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Strategies to Prevent Hospital Transfers in the SNF Environment

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Strategies to Prevent Avoidable Hospital Transfers in SNF Environment

Clinical Leadership Theme

This project focuses on the Clinical Nurse Leader's (CNL) curriculum element of *Care Environment Management.* In this project, the CNL functions as the team manager and care coordinator. The CNL will be leading, facilitating, and utilizing patients' outcome data to make changes in care processes to reduce acute hospital transfers in the skilled nursing facility (SNF). The CNL will serve as the lead for the interdisciplinary team and resource or point of contact for this project.

Roger's (1983) Diffusion of Innovations model will be the framework for this project. Stakeholders are expected to be actively involved in decisions about adoption or rejection of this project. Roger's conceptual model demonstrates the essential components of how innovations such as early identification of changes in condition of geriatric patients are diffuse among individuals and their microsystem. This project adopts evidence-based nursing practices within the context of diffusion of innovations model incorporating clinical decision tools (INTERACT) to reduce hospital transfers.

As the CNL in this project, the objective is to increase evidence-based practice, efficiency in microsystem processes, engagement of point of care nursing staff in the professional development, and quality improvement activities (AACN, 2013).

Statement Of The Problem/Project Overview

With the implementation of the Affordable Healthcare Act, Medicare is changing the way hospitals and SNFs fees for services. (Hardin & Hussy, 2003). Payments to the hospitals, post-acute care facilities, SNFs, and home health agencies will be dependent on the quality of care that is provided by the providers. Acute hospitals are now discharging patients to post-acute care

facilities earlier than before. Patients with chronic respiratory and chronic cardiac conditions are discharged and transitioned quickly from acute hospitals to SNFs (Elixhauser & Podulka, 2011).

A recent retrospective study found that over 5 million Medicare patients are transferred from hospitals to SNFs yearly (King, Gilmore-Bykovskyi, Roiland, Polnaszek, Bowers, & Kind, 2013). Often, these patients need short-term rehabilitation or skilled nursing services before they can safely return to the community. Communication between the hospital and SNF during this transition should be seamless and efficient. Patients with multiple chronic medical conditions may require frequent monitoring and are not safe to be discharged back home (King et. al, 2013).

Chronic cardiac and respiratory diagnoses are the most common diagnoses for Medicare readmission (Ouslander, Diaz, Hain, & Tappen, 2011). The transition from SNFs to acute hospitals can be costly and may put geriatric patients at a higher risk of hospital-acquired infections (Hallerbach, Francoeur, Pomerantz, Oliner, Morris, Eiger, Cohn, & Goldfinger, 2008). There are approximately 11 million Medicare acute hospital discharges every year in America. An estimated one in five (17.6%) of this population was readmitted back to the hospital within 30 days of the discharge (Park, Branch, Bulat, Vyas, & Roever, 2013). Avoiding acute hospital transfers for this patient population is desirable and cost effective if the care can be rendered at the SNF level.

According to Ouslander et al. (2011), there is evidence suggesting that SNF patients are often hospitalized inappropriately. The CNL's role within the SNF microsystem is to orchestrate, educate, and empower clinical staff, patients, and caregivers about safe care transition. The Institute of Medicine (2008) reported twenty-seven percent of older adults discharged from a hospital require care in SNF or rehabilitative care services, with an additional 15% needing home health services Golden, Martin, Silva, & Roos, 2011).

The purpose of this project is to reduce hospital readmissions in geriatric patients who are currently having any changes of medical condition within the SNF microsystem. The CNL will educate nurses to utilize (Interventions to Reduce Acute Care Transfers) INTERACT™ Early Warning Tool.

Rationale

The CNL will assess and use the performance improvement process called the Quality Management Committee (QMC). The QMC is responsible for developing a data collection system that supplies continual feedback regarding customer and employee satisfaction and quality outcomes (Nelson, Batalden, & Godfrey, 2007). The CNL is the leader of this team. The team members are comprised of the Executive Director (ED), Director of Nursing (DON), Resident Assessment Instrument Nurse (MDS), Facility Rehab Director (FRD), Business Office Manager (BOM), and the Sales and Marketing Director (SAM). The team meets weekly to evaluate day-to-day operations and use the Focus PDSA (Plan Do Study Act) method to analyze and review how the microsystem's performance is with achieving this project's objective of decreasing acute hospital readmission and transfers. Through focused PDSA, the CNL becomes a change agent within the microsystem.

Nursing Home Compare is also a government website that was used as a metric to evaluate the gap analysis for this project. Another team that the CNL has developed and implemented is PIT (Performance Improvement Teams). This team continues to communicate the "why" behind each strategic objective with first-line employees. This part is the innovative "buy in" of Roger's diffusion theory. The CNL encourages first line employees to participate in PITs because it encourages staff to take risks and allow them to offer and integrate innovative solutions to promote high performance.

Root cause analysis (RCA) was done, to identify the factors leading to increase incidences of avoidable hospital transfers and readmissions. Both internal and external data in the SNF's microsystem identified a common theme, lack of in communication between social services (discharge planners), nursing, and physicians. The CNL and DON also completed a retrospective RCA on acute hospital transfers (Appendix F).

Before the implementation of this project strength, weakness, opportunities, and threats (SWOT) analysis was completed (Appendix E). This SNF is the only SNF in Turlock, California that currently has managed care contracts. Patients admitted to the SNF have a higher acuity level due to these contracts.

After collecting data for a one year, it is evident that there has been an increase in acute hospital transfers. Productivity at the SNF has decreased due to the increased volume of patients, higher acuity level, and an increase in follows up appointments.

Opportunities for the implementation of this project are to reduce hospital readmissions and transfers; provide a continuum of care for patients during care transition, increase communication and collaboration with internal and external clinicians.

