

Nursing Home Strategies to Reduce Avoidable Hospitalizations, Part 3

September 20, 2018



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Objectives

- Describe strategies nursing homes are using to prevent hospital admissions
- Describe measures nursing homes are using to identify if strategies resulted in improvement



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National Nursing Home Quality Care Collaborative **CHANGE PACKAGE**



Strategy 6

Provide exceptional compassionate clinical care that treats the whole person

Change Concept 6.c

Transition with care (between shifts, departments, and all care settings)

https://www.lsqin.org/wp-content/uploads/2015/03/C2_Change_Package_20170425_508.pdf

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Speaker(s)

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Lyngblomsten Care Center



Lyngblomsten Care Center

- Lyngblomsten was organized in 1906 by 11 Norwegian women who wished to provide a home for the elderly. In 1912, after six years of fundraising, the dedicated women saw their dream become a reality with the completion of Lyngblomsten's first building.
- Lyngblomsten now has 3 buildings on the grounds: the care center and 2 independent apartment buildings

Lyngblomsten Care Center

- Lyngblomsten is a non-profit, faith-based organization that was gifted in 1960 to the ELCA and is currently overseen by 27 partnering congregations
- Lyngblomsten campus is located in St. Paul Minnesota, nestled between the Minnesota State Fair and Como Park
- Lyngblomsten Care Center is a 225-bed skilled nursing facility, with 195 skilled nursing beds and 30 short term rehab beds

PIP: Reduce Unnecessary Hospitalizations

- We chose this improvement project because we felt that many hospital transfers were not only unnecessary but could be upsetting to the resident.
- We believed often we could have provided the same care at Lyngblomsten that they received in the hospital in a more holistic manner.

PIP: Reduce Unnecessary Hospitalizations

- We felt there were numerous reasons identified that was causing unnecessary hospitalizations
 - Lack of staff, providers, and residents/resident representatives understanding of what services could be provided at Lyngblomsten.
 - Lack of staff knowledge of completing thorough assessments and SBAR charting.
 - Lack of staff confidence on how to present a change in condition to a provider and the resident/resident representative.

PIP: Reduce Unnecessary Hospitalizations

- We noticed that many of the residents, on return from the hospital, appeared in worse shape than when they left our facility.
- We felt there were risks in sending our residents to the hospital, such as;
 - skin breakdown
 - infections
 - falls
 - delirium
 - insomnia

Goal: What Did We Want to Accomplish?

- Our goal was to reduce the number of residents we sent to the hospital that could have been treated and cared for at Lyngblomsten
- We felt that this would provide better care to our residents because they would have continuity of care, remain in familiar environment, avoid an uncomfortable trip to the hospital and the possibility of errors due to miscommunication

How We Measured If Our Efforts Were Making a Difference

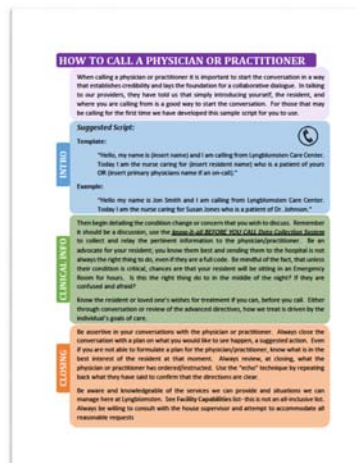
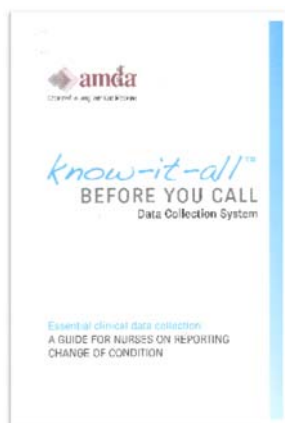
- When we started this project, almost 2 years ago, the rehospitalization rates were not being publicly reported
- We used the data generated from our EMR to calculate our rehospitalization rates
 - 2015 30 Day Readmission Rate 10.8%
 - 2016 30 Day Readmission Rate 12.73%

Changes We Made That Resulted in Improvement

Initially, we created a resource guide for staff that included:

- what to assess in a change of condition
- whether a change needs immediate notification or can wait till the next business day
- guidance on what to assess depending on what condition or symptom the resident presents
- care pathways for numerous changes
- a facility capabilities document
- a template on how to present a change in condition to a provider

Resource Tools



Changes We Made That Resulted in Improvement

- We conducted a Providers luncheon, inviting all the MDs and NPs. There we reviewed our Facility Capabilities and presented our goals to reduce unnecessary hospitalizations.
- At our biannual Family Night we presented this information along with risk of hospitalization to our families.
- We also started having a weekly meetings where we reviewed recent hospitalizations - we used the INTERACT Quality Improvement Tool.

