Detecting and Communicating Change of Condition

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September 20, 2022

ALLIANT HEALTH SOLUTIONS
QIN–QIO
Quality Innovation Network - Quality Improvement Organizations
CENTER S FOR MEDICARE & MEDICAI D SERVICES
iQUALITY IMPRO VEMENT & INNOVATION GROU P

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QUALITY IMPROVEMENT SPECIALIST

Danyce Seney is a quality improvement specialist and a registered nurse with Lean, Infection Control Preventionist and Educator for Adult Learner certifications.

Danyce supports skilled nursing facilities in utilizing a quality improvement framework to implement evidence-based interventions and strategies to improve patient safety, improve immunization rates and reduce avoidable readmissions.

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Amy Daly, MA, NHA

SENIOR QUALITY IMPROVEMENT SPECIALIST

Amy Daly is a licensed nursing home administrator with over 20 years of leadership and long-term care management experience. In addition to her prior work as a vice president of long-term care and a facility administrator, Amy has served on the boards of the Genesee Health Facilities Association as treasurer and education committee member and the Genesee Health Facilities Foundation. Amy serves as an NYS Department of Health Informal Dispute Resolution (IDR) panel member and has been an adjunct clinical instructor of dental hygiene at Monroe Community College. Amy has a master's degree in health promotion and a bachelor's degree in health sciences.

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Continuing Education Information - LIVE

Learning Outcome:
Following this activity, we expect learners to share what they plan to do differently when back at work in the post-activity poll.

Nursing Professional Development: ANCC Contact Hours & Accreditation Statement
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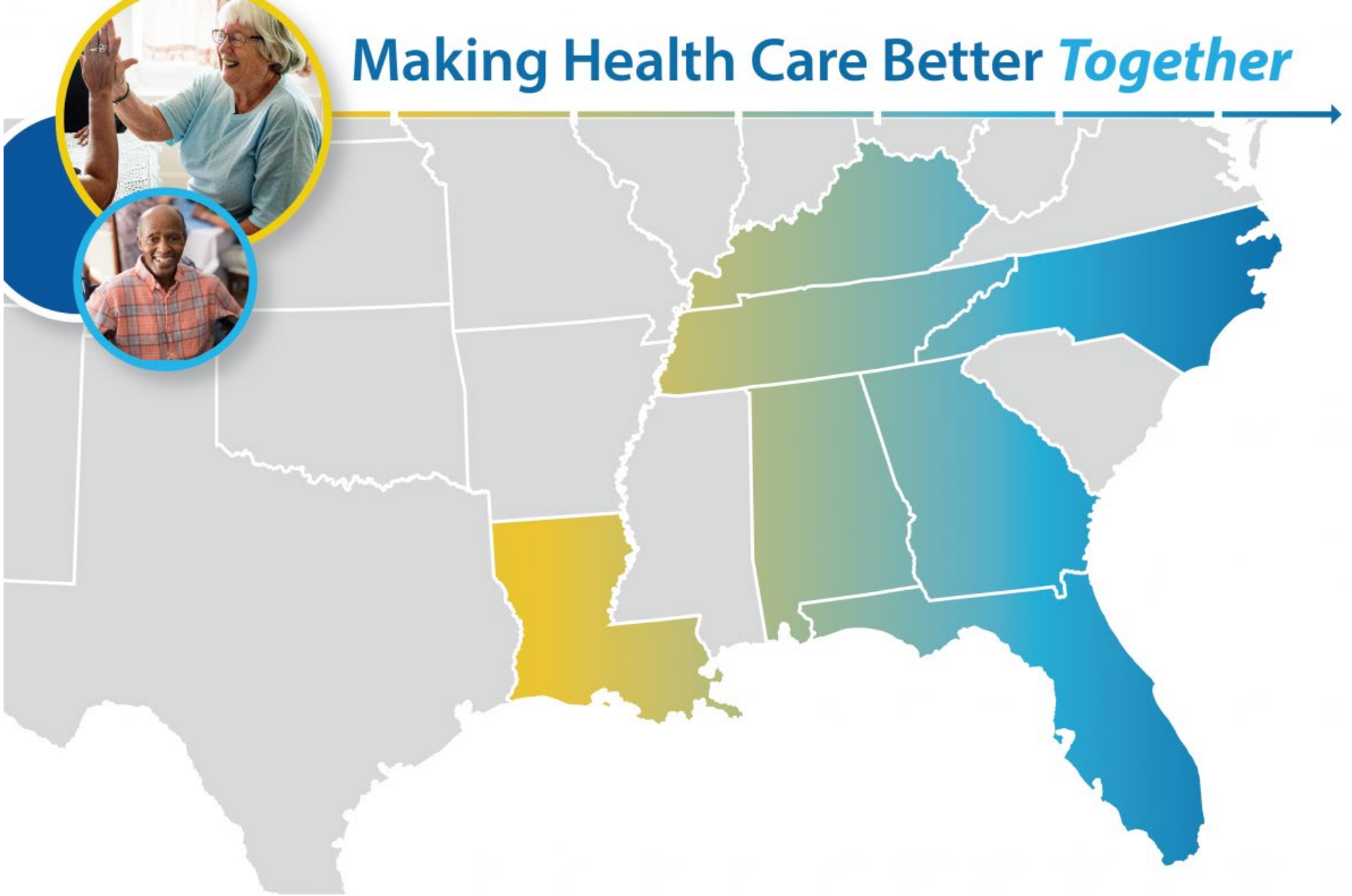