Threats to this project include: current nursing turnover rates could decrease continuity of care, noncompliant patients will continue to have unavoidable hospital transfers, and the interdisciplinary team may face challenges with insurance companies projecting early patient discharges. These patients may not be medically stable but are only allocated 14 days for skilled services (King et al., 2013). Another threat is not having sufficient health information or communication during care transition, which can create delays in medical treatment and increase the risk for hospital readmissions. Nurses are not familiar with using the INTERACT tool kit when communicating with other healthcare providers.

Methodology

The CNL and QMC team reviewed the current practices and tools compare to the INTERACT program. After consideration of the INTERACT tool the DON and CNL identified the two INTERACT communication tools and two INTERACT decision support tools to implement. Some examples of the INTERACT tools are shown in Appendix G. The INTERACT tools are designed to improve the identification, management, communication, evaluation, and documentation about acute changes in patients condition (Ouslander et al., 2011).

The CNL will train and educate clinical staff members at the SNF to fully understand and utilize evidence-based tool kit (INTERACT™ Early Warning Tool). INTERACT tool kit has clinical practices and pathways the nursing staff can use to help reduce hospital transfers. Implementing evidence base practices (INTERACT™ Early Warning Tool) will reduce 30 days hospital transfers and hospital readmission in geriatric patients with a change of medical or physical condition.

Roger's Diffusion of Innovations theory will be the framework of this project. The innovation-decision process in Roger's change theory is one that nurses and clinicians at the SNF will go through as they move from gaining the fundamental knowledge and concepts of using the INTERACT toolkit. All phases of these categories apply to the implementation of my project to reduce avoidable acute hospital readmission.

According to Roger's (2003) change theory, staff members' increased feelings of anxiety are normal in the change process. The CNL's role is important to this project because he/she is a change agent in the microsystem. The "buy-in" process is very challenging because nurses are accustomed to "just sending the patients" to the emergency room. By increasing the staff's

awareness and understanding of the impacts of acute hospital transfers the implementation of the project will have more acceptance (Kohles, Bligh, & Carsten, 2013).

The plan is to decrease acute hospital transfers and admissions by 2%. INTERACT toolkit, when implemented, should improve workflow. Nurses will recognize and initiate early interventions for patients who experience any acute changes in their condition. The CNL will integrate a new vision that can help nurses who are champions become an innovator of this project. The nurse champions can then become the leaders of this project and create potential opportunities for other nurses or followers (Kohles et al., 2013).

The CNL and nurse champions will foster an environment in the microsystem to improve healthcare outcomes through the daily use of INTERACT tool kits. The CNL will ensure the nurses utilize and understand clinical decision-making care paths. The CNL will provide proper training and ensure nursing staff has an understanding of the SBAR form and COC cards. Both these tools are designed to enhance the nursing evaluation and documentation on patients who have a change in condition and improve communication with physicians.

The cost of the anticipated project is as follows: 1) CNL intern hour: 220 hours free as I will be educating and implementing the project. I will be training six core nurses or "champions." This training is about an hour long during their shifts. 2) The cost of printing materials for education such (i.e. handouts and powerpoints) will be approximate $200-300. The total cost of implementing this project will be about $300.00.

The ROI (Return on Investment) for this project cannot be measured because it is a quality improvement program. By educating and empowering the clinicians with this toolkit, there will be a decrease in hospitalization rates because the nurses will treat the patients at the SNF instead of transferring them to the acute hospital. The SNF will be the preferred provider

for the Stanislaus County, therefore increasing revenue for the SNF. Clinicians will be more comfortable and prepared to treat patients with any changes of medical conditions using the INTERACT toolkit.

The Quality Management Committee will evaluate this project every Wednesday. Internal and external data on acute hospital transfers will serve as a metrics for the effectiveness of this program (Appendix B). The PDSA of the project is outline in Appendix A-C.

Data Source/Literature Review

The site for this project is a rural, post-acute care skilled nursing facility in Northern California. This institution serves adult and geriatric patients. The microsystem of focus for this project is geriatric patients experiencing an acute change of conditions.

PICOT Question

For geriatric patients with an acute change of condition in the SNF microsystem, how does incorporating a clinical decision support tool; Interventions to Reduce Acute Care Transfers (INTERACT), compared to no intervention or assessment, reduce avoidable hospital transfers and readmission rates in a 60 day period?

Search Strategy

Multiple databases were searched for this review of evidence: CINAHL, PubMed, and Cochrane. Subject heading search in all databases using the following MESH terms and various text terms: *readmission, COPD (Chronic obstructive pulmonary disease), CHF, chronic cardiac diagnosis, chronic respiratory exacerbation, skilled nursing care, skilled nursing facilities, post-acute care, Hospital readmission, INTERACT, and geriatrics.* Reference list of articles was also reviewed. Limitations were set to English with the publication dates no earlier than 2010. The selection and criteria of articles included the following: randomized and nonrandomized

controlled trails published in English, which assessed the following: interventions to reduce hospitalization in patients with chronic medical conditions or management of diseases. Studies were excluded if participants were younger than 55 years of age. Twelve articles were selected that met all exclusion and inclusion criteria. Ten articles were chosen for the purpose of this project.

Ouslander et al., (2010) conducted a quality improvement initiative to examine the frequency and reasons for avoidable hospitalizations of geriatric patients in Georgia over a 15-month period from May 1, 2005, to August 1, 2006.

