


Coaching Call

Change in Condition:
Heart Failure, Anticoagulants, and Medication Reconciliation

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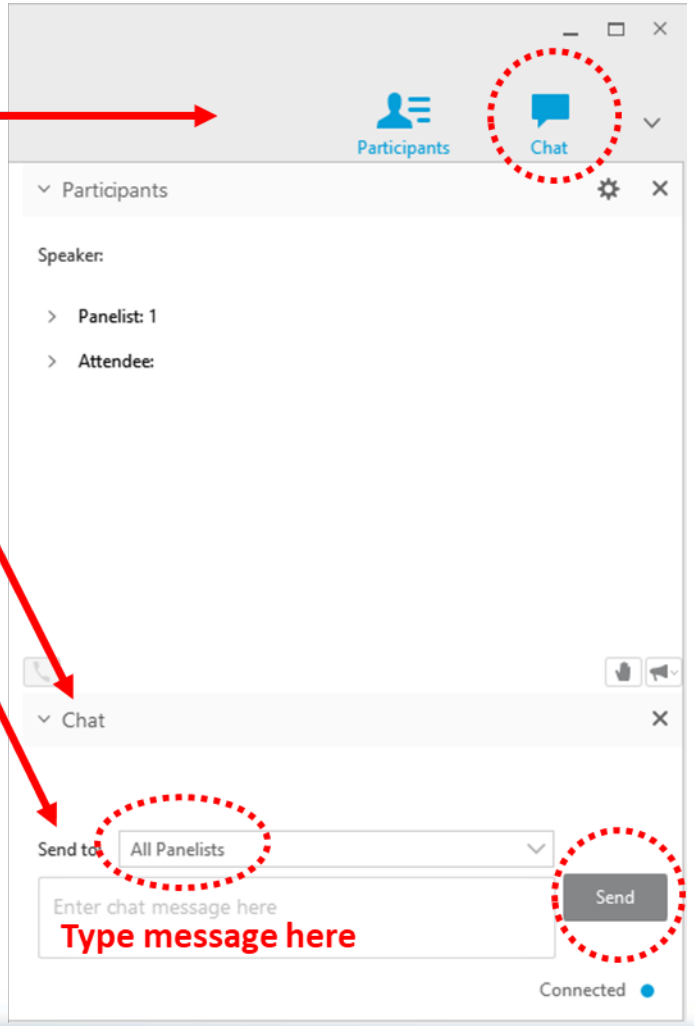
Health Services Advisory Group (HSAG)

May 1, 2018

How to Submit a Question

1. To submit a question, click on the **Chat** option at the top right of the presentation.
2. The **Chat** panel will open.
3. Indicate that you want to send a question to **All Panelists**.
4. Type your question in the box at the bottom of the panel.
5. Click on **Send**.

To connect to the audio portion of the webinar, please have WebEx call you.



April 25 Webinar Recap

Change in Condition: Heart Failure, Anticoagulants, and Medication Reconciliation

Presented by:
Pouya Afshar, MD, MBA
CMO, Integrated Healthcare Alliance, San Diego

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Nursing Communication

Physician wish list:

- What is the problem?
- What do you need me to do?
- When do I need to respond?

Successful delivery of a sales pitch:

Loss of attention/credibility if unable to get to the point in < 10 seconds

SBAR[1] = SOAP[2] for Nurses

60-second communication tool:

- Situation (10 seconds)
- Background (20 seconds)
- Assessment (20 seconds)
- Recommendation (10 seconds)

1. Situation, Background, Assessment, Recommendation (SBAR)
2. Subjective Objective Assessment Plan (SOAP)

Situation: The Problem

- Proper identification
  - Name of nurse calling
  - Name of facility
  - Name of patient
- Chief complaint
  - Patient John Smith has signs of worsening heart failure

Background: The Context

- Age
- Code status
- Type of heart failure
- Reason for hospitalization and date of discharge
- Other relevant medical history
- Current weight vs. admission weight
- Adherence to medications, diet, fluid restriction

