Emergency Department (ED) Visit Affinity Group

September 23, 2021

Event Hosts:

Carolyn Kazdan, MHSA, NHA
Julie Clark, BS, LPTA
Julie Kueker, MBA, MT(ASCP)

Beth Greene, MSW, LGSW
Melody Brown, MSM
Stacy Hull, LPC, MAC, CPCS

Georgia Health Care Association
Florida Health Care Association
North Carolina Health Care Facilities Association

Making Health Care Better *Together*

ALLIANT HEALTH SOLUTIONS

About Alliant Quality

Learning Objectives

- Learn how a hospital decision guide can be used to facilitate communication and reduce readmissions
- Learn how to define organizational trauma and describe strategies to mitigate trauma and create a trauma informed environment
- Provide input on future programming and resources to support you and your teams

Carolyn Kazdan, MHSA, NHA

AIM LEAD, CARE COORDINATION AND NURSING HOME

Ms. Kazdan currently holds the position of Director, Health Care Quality Improvement for IPRO, the Medicare Quality Improvement Organization for New York State. Ms. Kazdan leads IPRO's work with Project ECHO® and serves as the Care Transitions Lead for Alliant Quality. Ms. Kazdan previously led the IPRO's work with the NYS Partnership for Patients and the Centers for Medicare & Medicaid Services (CMS) Special Innovation Project on Transforming End of Life Care in the Nassau and Suffolk County region of New York State. Prior to joining IPRO, Ms. Kazdan served as a Licensed Nursing Home Administrator and Interim Regional Director of Operations in skilled nursing facilities and Continuing Care Retirement Communities in New York, Pennsylvania, Ohio and Maryland. Ms. Kazdan has served as a senior examiner for the American Healthcare Association's National Quality Award Program, and currently serves on the MOLST Statewide Implementation team and Executive Committee. Ms. Kazdan was awarded a Master's Degree in Health Services Administration by The George Washington University.

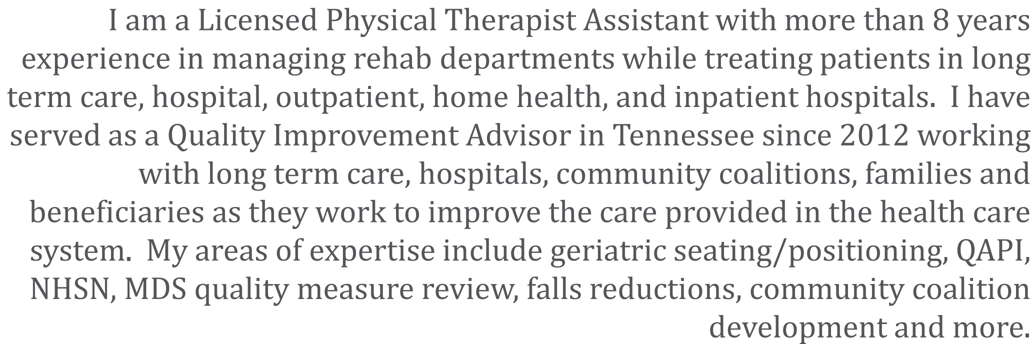
Carolyn enjoys visiting her grandchildren, photography, crocheting, needlepoint, reading and being at the beach!

"I don't have to chase extraordinary moments to find happiness - it's right in front of me if I'm paying attention and practicing gratitude"
– Brene Brown

Contact: ckazdan@ipro.org

Julie Clark, B.S., LPTA

SENIOR QUALITY IMPROVEMENT ADVISOR



I am a Licensed Physical Therapist Assistant with more than 8 years experience in managing rehab departments while treating patients in long term care, hospital, outpatient, home health, and inpatient hospitals. I have served as a Quality Improvement Advisor in Tennessee since 2012 working with long term care, hospitals, community coalitions, families and beneficiaries as they work to improve the care provided in the health care system. My areas of expertise include geriatric seating/positioning, QAPI, NHSN, MDS quality measure review, falls reductions, community coalition development and more.

My current hobbies include hiking in the mountains of East Tennessee, supporting people interested in changing to a clean eating through social media, and assisting my two sons on their journey through college at ETSU.

"Be the change that you wish to see in the world."
– Mahatma Gandhi

Contact: julie.clark@alliantquality.org

Julie Kueker, MBA, BS, MT (ASCP)

SENIOR QUALITY ADVISOR

I have been in healthcare for 38 years, getting my start in medical technology and infection control. In 1993, I achieved my MBA and from there moved to hospital administration working in quality management and physician peer review for a large teaching hospital in Shreveport. From there I took that quality experience to work for the Medicare Quality Improvement Organization (QIO) for Louisiana. I began my QIO work on the hospital team, but moved to the nursing home team about 15 years ago which has become my passion. My strengths include my quality background, infection control, QAPI, educating and helping providers design quality projects that leads to success for themselves and residents that they serve.

Julie enjoys visiting with her grandbaby (soon to be two of them!). In her spare time she likes to travel, antique hunt, read and play the piano.

"All beginnings require that you unlock a new door."
– Rabbi Nachman of Bratslav

Contact: Julie.Kueker@allianthealth.org

Stacy Hull, LPC, MAC, CPCS

STRATEGIC PARTNER: NATIONAL COVID-19 RESILIENCY NETWORK (NCRN)

Stacy Hull is a Licensed Professional Counselor and holds a certification as a Master Addiction Counselor. Stacy has worked in outpatient and residential settings providing mental health and substance use treatment to adults and children. These experiences help Stacy to excel at Alliant.

Additionally, Stacy has more than 25 years of clinical experience in service delivery and administrative leadership in the public behavioral health sector. She has also worked in hospitals, with physicians and inpatient psychiatric facilities to improve behavioral health outcomes in healthcare settings.

Stacy spends her time at Alliant focusing on behavioral health improvement.

"I've learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel."
– Maya Angelou

Contact: Stacy.Hull@AlliantHealth.org

Your input and needs inform our programming.

- During our July meeting, you identified action areas that can help reduce ED visits and avoidable readmissions.
- Why is this important during COVID surges?
  - Risks for patients of rehospitalization (can return more debilitated, increased family concerns/fears)
  - Time burden of an ED visit on staff
  - Stabilizing census
- Your input is why our focus is on the hospital decision guide today. *Go To The Hospital Or Stay Here: A Guide for Residents, Families, Friends and Caregivers* addresses multiple action areas from your force field analysis

Strategies for Change: Where should we focus next?