About Alliant Health Solutions

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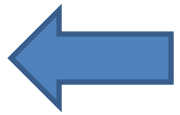
Reducing Avoidable ED Visits and Readmissions

Session 1:

- Overview of Interact® as a Quality Improvement Initiative
- Quality Measures Related to Re-Admissions and Emergency Department Visits
- Facility Capabilities and Impact on Admissions, Re-Admissions, ED Visits

Session 2:

- Detecting and Communicating Changes in Condition
- Impact Communication Can Have on Reducing Admissions and Emergency Department Visits
- Use of Tools like Stop & Watch, SBAR, Communication Checklists and Clinical Management



Session 3:

- Clinical Decision Support Tools and Advanced Care Planning
- Involving the Resident/Patient Voice in Care Decisions

Today's Learning Objectives

1. Learn key processes involved in detecting and communicating changes in condition.
2. Understand the role communication plays in the decision to transfer a patient.
3. Learn how early identification and communication tools can help reduce avoidable ED visits and Readmissions.

Use Tomorrow:

Assess how well early identification and communication tools are embedded in your processes. Work with your team to identify your priority for process improvement.

Reducing ED Visits and Readmissions: A Quality Improvement Approach

The INTERACT® program provides a variety of Resources and tools that can be used to customize a Readmission Reduction program.

Additionally, Alliant Health Solutions has tools and resources that can also help.

https://quality.allianthealth.org/

INTERACT® Tools Library – Pathway INTERACT® (pathway-interact.com)

