Health Care Quality Performance Measurement and Reporting Program (HCQP)

NURSING HOME SUBCOMMITTEE

October 21, 2008, 3:00-4:30pm
RIHCA, 57 Kilvert Street, Suite 200
Warwick, RI 02886

Goals/Objectives

- To share information on the satisfaction survey process and upcoming Safe Transitions Project.

Subcommittee Attendees

✓ Rosa Baier, MPH
✓ Lonnie Bisbano, Jr.
✓ Virginia Burke, Esq.
✓ Donna Lonschein, RN
✓ Samara Viner-Brown, MS
✓ Gail Patry, RN (*Chair*)
✓ Lynda Sprague

Time	Topic/Notes
3:00	**1. Welcome & Updates** Rosa Baier, MPH – Rosa opened the meeting and described the meeting objectives.
3:30	**2. Satisfaction Surveys** Rosa Baier, MPH – We are on track for all nursing homes to participate in the survey process and view their results online at the beginning of November. For most nursing homes, the cut-off date for My InnerView to receive surveys is October 29th and results are available online beginning November 5th. Several homes have a schedule that is one week later. – **Action item**: RIHCA (and possibly RIAFSA) will communicate with their memberships about the upcoming deadline, and the importance of high response rates to ensure accurate data. Rosa will ask My InnerView what happens to surveys submitted post deadline; will they be accepted?
3:30	**3. Safe Transitions Project** Gail Patry, RN – Gail described Quality Partners' upcoming Safe Transitions Project, which is part of the National Patient Safety Initiative work. Quality Partners was one of 14 states to receive competitive funding to work on improving care transitions. There will be a small pilot in

Time	Topic/Notes
	December, and then project begins with a cross-setting Health Fair in January. – The overarching goals of the Safe Transitions Project are to reduce 30-day rehospitalization rates, improve care coordination and communication across settings, and increase patient satisfaction. For nursing homes, the project can help maintain/increase daily census and reduce the likelihood that residents return from the hospital with additional problems. – Although the project does not begin until January, Lonnie suggested that Quality Partners identify useful tools for nursing homes, and work with RIHCA and RIAFSA to disseminate them to nursing homes interested in getting a head start improving their residents' care transitions. Gail reviewed several handouts with meeting attendees, and the group discussed the purpose and target audience of each tool. – **Action items**: Gail and Rosa will create a short "Table of Contents" for the tools, providing a brief description of the tool, who should use it, and when. RIHCA and RIAFSA will disseminate this information to their members.
4:00	**4. Open Forum** Gail Patry, RN – Rosa encouraged meeting participants to submit agenda items for future meetings; this forum may be helpful to others who want stakeholder input. – Gail adjourned the meeting at 4:10.

Safe Transitions

Together, Quality Partners, the Rhode Island Health Care Association (RIHCA), and the Rhode Island Association of Homes and Services for the Aged (RIAFSA) want to share tools and information with you about changes your nursing home can make to improve your residents' care transitions and reduce rehospitalization rates. This packet includes several tools.

Why safe transitions? Why now?

Rehospitalization is gaining attention nationally and can affect your nursing home's bottom line. About one in five Medicare beneficiaries is rehospitalized within 30 days of discharge, and evidence suggests that up to 50% of these hospitalizations are avoidable. Reducing avoidable hospitalizations is an important opportunity for your nursing home to remain ahead of the CMS curve—and do the right thing for your residents. You can also benefit through improved relationships with your local hospitals, home health agencies, and physicians, as well as through improved resident and family satisfaction survey results.

Room for Improvement

The process by which patients move from hospitals to nursing homes and other care settings is increasingly problematic as hospital stays shorten and as care becomes more fragmented. Medicare patients report greater dissatisfaction related to discharges than to any other aspect of care that CMS measures. This can be addressed by improving patient education and system processes at and after discharge. Improvement in these processes correlates with substantial reductions in early rehospitalization for particular conditions, such as heart failure.

System Factors

There are several factors that affect avoidable rehospitalization. These fall into two general categories:

- Patient and caregiver factors: Poor understanding of care goals; inability to manage emerging symptoms; confusion about medications; and lack of access to clinical support.

