Learning Session Six
Webinar #3

Nursing Home Strategies to Reduce Avoidable Hospitalizations, Part 1

August 30, 2018

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

Lake Superior Quality Innovation Network
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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

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

Bronson Commons

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Speaker

Season Marinich, MSN, RN
Director of Nursing

Bronson Commons
Post-Acute Care and
Skilled Nursing Facility
23332 Red Arrow Hwy.
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Bronson Commons

Bronson Commons is a 100-bed, all-private room, post-acute care facility located in Mattawan, Mich. We offer short-term nursing care and therapy in a facility specifically designed for adult patients following illness, injury, or hospitalization.

Bronson Commons

Services offered:

- Medical team of physicians, nurse practitioners, therapists, nurses and nurse assistants on site daily
- Rehabilitation services, including physical, occupational, and speech therapy
- Registered dietitian
- Certified dementia practitioner
- Diabetic management and education
- Colostomy management and education
- Gastric tube care and tube feeding
- Peripheral intravenous (IV) initiation and management
- IV piggy back medication administration
- Laboratory, radiology, ultrasound and other diagnostic services
- Nebulizer treatments
- Oxygen management
- Foley catheter management
- Psychiatric, hearing, podiatry, dental and optical services
- Tracheostomy care and education
- Urostomy care and education
- Wound care, including complex wounds

Ever-Changing Population

- Significant increase in PAC population-higher acuity patients= high risk for readmission
- More than doubled number of admissions
- In 2013 -269 annual admissions
  2017 Admissions= 703
  2018 projected admissions= 775

Readmission Reduction Program

Quality improvement program to reduce frequency of transfers to acute care and ensure patient centered care by the right provider, at the right time, place, and cost.

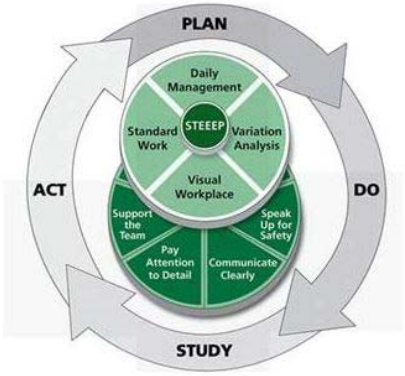
Program strategies to decrease our facility readmission rate have been evolving over the last 3 years. We are part of the State of Michigan Interact pilot project (Interventions to Reduce Acute Care Transfers). This program is designed to improve the identification, evaluation, and communication about changes in patient status. Our readmission reduction work follows these same concepts and we have built upon them to individualize our program.

What Are You Trying to Accomplish?

Goal Statement:

Our goal is to work as an interdisciplinary team along with our partners and community to decrease unnecessary transfers to the emergency department and unnecessary readmissions which are often costly as well as physically and emotionally challenging for patients and families.

PDSA



How Will You Know That Change Is an Improvement?

- Data Mining
- Interact 4.0 Hospital Rate Tracking Tool
- Monthly readmission rate
- Specific patient data points

Admission day of week	Transferring clinician
Admission source	Transfer outcome
Health plan	Transfer s/sx
Transfer time of day	Transfer diagnosis

Changes Made That Resulted in Improvement

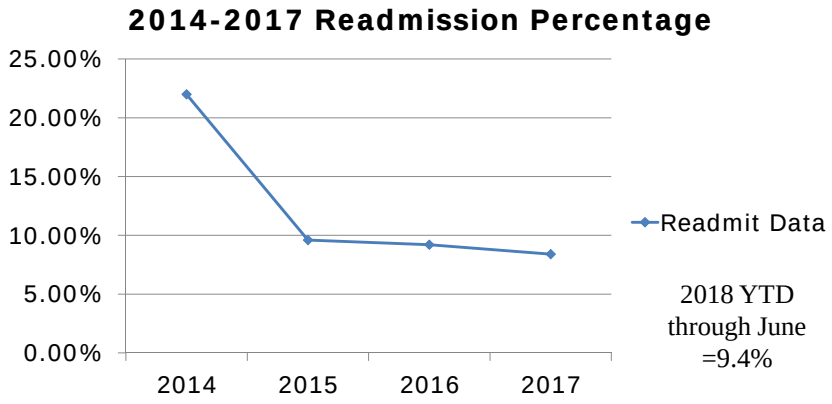
Readmission Reduction Committee

- Patient Name and admission date
- Primary diagnosis
- Reason and date of transfer to acute care
- Patient acute change in condition assessment review
- Nurse to Provider SBAR review
- In facility interventions
- Status of transfer (ED visit only, observation or inpatient admission)
- Transferring Nurse and Provider
- Identified opportunities for improvement
- Transfer preventable?