Broad Categories	Potential focus areas within each category
1. Partnering with Hospital EDs	• Learning what is important to your Hospital ED physicians • Assessment skills • Collaborating to development a standardized warm hand off protocol • Communication of facility capabilities and updating that communication as capabilities change
2. Engaging Medical Directors/ Attending Physicians/NPs/PAs in Readmission Initiatives	• Understanding of capabilities (by attending, covering and telehealth physicians) • Buy in with your goals • Participation in hand off protocol • Role of the Medical Director • Communication Tools for changes in condition • Role of telehealth • Advance Care Planning

3. The Role of Staff in Readmission Initiatives	• Staff participation on QAPI team to reduce ED visits
	• Staff education
	    • Facility Capabilities
	    • Risks and benefits of transfers
	    • Clinical Assessment
	    • Communication tools (e.g., Interact change of condition tools)
	    • Warm Hand Off
	• Staff competencies and ongoing monitoring (onboarding and annual)

4. Readmission Root Cause Analysis	• Using data • Using QI tools to validate your process • Patient and Family interviews

Go To The Hospital or Stay Here?

GO TO THE HOSPITAL
OR STAY HERE?

A Decision Guide for Residents, Their Families, Friends and Caregivers

CMS

"The Decision Guide tools and resources have really helped us think differently on how we can prepare our Residents and Families for changes in condition and to let them know, WE take care of them in our Nursing Facility." NC SNF

Education & Resources

Use this section to access Training & Educational Videos, Case Studies and Webinar Presentations

Information for Residents & Families — click here

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Ordering information

To order printed, full-color guides with same-day shipping:

Booklet Trifold

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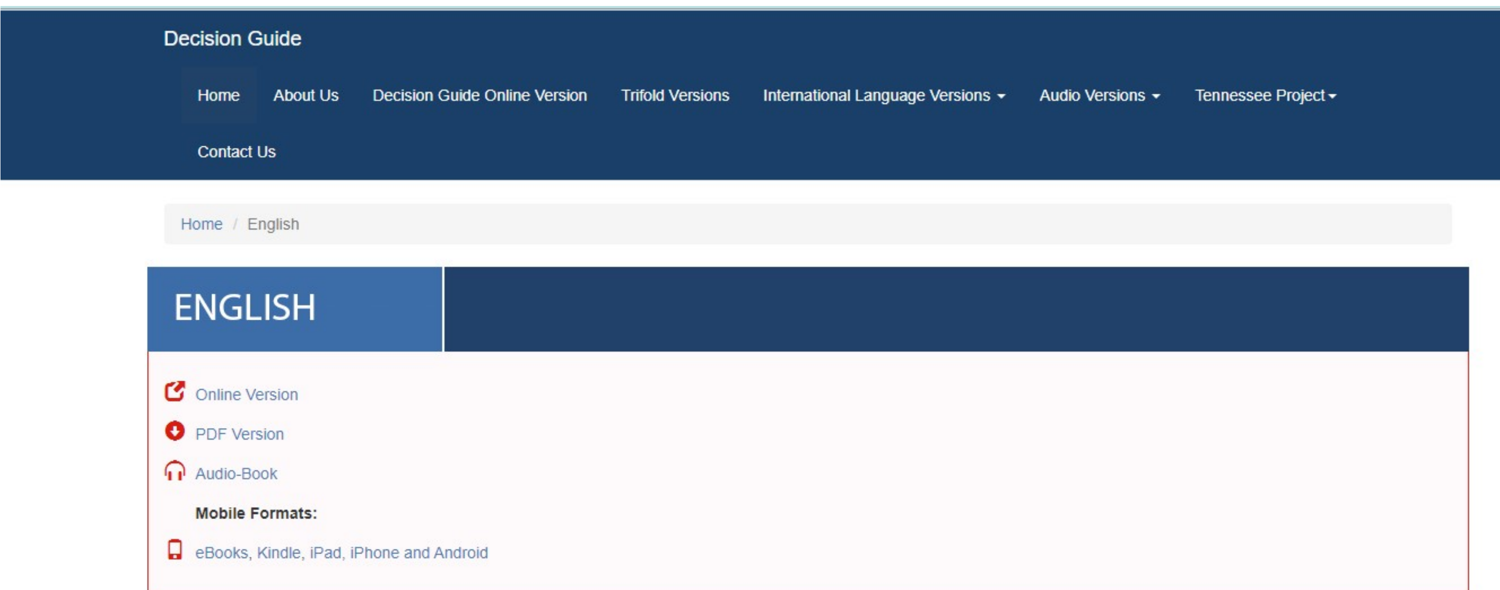
Funding for development of original Guide provided by Patient-Centered Outcomes Research Institute (PCORI). Funding for this updated Guide provided by the Eight States of CMS Region IV (Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee) Copyright Florida Atlantic University

CMS Project Admin

http://www.decisionguide.org/

Hospital Guide Versions



Available Languages:

- Spanish
- French
- Filipino
- Creole
- Chinese

Audio Versions:

- English
- Spanish

Using the Virtual Guide

Discussion Framework

Did you know that almost half of transfers to the hospital may be avoidable?

This Guide will help you understand why these transfers are made and how you can be involved in the decision.

CHANGE IN CONDITION

The question of sending you to the hospital or keeping you here may come up if your condition changes. This change could be a fever, shortness of breath, pain, an injury from a fall, or other change in your condition. If this happens, your medical provider has the responsibility to explain the change and the decisions that may need to be made to provide you the best possible treatment.

WHY THINK ABOUT THIS NOW?

This information is being provided to you so that you can make an informed decision if the question of going to the hospital arises.

It can be difficult to weigh the pros and cons of a transfer to the hospital when you become ill or to decide what treatment you prefer in the middle of a crisis.

IF IT IS NOT AN EMERGENCY

If this is not an emergency, the nurse will assess your condition:

- Ask you what happened, how you feel, where it hurts
- Listen to your heart and lungs
- Take your temperature, blood pressure, oxygen level
- Test your blood and urine

You can ask for the results and tell the nurse if you think your doctor, family, a friend or caregiver need to be called. If you have concerns about going to the hospital, this is the time to express them.