Free INTERACT® Resources

Training and Implementation Assistance

INTERACT® Training and Education

Case Examples

Case Study with Hospital Transfer

Case Study without Hospital Transfer

Care Transition Resources

AHRQ Training Modules on Patient Safety in Long-Term Care Facilities

National Transitions of Care Coalition

The Care Transitions Program

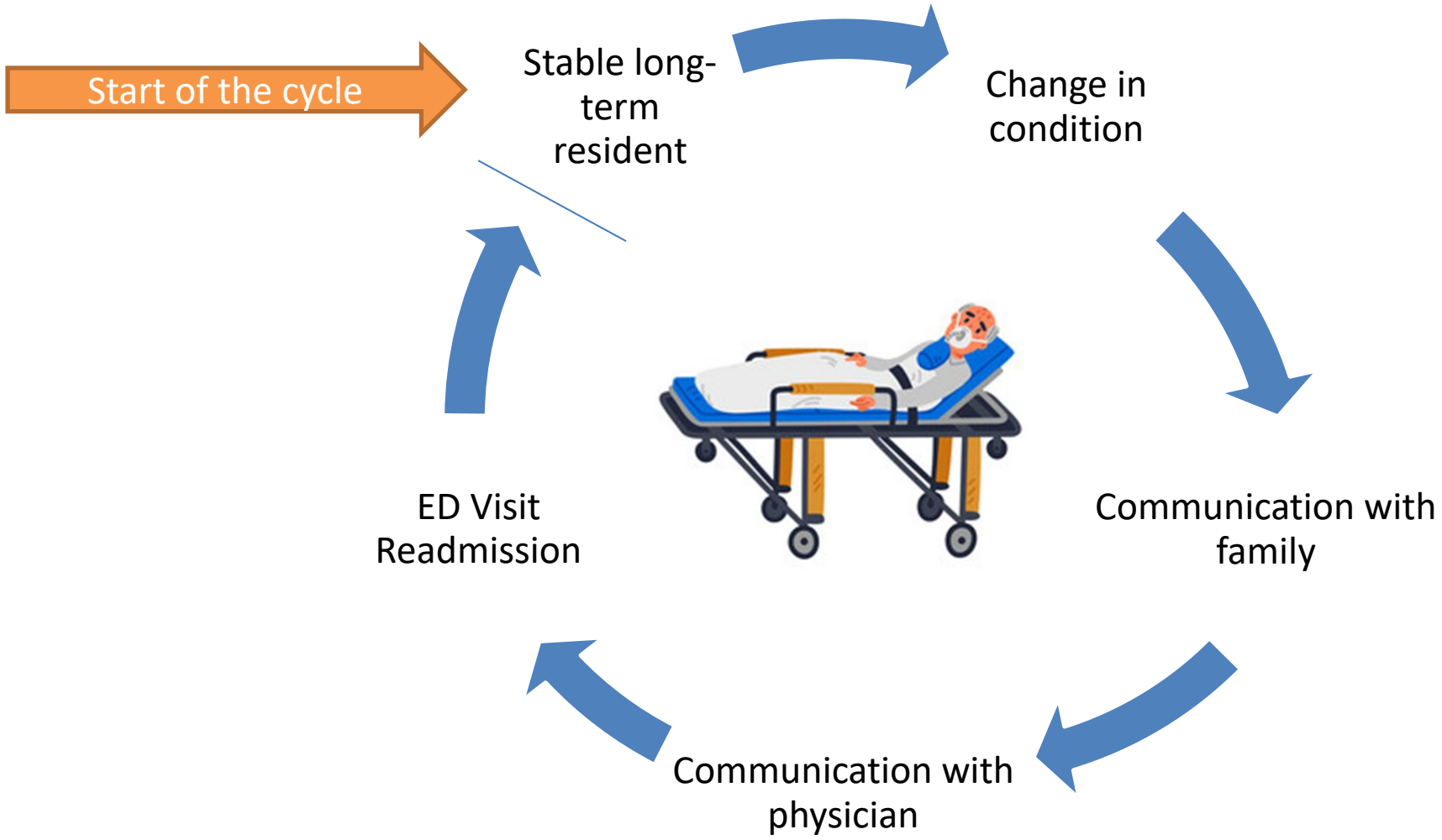
IHI STARR Program

Boston University Project Red

AHA Action Guide to Reduce Readmissions

American College of Cardiology Hospital to Home (H2H) Initiative

The Readmission/ED Visit Cycle



Opportunities to Impact the Cycle or Decision

Identifying a change in condition

1. A proactive process is in place to identify at-risk residents.
2. Staff engagement in reporting observations of changes.
3. Families and care partners are educated and encouraged to report observations of subtle changes.
4. Changes are communicated and discussed with the interdisciplinary team.
5. A consistent process for making and communicating changes to the care plan.
6. Clear process evenings and weekends or when there is no RN on duty.
7. Shift to shift communication of subtle and acute changes.
8. Assessment and critical thinking before notification of provider.