Assessment: Analysis

- Symptoms
  (SOB/DOE,[1] edema, fatigue, confusion)
- Onset, severity
- Physical assessment
  (vitals, JVD,[2] edema, urine output)
- Medications
  (dosage of diuretics, adherence)

Analysis:

Patient is having a CHF[3] exacerbation in setting of medication/dietary non-compliance

1. Shortness of breath (SOB)/dyspnea on exertion (DOE)
2. Jugular vein distention (JVD)
3. Congestive Heart Failure (CHF)

Recommendation: The Plan

- Increase diuretics
- Frequent vitals
- Labs
- Dietary consult
- Goals of care
- Palliative/hospice consult
- Update patient/family
- Proper sign-out to upcoming nurses

Reducing Readmissions Preparation Program

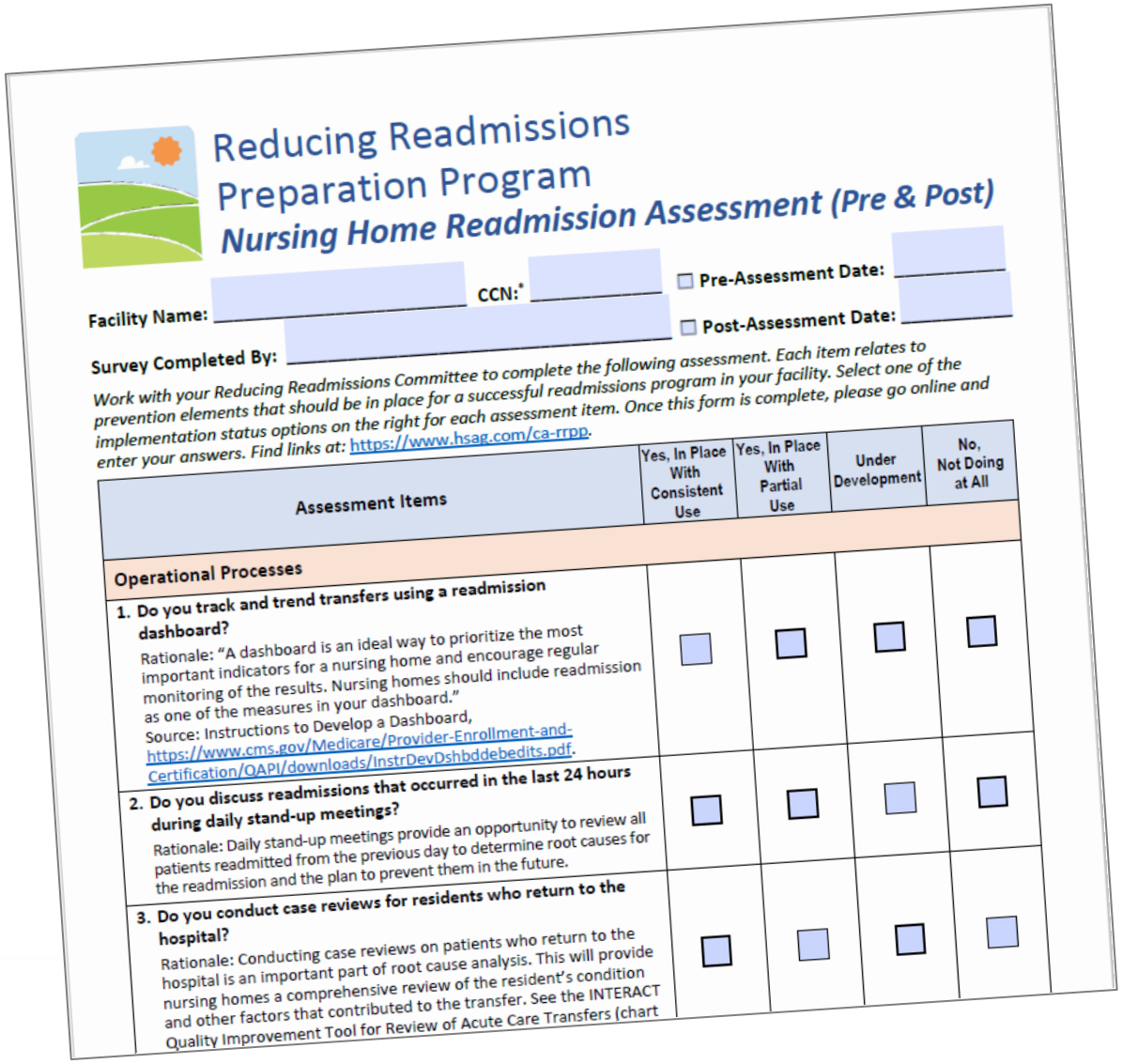
Assessment

California
www.hsag.com/ca-rrpp

Arizona
www.hsag.com/az-rrpp

Ohio
www.hsag.com/oh-rrpp

Readmission Assessment Form



Reducing Readmissions Preparation Program

Nursing Home Readmission Assessment (Pre & Post)

Facility Name: _____ **CCN:*** _____ ☐ **Pre-Assessment Date:** _____

Survey Completed By: _____ ☐ **Post-Assessment Date:** _____

Work with your Reducing Readmissions Committee to complete the following assessment. Each item relates to prevention elements that should be in place for a successful readmissions program in your facility. Select one of the implementation status options on the right for each assessment item. Once this form is complete, please go online and enter your answers. Find links at: https://www.hsag.com/ca-rrpp.

Assessment Items	Yes, In Place With Consistent Use	Yes, In Place With Partial Use	Under Development	No, Not Doing at All
Operational Processes				
1. Do you track and trend transfers using a readmission dashboard? Rationale: "A dashboard is an ideal way to prioritize the most important indicators for a nursing home and encourage regular monitoring of the results. Nursing homes should include readmission as one of the measures in your dashboard." Source: Instructions to Develop a Dashboard, https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/InstrDevDshbddebedits.pdf.	☐	☐	☐	☐
2. Do you discuss readmissions that occurred in the last 24 hours during daily stand-up meetings? Rationale: Daily stand-up meetings provide an opportunity to review all patients readmitted from the previous day to determine root causes for the readmission and the plan to prevent them in the future.	☐	☐	☐	☐