Changes Made That Resulted In Improvement

- Education
- Respiratory Therapist Rounding
- Advanced Care Planning
- Provider Engagement
- Interdisciplinary Team Collaboration

Progress to Date

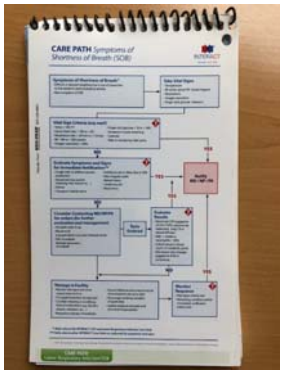


Future Work

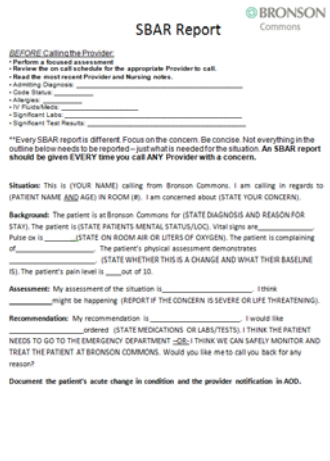
- Sustainability: higher acuity patients/decreasing length of stay/decreasing reimbursement
- Continued focus on discharge planning
- DC follow up phone calls
- Data tracking, trending, and analysis of readmissions post-DC from facility

Resources/Tools

- http:/www.pathway-interact.com/



Resources/Tools



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SBAR Report

BEFORE Calling the Provider:
- **Perform a focused assessment**
- **Review the on call schedule for the appropriate Provider to call.**
- **Read the most recent Provider and Nursing notes.**
- Admitting Diagnosis: _____
- Code Status: _____
- Allergies: _____
- IV Fluids/Meds: _____
- Significant Labs: _____
- Significant Test Results: _____

"Every SBAR report is different. Focus on the concern. Be concise. Not everything in the outline below needs to be reported – just what is needed for the situation. **An SBAR report should be given EVERY time you call ANY Provider with a concern.

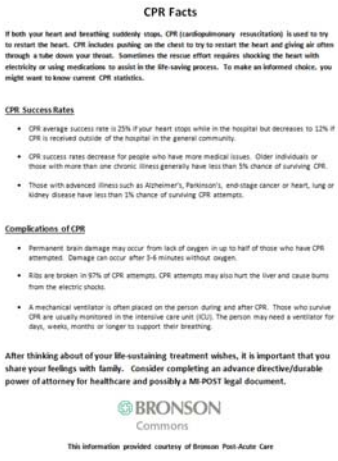
Situation: This is (YOUR NAME) calling from Bronson Commons. I am calling in regards to (PATIENT NAME AND AGE) IN ROOM (#). I am concerned about (STATE YOUR CONCERN).

Background: The patient is at Bronson Commons for (STATE DIAGNOSIS AND REASON FOR STAY). The patient is (STATE PATIENTS MENTAL STATUS/LOC). Vital signs are_____, Pulse ox is _____(STATE ON ROOM AIR OR LITERS OF OXYGEN). The patient is complaining of_____. The patient's physical assessment demonstrates _____(STATE WHETHER THIS IS A CHANGE AND WHAT THEIR BASELINE IS). The patient's pain level is ____out of 10.

Assessment: My assessment of the situation is_____. I think _____might be happening (REPORT IF THE CONCERN IS SEVERE OR LIFE THREATENING).

Recommendation: My recommendation is_____. I would like _____ordered (STATE MEDICATIONS OR LABS/TESTS). I THINK THE PATIENT NEEDS TO GO TO THE EMERGENCY DEPARTMENT -OR- I THINK WE CAN SAFELY MONITOR AND TREAT THE PATIENT AT BRONSON COMMONS. Would you like me to call you back for any reason?

Document the patient's acute change in condition and the provider notification in AOD.



CPR Facts

If both your heart and breathing suddenly stops, CPR (cardiopulmonary resuscitation) is used to try to restart the heart. CPR includes pushing on the chest to try to restart the heart and giving air often through a tube down your throat. Sometimes the rescue effort requires shocking the heart with electricity or using medications to assist in the life-saving process. To make an informed choice, you might want to know current CPR statistics.

CPR Success Rates

- CPR average success rate is 25% if your heart stops while in the hospital but decreases to 12% if CPR is received outside of the hospital in the general community.
- CPR success rates decrease for people who have more medical issues. Older individuals or those with more than one chronic illness generally have less than 5% chance of surviving CPR.
- Those with advanced illness such as Alzheimer's, Parkinson's, end-stage cancer or heart, lung or kidney disease have less than 1% chance of surviving CPR attempts.

Complications of CPR

- Permanent brain damage may occur from lack of oxygen in up to half of those who have CPR attempted. Damage can occur after 3-6 minutes without oxygen.
- Ribs are broken in 97% of CPR attempts. CPR attempts may also hurt the liver and cause burns from the electric shocks.
- A mechanical ventilator is often placed on the person during and after CPR. Those who survive CPR are usually monitored in the intensive care unit (ICU). The person may need a ventilator for days, weeks, months or longer to support their breathing.

After thinking about of your life-sustaining treatment wishes, it is important that you share your feelings with family. Consider completing an advance directive/durable power of attorney for healthcare and possibly a MI-POST legal document.

