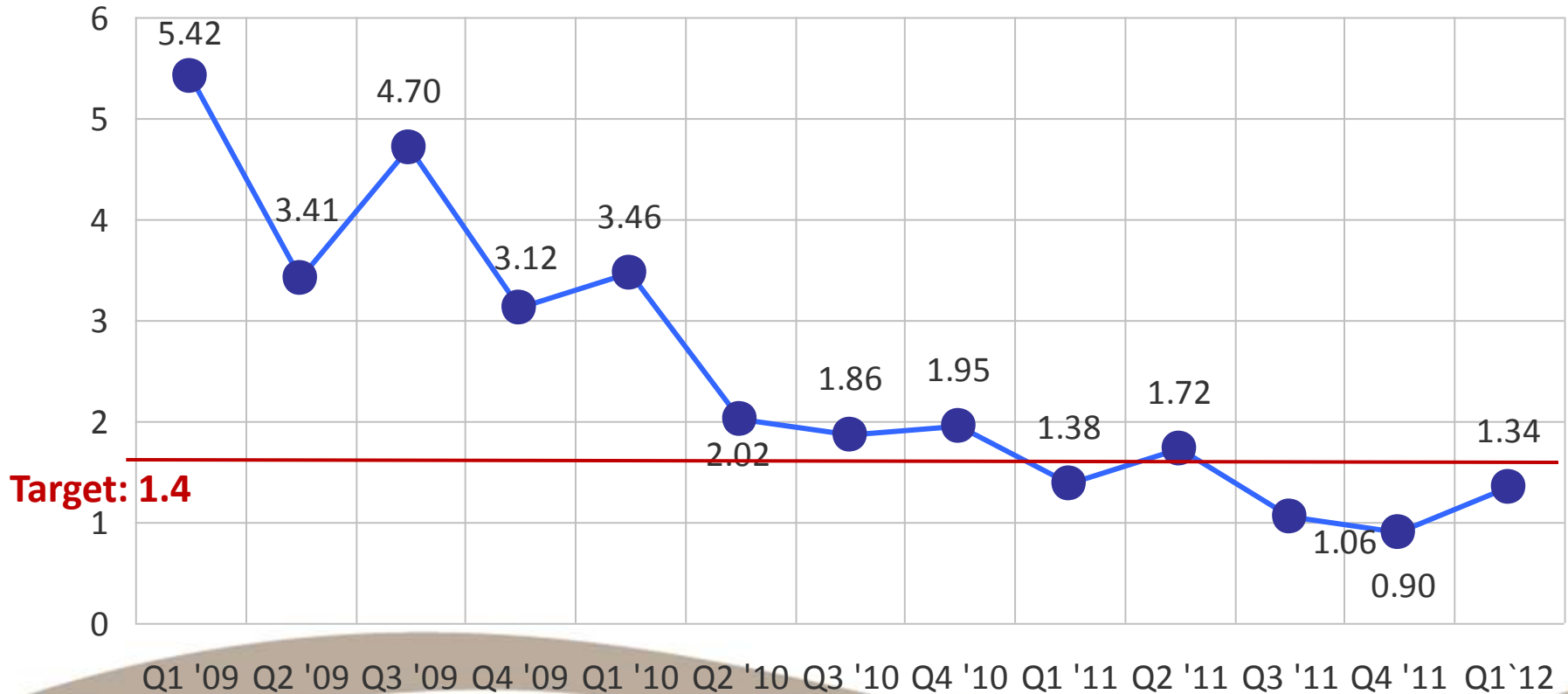
## Falls with Injury Rate per 1,000 bed days of care



# Falls Prevention Workgroup for Senior Living

## Falls with Injury Rate for SNF/NF

Minor & major injuries/1000 bed days of care





# Falls Prevention Workgroup for Senior Living

2012 Innovative Programming Award  
Maine Health Care Association




# UTI Prevention

- Increased Staff & Resident Education
- Following CDC Guidelines for CAUTI
- Purchased Bladder Scan equipment
- Reporting stats Quarterly to Hospital Infection Prevention Committee regarding numbers of CAUTI vs. UTI w/out catheter