Medical records were reviewed from May 1, 2005, to August 1, 2006, by expert panels. The group of experts provided input into the development of tools and strategies for interventions to reduce avoidable hospitalizations. A structured implicit record review (SIR) was used to rate acute hospital admissions as unavoidable or potentially avoidable, with identification of the reason (Ouslander et al., 2010). Two hundred hospitalizations were reviewed. One hundred and thirty-four or 67.0% were rated as potentially avoidable (Ouslander et al., 2010). According to Ouslander et al. (2010) early interventions, diagnosis, and aggressive treatment at the SNF could have prevented some of the hospitalization. Factors that can contribute to avoidable hospitalizations are poor symptom control, noncompliance of medication regiment, inadequate patient and caregiver education, and insufficient social support. Toles et al. (2012) used prior framework to guide their study. The authors conducted a longitudinal, multiple case study of transitional care provided in SNFs. The purpose of this study was to explore the care processes and staff interaction strategies during care transition. The authors observed that transitional care was an interdisciplinary approach.

Hallerbach et al. (2008) used a nonrandomized case-control study to elucidate characteristics of patients diagnosed with exacerbation of heart failure who were rehospitalized within 30 days. The study method included a retrospective chart review, quantitative analysis, and descriptive statistics aimed to group the patients according to common characteristics (Hallerbach et al., 2008).

Timeline

The project began in February 2016 and is scheduled to conclude in the middle of August 2016 (Appendix D). The CNL and DON have been working with the Staff Development Coordinator to schedule in-services for the nursing staff. In January, the CNL along with the DON will introduce the program to all stakeholders. Care pathways will also be introduced to nurse champions and nurses. INTERACT toolkit will be integrated into the EHR in May. Full implementation of the project will be done at the ending of May, beginning of June 2016. The Health Information Manager, DON, and CNL will perform daily audits on any change of condition within the facility. Chart review will be done weekly by the CNL and DON to ensure that any patients who were transferred out of the INTERACT hospital tool were utilized.

Expected Results

An expected outcome is to decrease hospital readmissions and transfer rates in the SNF microsystem. Early identification and interventions by the nurses will help decrease unavoidable hospital transfers and admissions. Implementation of this project will help nurses provide strategies to improve the delivery of care for patients experience a change in physical and medical condition.

This project will help foster and improve communication among health care providers in the SNF's microsystem. There will also be an improvement in clinical competencies and

assessment processes with the nursing staff resulting in an increase in quality healthcare outcomes.

Nursing Relevance

Early identification of at-risk patients by the nurses in the SNF environment will reduce hospital readmission in geriatric patients. The nurse well acknowledges that complex medical diagnosis can be treated at the SNF's microsystem. Roger's diffusion model of patient care can help the nurses identify the needs of this patient population.

Preventing acute care hospital transfers and admissions is a multifaceted approach that involves active participation from all members of the interdisciplinary team. Toolkits such as the INTERACT™ Early Warning can be used as one of the interventions to reduce hospital readmission.

Summary Report

Hospitalizations are common in the geriatric population; in 2006, 23.5% of the people admitted to SNFs were readmitted to the hospital within 30 days. Many of these hospital admissions are avoidable, inappropriate, or related to conditions that could be treated at the SNF's microsystem (Ouslander et al., 2010). Multifaceted strategies are needed to reduce hospital transfers. While the use of INTERACT™ tool kits can assist in decreasing hospital transfers not all change of conditions can theoretically be managed at the SNF level. Patients who experience a change of condition requiring comprehensive interventions should be transfers to the acute hospital.

The Change in Condition File Cards (COC) cards are decision support tools the nursing staff can use when determining whether to report specific symptoms, signs, and lab results immediately, vs. non-immediately (Ouslander et al., 2011). Care Paths will also be available in a

binder at the nurses' stations. These are educational decision support tools that provide guidance on the recognition, evaluation, and management of ten conditions that commonly cause hospital transfers (Appendix G).

Since the implementation of this CNL project, there has bine a decrease in acute hospitals. In March of 2016, 12.31% of patients were transferred to the acute from the SNF environment; as of July 2016, the percentage of acute hospital transfers has decreased significantly to 5.36% (Appendix H). The CNL's role in the SNF environment is to implement evidence-based projects to reduce preventable hospitalizations. As a CNL evaluating benchmarks are key metrics to sustainability of this project. Comparing the SNF's acute hospital transfers to both national and state level reveals that the project has been successful.

Reference

American Association of Colleges of Nursing (2013). Competencies and Curricular Expectations for Clinical Nurse Leader Education and Practice. Retrieved from http://www.aacn.nche.edu/cnl/CNL-Competencies-October-2013.pdf

Baker, C. L., Zou, K. H., & Su, J. (2013). Risk assessment of readmission following an initial COPD-related hospitalization. *International Journal of Chronic Obstructive Pulmonary Disease, 8*, 551-559. doi:10.2147/COPD.S51507

Casarett, D., Karlawish, J., Morales, K., Crowley, R., Mirsch, T., & Asch, D. A. (2005). Improving the use of hospice services in nursing homes: a randomized controlled trial. *Jama*, *294*(2), 211-217.

Elixhauser A, Au DH, & Podulka J. (2011, September). *Readmissions for Chronic Obstructive Pulmonary Disease, 2008*: *Statistical Brief #121* (2011 Healthcare Cost and Utilization Project (HCUP) Statistical Briefs). Retrieved from the Agency for Healthcare Research and Quality website: http://www.ncbi.nlm.nih.gov/books/NBK65392/?report=classic

Fan, V. S., Gaziano, M., Lew, R., Bourbeau, J., Adams, S. G., Leatherman, S., Thwin, S., Huang, G. D., Robbins, R., Sriram, P. S., Sharafkhaneh, A., Mador, J., Sarosi, G., Panos, R. J., Rastogi, P., Wagner, T. H., Mazzuca, S. A., Shannon, C., Colling, C., Liang, M. H., Stoller, J. K., Fiore, L., & Niewoehner, D. E. (2012). A comprehensive care management program to prevent chronic obstructive pulmonary disease hospitalizations: A randomized controlled trail. *Annals of Internal Medicine, 156*(10), 673-683.