Opportunities to Impact the Cycle or Decision

Communication with Family

- Facility Capabilities
  - ✓ Services available are discussed with residents, care partners, and patients, starting with admission-physicians, NPs, PAs
  - ✓ Staff awareness and comfort with services and their ability to provide
- Goals of Care
  - ✓ Known, focus of care plan, communicated
- Communication between staff, families, residents and physicians
  - ✓ Timely, clear communication of plan and how the facility can manage care with the current change
  - ✓ Baseline of a trusting relationship with family

Virtual, audio and printable resources in English, Spanish, French, Filipino, Creole and Chinese

decisionguide.org

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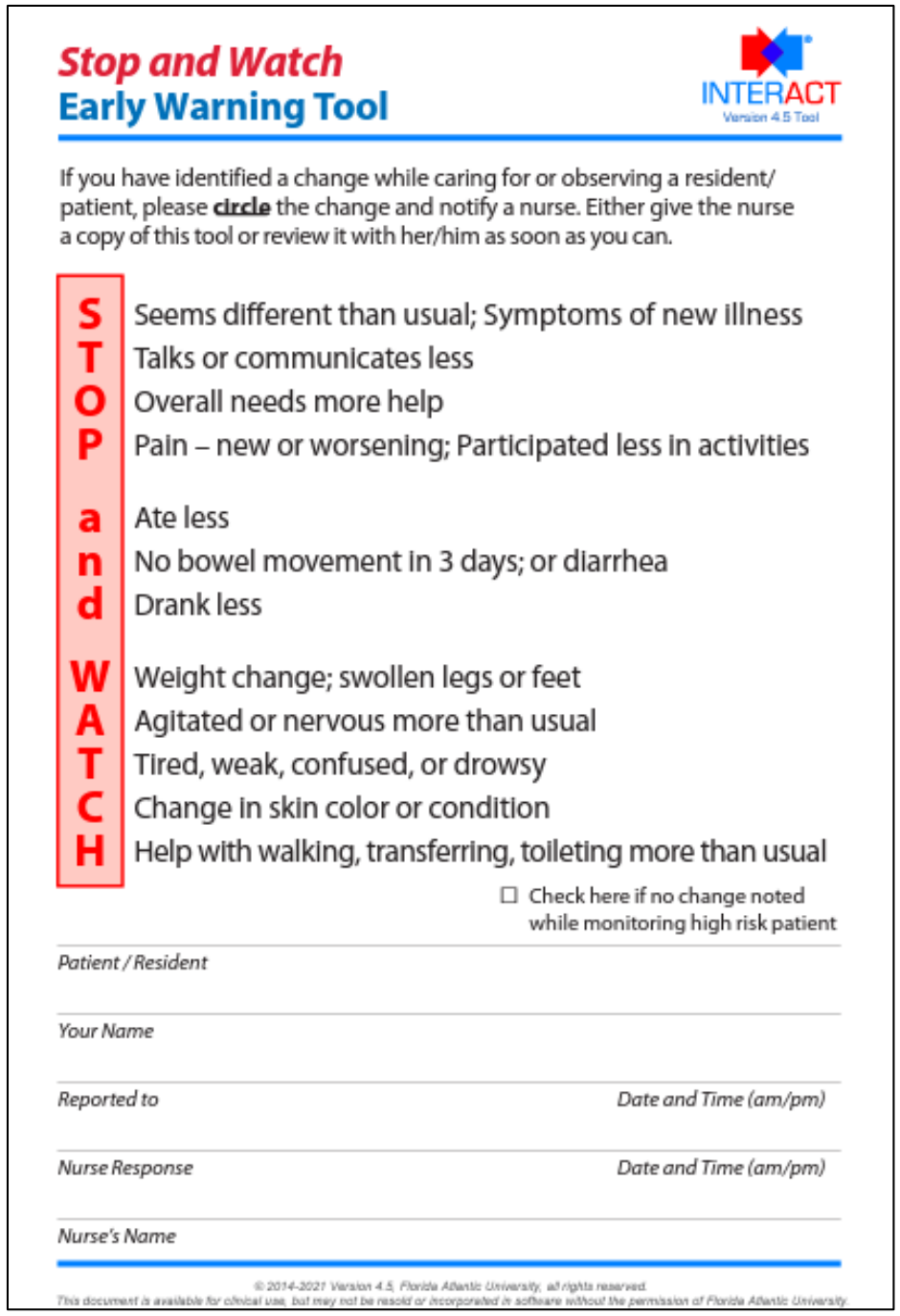
Opportunities To Impact the Cycle or Decision