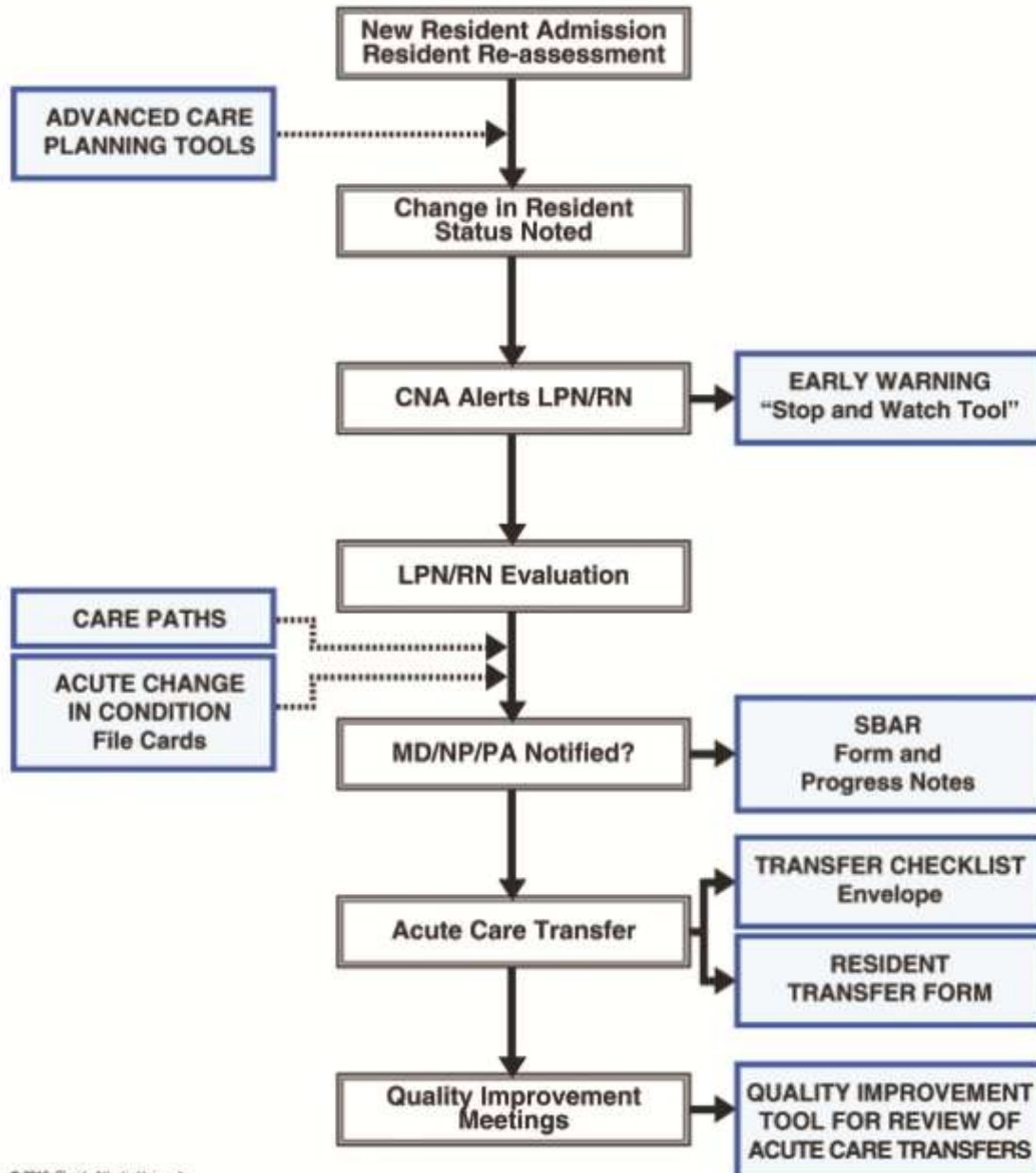
# Continuity of Care Committee

- Meets every other month
- Hospital Patient Care Coordinators & Leaders
- Home Care Intake & Leaders
- Long Term Care Admissions & Leaders
- Community Partners
- Transitions Coaches
- Focus Case Reviews—Alternate Months

# INTERACT

- **I**nterventions to
  - **R**educe
  - **A**cute
  - **C**are
  - **T**ransfers
- 

# Using the INTERACT<sup>II</sup> Tools in Every Day Work in the Nursing Home





## EARLY WARNING TOOL

**"Stop and Watch"**

If you have identified an important change while caring for a resident today, please circle the change and discuss it with the charge nurse before the end of your shift.