Feemster, L. C., & Au, D. H. (2014). Penalizing Hospitals for Chronic Obstructive Pulmonary Disease Readmissions. *American Journal of Respiratory and Critical Care Medicine, 189*(6), 634–639. http://doi.org/10.1164/rccm.201308-1541PP

Grosso, L. M., Lindenauer, P., Wang, C., Savage, S., Potteiger, J., Abedin, Z., Geary, L. L., Wang, Y., Drye, E. E., & Krumholz, H. M. (2015, April). *Hospital-level 30-day readmission following admission for an acute exacerbation of chronic obstructive pulmonary disease*. Retrieved from http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html

Golden, Adam G,M.D., M.B.A., Martin, S., B.S.W., da Silva, M., RN, & Roos, B. A., M.D. (2011). Care management and the transition of older adults from a skilled nursing facility back into the community. *Care Management Journals, 12*(2), 54-9. Retrieved from http://search.proquest.com/docview/871224840?accountid=458

Hallerbach, M., Francoeur, A., Pomerantz, S., Oliner, C., Morris, L., Eiger, G., Cohn, J., & Goldfinger, M. (2008). Patterns and predictors of early hospital readmission in patients with congestive heart failure. *American Journal of Medical Quality, 23*(1), 18-23.

Hardin, S. & Hussy, L. (2003). AACN Synergy model for care: Case study of patient with CHF. Critical Care Nurse, 23(1), 73-76.

Hansen, L. O., Young, R. S., Hinami, K., Leung, A., & Williams, M. V. (2011). Interventions to reduce 30-day rehospitalization: a systematic review. *Annals Of Internal Medicine, 155*(8), 520-528. doi:10.7326/0003-4819-155-8-201110180-00008

Khalifehzadeh, A., Jahromi, M. K., & Yazdannik, A. (2012). The impact of Synergy Model on nurses' performance and the satisfaction of patients with acute coronary syndrome. *Iranian Journal of Nursing and Midwifery Research, 17*(1), 16–20.

King, B. J., Gilmore-Bykovskyi, A. L., Roiland, R. A., Polnaszek, B. E., Bowers, B. J., & Kind, A. J. (2013). The consequences of poor communication during transitions from hospital to skilled nursing facility: a qualitative study. *Journal of the American Geriatrics Society, 61*(7), 1095-1102. doi:10.1111/jgs.12328

Kohles, J. C., Bligh, M. C., & Carsten, M. K. (2013). The vision integration process: Applying Rogers' diffusion. *Leadership, 9*(4), 466–485. doi:10.1177/1742715012459784

Kwok, T., Lum, C. M., Chan, H. S., Ma, H. M., Lee, D., & Woo, J. (2004). A randomized, controlled trail of intensive community nurse-supported discharge program in preventing hospital readmissions of older patients with chronic lung disease. *American Geriatrics Society, 52*(8), 1240-1246.

Maslow, K. & Ouslander, J. G. (2012). Measurement of potentially preventable hospitalizations. Long-term Quality Alliance, White Paper. Retrieved, from http://www.interact2.net/docs/publications/LTQA%20PreventableHospitalizations_021512_2.pdf

Mazimba, S., Grant, N., Parikh, A., Mwandia, G., Makola, D., Chilomo, C., Redko, C., & Hahn, H. S. (2014). Heart failure performance measures: do they have an impact on 30-day readmission rates? *American Journal of Medical Quality, 28*(4), 324-329.

Ouslander, J. G., Diaz, S., Hain, D., & Tappen, R. (2011). Frequency and diagnoses associated with 7- and 30-day readmission of Skilled Nursing Facility patients to a nonteaching community hospital. *Journal of the American Medical Directors Association*. doi:DOI:10.1016/j.jamda.2010.02.015

Ouslander, J. G., Lamb, G., Perloe, M., Givens, J. H., Kluge, L., Rutland, T., Atherly, A., & Saliba, D. (2010). Potentially Avoidable Hospitalizations of Nursing Home Residents:

Frequency, Causes, and Costs. *The American Geriatrics Society, 58*(4), 627-635. doi:10.1111/j.1532-5415.2010.02768.x

Ouslander, J. G., Lamb, G., Tappen, R., Herndon, L., Diaz, S., Roos, B. A., & Bonner, A. (2011). Interventions to Reduce Hospitalizations from Nursing Homes: Evaluation of the INTERACT II Collaborative Quality Improvement Project. *Journal Of The American Geriatrics Society, 59*(4), 745-753. doi:10.1111/j.1532-5415.2011.03333.x

Park, H. K., Branch, L. G., Bulat, T., Vyas, B. B., & Roever, C. P. (2013). Influence of a Transitional Care Clinic on Subsequent 30-Day Hospitalizations and Emergency Department Visits in Individuals Discharged from a Skilled Nursing Facility. *Journal Of The American Geriatrics Society, 61*(1), 137-142. doi:10.1111/jgs.12051

Prieto-Centurion, V., Markos, M. A., Ramey, N. I., Gussin, H. A., Nyenhuis, S. M., Joo, M. J., Prasad, B., Bracken, N., DiDomenico, R., Goodwin, P. O., Jaffe, H. A., Kalhan, R., Pickard, A. S., Pittendrigh, B. R., Schatz, B., Sullivan, J. L., Thomashow, B. M., Williams, M. V., & Krishnan, J. A. (2014). Interventions to reduce rehospitalizations after Chronic Obstructive Pulmonary Disease Exacerbations. *AnnalsATS, 11*(3), 417-424. doi:10.1513/AnnalsATS.201308-254OC

Rogers, E. M. (1983). *Diffusion of Innovations* (3rd ed.). New York, NY: The Free Press.