3. Do you conduct case reviews for residents who return to the hospital? Rationale: Conducting case reviews on patients who return to the hospital is an important part of root cause analysis. This will provide nursing homes a comprehensive review of the resident's condition and other factors that contributed to the transfer. See the INTERACT Quality Improvement Tool for Review of Acute Care Transfers (chart	☐	☐	☐	☐

Nursing Home Readmission Pre-Assessment

- 19 assessment items
- Categories:
  - Operational Processes
  - Pre-Admission
  - Admission/Transfer From Hospital
- Preliminary summary findings
  - Collated March 2018

Summary Points From Assessments Received

Nearly 40% of the assessment items are NOT fully in place with consistent use by at least 50% of respondents.

Operational Processes

- Do not track and trend transfers using a readmission dashboard (Q1)
- Do not conduct case reviews for residents who return to the hospital (Q3)
- Do not use chart audit tools for readmission case reviews (Q4)
- Do not have more than one readmission performance improvement project (Q5)
- Do not have a readmissions committee that meets monthly (Q7)

Admission/Transfer From Hospital

- Do not have a process for measuring if a resident is at risk for readmission (Q13)

Discharge to Home

- Do not conduct post-discharge follow-up phone calls to residents/families within 24–48 hours of discharge (Q18)

Results: Operational Processes Items Summary

Assessment Items	Yes, In Place With Consistent Use	Yes, In Place With Partial Use	Under Development	No, Not Doing at All
1. Do you track and trend transfers using a readmission dashboard?	36%	19%	22%	22%
2. Do you discuss readmissions that occurred in the last hours during daily stand-up meetings?	69%	7%	6%	6%
3. Do you conduct case reviews for residents who return to the hospital?	44%	33%	3%	19%
4. Do you use the INTERACT audit tools (or other evidence-based tools) for your readmission case reviews on residents who return to the hospital? (n=35)	46%	14%	9%	31%
5. Do you have more than one Performance Improvement Project(s) (PIP) specific to readmission prevention?	17%	25%	33%	25%
6. Do you have annual competencies with your nurses related to effective team communication?	53%	22%	14%	11%
7. Do you have a readmissions committee that meets monthly? (See form on following slide)	28%	17%	25%	31%
8. Do you report on readmissions, including data, to your Quality Assessment and Performance Improvement (QAPI) committee monthly?	67%	14%	8%	11%