- System factors: Inaccurate, incomplete, or delayed communications with receiving providers; failure to prescribe evidence-based medications for patient conditions; inadequate patient education and expectation-setting; failure to arrange timely follow-up; and lack of support services for the patient transition process between care settings.

Opportunity for Nursing Homes

Rhode Island's nursing homes are proactive participants in improving quality of care; you are instrumental in the dialogue on how to ensure high-quality care transitions for your residents. The enclosed tools can help your nursing home improve information transfer and patient self-management—both important factors in improving safe transitions and reducing rehospitalizations.

This material was prepared by Quality Partners of Rhode Island, the Medicare Quality Improvement Organization for Rhode Island, under contract with the Centers for Medicare & Medicaid Services, an agency of the U.S. Department of Health and Human Services. Publication #: 9SOW-RI-7.2-09-2008-357.

Planning for Your Discharge:

A checklist for patients and caregivers preparing to leave a hospital, nursing home, or other health care setting

NAME: _____

DEPARTMENT of HEALTH & HUMAN SERVICES · USA

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Planning for Your Discharge

During your stay in a hospital, nursing home, or other health care setting, the staff will work with you to plan for your discharge. You and your caregiver are important members of the planning team. (Caregivers are family members or others who will be helping you after discharge.) Below is a checklist of important things you should know to plan for a safe discharge.

Instructions:

- **Review the checklist early and often during your stay.**
- **Talk to the staff (for example, a discharge planner, social worker, or nurse) about the items on the checklist.**
- **Check the box next to each item when you or your caregiver complete it.**
- **Use the notes page to write down important information that you need to remember.**
- **Skip any items that don't apply to you.**

1.	Do you know where you will get care and who will be helping you after you are discharged? You may be at home or in another setting. • Ask the staff to explain your options and make sure they understand your wishes.	☐ **You**	☐ **Your family member or other caregiver**
2.	Do you understand your health condition(s)? • Ask what is likely to happen with your health.	☐ **You**	☐ **Your family member or other caregiver**
3.	Do you know what problems to watch for and how to handle them? • Ask what to do and who to call if you have problems.	☐ **You**	☐ **Your family member or other caregiver**
4.	Do you know what each of your prescription drugs does? Do you know how to take them, and what side effects to watch for? • Ask who you should call if you have questions. • Tell the staff what prescription drugs, over-the-counter drugs, or supplements you took before you came to the hospital or other health care setting. • Ask if you should still take them after you leave.	☐ **You**	☐ **Your family member or other caregiver**

5.	Do you know what medical equipment (like a walker) you will need? • Ask who to call if you have questions about your equipment after you leave.	☐ **You**	☐ **Your family member or other caregiver**
6.	Do you know which of the items below you will need help with and for how long? • Bathing, dressing, grooming, using the bathroom • Shopping for food, making meals, doing housework, paying bills • Getting to doctors appointments, picking up prescription drugs	☐ **You**	☐ **Your family member or other caregiver**
7.	Do you feel comfortable doing other tasks that require special skill like using medical equipment, changing a bandage, or giving a shot? • Ask someone to show you if you're not sure. Then, show them you can do these tasks. • Ask who to call if you need help.	☐ **You**	☐ **Your family member or other caregiver**
8.	**Question for the family member or other caregiver:** Do you understand what help the patient will need from you? (This may be some or all of the items from Question 6 or 7.) Are you able to give that help? • If you aren't able to give that help, ask the staff to change the discharge plan so you both get the help you need.	☐ **You**	☐ **Your family member or other caregiver**
9.	Are you worried about how you or your family are coping with your illness? • Ask to speak to a therapist or find out about support groups, if needed.	☐ **You**	☐ **Your family member or other caregiver**
10.	Do you know what doctor or other healthcare provider to call if you have questions or problems? • Write down their names and telephone numbers.	☐ **You**	☐ **Your family member or other caregiver**
11.	Do you know what appointments and tests you will need in the next several weeks?	☐ **You**	☐ **Your family member or other caregiver**