Schroedl, C. J., Yount, S. E., Szmuilowicz, E., Hutchison, P. J., Rosenberg, S. R., & Kalhan, R. (2014). A qualitative study of unmet healthcare needs in chronic obstructive pulmonary disease: A potential role for specialist palliative care? *Annals of the American Thoracic Society, 11*(9), 1433-1438. doi:http://dx.doi.org/10.1513/AnnalsATS.201404-155BC

Toles, M., Barroso, J., Colon-Emeric, C., Corazzini, K., & Anderson, R. A. (2012). Staff interaction strategies that optimize delivery of transitional care in a skilled nursing facility. *Family and Community Health, 35*(4), 334-344.

Trueman, J., & Trueman, I. (2011). Developing criteria to assist in the palliative phase of COPD. *British Journal Of Nursing, 20*(6), 364-369

Appendix A

Charter and Goals Worksheet

Quality Management Committee
Team Charter

X Quality Sub-Committee	□ Performance Improvement Team
Date Chartered:	Febuary 2016
Title:	Acute Care Transfer (ACT) Quality Sub-Committee
Team Structure	
Team Leader:	Director of Nursing/ Clinical Nurse Leader Intern
Team Members:	• Social Services • Medical Records • Nursing Supervisor/Charge Nurse
Team Purpose	
Mission:	The objective of this process is to fully implement and sustain critical processes to manage acute care transfers to prevent avoidable transfers which directly effect re-hospitalization rates and referral relationships, as well as mitigate regulatory and legal risk.
Quality Issue(s) or opportunity identified which initiated charter:	As part of our continued pursuit of clinical excellence we are initiating a process to enhance evaluation and verification of appropriate hospital transfers as part of the Change of Condition process.
Resources/Boundaries:	• Meet weekly, at established consistent day/time, to review all acute care transfers • Team has authority to develop appropriate action plans to address improvement opportunities • Resources to reeducate staff must be allocated to ensure action plans are carried out
Primary Measurements:	• Number of monthly acute care transfers • Percentage of avoidable transfers • QI Review process compliance score
Reporting/Documentation Requirements:	Weekly ACT QI document completion, meeting minutes, and updated action plan reported to QMC on a monthly basis. Immediate directed action must be taken on deficient practice.
Target Date(s):	Charter to be fully implemented within 30 days from training. Charter is to remain in place.
Approvals	
QMP Chairman (name):	
Approval Signature:	
Date Approved:	

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Appendix B
Goals/Statement Outcomes

Worksheet Title: Acute Care Transfer Global Goals

Goal #	Goal, Stated as a Desired Outcome	*Measure(s): What would be the observable signs of success?*	*Date: when do you intend for this to be accomplished?*	*OPR – Who is the overall owner(s) of this goal*
#1	**Conduct a weekly in-depth analysis of all acute care transfers**	100% of all acute care transfers will be documented on ACT QI Analysis Standard audit form with appropriate scoring	Immediately upon establishment of charter	**Clinical Nurse Leader**
#2	**Use tracking and trending data from audit to develop appropriate action plans for improvement**	Detailed action plans are fully documented for all improvement opportunities identified	Directed action occurs immediately upon identification, formal action plan should be developed within 30 days of charter initiation and updated weekly	**Clinical Nurse Leader**
#3	**Communicate tracking and trending results to BLT weekly with summary to QMC on a monthly basis**	BLT/QMC meeting minutes reflect discussion and review of ACT analysis. Action plans are monitored to ensure compliance.	Immediately upon establishment of charter and ongoing	**Clinical Nurse Leader**
#4	**Monitor ACT QI Audit Scores and 30-Day Hospital Readmissions to ensure avoidable transfers are reduced/eliminated.**	• ACT QI Compliance 80% or above • 30-day hospital readmission rate of 20% or below	80% Audit score within 60 days of implementation 20% 30-day hospital readmission rate achieved by end of Q3 and on-going	**BLT/QMC**

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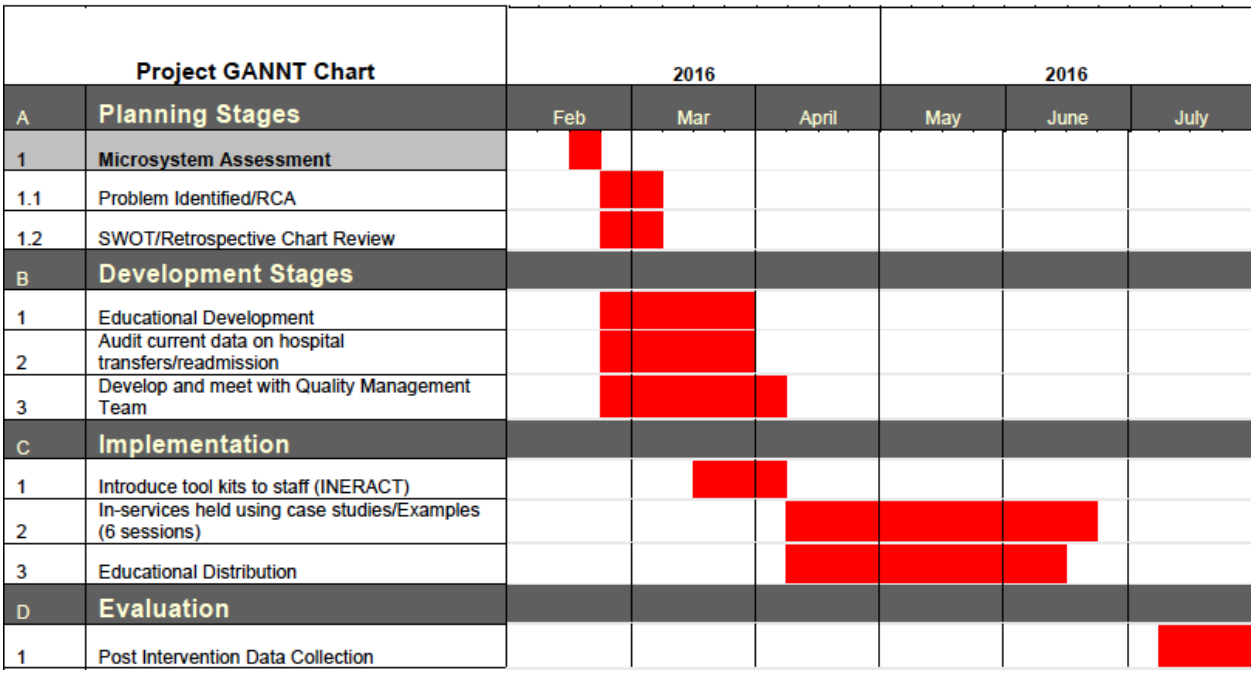
Appendix C
Actions and Task to Reduce Hospital Transfers