Results reviewed during March Coaching Call

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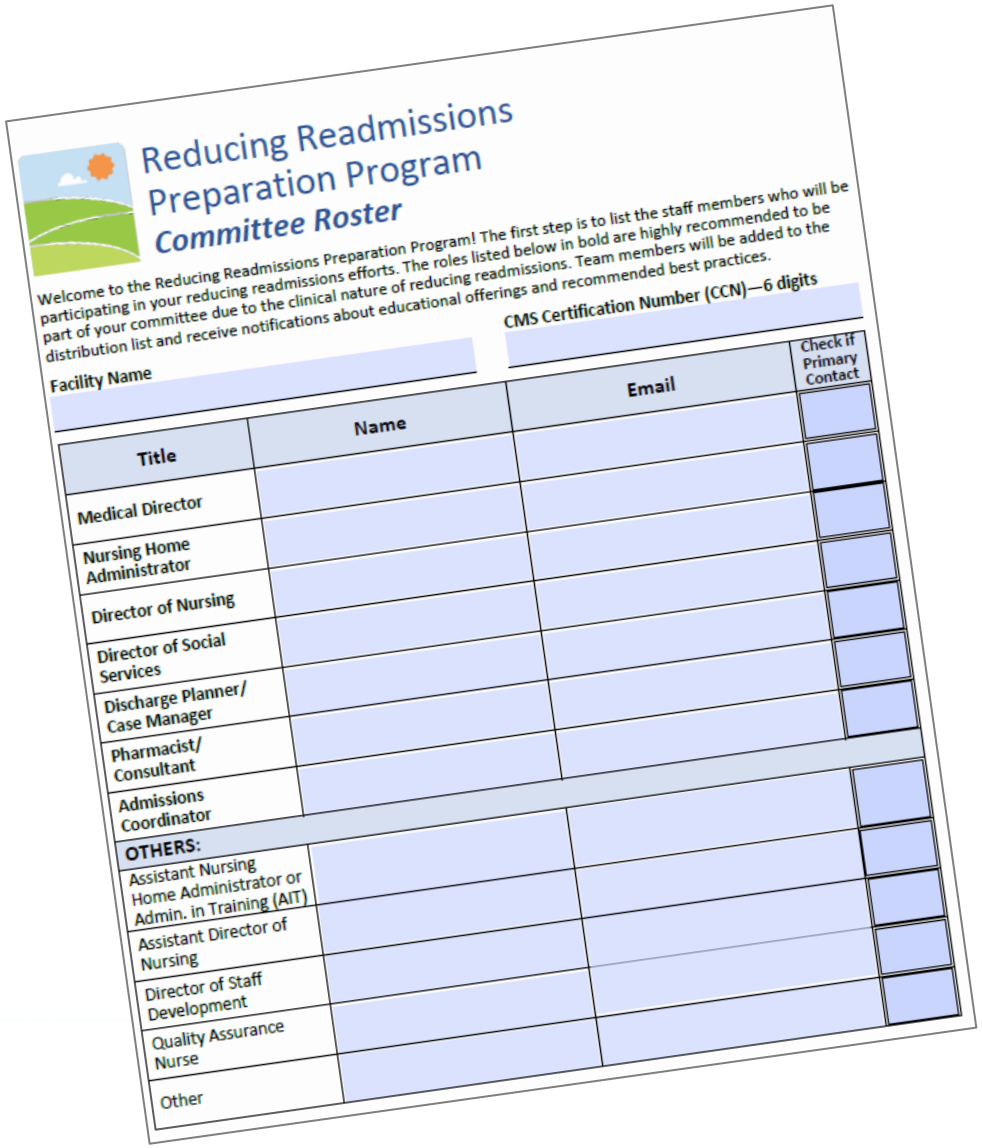
Readmissions Committee Roster Form



Reducing Readmissions Preparation Program

Committee Roster

Welcome to the Reducing Readmissions Preparation Program! The first step is to list the staff members who will be participating in your reducing readmissions efforts. The roles listed below in bold are highly recommended to be part of your committee due to the clinical nature of reducing readmissions. Team members will be added to the distribution list and receive notifications about educational offerings and recommended best practices.