12.	Do you have written discharge instructions that you understand, your list of drugs, and a summary of your current health status? • Bring this information with you to your follow-up appointments.	☐ **You**	☐ **Your family member or other caregiver**
13.	If you will get services from a home health agency, compare the agencies in your area. • Visit **www.medicare.gov/HHCompare/Home.asp**. People with Medicare can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.	☐ **You**	☐ **Your family member or other caregiver**
14.	If you will get services in a nursing home, compare the nursing homes. • Visit **www.medicare.gov/NHCompare/Home.asp**. People with Medicare can also call 1-800-MEDICARE. TTY users should call 1-877-486-2048. • If possible, visit the nursing homes. For a tip sheet on what to look for when visiting a nursing home, visit **www.medicare.gov/Nursing/Checklist.pdf**.	☐ **You**	☐ **Your family member or other caregiver**
15.	The back of this checklist has the names of agencies that can offer you and your caregiver more support. Find information on the following: • Community resources to help you live at home. • Other resources to help you make long-term care decisions.	☐ **You**	☐ **Your family member or other caregiver**
16.	Do you understand how much of your prescription drugs, equipment, and services will be covered by your insurance and what you will have to pay? • Ask to speak to a social worker about possible resources to help with insurance or payment.	☐ **You**	☐ **Your family member or other caregiver**

* **Important note:** If you have Medicare and feel you are being asked to leave a hospital or other health care setting too soon, you may have the right to ask for a review of the discharge decision by an independent reviewer called a Quality Improvement Organization (QIO). The QIO can explain your appeal rights. To get the number for the QIO in your state, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Important Information

The publicly-funded agencies below can give you and your caregiver more information on community services, like home-delivered meals and rides to appointments. They can also help you to make long-term care decisions. Ask a social worker in your health care setting for more information on community services and support.

Area Agencies on Aging (AAAs)

AAAs assist adults age 60 and older and their caregivers. To find the AAA in your area, call The Eldercare Locator at 1-800-677-1116 weekdays from 9:00 a.m. to 8:00 p.m. (EST) or visit **www.eldercare.gov**.

Aging and Disability Resource Centers (ADRCs)

ADRCs assist people of all incomes and ages. Forty-three states have ADRCs. To find out if your area is served by an ADRC, visit **www.adrc-tae.org**.

Centers for Independent Living (CILs)

CILs assist people with disabilities. A state-by-state directory of CILs can be found by visiting **www.ilru.org/html/publications/directory/index.html**.

State Technology Assistance Project

The State Technology Assistance Project has information on medical equipment and other assistive technology. Contact the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) at (703) 524-6686 to get the contact information for your state or visit **http://www.resna.org.**

State Medicaid Agency

The State Medical Assistance (Medicaid) office provides information about Medicaid. To find your local office, visit **www.nasmd.org/links/links.asp**. (Scroll halfway down the page to see a clickable map of the United States.) You can also call 1-800-MEDICARE, and say, "Medicaid."

Medicare

For more information about the Medicare Program, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can also visit **www.medicare.gov/LongTermCare/Static/Counseling.asp**.

My Health. My Medicare.

CMS Pub. No. 11376
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Notes

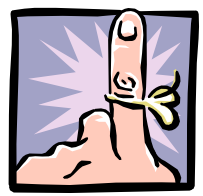
*This checklist isn't a legal document. The official Medicare program provisions are contained in the relevant laws, regulations, and rulings.

Call (_____)
at (___) ___-____

with questions or concerns
if you have difficulty contacting your
PCP, specialist, or home care nurse

Personal Health Record

If you have questions or concerns,
contact (_____)
at (___) ___-____



REMEMBER
to take this Record with you
to all your doctor visits

The Personal Health Record of:

_____

Personal Information

Address:

Home Phone#:
Alternate Phone #:
Birth Date:
Hospital ID #:
PCP Name:
Advance Directives?:

Hospitalization Information

Admitted:__/__/__ Discharged:__/__/__
Reason for Hospitalization:

Caregiver Information

Name:
Home Phone #:
Alternate Phone #:
Relation to Patient:

Notes for My Primary Care Physician:

Medical History

- ❑ Arthritis
- ❑ Abnormal Heart Rhythm
- ❑ Cancer
- ❑ Diabetes
- ❑ Hardening of the Arteries
- ❑ Heart Disease
- ❑ Heart Failure
- ❑ High Blood Pressure
- ❑ Hip Fracture
- ❑ Lung Disease
- ❑ Medical/Surgical Back conditions
- ❑ Pneumonia
- ❑ Stroke

Other Diagnoses:

Intervention Activities Checklist

Before I leave the care facility, the following tasks should be completed:

- ❑ I have been involved in decisions about what will take place after I leave the facility.
- ❑ I understand where I am going after I leave this facility and what will happen to me once I arrive.
- ❑ I have the name and phone number of a person I should contact if a problem arise during my transfer.
- ❑ I understand what my medications are, how to obtain them and how to take them.
- ❑ I understand the potential side effects of my medications and whom I should call if I experience them.
- ❑ I understand what symptoms I need to watch out for and whom to call should I notice them.
- ❑ I understand how to keep my health problems from becoming worse.
- ❑ My doctor or nurse has answered my most important questions prior to leaving the facility.
- ❑ My family or someone close to me knows that I am coming home and what I will need once I leave the facility.
- ❑ If I am going directly home, I have scheduled a follow-up appointment with my doctor, and I have transportation to this appointment.

This tool was developed by Dr. Eric Coleman, UCHSC, HCPR, with funding from the John A. Hartford Foundation and the Robert Wood Johnson Foundation

To better manage my health and medications, I will…

- Take this Personal Health Record, with me to wherever I go, including ALL doctor visits and future hospitalizations.
- Call my doctor if I have questions about my medications or if I want to change how I take my medications.
- Tell my doctors about ALL medications I am taking, including over-the-counter drugs, vitamins and herbal formulas.
- Update my Medication Record with any changes to my medications.
- Know why I am taking each of my medications.
- Know how much, when and for how long I am to take each medication.
- Know possible medication side effects to watch out for and what to do if I notice any.

Medication Record

Medication Record

Name	Dose	Reason	New?
Azmacort MDI	4 puffs 2 times a day	Emphysema	☐
Oxygen	2 liters per minute	Emphysema	☐
Triam/HCTZ	75/50-take½ pill once per day	Leg swelling	X
Warfarin	5.0 mg once per day	Blood thinner	☐
Atenolol	.25 mg once per day	Blood pressure	☐
Atorvastatin	10 mg at bedtime	Cholesterol	☐
Multi-vitamin	once per day		☐

Allergies: Penicillin → Rash

Notes for My Primary Care Physician:

1. Do I need take the Triam/HCTZ even when I do not have swelling?
2. How long will I receive home health care?
3. When is my next blood draw to check the Warfarin?

EXAMPLE

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INTERACT
Interventions to Reduce Acute Care Transfers

Early Warning Report

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

Resident _____

Seems like himself/herself
Talking the same
Overall function the same
Participated in usual activities
Ate the same amount
N
Drank the same amount

} **NO?**

Weak
Agitated or nervous
Tired or drowsy
Confused
Help with dressing, toileting, transfers

} **YES?**

Staff _____ Reported to _____

Date _____ Time _____

Adapted from Boockvar, Kenneth et all, *JAGS* 48: 1086-1091,2000.

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Early Warning Daily Assessment to Identify Residents with Acute Changes

Answer these questions about each of the residents you care for every day. If you detect a change, fill out an Early Warning Report and discuss the change with the charge nurse.

Seems like himself/herself
Talking the same
Overall function the same
Participated in usual activities

Ate the same amount
N
Drank the same amount

NO?

Complete an Early Warning Report and discuss with the Charge Nurse

Weak
Agitated or nervous
Tired or drowsy
Confused
Help with dressing, toileting, and transfers

YES?

INTERACT
Interventions to Reduce Acute Care Transfers

SBAR

Physician/NP/PA Communication

Before calling MD/NP/PA:

- ❑ Assess the resident.
- ❑ Check vital signs and pulse ox/and or finger stick glucose if indicated.
- ❑ Review chart (most recent progress note and nurses note from previous shift).
- ❑ Have ALL information AVAILABLE when reporting (**resident chart, advance directive (DNR, Do Not Hospitalize, other care limiting orders)** allergies, medication list).