INTERACT Meetings

- INTERACT Meetings happen once a week. Our Medical Director and Nursing Administration are present and all other nurses and providers are invited (nurses that attend are paid their wage and a \$25.00 bonus).
- An email goes out the week before stating which residents will be reviewed.
- We use the INTERACT Quality Improvement Tool. The Clinical Manger fills this out before the meeting.
- The meetings are conducted like a case review.

INTERACT Meetings

- The Clinical Manager or nurse that was involved with the transfer (if available), presents the case.
- If the provider is available they often will provide the clinical rationale for the hospitalization
- The case is reviewed to see if the hospitalization could have been avoided and if there are any opportunities for improvement.
- Our Medical Director often will add relevant teaching at each meeting based on the findings or related information.

INTERACT Meetings

- The teaching could be how to complete a physical assessment or could be the latest information on a new class of medication.
- When appropriate the lessons learned are summarized and distributed to staff by posting on the units or in our employee newsletter so those that cannot attend have the opportunity to learn from the INTERACT meetings.

Lessons Learned

Lessons Learned

- Simple physical assessments- abdominal
- Communicating the availability of diagnostic testing
- Communicating to families' facility capabilities
- Communicating with confidence
- Developing treatment strategy - *e.g., implement these interventions (which would be first steps at the hospital), monitor, if worsens then re-eval the need to go in for more invasive interventions*

Lessons Learned (cont)

- Communicating during a stressful situation
- Noted that residents were being sent to the hospital directly from a clinic or dialysis appointment. We drafted a letter that accompanies the referral form and states: "In the unfortunate event that you find the condition of our resident deteriorating and your protocols would warrant an acute hospital transfer, we ask that you contact us to discuss what interventions might be appropriate...."

Changes We Made That Resulted in Improvement

- Creating the Nurse Resource guide
- Providing education to nurses on assessment, SBAR, awareness of facility capabilities and how to communicate effectively with providers and the resident/resident representative
- Presenting this information to our Providers and Family members
- Weekly INTERACT meetings
- Learnings from meetings communicated to staff

Progress-to-Date

- Our rehospitalization rates have not necessarily improved greatly, but they have also not worsened. We feel that our acuity has actually increased, but not our rehospitalization rates.
- We feel that even though hospitalization rates may not have greatly improved, we have improved the care to our residents.
 - 2017 30 Day Readmission Rate 11.33%
 - 2018 1st/2nd Qtr 30 Day Readmission Rate 12.07%

Resources/Tools

- INTERACT Version 4.0 tool, Quality Improvement Tool for Review of Acute Care Transfers 2014 Florida Atlantic University: http://www.pathway-interact.com/wp-content/uploads/2017/04/148604-QI_Tool-for-Review-Acute-Care-Transf_AL.pdf
- AMDA Know it Before You Call Data Collection System, Dedicated to Long Term Care <https://paltc.org/product-store/know-it-all%E2%84%A2-you-call-data-collection-system-paltc-assisted-living-setting>

Resources/Tools

- Go To The Hospital Or Stay Here?, Florida Atlantic University
http://pubweb.fau.edu/media/hospitalguides/Decision%20Guide%20Booklet_ENGLISH.PDF

Advantage Living Center

Redford, MI



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SPEAKER

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VALUE BASED PURCHASING (VBP)

Protecting Access to Medicare Act, established in 2014 (also known as the “Doc Fix”), was a value-based purchasing (VBP) program for skilled nursing facilities (SNFs). This program establishes a hospital readmissions reduction program for these providers, encouraging SNFs to address potentially avoidable readmissions by establishing an incentive pool for high performers.