Facility Name

CMS Certification Number (CCN)—6 digits

Title	Name	Email	Check if Primary Contact
Medical Director			
Nursing Home Administrator			
Director of Nursing			
Director of Social Services			
Discharge Planner/ Case Manager			
Pharmacist/ Consultant			
Admissions Coordinator			
OTHERS:			
Assistant Nursing Home Administrator or Admin. in Training (AIT)			
Assistant Director of Nursing			
Director of Staff Development			
Quality Assurance Nurse			
Other			

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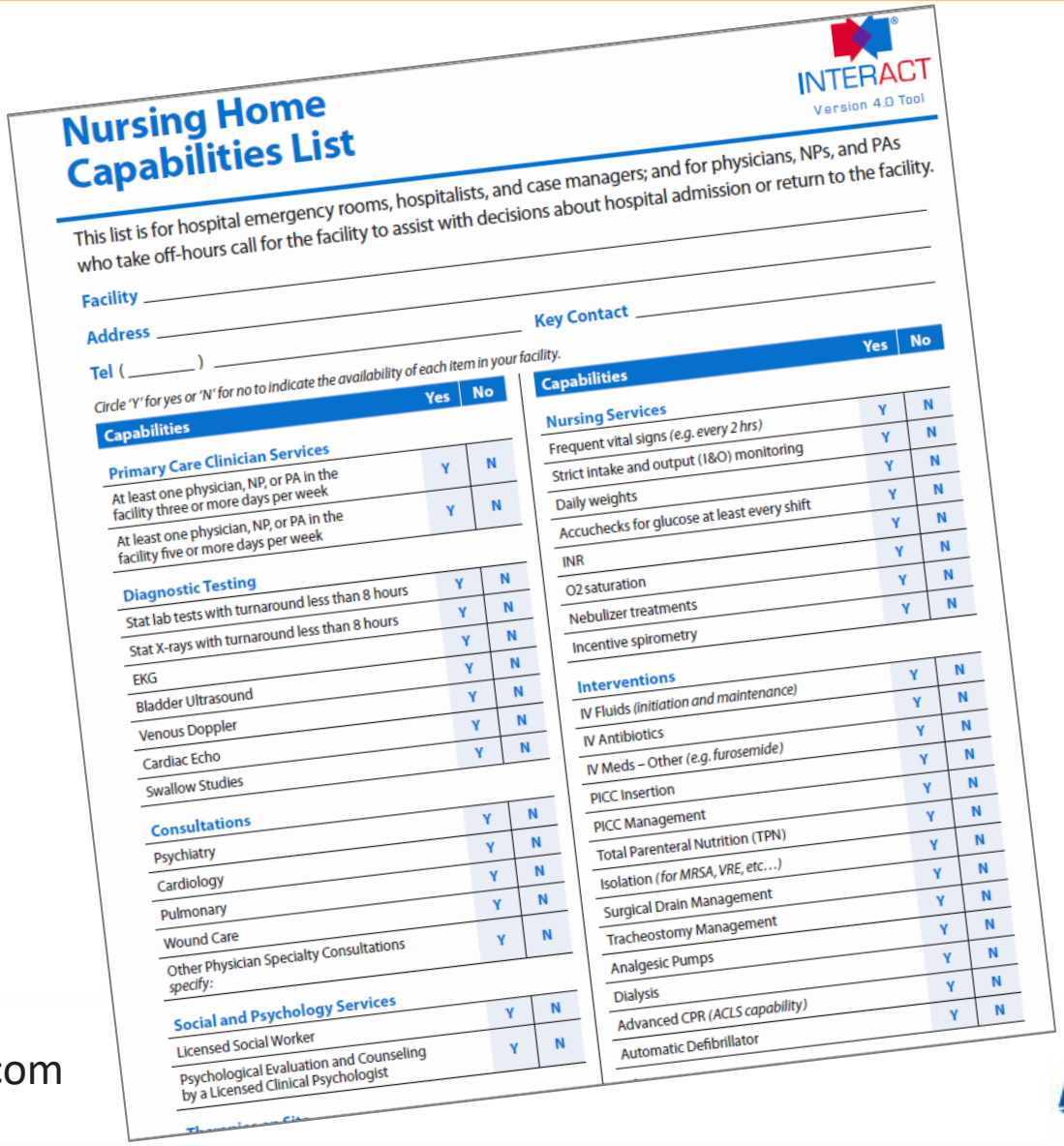
Results reviewed during March Coaching Call