	Action/Task	Owner	Due Date	Status/Comments
1	Establish / set day of week and time for weekly meeting	Clinical Nurse Leader	During first meeting of QM	
2	Bring laptop to weekly meeting	SS	Weekly	
3	Compile list of all residents with P3 completed for review. Check / highlight those reviewed on list, maintain checked/highlighted list in binder to ascertain 100% transfers reviewed *Covenant Care Intranet > Incident Tracking System > Advanced Search > By Location > Select Location > P3 Column (select those completed that have not previously been reviewed*	Med Rec	By end of business day prior to meeting	
4	Medical Records Dept will collect and provide medical records of all residents transferred to acute and bring to meeting	Med Rec	Prior to meeting	
5	DON / Medical Records will bring blank **Acute Care Transfer Analysis Performance Improvement Tool** to be completed during weekly meeting	Clinical Nurse Leader /DON/Med. Rec.	Weekly	
6	DON / Medical Records provide completed **Stop and Watch** tools for all transfers to Acute for review and determination of completion / follow-up	Clinical Nurse Leader /DON/Med. Rec.	Weekly	
7	Review all COC SBAR's, nursing progress notes, skilled nursing notes, Voocollect ADL's and alerts, lab results, MD progress notes, MD orders and other pertinent ancillary staff progress notes as appropriate for 7 days prior to transfer to determine recognition of change of condition and appropriate interventions	QMC	During meeting	
8	Review pertinent COC SBAR's for completion and correct SBAR utilized	QMC	During meeting	
9	Review nursing documentation of physician notification and physician response.	QMC	During meeting	

10	Review nursing documentation for implementation of physician orders within 30 minutes of receipt	QMC	During meeting	
11	Review most recent IDT Walking Round Form to determine review of current Advanced Directive/POLST/Preferred Intensity of Care with resident / responsible party	QMC	During meeting	
12	Determine completion and accuracy of all areas completed on Acute Care Transfer form	QMC	During meeting	
13	Review Acute Care Transfer database to determine entry to system within 72 hour *Covenant Care Intranet > Incident Tracking System > Advanced Search > Locatio > Show Option > QI Completed Date*	Med. Rec.	By end of business day prior to meeting	
14	Recap collected data to determine if transfer was avoidable or unavoidable	QMC	During meeting	
15	Document all findings on audit form, calculate % of met/not met, enter into OTR (once available)	QMC	During meeting	
16	Complete meeting minutes using appropriate QMP meeting minutes forms	QMC	During meeting	