Communication with Medical Provider

- Calling medical provider
  - ✓ Process to communicate changes to the medical provider in a timely manner so that interventions may be initiated to avoid transfer
  - ✓ Hand-off around at-risk residents to the on-call provider
  - ✓ Facility process to assess/discuss prior to calling the provider

- Physician decision on transfer-
  - ✓ Provider confidence in the information provided to make the decision to stay or go
  - ✓ Primary, on-call and specialty provider awareness of facility capabilities
  - ✓ Staff confidence in their assessment and care available to be provided when discussing a change of condition with the physician?



Stop and Watch
Early Warning Tool

INTERACT
Version 4.5 Tool

If you have identified a change while caring for or observing a resident/patient, 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 Seems different than usual; Symptoms of new illness
T Talks or communicates less
O Overall needs more help
P Pain – new or worsening; Participated less in activities

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

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

☐ Check here if no change noted while monitoring high risk patient

Patient / Resident

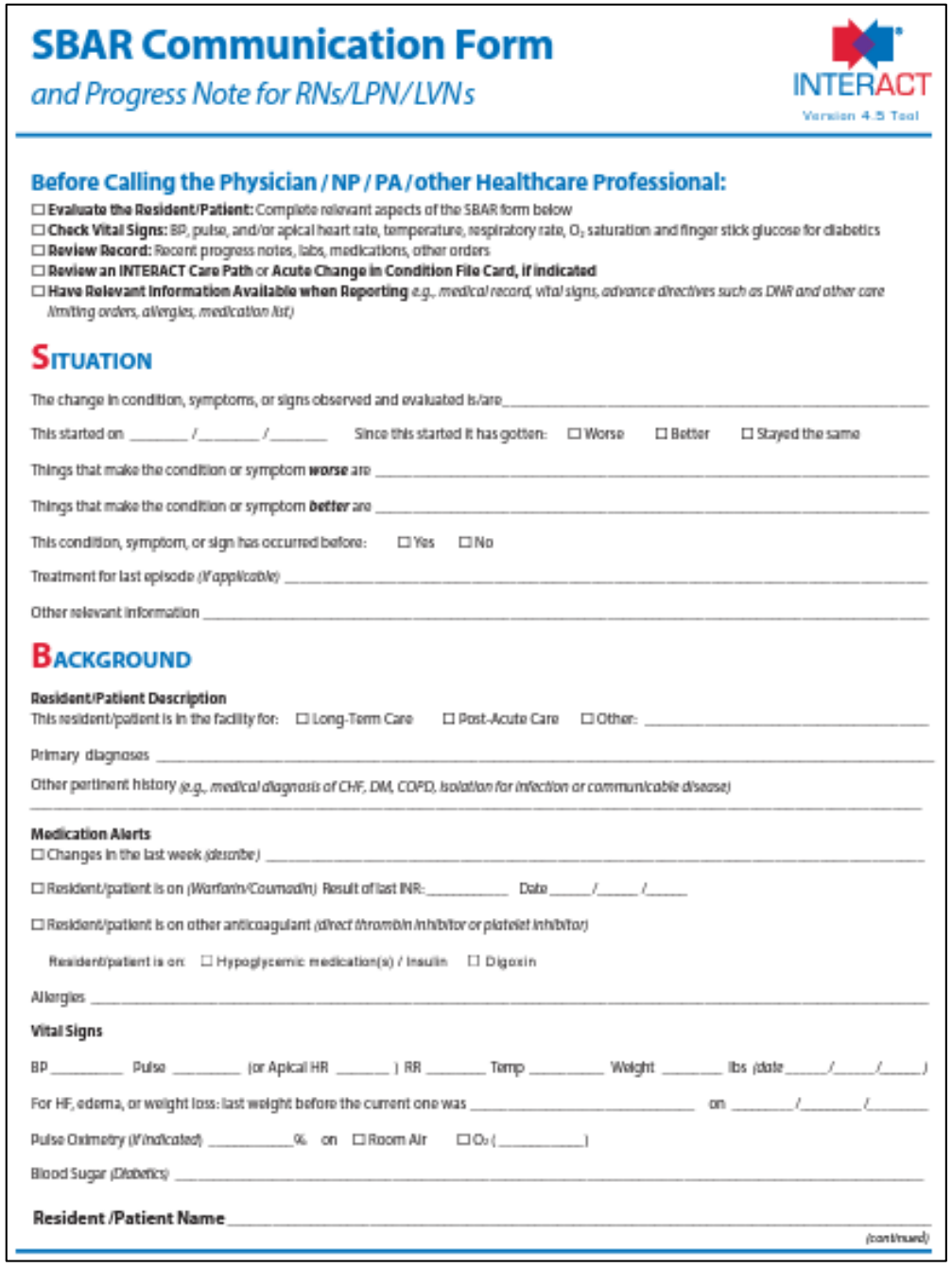
Your Name

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

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

Nurse's Name

- The INTERACT® Stop and Watch is an Early Warning Tool
- Available in English, Spanish and Creole
- Can be used on paper or incorporated into your Electronic Medical System
- An effective way for any staff in any department to communicate that something is different with a resident/patient
- Additionally, if monitoring a high-risk resident/patient, a way to note there was no change noted



SBAR Communication Form

and Progress Note for RNs/LPN/LVNs

INTERACT
Version 4.5 Tool

Before Calling the Physician / NP / PA / other Healthcare Professional:

- ☐ **Evaluate the Resident/Patient:** Complete relevant aspects of the SBAR form below