Name of Resident \_\_\_\_\_

- S**eems different than usual
- T**alks or communicates less than usual
- O**verall needs more help than usual
- P**articipated in activities less than usual

**A**te less than usual (Not because of dislike of food)

**N**

**D**rank less than usual

**W**eight change

**A**gitated or nervous more than usual

**T**ired, weak, confused, or drowsy

**C**hange in skin color or condition

**H**elp with walking, transferring, toileting more than usual

Staff \_\_\_\_\_

Reported to \_\_\_\_\_

Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Time \_\_\_\_\_

**Change in Condition:**  
When to report to the MD/NP/PA



**Immediate Notification:**

Any symptom, sign or apparent discomfort that is:

1. **Sudden** in onset
2. **A marked change** (i.e. more severe) in relation to usual symptoms and signs
3. **Unrelieved** by measures already prescribed

**Sources:**

AMOA Clinical Practice Guideline – Acute Changes in Condition in the Long-Term Care Setting 2003, Outlander, J, Osterweil, D, Morley, J. *Medical Care in the Nursing Home*, McGraw-Hill, 1996

This document was prepared by INTERACT, the Interdisciplinary Quality Improvement Organization for Seniors, under contract with the Center for Seniors & Assisted Services, CDS, an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CDS policy. Publication No. B30W-SA-NE08-07

**Vital Signs**  
(Report Why Vital Signs Were Taken)



Vital Sign	Report Immediately	Report on Next Work Day
Blood Pressure Pulse Respiratory Rate	<ul style="list-style-type: none"> <li>Systolic BP &gt; 210 mmHg, &lt; 90 mmHg</li> <li>Diastolic BP &gt; 115 mmHg</li> <li>Resting pulse &gt; 130 bpm, &lt; 55 bpm, or &gt; 110 bpm and patient has dyspnea or palpitations</li> <li>Respirations &gt; 28, &lt; 10/minute</li> <li>Oral (electric thermometer) temperature &gt; 101°F</li> </ul>	<ul style="list-style-type: none"> <li>Diastolic BP routinely &gt; 90 mmHg</li> <li>Resting pulse &gt; 120 bpm on repeat exam</li> </ul>
Weight Loss		<ul style="list-style-type: none"> <li>New Onset of anorexia with or without weight loss</li> <li>5% or more within 30 days</li> <li>10% or more within 6 months</li> </ul>