Pre-Admission Items Summary

Assessment Items	Yes, In Place With Consistent Use	Yes, In Place With Partial Use	Under Development	No, Not Doing at All
Pre-Admission				
9. Does your primary transferring hospital know your nursing home capabilities? (See example next slide)	68%	13%	0%	13%
10. Do you obtain a standardized telephone "hand-off" report from the hospital prior to patient transfer/admission to your facility?	71%	21%	0%	3%
11. Does your primary transferring hospital share all necessary medical history and documents when patient transfers to your facility?	Results to be reviewed during next Coaching Call			

Nursing Home Capabilities List



Nursing Home Capabilities List

INTERACT® Version 4.0 Tool

This list is for hospital emergency rooms, hospitalists, and case managers; and for physicians, NPs, and PAs who take off-hours call for the facility to assist with decisions about hospital admission or return to the facility.

Facility _____

Address _____ Key Contact _____

Tel (_____) _____

Circle 'Y' for yes or 'N' for no to indicate the availability of each item in your facility.

Capabilities	Yes	No
Primary Care Clinician Services		
At least one physician, NP, or PA in the facility three or more days per week	Y	N
At least one physician, NP, or PA in the facility five or more days per week	Y	N
Diagnostic Testing		
Stat lab tests with turnaround less than 8 hours	Y	N
Stat X-rays with turnaround less than 8 hours	Y	N
EKG	Y	N
Bladder Ultrasound	Y	N
Venous Doppler	Y	N
Cardiac Echo	Y	N
Swallow Studies	Y	N
Consultations		
Psychiatry	Y	N
Cardiology	Y	N
Pulmonary	Y	N
Wound Care	Y	N
Other Physician Specialty Consultations *specify:*	Y	N
Social and Psychology Services		
Licensed Social Worker	Y	N
Psychological Evaluation and Counseling by a Licensed Clinical Psychologist	Y	N

Capabilities	Yes	No
Nursing Services		
Frequent vital signs *(e.g. every 2 hrs)*	Y	N
Strict intake and output (I&O) monitoring	Y	N
Daily weights	Y	N
Accuchecks for glucose at least every shift	Y	N
INR	Y	N
O2 saturation	Y	N
Nebulizer treatments	Y	N
Incentive spirometry	Y	N
Interventions		
IV Fluids *(initiation and maintenance)*	Y	N
IV Antibiotics	Y	N
IV Meds – Other *(e.g. furosemide)*	Y	N
PICC Insertion	Y	N
PICC Management	Y	N
Total Parenteral Nutrition (TPN)	Y	N
Isolation *(for MRSA, VRE, etc…)*	Y	N
Surgical Drain Management	Y	N
Tracheostomy Management	Y	N
Analgesic Pumps	Y	N
Dialysis	Y	N
Advanced CPR *(ACLS capability)*	Y	N
Automatic Defibrillator	Y	N

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Pre-Admission Items Summary

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Admission/Transfer From Hospital Items Summary

Assessment Items	Yes, In Place With Consistent Use	Yes, In Place With Partial Use	Under Development	No, Not Doing at All
Admission/Transfer From Hospital				
12. Do you conduct an orientation for new residents and family members about the nursing home?				
13. Do you have a process for measuring if a resident is at risk for readmission?				
14. Do you always have telephone access to your medical director (24/7) to ensure timely responses to urgent clinical needs?				