S SITUATION

I am calling about _____ (**resident's name**)

The **problem** I am calling about is _____

B BACKGROUND

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

Pertinent **medical history**_____

Most recent **findings**_____

Mental status _____ Neuro changes _____ Temp _____

BP_____Pulse rate/quality/rhythm_____ Resp rate/quality _____

Lung sounds_____Pulse Oximetry_____% Oxygen_____ L/min via _____

GI/GU changes (nausea/vomiting/diarrhea/impaction/hydration) _____

Weight_____(actual) Loss or Gain Skin color _____ Blood Glucose _____

Wound status (drainage, wound bed, treatment) _____

Pain level/location/status _____

Change in function _____

Medication changes in the last week include _____

DNR Status _____

Other _____

A ASSESSMENT

What do you think is going on with the resident? (Cardiac, infection, respiratory, urinary, neuro, mental status?)

I think that the problem is_____

or

I am not sure of what the problem is, but there has been an acute change in condition.

R RECOMMENDATION

I suggest or request:

- ❑ Physician visit
- ❑ Monitor vital signs (Frequency_____) and observe
- ❑ Lab work _____
- ❑ Urinalysis, C & S ❑ X-rays ❑ EKG
- ❑ Medication changes_____
- ❑ Wound care changes_____
- ❑ Nutrition or fluid restriction changes_____
- ❑ Other_____

Staff name _____

Reporting to: ❑ Licensed nurse ❑ MD/NP/PA

Date _____ Time _____ ❑ AM ❑ PM

If to MD/NP/PA, communicated by:

- ❑ Phone
- ❑ Fax (attach confirmation)
- ❑ In person

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INTERACT

INTERACT
Interventions to Reduce Acute Care Transfers

SBAR

Congestive Heart Failure (CHF)

Before calling MD/NP/PA:

- ❑ Assess the resident.
- ❑ Check vital signs, and pulse ox and/or finger stick glucose if indicated.
- ❑ Review chart (most recent progress note and nurses notes from previous shift).
- ❑ Have ALL information AVAILABLE when reporting (Resident chart, **advance directive status (DNR**, **Do Not Hospitalize, other care limiting orders)** allergies, medication list).

S SITUATION

- ✓ I am calling about _____
- ✓ He/she has signs and symptoms of new or worsening CHF, specifically:
  - ❑ Unrelieved or new shortness of breath at rest
  - ❑ Unrelieved or new chest pain
  - ❑ Wheezing or chest tightness at rest
  - ❑ Inability to sleep without sitting up
  - ❑ Inability to stand without severe dizziness or light headedness
  - ❑ Weight gain of > 5 lbs in 3 days
  - ❑ Markedly increased edema

B BACKGROUND

- ✓ The resident's primary diagnoses are _____
- ✓ Medication changes in the last week include _____
- ✓ The resident **[meets/does not meet]** the CHF Care Path criteria for management of signs and symptoms in the nursing home:
  - ❑ Temperature_____
  - ❑ Apical heart rate _____
  - ❑ Respiratory rate _____
  - ❑ BP_____
  - ❑ Oxygen sat _____
  - ❑ Glucose (if applicable) _____

A ASSESSMENT

I think the resident has signs and symptoms of new or worsening CHF. They **[do/do not]** meet the Care Path criteria for management of signs and symptoms in the nursing home.

R RECOMMENDATION

My recommendations are:

- ❑ Manage in the nursing home
- ❑ Consider lab tests (Complete Blood Count, Basic Metabolic Panel, Chest x-ray)
- ❑ Initiate or increase diuretic dose if indicated
- ❑ Oxygen supplementation if indicated
- ❑ Monitor VS (BP and apical heart rate) Q4H for 24-72 hours
- ❑ Transfer to acute care facility.
- ❑ Other (specify) _____

Staff name_____

Reporting to:____Licensed nurse _____MD/NP/PA

Date _____ Time _____ ❑ AM ❑ PM

If to MD/NP/PA, communicated by:

- ❑ Phone
- ❑ Fax (attach confirmation)
- ❑ In person

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INTERACT