**Laboratory Tests/Diagnostic Procedures**  
(Report Why the Test or Procedure was Done)



Test/Procedure	Report Immediately	Report on Next Work Day
Complete Blood Count	<ul style="list-style-type: none"> <li>WBC &gt; 42,000</li> <li>Neutrophils &gt; 80% &lt; 4%</li> <li>Hemoglobin &lt; 2%</li> <li>Platelets &lt; 50,000</li> </ul>	WBC > 10,000 without symptoms of fever
Chemistry	<ul style="list-style-type: none"> <li>Blood Urea Nitrogen (BUN) &gt; 60 mg/dL</li> <li>Calcium (Ca) &lt; 12.5 mg/dL</li> <li>Potassium (K) &lt; 3.5, &gt; 6.0 mg/dL</li> <li>Sodium (Na) &lt; 125, &gt; 155 mg/dL</li> <li>Blood Glucose                             <ul style="list-style-type: none"> <li>&gt; 300 mg/dL in diabetic patient not using sliding scale insulin</li> <li>&gt; 420 mg/dL (or machine registers high) in diabetic patients using sliding scale insulin</li> <li>&gt; 170 mg/dL in diabetic patient</li> <li>&gt; 470 mg/dL in non-diabetic patient</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Glucose consistently &gt; 200 mg/dL</li> <li>Hb A1c (any value)</li> <li>Albumin (any value)</li> <li>Bilirubin (any value)</li> <li>Cholesterol (any value)</li> <li>Triglycerides (any value)</li> <li>Other chemistry values</li> </ul>
Consult Reports	Consultant report recommending immediate action or changes in patient's management by the MD	Routine consultant report recommending routine action or changes in patient's management
Drug Levels	Levels above therapeutic range of any drug (not renal dose)	Any therapeutic or low level, unless resident shows evidence of possible adverse drug reaction despite therapeutic or low result
Prothrombin Time (PT) International Normalized Ratio (INR)	All INRs should be reported on the day they are drawn	
Urinalysis	Abnormal result in patient with signs and symptoms possibly related to urinary tract infection or uropathy (e.g., fever, burning sensation, pain/abnormal mental status)	Abnormal result in patient with no signs or symptoms
Urine Culture	> 100,000 colony count with symptoms	Any colony count, no symptoms
X-ray	New or unsuspected finding (e.g., fracture, pneumonia, CHF)	Old or long-standing finding, no change

**Signs & Symptoms**  
A's



Symptom or Sign	Immediate	Non-Immediate	Routine
	(Notify the attending or on-call MD, NP, or PA on call as soon as possible)	(Notify the attending or on-call MD, NP, or PA no later than the next work day)	(Notify the attending or on-call MD, NP, or PA no later than the next regular visit or phone or fax communication)
Abdominal Pain	Abrupt onset severe pain or distention, (3) with fever, vomiting	Moderate diffuse or localized pain, unrelieved by antacids or laxatives	Persistent mild to moderate discomfort, without associated symptoms
Abdominal distention	Rapid onset, CR presence of marked tenderness, fever, vomiting, GI bleeding	Progressive or persistent distention not associated with symptoms	Gradual increase in abdominal girth not associated with acute symptoms
Abdominal discomfort (e.g., bloating, cramps, etc.)	Associated with fever, continuous GI bleeding, or other acute symptoms	Persistent discomfort not associated with other acute symptoms	Mild or occasional discomfort but not persistent
Admission	Accompanied by significant pain or bleeding	If bleeding continues or if associated with evidence of local infection	N/A
Agitation or behavioral instability	Abrupt onset of significant change from usual, CR associated with fever or new onset abnormal neurological signs	Confused progression or persistence of symptoms	Gradually progressive or persistent decline
Anorexia, decreased	N/A	Significant decline in food and fluid intake of someone with marginal hydration and nutritional status	Frequent or persistent poor appetite with gradual weight loss
Asthma	Acute episode with wheezing, dyspnea, or respiratory distress	Self limited episode that was more extensive or less responsive to treatment than the usual	N/A

# SBAR

Physician/NP/PA Communication and Progress Note  
For New Symptoms, Signs and Other Changes in Condition



## Before Calling MD/NP/PA:

- Evaluate the resident and 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: recent progress notes, labs, orders
- Review relevant INTERACT II Care Path or Acute Change in Status File Card
- 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

The symptom/sign/change I'm calling about is \_\_\_\_\_

This started \_\_\_\_\_

This has gotten (circle one) worse/better/stayed the same since it started

Things that make the condition worse are \_\_\_\_\_

Things that make the condition better are \_\_\_\_\_

Other things that have occurred with this change are \_\_\_\_\_

## B BACKGROUND

Primary diagnosis and/or reason resident is at the nursing home \_\_\_\_\_

Pertinent history (e.g. recent falls, fever, decreased intake, pain, SOB, other) \_\_\_\_\_

Vital signs BP \_\_\_\_\_ / \_\_\_\_\_ HR \_\_\_\_\_ RR \_\_\_\_\_ Temp \_\_\_\_\_

Pulse Oximetry \_\_\_\_\_ % On RA \_\_\_\_\_ on O2 at \_\_\_\_\_ L/min via \_\_\_\_\_ (NC, mask)