IN AN EMERGENCY

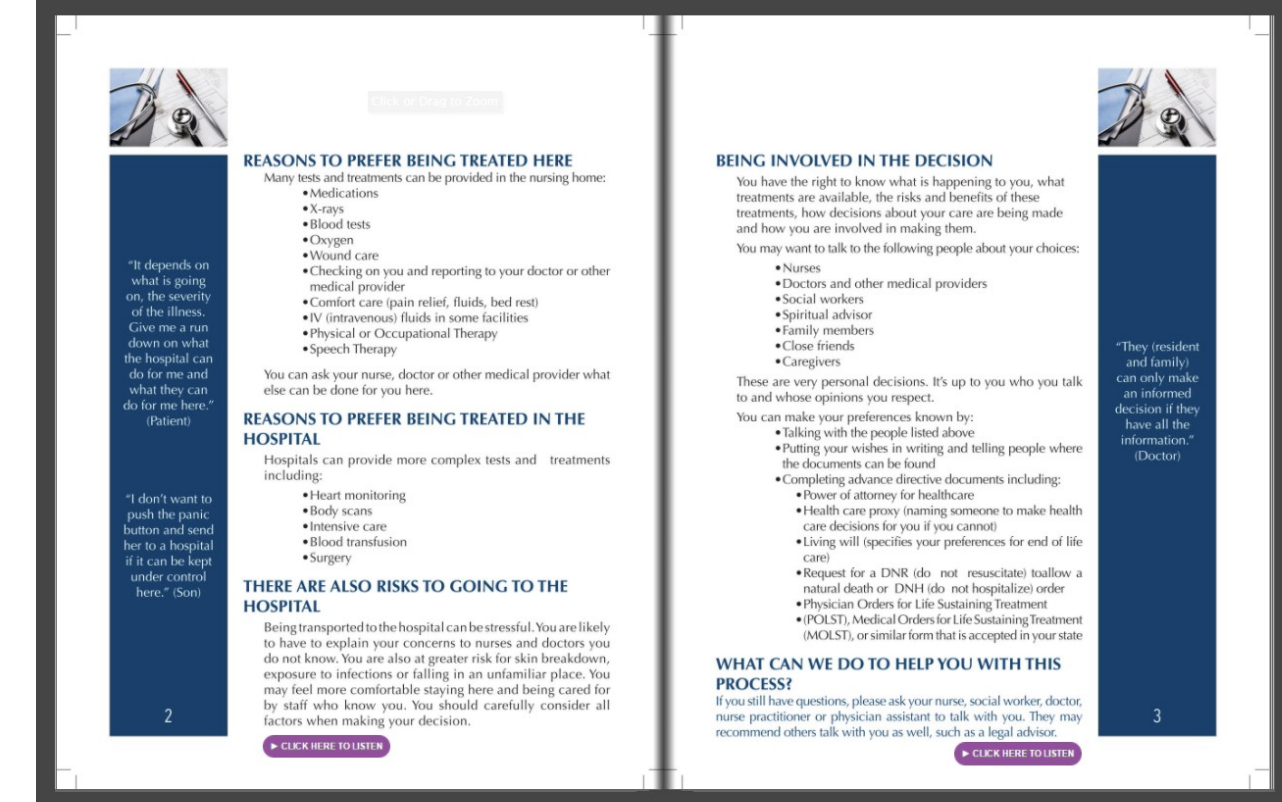
In a life threatening situation, the staff may call 911 to transport you to the hospital emergency department right away unless you have given them a Do Not Hospitalize request. They will also call your doctor or other medical provider (such as nurse practitioner or physician assistant) and a family member, friend or caregiver. You have the right to tell the staff ahead of time who you want called in an emergency.

► CLICK HERE TO LISTEN

"I want to be involved 100%."
(Patient)

"We do our best to keep them here. We do tests first, the proper assessment, diagnostic tests, whatever we can do here before we would transfer to the hospital."
(Nurse)

Risks, Benefits & Shared Decision-Making



"It depends on what is going on, the severity of the illness. Give me a run down on what the hospital can do for me and what they can do for me here." (Patient)

"I don't want to push the panic button and send her to a hospital if it can be kept under control here." (Son)

REASONS TO PREFER BEING TREATED HERE

Many tests and treatments can be provided in the nursing home:

- Medications
- X-rays
- Blood tests
- Oxygen
- Wound care
- Checking on you and reporting to your doctor or other medical provider
- Comfort care (pain relief, fluids, bed rest)
- IV (intravenous) fluids in some facilities
- Physical or Occupational Therapy
- Speech Therapy

You can ask your nurse, doctor or other medical provider what else can be done for you here.

REASONS TO PREFER BEING TREATED IN THE HOSPITAL

Hospitals can provide more complex tests and treatments including:

- Heart monitoring
- Body scans
- Intensive care
- Blood transfusion
- Surgery

THERE ARE ALSO RISKS TO GOING TO THE HOSPITAL

Being transported to the hospital can be stressful. You are likely to have to explain your concerns to nurses and doctors you do not know. You are also at greater risk for skin breakdown, exposure to infections or falling in an unfamiliar place. You may feel more comfortable staying here and being cared for by staff who know you. You should carefully consider all factors when making your decision.

► CLICK HERE TO LISTEN

2

BEING INVOLVED IN THE DECISION

You have the right to know what is happening to you, what treatments are available, the risks and benefits of these treatments, how decisions about your care are being made and how you are involved in making them.

You may want to talk to the following people about your choices:

- Nurses
- Doctors and other medical providers
- Social workers
- Spiritual advisor
- Family members
- Close friends
- Caregivers

These are very personal decisions. It's up to you who you talk to and whose opinions you respect.

You can make your preferences known by:

- Talking with the people listed above
- Putting your wishes in writing and telling people where the documents can be found
- Completing advance directive documents including:
  - Power of attorney for healthcare
  - Health care proxy (naming someone to make health care decisions for you if you cannot)
  - Living will (specifies your preferences for end of life care)
  - Request for a DNR (do not resuscitate) toallow a natural death or DNH (do not hospitalize) order
  - Physician Orders for Life Sustaining Treatment
  - (POLST), Medical Orders for Life Sustaining Treatment (MOLST), or similar form that is accepted in your state

WHAT CAN WE DO TO HELP YOU WITH THIS PROCESS?

If you still have questions, please ask your nurse, social worker, doctor, nurse practitioner or physician assistant to talk with you. They may recommend others talk with you as well, such as a legal advisor.