“WE GIVETH AND WE TAKETH AWAY”

CMS announced that there will be penalties imposed for preventable and potentially avoidable 30 day readmissions

- Heart attack
- Heart failure
- Pneumonia
- COPD
- Joint replacement complications

CONTRIBUTING FACTORS

- Studies have shown that patients readmitted to the hospital within 8 days are generally related to complications from the original condition.
- And normally closer to 30 days after discharge is likely due to lack of follow-up care and/or developed new illness or complications.
- Patients discharged from hospital to SNF between 8 am – 1pm are less likely to be admitted to the hospital.
- Why do you think that is a factor in decreasing readmission rates?

OTHER FACTORS

According to the Journal of Healthcare Quality;

- Gender,
- Age
- Income

are ALL good predictors of 30 day readmission to the acute care setting.

It is further stated that, “If you want to make significant improvement in readmission rates, a facility needs to recognize the healthcare personalities of its patients.”

AT RISK POPULATIONS

Medicaid and uninsured patients are at increased risk
of preventable readmissions;

approximately 50% higher

Education and knowledge base

Lack of family support

Limited English language

**WHAT CAN YOUR FACILITY DO
TO REDUCE HOSPITAL ADMISSIONS?**

ADVANTAGE LIVING CENTER REDFORD GAME PLAN

WE RECOGNIZE THAT EVERY DAY IS GAME DAY!!

The first 24 hour that patient enters your facility is crucial

1. Be sure to have manager stop in within the first 24 hours to answer and questions and help orientate patient to facility. This will decrease the anxiety of patient and family knowing they have a point person to talk with.
2. Ensure that the patient is evaluated by the MD.
3. The admission nurse should begin the sepsis screening too and should continue for 7 days post admit. Address concerns immediately with MD or Midlevel provider.
4. Nursing staff shall complete walking rounds.

UNIT MANAGERS ARE GAME CHANGERS

5. Managers should review daily charting in progress notes and 24 hour report. It is equally important to review order listing summary located in PCC to ensure that orders are processed and carried out timely and accurately.

A daily review of orders will decrease the likeliness of missing important results that can be used to treat your patient.

GRAND ROUNDS TIME

6. **Grand Rounds** with the IDT team and MD or Mid level allows various people to look at the patient objectively to find things that is missed in documentation.

Encourage IDT to have one individual from each discipline participate in Grand Rounds

Upon discharge from your facility provide a follow up phone call to patient and family with 24 to 72 hours; this may help address concerns that they often return to the hospital when uncertain what they should do.

JOIN A PREVENTION FOCUSED COLLABORATIVE

This will help the facility to understand why patients are readmitted, and identify best practices to reduce the readmission rate.

Bethany Retirement Living





Nursing Home Strategies to Reduce Avoidable Hospitalizations



**Dawn Hummel, RN, CDON/LTC, C-NE –
Senior Executive of Resident Care,
Skilled Operations
at Bethany Retirement Living**

I have been with Bethany Retirement Living for 15 years and value the opportunity I have to enrich the lives of our residents.




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go the
EXTRA mile,
it's never
CROWDED.


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Nursing Home Strategies to Reduce Avoidable Hospitalizations

- ☐ Start Conversations Early



Nursing Home Strategies to Reduce Avoidable Hospitalizations

- ☐ Have Conversations Often



Nursing Home Strategies to Reduce Avoidable Hospitalizations

- Risks associated with Hospitalizations
 - Stressful transportation
 - New nurses/doctors that don't know you
 - Greater risk for skin breakdown, exposure to infection or falling in an unfamiliar place



Nursing Home Strategies to Reduce Avoidable Hospitalizations

- Denote those patients/residents who wish “No Hospitalizations”



- Continually discuss with MDs (especially those On Call) what our capabilities are