Change in function or mobility \_\_\_\_\_

Medication changes or new orders in the last two weeks \_\_\_\_\_

Mental status changes (e.g. confusion/agitation/lethargy) \_\_\_\_\_

GI/GU changes (circle) (e.g. nausea/vomiting/diarrhea/impaction/distension/decreased urinary output/other) \_\_\_\_\_

Pain level/location \_\_\_\_\_

Change in intake/hydration \_\_\_\_\_

Change in skin or wound status \_\_\_\_\_

Labs \_\_\_\_\_

Advance directives (circle) (Full code, DNR, DNI, DNH, other, not documented)

Allergies \_\_\_\_\_ Any other data \_\_\_\_\_

## A ASSESSMENT (RN) OR APPEARANCE (LPN)

(For RNs): What do you think is going on with the resident? (e.g. cardiac, 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 resident appears (e.g. SOB, in pain, more confused) \_\_\_\_\_

## R REQUEST

I suggest or request (check all that apply):

- |   |  |
|---|--|
| <input type="checkbox"/> Provider visit (MD/NP/PA)          | <input type="checkbox"/> Monitor vital signs and observe |
| <input type="checkbox"/> Lab work, x-rays, EKG, other tests | <input type="checkbox"/> Change in current orders _____  |
| <input type="checkbox"/> IV or SC fluids                    | <input type="checkbox"/> New orders _____                |
| <input type="checkbox"/> Other (specify) _____              | <input type="checkbox"/> Transfer to the hospital        |

Staff name \_\_\_\_\_ RN/LPN

Reported to: Name \_\_\_\_\_ (MD/NP/PA) Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Time \_\_\_\_\_ a.m./p.m.

If to MD/NP/PA, communicated by:  Phone  In person

Resident name \_\_\_\_\_



# QUALITY IMPROVEMENT TOOL



The goal of this tool is to review transfers in order to identify opportunities to improve the identification, evaluation, and management of changes in resident condition and other situations that commonly result in transfers, and when feasible and safe, to prevent transfers to the hospital. This tool is intended to be completed retrospectively after the transfer to look back and identify opportunities for improvement in reducing preventable transfers.

## Section 1: BACKGROUND INFORMATION

Resident's Last Name	First Name	Age	Unit/Room #
----------------------	------------	-----	-------------

a. Date of most recent admission to nursing home: \_\_\_\_/\_\_\_\_/\_\_\_\_

b. Resident hospitalized in the past 12 months?  No  Yes **If yes, list dates and reasons below:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Section 2: DESCRIBE THE ACUTE CHANGE IN CONDITION THAT LED TO TRANSFER

Date the change in condition first noticed: \_\_\_\_/\_\_\_\_/\_\_\_\_

a. Check all that apply:

- |   |  |  |  |
|---|--|--|--|
| <b>CHANGE IN:</b><br><input type="checkbox"/> Appetite/intake<br><input type="checkbox"/> Behavior<br><input type="checkbox"/> Function<br><input type="checkbox"/> Skin or a wound | <b>NEW CONDITION:</b><br><input type="checkbox"/> Bleeding<br><input type="checkbox"/> Breathing difficulty or SOB<br><input type="checkbox"/> Constipation<br><input type="checkbox"/> Diarrhea<br><input type="checkbox"/> Fall<br><input type="checkbox"/> Pain (new or worsened)<br><input type="checkbox"/> Other (specify) _____ | <b>NEW SYMPTOM(S)/SIGN(S) OF:</b><br><input type="checkbox"/> Altered mental status<br><input type="checkbox"/> Congestive heart failure<br><input type="checkbox"/> Dehydration<br><input type="checkbox"/> Fever<br><input type="checkbox"/> Lower respiratory infection<br><input type="checkbox"/> Urinary tract infection | <b>OTHER CHANGE:</b><br><input type="checkbox"/> Abnormal lab value(s)<br><input type="checkbox"/> Abnormal vital signs<br><input type="checkbox"/> Family concern<br><input type="checkbox"/> Other (specify) _____ |
|---|--|--|--|

b. Briefly describe the symptom, sign or change in condition that led to the transfer:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Section 3: EVALUATION AND MANAGEMENT

a. Check all that apply:

- |  |   |  |  |
|--|---|--|--|
| <b>TOOLS USED:</b><br><input type="checkbox"/> Stop and Watch<br><input type="checkbox"/> SBAR Progress Note<br><input type="checkbox"/> Care Path<br><input type="checkbox"/> Change in Condition Cards | <b>MEDICAL EVALUATION:</b><br><input type="checkbox"/> Telephone only<br><input type="checkbox"/> On-site visit - MD<br><input type="checkbox"/> On-site visit - NP or PA | <b>TESTING:</b><br><input type="checkbox"/> Blood tests<br><input type="checkbox"/> Urinalysis or culture<br><input type="checkbox"/> Xray<br><input type="checkbox"/> Other (specify) _____ | <b>INTERVENTIONS:</b><br><input type="checkbox"/> New medication<br><input type="checkbox"/> IV or SC fluids<br><input type="checkbox"/> Other (specify) _____ |
|--|---|--|--|

b. Briefly describe how the symptoms, signs, or change was evaluated and managed before hospital transfer:

\_\_\_\_\_  
\_\_\_\_\_

c. Was advanced care planning (e.g. DNR, DNH, palliative or hospice care) discussed?  No  Yes

d. Was the resident transferred to the hospital?  No (skip to Section 5)  Yes (complete Sections 4 and 5)

## Section 4: TRANSFER INFORMATION

Date of transfer: \_\_\_\_/\_\_\_\_/\_\_\_\_ Day (circle): M T W Th F Sa Su Time of transfer: \_\_\_\_ a.m./p.m.

MD authorizing transfer:  Primary MD  Covering MD  Other (\_\_\_\_\_)

a. What contributed to the transfer? (Check all that apply):

- |   |  |
|---|--|
| <input type="checkbox"/> Abnormal vital signs<br><input type="checkbox"/> Abnormal lab(s)<br><input type="checkbox"/> Injury<br><input type="checkbox"/> Worsening condition despite intervention | <input type="checkbox"/> MD insisted on transfer<br><input type="checkbox"/> Resident preference or insistence<br><input type="checkbox"/> Family preference or insistence<br><input type="checkbox"/> Other (specify) _____ |
|---|--|

b. Briefly describe the main reason(s) for transfer:

\_\_\_\_\_  
\_\_\_\_\_

## Section 5: OPPORTUNITIES FOR IMPROVEMENT

a. After review of how the new symptoms, signs, or other change were evaluated and managed, has your team identified any opportunities for improvement?  No  Yes **If yes, describe briefly**

\_\_\_\_\_  
\_\_\_\_\_

b. In retrospect, does your team think this transfer might have been prevented?

No  Yes **If yes, check all that apply and describe briefly**

- |   |
|---|
| <input type="checkbox"/> The new sign, symptom, or other change might have been detected earlier<br><input type="checkbox"/> The condition might have been managed safely in the facility without transfer<br><input type="checkbox"/> Advance directives and/or palliative or hospice care could have been discussed<br><input type="checkbox"/> Other (specify) _____ |
|---|

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name of person completing form

Date of completion

# American Health Care Association

- By March 2015, reduce the number of hospital readmissions within 30 days during a SNF stay by 15 percent

## THE GOALS

1. Safely Reduce Hospital Readmissions
2. Increase Staff Stability
3. Increase Customer Satisfaction
4. Safely Reduce the Off-Label Use of Antipsychotics

## THE BUSINESS CASE

*Reasons why achieving this goal will improve your organization*

**TARGET:** *Safely reduce the number of hospital readmissions within 30 days during a SNF stay by 15 percent, by March 2015.*

### QUALITY OUTCOMES

- ▶ Decreases health care-acquired (HAC) issues, resulting in less opportunity for skin breakdown, injury or harm from transfers.
- ▶ Decreases the exacerbation of symptoms for people with dementia.
- ▶ As a result of managed clinical care transfers; transfers to the hospital are more appropriate.
- ▶ By increasing the nursing skill set, improves care and prevents relapses in acute medical conditions.
- ▶ Centers that utilize physician extenders are more likely to have better quality outcomes because assessments are more thorough.