► CLICK HERE TO LISTEN

"They (resident and family) can only make an informed decision if they have all the information." (Doctor)

3

Advance Care Planning

FAQs (Frequently Asked Questions) *continued*

"It's my lungs. There's nothing they can do for me any more so I would rather stay here where they know me and I can be comfortable. It would be different if, when they were finished, they could say 'you can get up out of that chair and go to the ball'. But that is not going to happen." (Patient)

18. **Why is this decision so important?**

There are several reasons why this decision is important. Sometimes residents, their family members, friends or caregivers become very anxious when a resident becomes ill and ask that the person be sent to the hospital when treatment could be provided here. There are some risks and discomfort associated with being sent to the hospital. The transfer itself, a new environment, new staff and new routines can be sources of discomfort. The risks include falls, skin breakdown (pressure sores) and more exposure to potentially dangerous infections. Both the transfer and hospital care are very expensive. Some of these expenses may not be covered by your insurance. You may want to ask about this so that you can consider this information in making your decision.

COMFORT CARE, PALLIATIVE CARE, AND HOSPICE CARE AS WELL AS ADVANCE DIRECTIVES

1. **What is the difference between hospice and palliative care?**

Hospice care and palliative care are similar but hospice care is intended for those who are in the final months of their life (usually 6 months or less) while palliative care can continue for many months, even years. hospice care focuses on pain control, symptom management, emotional and spiritual support.

2. **What is "comfort care"?**

Comfort care or palliative care focuses on easing pain and other symptoms such as nausea, fatigue, depression, breathing problems, constipation or diarrhea that are the result of your illness or the treatment of your illness. Palliative care teams also help you cope with your illness, providing practical solutions, emotional and spiritual care. The goal is to preserve your peace, comfort and dignity as much as possible.

3. **What happens if I am getting hospice care when I go to the hospital?**

If you go to the hospital, you may have to re-qualify for hospice after returning here. If there is time, hospice should be called before you are transferred to the hospital.

► CLICK HERE TO LISTEN

4. **What are advance directives? Should I have them?**

Advance directives are documents that tell your health care providers what kind of care you want to receive if you are unable to be involved in the decision. You can say you don't want certain treatments such as CPR (resuscitation) if your heart stops, to be put on a breathing machine if you can't breathe on your own, or if you want a feeding tube if you cannot eat. You can also state that you want all the treatment available if that is your preference. You can designate someone to make decisions for you if you cannot (or do not want to) do it yourself.

5. **If I have advance directives, will my wishes be honored?**

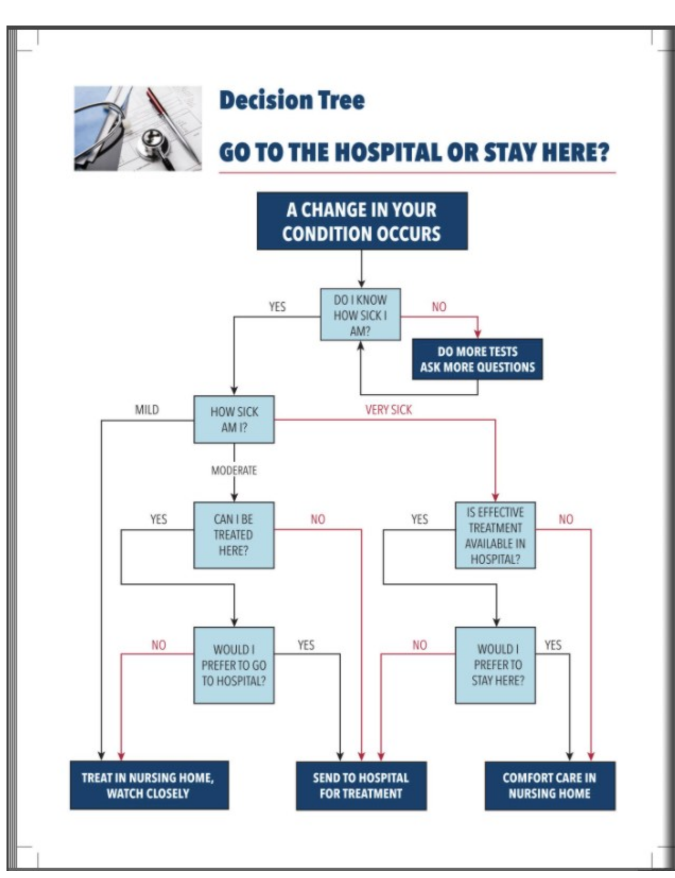
To make sure that your wishes are honored, review them with the staff, your family, a friend, or care provider ahead of time. Be sure a copy is on your chart at the hospital and available here as well. It's a good idea to give copies of your advance directives to your family, a friend, or caregiver and medical care provider ahead of time. You can update your advance directives at any time.

6. **Once I have expressed my wishes in advance directives, can I change my mind?**

Yes, you can change your mind and your advance directives at any time. If you want to change your advance directives, tell your care provider, family, friend or caregiver what changes you would like to make.

► CLICK HERE TO LISTEN

Hospitalization Decision Tree



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Education Materials

Educational Materials for Staff

Videos

The Usefulness of the Guide

Dr Adrienne Mims shares her perspective as a gerontologist and the family member of a nursing home resident

An Introduction from the Project Director

Dr Ruth Tappen describes the development of the Decision Guide

A Testimonial from a Nursing Home Resident

Paul, a rehab center resident talks about how the Guide and better information could have helped avoid an unnecessary hospital transfer.