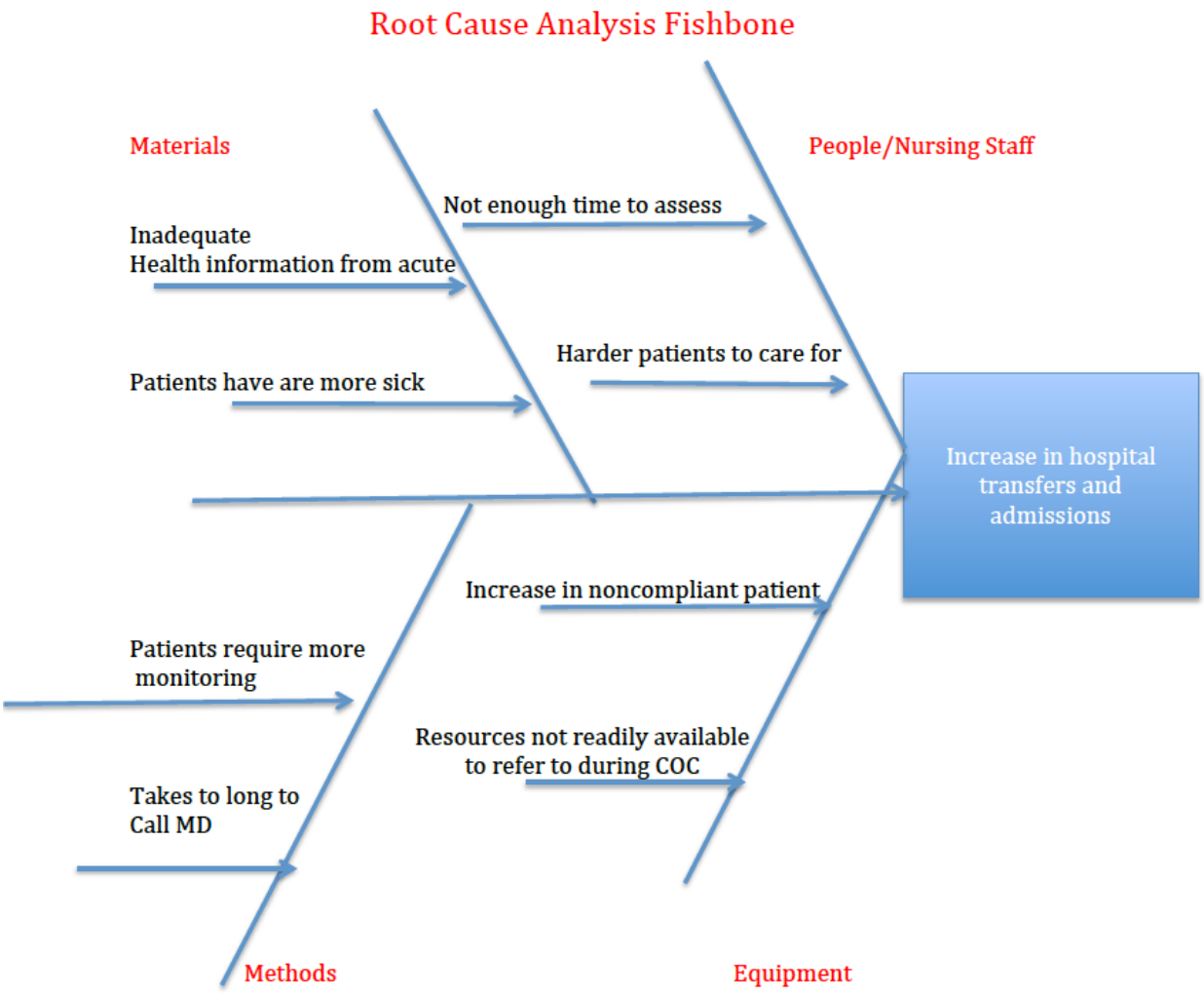
Appendix D
GANNT Chart: Timeline



Appendix E
SWOT Analysis

Strengths • Only SNF in Turlock, CA with Managed Care Contracts • Only SNF in Turlock, CA joined Navi for Bundle Payments • Strong Clinical Team	*Weaknesses* • Higher acuity level due to being only SNF in Turlock with Managed Care contracts • High nurse turn over rate • Increase volume of patients
Opportunities • Collaborate with internal and external teams and partners to develop case management processes • Be the provider of choice for manage care customers • Reduce hospital readmissions	*Threats* • Managed Care patients require more time • Nursing turn over rate can decrease continuity of care • Nursing burn out related to increase in skills mix

Appendix F
Fishbone Analysis



Appendix G
INTERACT Toolkits
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Stop and Watch
Early Warning Tool

INTERACT
Version 3.0 Tool

If you have identified a change while caring for or observing a resident, please **circle** the change and notify a nurse. Either give the nurse a copy of this tool or review it with her/him as soon as you can.

S
T
O
P
Seems different than usual
Talks or communicates less
Overall needs more help
Pain – new or worsening; Participated less in activities

a
n
d
Ate less
No bowel movement in 3 days; or diarrhea
Drank less

W
A
T
C
H
Weight change
Agitated or nervous more than usual
Tired, weak, confused, or drowsy
Change in skin color or condition
Help with walking, transferring, toileting more than usual

Name of Resident

Your Name

Reported to *Date and Time (am/pm)*

Nurse Response *Date and Time (am/pm)*

Nurse's Name

Appendix G
INTERACT Toolkits
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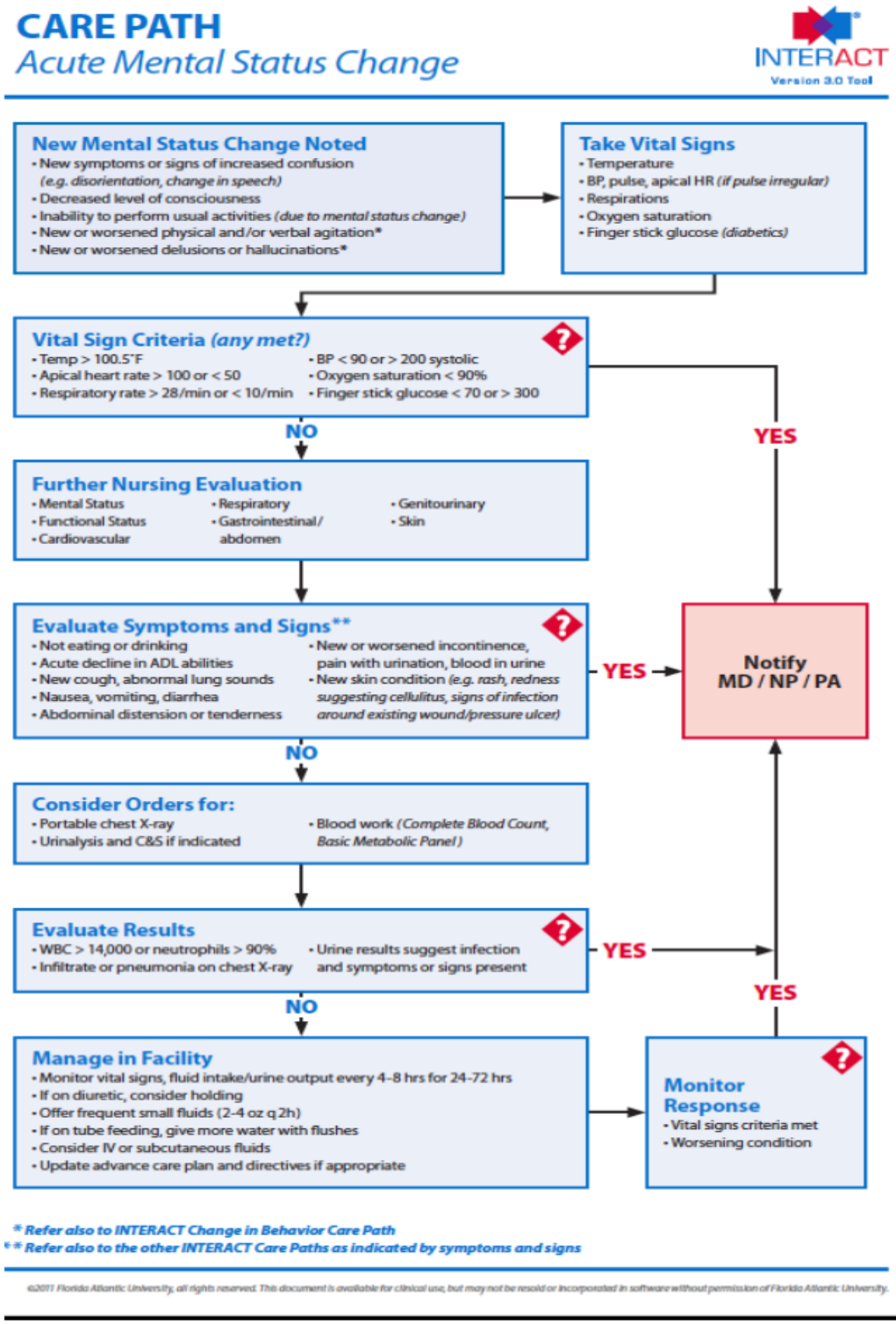