### STAFF STABILITY

- ▶ Means less stress for nurses who must take time for the readmission and transfer requirements.
- ▶ By upgrading nursing skills, nurses' satisfaction can improve. This may also attract more qualified nurses, which can help to ensure that readmissions are appropriate.
- ▶ Respect for clinical skills of staff by referral sources will grow and result in better physician relations.
- ▶ The reputation of SNF nurses as problem solvers makes it easier to recruit like-minded nurses and attract higher census.

### BUSINESS OPPORTUNITIES

- ▶ Better outcomes make your facility more attractive as a preferred provider in integrated care models.
- ▶ Can result in a higher Medicare census and improved payer mix.
- ▶ Specializing in post-acute care may lower readmissions, creating an expansion of services for niche markets.
- ▶ Providers can focus on tracking residents post discharge.

### FINANCIAL STABILITY

- ▶ MedPAC has recommended a program that is included in the President's budget which proposes financial penalties for centers with high rates of readmissions.
- ▶ Decreases the opportunity for pressure ulcers. The cost associated with a secondary diagnosis of a pressure ulcer is \$14,000.
- ▶ Provides stronger negotiating power as a preferred provider by Accountable Care Organizations and other networks.
- ▶ Can result in a higher acuity patient, optimizing Resource Utilization Group scores.
- ▶ Elimination of "observation" stays assures the more appropriate use of the Medicare Part A hospital benefit.

### REGULATORY COMPLIANCE

- ▶ May result in fewer deficiency citations as CMS has incorporated readmissions review into the new OIG surveys.
- ▶ The issue is anticipated to become a quality measure and the reduction of hospital readmissions will support higher Five Star ratings.

### CUSTOMER SATISFACTION

- ▶ Results in less transfer trauma and family anxiety, increasing their likelihood of recommending the facility as a place to receive care.
- ▶ Clear discharge instructions will enhance transitions, resulting in more positive patient recommendations of the facility.
- ▶ Using physician extenders supports increased customer satisfaction because of better education on disease management.

Learn more at [qualityinitiative.ahcanca.org](http://qualityinitiative.ahcanca.org)

# 2009 & 2010 Data

## SNF Readmissions



	April	May	June	July	August	September	October	November	December	January	February	March
2009	14%	9%	17%	4%	33%	22%	26%	30%	13%	36%	12%	18%
2010	8%	21%	0%	0%	19%	18%	21%	27%	15%	32%	18%	25%

2009 Average 17%

2010 Average 17%

# 2011 & 2012 Data

## SNF Readmissions



	October	November	December	January	February	March	April	May	June	July	August	September
2011	21%	27%	15%	32%	18%	25%	13%	8%	17%	17%	9%	13%
2012	35%	13%	33%	14%	21%	5%	18%	0%	13%	9%	0%	0%
Goal	15%	15%	15%	15%	15%	15%	15%	15%	15%	15%	15%	15%

2011 Average 18%

2012 Average 13%

# Other Factors

- Effective Communication
  - IMAR
  - POLST
  - Families
  - All Staff
- Educate, Educate, Educate
- PDSA
- Nursing Process Improvement

# Next Steps

- At Risk Committee—Weekly—Multidisciplinary
  - Falls, Weight Loss, Skin Issues, Infections, Antipsychotic Medications
- Addition of Sandra Cadwell, NP
- Participating in Hospital Interdisciplinary Care Rounds—Starting Dec 11
- Reduction of Antipsychotic Medication Initiative

# Links & Contact

Mary Sargent, Administrator

[msargent@penbayhealthcare.org](mailto:msargent@penbayhealthcare.org)

207-230-6209

Nancy Marcille, Director of Nursing

[nmarcille@penbayhealthcare.org](mailto:nmarcille@penbayhealthcare.org)

207-230-6275

American Health Care Association

[www.ahcancal.org](http://www.ahcancal.org)

INTERACT II

[www.interact2.net](http://www.interact2.net)