Introduction for a new Resident and Family Member

Teaming with Resident to Prevent Hospitalization

A resident's change in condition that

Engaging the Resident and Family in the Plan of Care

Resident and family learn how following the recommended diet

Sample PDSA Worksheet

Quality Improvement Initiative (QII) PDSA Worksheet

QUALITY IMPROVEMENT INITIATIVE

Facility Name: ______________________________ CCN# ____________________

Date: ____________

Goal Setting: Describe the problem to be solved

State the problem ex: who, what when, where, how, how long	Through Root Cause Analysis (RCA) we have identified an opportunity for improvement with communication prior to potential transmissions of care to the emergency department. RCA identified some transfers to ED could have been evaluated/ treated at the facility. Implementation of the Stay Here or Go to the Hospital Decision guide will be utilized in this PLAN to improve this communication process and potentially reduce preventable emergency department transfers. ☐ 1 Training staff with the Stay Here or Go to the Hospital Decision guide will increase their knowledge and skills with discussions between them and the resident and/or caregivers. ☐ 2. Including the Stay Here or Go to the Hospital Decision Guide in the admission welcome packet with an overview of the flyer from the Admission staff member will enhance the awareness of interventions that can be provided at the facility thus reducing the experience of a preventable transfer. ☐ 3. Building a QAPI PIP team to engage with area hospitals during the development of this new process. ☐ 4. Create a process to order/print the guide and have it available in various areas in the facility where staff / residents/ and caregivers can access them. ☐ 5. Build training of the guide into new staff and contract staff onboarding/orientation. ☐ 6. Integrate discussion of current risks for readmission and the Hospital Decision Guide into all care conference agendas.
Identify the Infection Prevention Category	N/A
If category is "Other," enter category here	N/A

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SMART Goals and Process Changes

What do we want to accomplish/ what idea do you want to test? Identify the goal and estimated timeframe for resolution **Specific**- What do you want to achieve? Increase knowledge and understanding of vaccine benefits and EUA process/ create small groups for education and communication opportunities to decrease feelings of pressure/ print new material in different languages/overcome misinformation with facts and My Why vaccination stories of vaccinated staff. **Measurable**- What data will you review? Vaccination rates/ staff feedback/ pre and posttests/ **Attainable**- Goal rate (start small and set reach goal too) **Relevant/Realistic**- is this topic needed and why? Low rate of vaccination number/staff feeling pressured/ misinformation impacting decisions. **Time-Bound**- set monthly goals and a goal to complete by date.	SMART goal here **Sample SMART goals-** ☐ 1. Within *(time frame)* all staff will be provided education on the use of the ***Go To The Hospital or Stay Here? A Decision Guide for Residents, Families, Friends and Caregivers***. After this initial education the use of the guide is expected to increase the confidence of staff in facilitation change in condition conversations between staff and residents/caregivers. This enhanced communication should lead to reductions in preventable ED visits and increase in the care interventions provided at the facility. ☐ 2. Within (*time frame*) the Hospital Decision Guide will be included in the admission packet. Admission staff will discuss the flyer and the goal of reducing preventable transfers in efforts to alleviate stress from these types of interventions during each admission session. Providing this information at admission will increase the knowledge of the use of the guide and the goal of the facility to each new resident/caregiver. ☐ 3. Within (*time frame*) the QAPI PIP team will have contacted each referring hospital and explained the new process of utilizing the guide at the facility. Team will express this is an intervention aimed at reducing avoidable ED transfers by utilizing interventions at the facility. This communication with the referring hospitals is expected to produce a collaborative approach to reducing preventable transfers. ☐ 4. Within *(time frame)* all Care Conference team members will be educated on the content and use of the guide and strategies for integrating discussion on current readmissions risks and the guide into care conference agendas. ☐ 5.
What change can be made that will result in improvement? e.g., safety, effectiveness, patient-centered care, timely, efficiency, equitability, etc.	What are you going to change based on your RCA that you feel will result in improvement? 1. Change in education processes to add education on the contents and use of the Decision Guide 2. Change in Admission processes to include addition and review of the Decision Guide 3. Change in Care Conference process to include discussion of the Decision Guide and current readmission risks
Who will be affected by accomplishing the goal?	Staff, Residents, Families, Caregivers

Using Smart Goals 1-4 as examples, create SMART goals for the remaining interventions

Creating Actionable Interventions

Plan: Describe the change (intervention) to be implemented

What exactly will be done? e.g., initial intervention(s), expected outcome for each intervention, goal(s), and expected overall outcome goal rate in a percentage format	List interventions you will provide and your expectations for improvement rates. Sample= ☒ **1. Training staff with the Hospital Decision guide will increase their knowledge and skills with discussions between them and the resident and/or caregivers. =** This intervention is expected to reduce preventable ED transfers and increase interventions provided at the facility. ☐ **2. Including the Hospital Decision Guide in the admission welcome packet with an overview of the flyer from the admission staff member =** This intervention will increase the understanding and enhance the awareness of interventions that can be provided at the facility thus reducing the experience of a preventable transfer. ☐ **3. Building a QAPI PIP team to engage with area hospitals =** This intervention is expected to enhance communication with area hospitals while building a collaborative approach to reducing preventable ED transfers. ☐ **4. Create a process to order/print the guide to have available in various areas/languages in the facility where staff, residents and caregivers can access =** This process will ensure access to the guide during communication regarding changes in condition and potential ED transfers ☐ **5. Build training of the guide into new staff and contract staff onboarding/orientation =** This intervention will ensure all new staff and contract staff are aware of and compliant with guide use. ☐ **6. Integrating discussion of readmission risks and the decision guide into care conferences =** This intervention will further embed the focus on care planning for and reducing readmission risks and prepare patients, families and caregivers for conversations with changes in condition occur.

Identifying Process Owners

Who will be responsible for implementing the change?	Identify the individual(s) in facility who can lead implementation of this change. (e.g. member of the QAPI team, Staff Educator, Social Work, Admissions or Care Management). One or more individuals can share the responsibility as lead(s)
Where will it take place?	Where and when will you provide the interventions listed? **Sample**= Stay Here or Go to the Hospital guide will be shared at time of admission or shortly thereafter with resident/caregiver. **Sample**=Small group meetings will take place at the facility in the ABC room from 4:00 p.m., to 4:30 p.m. each Friday and Saturday for two weeks, where all staff will be educated on the guide and expectations of use. **Sample**= During discussions with the resident/ caregiver of need for interventions/care for the resident when these interventions/care can be provided at the facility.