Results to be reviewed during next Coaching Call

Register Now for Upcoming Webinars

INTERVENTION STRATEGIES

Running a Readmission Review Committee

Wednesday, May 23, 2018
11 a.m.–12 noon PT
Continuing Education Credit

COACHING CALL

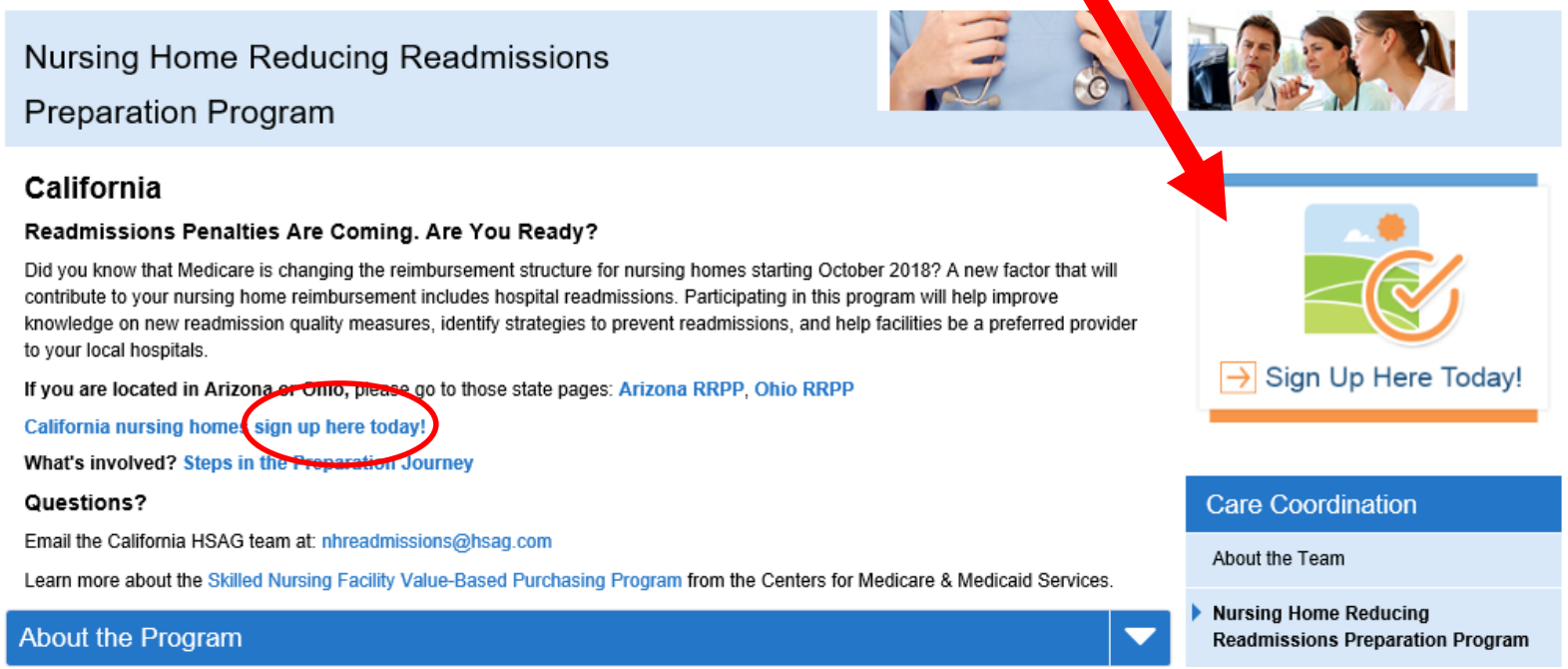
RRPP Coaching Call

Tuesday, June 5, 2018
12 noon PT

www.hsag.com/events

Sign up Today—Start the Journey

Complete commitment agreement:



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Thank you!

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State Program Director
HSAG




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