Using the INTERACT Tools In Every Day Care



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graph TD
    A[New Resident Admission Resident Re-Assessment] --> B[Advance Care Planning Tools]
    A --> C[Medication Reconciliation Worksheet]
    A --> D[Change in Resident Status Noted]
    D --> E[ONA, Other Direct Care Staff, or Family Alerts LPI/IN]
    E --> F[LPI/IN Evaluation]
    F --> G[Stop and Watch Early Warning Tool]
    F --> H[SBAR Form and Progress Note]
    F --> I[MED/IN/PA Notified]
    I --> J[Transfer Checklist Envelopes]
    I --> K[Transfer Data List and Sample Forms]
    I --> L[Acute Care Transfer]
    L --> M[Hospital Communications Tools]
    L --> N[Hospitalization Rule Tracking Tool]
    L --> O[Quality Improvement Program]
    O --> P[Apply Learning to Improve care processes and education]
    O --> N
    N --> Q[Quality Improvement Tool for Review of Acute Care Transfers]
    Q --> R[Quality Improvement Program]
  
```



- ## Effective Team Communications



Nursing Home Strategies to Reduce Avoidable Hospitalizations



Autumnwood of Deckerville



Speaker

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Identified Problems

- In 2016 our facilities 30-Day Readmission Rate at time was creeping up to 40%
- Our biggest identified problem was physician involvement & staff education
- This information was identified in review of cases and a general questionnaire that was completed by nursing staff

Goals

- Reduction of 30-Day Readmissions to 20% or less
- Re-educate the staff - You can have all the tools in the world, but what's needed is the knowledge of how to use them, and, most important, **WHY**.
- **Physician Involvement**

Re-Education

- Off-Site training Lunch- “Lunch & Learn”
- Quick Guide References @ their finger tips
- Re-Education of SBAR, Stop and Watch, E-Interact

Successes

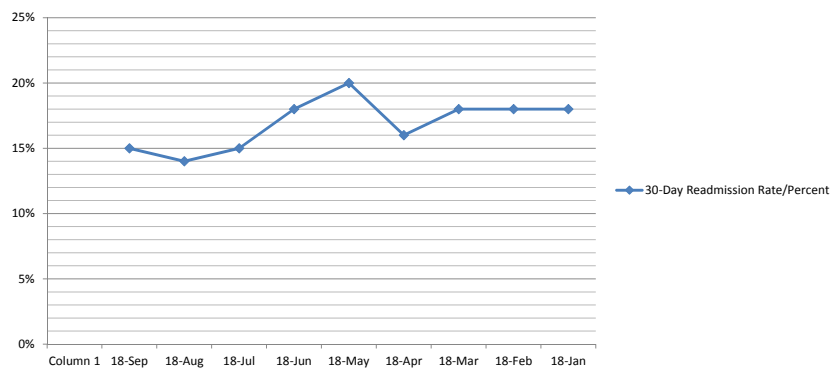
- “Lunch and Learn” was a huge success.
- Re-Admission rate dropped 15% following Quarter, and continued to drop to today; where we are less than 10% some months.
- What worked- Re-Education (in a different way), physician involvement, and manager involvement prior to discharge. Helping build confidence.

What Didn't Work

- Flooding them with tools
- Completing PIPs with no REAL engagement from staff.
- Making assumptions that your staff TRULY understand what a 30-Day Readmission means.

Progress-to-Date

30-Day Readmission Rate/Percent



What AD Learned?

Yes we did meet our goal!

- The right kind of training is instrumental!
- Physician involvement is key!
- Getting your staff to buy in!

Questions via phone or chat....



RECAP: LEARNING SESSION #6

Learning Session Six Webinars

Webinar 1 (pre-recorded): [Reducing Hospital Admissions to Improve Resident Outcomes, Quality, and Financial Incentives](#). Please watch this overview before the live webinars begin on August 24, 2018. [PDF slide handouts](#).

Webinar 2: Using QAPI to Reduce Readmissions • August 24, 2018.

- Post-Work Handout: [Change of Condition Process Eval Tool](#).
- Handout: [Accessing Rehospitalization Data Tip Sheet](#).
- Handout: [Reducing Hospitalizations Probing Questions](#).
- [PDF slide handouts](#).
- [Recording](#).

<https://www.lsqin.org/initiatives/nursing-home-quality/l6/>

Webinar 3: Nursing Home Strategies to Reduce Avoidable Hospitalizations, Part 1 • August 30, 2018.

- [Recording](#).
- [PDF slide handouts](#).

Webinar 4: Nursing Home Strategies to Reduce Avoidable Hospitalizations, Part 2 • September 11, 2018. [Event listing](#). [Register](#).

- [PDF slide handouts](#).
- [Change of Condition: Communication Process Tool](#).

Webinar 5: Nursing Home Strategies to Reduce Avoidable Hospitalizations, Part 3 • September 20,

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