Measuring Intervention Effectiveness

What will be measured / Describe the measure(s) to determine if prediction succeeds?	What data or outcome will you measure? Samples= 1. Pretest and Posttest from staff training on the guide and expectations of use 2. Number of Guides provided during admissions each month (the total number of admissions and total number of guides used should match) 3. Number of ED visits will be measured over 30d/60d/90d to determine if rate of ED visits have decreased in comparison to previous time frame 4. Number of guides printed/ordered each month and placed in appropriate areas of the facility. (Audit by surveillance rounds) 5. Number of new or contract staff compared to number of completed trainings of the guide during orientation/onboarding. 6. Number of care conferences with documentation of discussion of readmission risks and the Decision Guide
Who will be responsible for measuring the data?	This can be a group or an individual.
How will the data be collected / computed / analyzed?	Examples: 1. After staff training all pretests and posttest will be reviewed. Staff not at 100% on posttests will be provided additional training on questions missed. 2. Monthly comparison of guides ordered/printed and number of admissions. 3. Electronic health record for transfers and/or discharges to ED will be reviewed by QAPI committee monthly to identify possible preventable transfers that occurred and successful use of the guide that assisted in avoiding the preventable ED transfer. 4. Surveillance audits of locations of the guide will be conducted (daily/weekly) to ensure availability during time of communication with resident/caregivers. 5. Audits of new staff orientation/onboarding monthly by QAPI committee to ensure all new and contract staff have been educated. 6. Care Conference documentation will be reviewed for integration of readmission risks and reference to the Decision Guide

Measuring Intervention Effectiveness

What is the current data figure for that measure? e.g., count, percent, rate, etc.	1. Baseline Data = number of staff trained on the Stay Here or Go to the Hospital Guide 2. Baseline data= number of guides ordered/printed at start of process development 3. Baseline Data=number of preventable ED transfers at start of process 4. Baseline Data = number of transferring hospitals communicated with about the guide 5. Baseline data= number of guides placed in locations throughout the facility. 6. Baseline data= staff pretests and posttest results after first training sessions
What should the number increase/decrease to in order to meet the goal?	Goal rate should be above your baseline rates-
Did you base the measure or figure you want to attain on a particular best practice/average score/ benchmark?	Based on best practice of the Hospital Decision Guide as it has been successful in reducing preventable ED transfers with improved communication of services/interventions that can be provided at the facility.

Do: Implement Change

Do: Implement Change

Enrollment in upcoming learning collaborative. The learning collaborative will provide group technical assistance using a data driven, action-oriented approach. Unlike individual learning, people engaged in learning collaborative events capitalize on one another's resources and skills.

Alliant Quality Registration Page for all events - https://www.alliantquality.org/virtual-educational-events/

Alliant YouTube Channel- https://www.youtube.com/channel/UC9mITtil3mHpVNd87vaxD6w

Was the plan executed?	Here you will enter when the plan started.
How long was the plan executed?	Here you will enter when it started and how long it lasted.
Document any unexpected events or problems	This can be many things so add every event that was unexpected.
Describe what actually happened when you ran the test e.g., the indicators measured, the adoption of the change by staff, process change, etc.	Did you see improvement in reducing preventable ED transfers? How did your staff/ residents/caregivers respond to the use of the guide?

Study: Review and Reflect

Study: Review and Reflect on Results of the Change

Schedule monthly reviews of the changes being made

Describe the measured results and how they compared to the predictions State at least 1 or more interventions that contributed to the improvement of the problem	When you review what you have implemented you will add notes here on what you felt was the most effective in moving toward improvement. Example: Utilizing the guide empowered our staff to have conversations with residents/caregivers regarding the interventions the facility can provide. This helped reduce our preventable ED transfers and provided person centered care to our residents.
Graphically illustrate data improvement comparison from baseline to current data in percentage(s)	Here you will enter data for the length of the PDSA. You should see movement toward your goal rates.

Is this change likely to continue? Identify at least one or more of the continued sustainable interventions that addresses the problem	Yes, what are some of the interventions that helped the change effort? Example: placing the guide in locations throughout the facility increased the availability and awareness of the guide.

Act: Modifying Plans as You Learn

Act: Determine the Action Needed Based on Results of the Change

Monitor data and adjust interventions/tactics.

What will you take forward from this PDSA?	Adopt, Adapt, or Abandon PDSA PLAN?
Describe what modifications to the plan will be made from what you learned	If you **Adopt** the PLAN will you modify to -spread further- move to a stretch goal? If you are **Adapting** the PLAN what changes will you make and list, why? If you **Abandon** the PLAN possibly list, why here.

Alliant Resources

Intervention/Improvement Details:

Action Step	Person Responsible	Completion Date	Outcome
Attended/Watched Recording Alliant Quality ED Affinity Group Meetings	List who attended or watched recorded		
Review recording of Alliant Quality Webinar demonstrating the tool Alliant Quality Hospital Decision Guide Webinar with Dr. Ruth Tappen			
Join Alliant Quality ED Affinity Group Hospital Decision Guide Office Hours (join 1, 2 or 3 sessions) on October 14th, October 21st, October 28th at 10:00 – 10:30 CST/ 11:00 – 11:30 EST **Registration links for Office Hours:** October 14th: https://allianthealthgroup.webex.com/allianthealthgroup/onstage/g.php?MTID=e06c348128eed82d437110b0e46498776 October 21st: https://allianthealthgroup.webex.com/allianthealthgroup/onstage/g.php?MTID=ebe64ac0109c52db7394114289590355b October 28th: https://allianthealthgroup.webex.com/allianthealthgroup/onstage/g.php?MTID=e48ff27e022a818c9b22933da3a1a3d5d			

RCA

Findings from the Root Cause Analysis:

Category	Barriers Identified

Communication/Notes:

Questions?

Building a Trauma-Informed Organization

National COVID-19 Resiliency Network(NCRN) General Overview

NCRN is a national initiative made up of local, state and national partners working collectively to mitigate the impact of COVID-19 on the following racial and ethic groups: African Americans, Latinos, Asian Americans, Native Hawaiians, Pacific Islanders, American Indians, and Alaska Natives. NCRN is also addressing the impact of the pandemic in rural areas.

The partnership focuses on six foundational areas:

Identify and Engage Vulnerable Communities

through local, state, territory, tribes and national partners.

Nurture Existing and Develop New Partnerships

to ensure an active information dissemination network.

Disseminate Culturally & Linguistically Appropriate Information

In partnership with vulnerable communities and national, state, local, territory, tribe and government organizations

Link Vulnerable Communities to Resources with Technology

Connecting communities to community health workers, healthcare and social services.

Monitor and Evaluate

identifying successes and measuring outcomes to improve the program.

Comprehensive Dissemination

using mainstream media, white papers, and publications to educate and train the response workforce.