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This information provided courtesy of Bronson Post-Acute Care

Cuyuna Regional Medical Center

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Speaker

- Nancy Stratman, LNHA
  - Senior Services Administrator
  - Cuyuna Regional Medical Center
  - Crosby, MN
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CRMC – Cuyuna Regional Medical Center

- Critical Assess Hospital
  - Average daily census of 17
  - Hospital does not use swing beds
- Clinics in Crosby, Baxter & Longville
  - 70,000 clinic visits per year
  - Clinic to open in Breezy Point in April ’19

CRMC Care Center

- 113 LTC beds facility
  - Attached to the hospital
  - 31 beds TCU; 20 beds memory care
- In process of “right-sizing” to 75 beds
  - Ortho clinic expansion
  - Average census for past 3 years has been 81

Other “partner” services at CRMC

- Home Health Partnership
  - Home Care, Palliative Care and Hospice
- Heartwood – joint venture with Presbyterian Homes
  - Assisted living with memory care; independent apartments
- Community Paramedic

Reduce Avoidable Hospitalizations

- Why?
  - Increased awareness and concern from new hospitalist director (“Who didn’t have the talk?”)
  - Need for successful discharge (ACO, CMS data, etc.) - - to be a good partner
  - Hospital census
- Prior: business as usual/send them/they are back in the hospital

What Are You Trying to Accomplish?

- Successful discharge
  - Ensure supports and services in place
- "Sends" when appropriate and with objective considerations (SBAR)
- "We can do better"

How Will You Know That Change Is an Improvement?

- Sends to the hospital will be justified
- CMS data

Changes Made That Resulted in Improvement

- Deep dive review of any resident who was discharged and is readmitted to the hospital
  - Transitional care nurse dedicated to senior population
  - A culture of “We can do better; What could we have done differently?”
  - Hardwiring SBAR with nurses when communicating especially with the hospitalist
  - Conversation with “agents” listed on Advance Care Directive

Plan-Do-Study-Act/PDSA

- Awareness mostly based on “we can do better”
- Identifying when most hospital admits occur from LTC
  - Weekends
  - “Who is the hospitalist?”

Changes Made That Resulted in Improvement

- Huddles when there is a rehospitalization/hospitalization
  - Review of chart
  - Do we need to support the charge nurse differently
- Review of the Advance Care Directive and POLST
- Training and audits of use of SBAR – nurse educator
- Conferring with Med Dir/APP and CMO as appropriate

Progress to Date

- ACD/POLST posted in the closet of each resident
  - Reviewed quarterly at care conferences
  - Crucial conversations with “agents” of ACD
- Nurse appreciation for SBAR
- Med Dir (often primary care physician in the Care Center) is made aware of the situation that lead up to the transfer to hospital
- Strategy: implement INTERACT® within Point Click Care

Resources/Tools

Honoring Choices

- https://www.honoringchoices.org/
  - Tools & Resources - - Informational Materials
    - Artificial Hydration and Nutrition
    - CPR

Resthaven Care Center

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Speaker

Michelle Scholten
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Resthaven

- Located in Holland, Michigan
- 145 bed SNF, 16 bed ST Rehab, 40 bed locked dementia unit, 10 bed greenhouse, 79 bed LTC
- 4.2 staffing level, ST rehab, Dementia care, Palliative Care, Custodial care

What Are You Trying to Accomplish?

- Keep residents in-house while providing excellent care
- Optimize financial incentives related to rehospitalizations

How Will You Know That Change Is an Improvement?

- Track our return to hospital rates
- Identify if there are any opportunities to prevent readmissions

Changes Made That Resulted in Improvement

- Changed our view from "*when in doubt – send them out*" to ask *Why exactly are we sending them out?*
- Unit manager worked with her nursing staff to ask:
  - *What is the goal?*
  - *Is hospitalization necessary?*
  - *What can they do at the hospital that we cannot do?*
  - *Are there skills that we need in order to do that?*

Changes Made That Resulted in Improvement

- Educated nurses on the importance of keeping residents in-house
- Educated nurses to determine the benefit of sending residents to the hospital vs. keeping them in the nursing home
- Worked with nurses to develop skills necessary to keep resident in the nursing home

Changes Made That Resulted in Improvement

- Educated physicians
- Empowered staff to make the decision regarding transferring the resident to the hospital

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Progress to Date

- Review our systems and processes and each readmission using the Interact® Quality Improvement tool.
- We at this point feel that each readmission was necessary.
- Being proactive, continuous education of staff and including staff in the decisions and empowering them to make decisions have all proven to be positive tools that we will continue to use.

Next Steps: Participate in These Webinars:

- Watch this pre-recorded 24 minute webinar, *Reducing Hospital Admissions to Improve Resident Outcomes, Quality, and Financial Incentives*

  https://www.youtube.com/watch?v=PcMcyoYpWD8&feature=youtu.be
- September 11, 2018: Nursing Home Strategies to Reduce Avoidable Hospitalizations, Part 2
- September 20, 2018: Nursing Home Strategies to Reduce Avoidable Hospitalizations, Part 3

More information, including registration links:
https://www.lsqin.org/initiatives/nursing-home-quality/ls6/

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