Appendix G
INTERACT Toolkits
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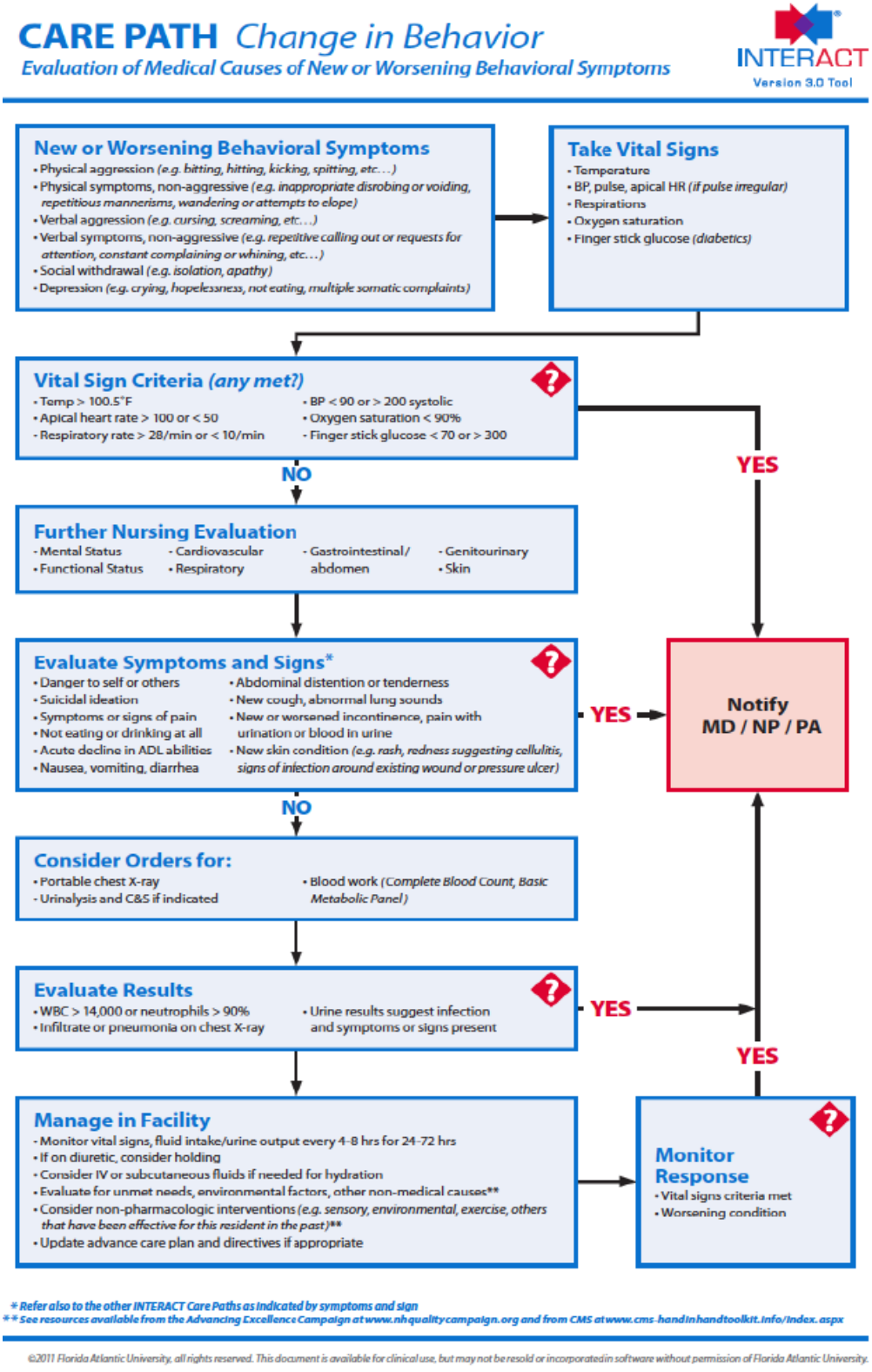

Appendix H
Results of Implementation of CNL Project

	Acute Hospital Transfer Data	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016
Microsystem								
	Entries from Acute Hospital	60	65	71	67	61	56	5
	Discharges back to Acute Hospital	8	8	6	6	4	3	0
	Percent back to Acute Hospital	1.67	12.31	8.45	8.96	6.56	5.36	0.00
CA Averages								
	Entries from Acute Hospital	31.42	36.42	33.32	31.83	31.68	29.76	4.53
	Discharges back to Acute Hospital	6.40	6.94	5.87	5.90	5.86	3.50	1.00
	Percent back to Acute Hospital	20.37	19.06	17.62	18.54	18.50	11.76	22.08
US Averages								
	Entries from Acute Hospital	21.84	23.67	22.29	21.52	22.12	20.55	3.88
	Discharges back to Acute Hospital	4.55	4.98	4.36	4.35	4.44	3.01	1.00
	Percent back to Acute Hospital	20.83	21.04	19.56	20.21	20.07	14.65	25.77