National COVID-19 Resiliency Network | Morehouse School of Medicine

Objectives

- Define organizational trauma
- Understand the causes of organizational trauma
- Understand the impact the pandemic has had on mental wellness
- Recognize six principles in creating a trauma informed approach

Organizational Trauma

Occurs when an individual or group is confronted with actual or threatened death, serious injuries, sexual violation, or is exposed to death, injury, or suffering of other people within the same working environment.

What is an Organization?

An organization is a group of people organized for a common purpose

— Values and mission statements
— Policies and procedures
— Language and acronyms
— Unique culture and habits

Culture of Organizations

- Core character and uniqueness
- Collective identity
- Norms, values and standards
- Personality and spirit
- Purpose of the organization’s existence
- Relationship of the organization to society
- Guidance on the way the work is done

Causes of Organizational Trauma

- Major reorganizations
- Turnover of senior leadership
- Violence in the workplace
- Natural disasters
- Death or serious injury

Occurrence of Organizational Trauma

- Single catastrophic event
- Empathic nature of the work
- Redemptive nature of the work
- Ongoing wounding

Stressors of the Pandemic

- Fear, worry and anxiety
- Experiencing death at alarming rates
- Personal and family safety concerns
- Resurgent of COVID-19 positive cases
- Unresolved grief and loss
- Staffing shortages
- Feeling powerless
- Guilt and remorse
- Visitation restrictions
- Social isolation
- Economic recession
- Financial strain/loss jobs
- Food and supply shortages
- More rules and regulations
- Social injustice
- Virtual learning/returning to school
- Competing demands

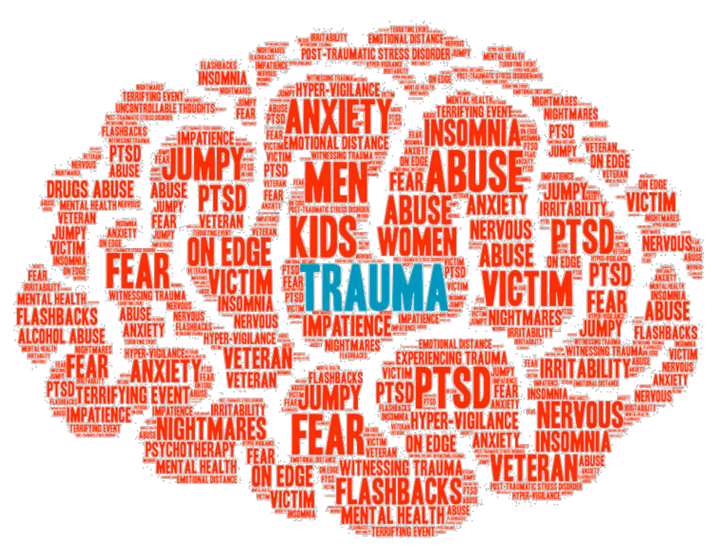
Post-Traumatic Stress Disorder

Post Traumatic Stress Disorder (PTSD) is an anxiety disorder in which a person who has experienced a traumatic event, witnessed an event or been exposed to an event continues to experience fear and related symptoms even when they are no longer in danger.

Symptom Clusters

PTSD is often characterized by four (4) symptom clusters:

- Intense reliving of the traumatic event(s)
- Avoidance of events, locations or people that are reminders of the traumatic event(s)
- Negative cognitions and mood
- Increase in arousal and responses



What Can You Do About It?

Creating a Trauma-Informed Organization

A trauma-informed organization views all practices and services through the lens of trauma. It is a strengths-based approach that recognizes the impact of trauma and aims to create environments and services that are welcoming, safe and engaging for both care recipients and providers.

Six Principles: A Trauma Informed Approach

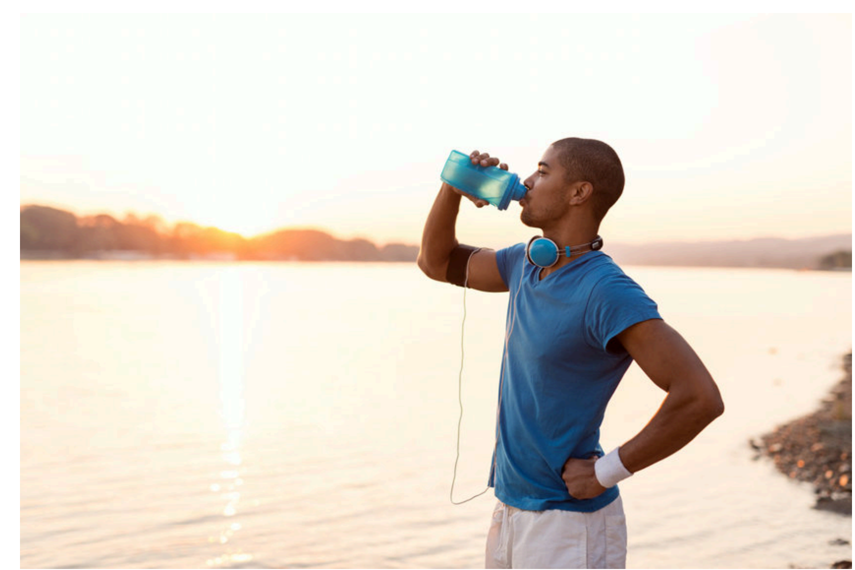
- Safety
- Trust and transparency
- Collaboration
- Peer Support
- Empowerment
- Cultural, Historical and Gender Issues

The Role of Leadership

- Act as a role model
- Acknowledge the traumatic event
- Offer optimism, confidence and energy
- Create space for healing
- Ask for outside help if necessary

Resiliency Factors

- Self-care
- Talk to a trusted person
- Professional support



Something to Think About

How will you open a productive and sincere dialogue about traumatic experiences with your team?

Resources for Mental Health Support

- **Mental Health America -** On line mental health screening tools - https://www.mhanational.org/self-help-tools
- **Disaster Distress Helpline -** 1-800-985-5990 or text **TalkWithUs** to 66746 - SAMHSA's Disaster Distress Helpline provides 24/7, 365-day-a-year crisis counseling and support to people experiencing emotional distress related to natural or human-caused disasters. https://www.samhsa.gov/find-help/disaster-distress-helpline
- **National Suicide Prevention Lifeline -** 1-800-273-TALK (8255) **en español: 1-888-628-9454 -** Free and confidential support for people in distress 24/7. https://suicidepreventionlifeline.org/
- **National Center for PTSD Crisis Line -** 1-800-273-8255 - https://www.veteranscrisisline.net/get-help/chat
- **National Helpline -** 1-800-662-HELP (4357) - SAMHSA's National Helpline is a free, confidential, 24/7, 365-day-a-year treatment referral and information service (in English and Spanish) for individuals and families facing mental and/or substance use disorders. https://www.samhsa.gov/find-help/national-helpline
- **Crisis Text Line -** The Crisis Text hotline is available 24 hours a day, seven days a week throughout the U.S. The Crisis Text Line serves anyone, in any type of crisis, connecting them with a crisis counselor who can provide support and information (text HELLO to 741741)

National COVID-19 Resiliency Network Resources (NCRN)

- NCRN webpage (13 languages), NCRN newsletter & join NCRN Regional Community Coalition: at https://ncrn.msm.edu/s/?language=en_US&targetlanguage=en_US
- NCRN Apps:
  - iOS version
  - Android version
- NCRN Call Center at 1-877-904-5097. Operators are available between 9 a.m. – 9 p.m. Monday – Friday

Questions?

Contact Information

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- Organizational Trauma and Healing: Pat Vivian and Shana Horman
- National Institute of Mental Health
- Mental Health America
- Office of Victims of Crime Training and Technical Assistance Center
- Center for Preparedness and Response: https://www.cdc.gov/cpr/

CMS 12th SOW Goals

Behavioral Health Outcomes & Opioid Misuse

- ✓ Promote opioid best practices
- ✓ Decrease high dose opioid prescribing and opioid adverse events in all settings
- ✓ Increase access to behavioral health services

Patient Safety

- ✓ Reduce risky medication combinations
- ✓ Reduce adverse drug events
- ✓ Reduce C. diff in all settings

Chronic Disease Self-Management

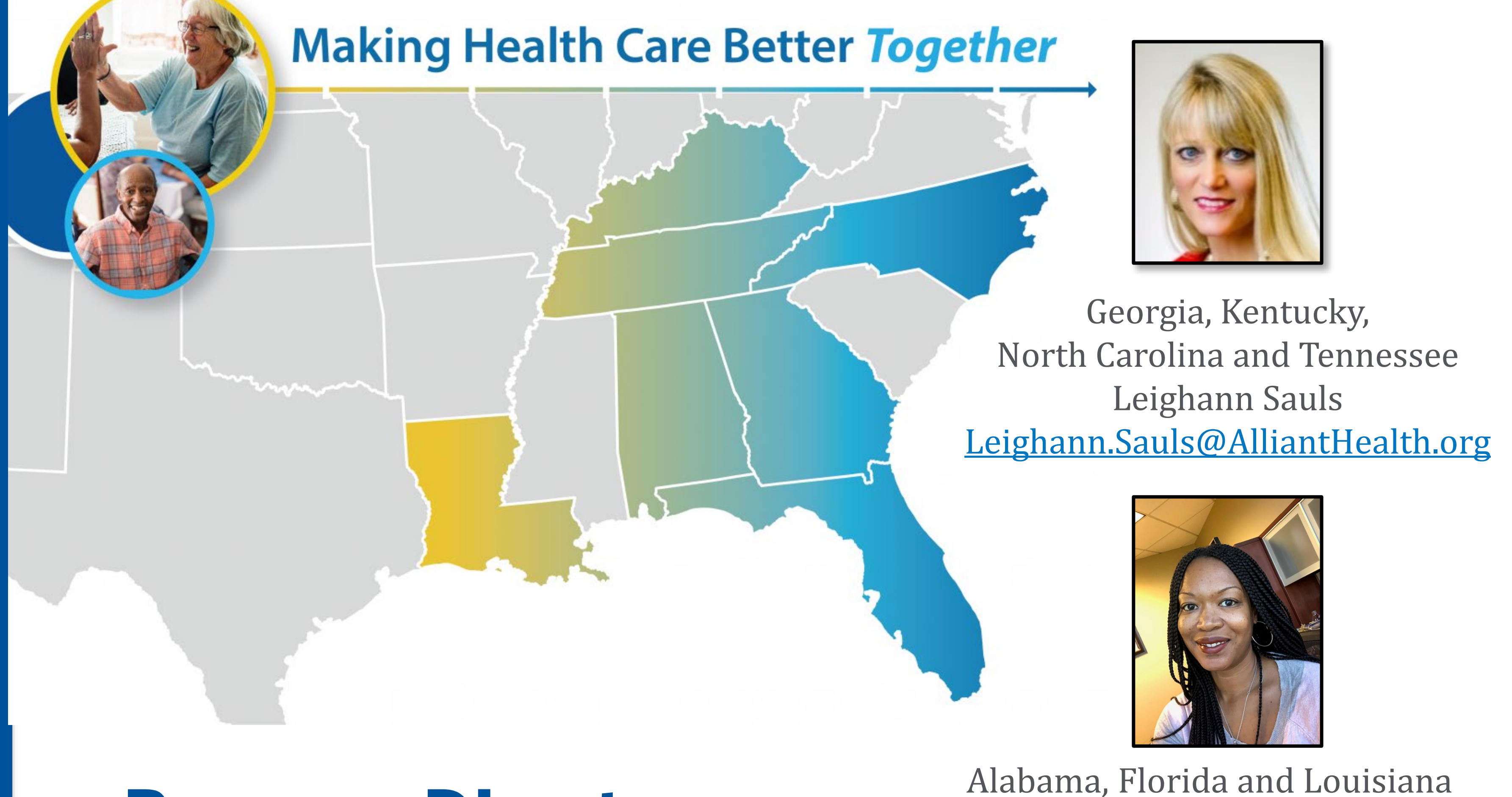
- ✓ Increase performance on ABCS clinical quality measures (i.e., aspirin use, blood pressure control, cholesterol management, cardiac rehab)
- ✓ Identify patients at high-risk for developing kidney disease & improve outcomes
- ✓ Identify patients at high risk for diabetes-related complications & improve outcomes

Quality of Care Transitions

- ✓ Convene community coalitions
- ✓ Identify and promote optical care for super utilizers
- ✓ Reduce community-based adverse drug events

Nursing Home Quality

- ✓ Improve the mean total quality score
- ✓ Develop national baselines for healthcare related infections in nursing homes
- ✓ Reduce emergency department visits and readmissions of short stay residents



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