- ☐ **Check Vital Signs:** BP, pulse, and/or apical heart rate, temperature, respiratory rate, O_2 saturation and finger stick glucose for diabetics
- ☐ **Review Record:** Recent progress notes, labs, medications, other orders
- ☐ **Review an INTERACT Care Path** or **Acute Change in Condition File Card, if indicated**
- ☐ **Have Relevant Information Available when Reporting** *e.g., medical record, vital signs, advance directives such as DNR and other care limiting orders, allergies, medication list)*

SITUATION

The change in condition, symptoms, or signs observed and evaluated is/are _____

This started on _____ /_____ /_____ Since this started it has gotten: ☐ Worse ☐ Better ☐ Stayed the same

Things that make the condition or symptom **worse** are _____

Things that make the condition or symptom **better** are _____

This condition, symptom, or sign has occurred before: ☐ Yes ☐ No

Treatment for last episode *(if applicable)* _____

Other relevant information _____

BACKGROUND

Resident/Patient Description

This resident/patient is in the facility for: ☐ Long-Term Care ☐ Post-Acute Care ☐ Other: _____

Primary diagnoses _____

Other pertinent history *(e.g., medical diagnosis of CHF, DM, COPD, isolation for infection or communicable disease)*

_____

Medication Alerts

☐ Changes in the last week *(describe)* _____

☐ Resident/patient is on *(Warfarin/Coumadin)* Result of last INR: _____ Date _____/_____/_____

☐ Resident/patient is on other anticoagulant *(direct thrombin inhibitor or platelet inhibitor)*

Resident/patient is on: ☐ Hypoglycemic medication(s) / Insulin ☐ Digoxin

Allergies _____

Vital Signs

BP _____ Pulse _____ (or Apical HR _____) RR _____ Temp _____ Weight _____ lbs *(date* _____/_____/_____*)*

For HF, edema, or weight loss: last weight before the current one was _____ on _____/_____/_____

Pulse Oximetry *(if indicated)* _____% on ☐ Room Air ☐ O_2 (_____)

Blood Sugar *(Diabetics)* _____

Resident /Patient Name _____

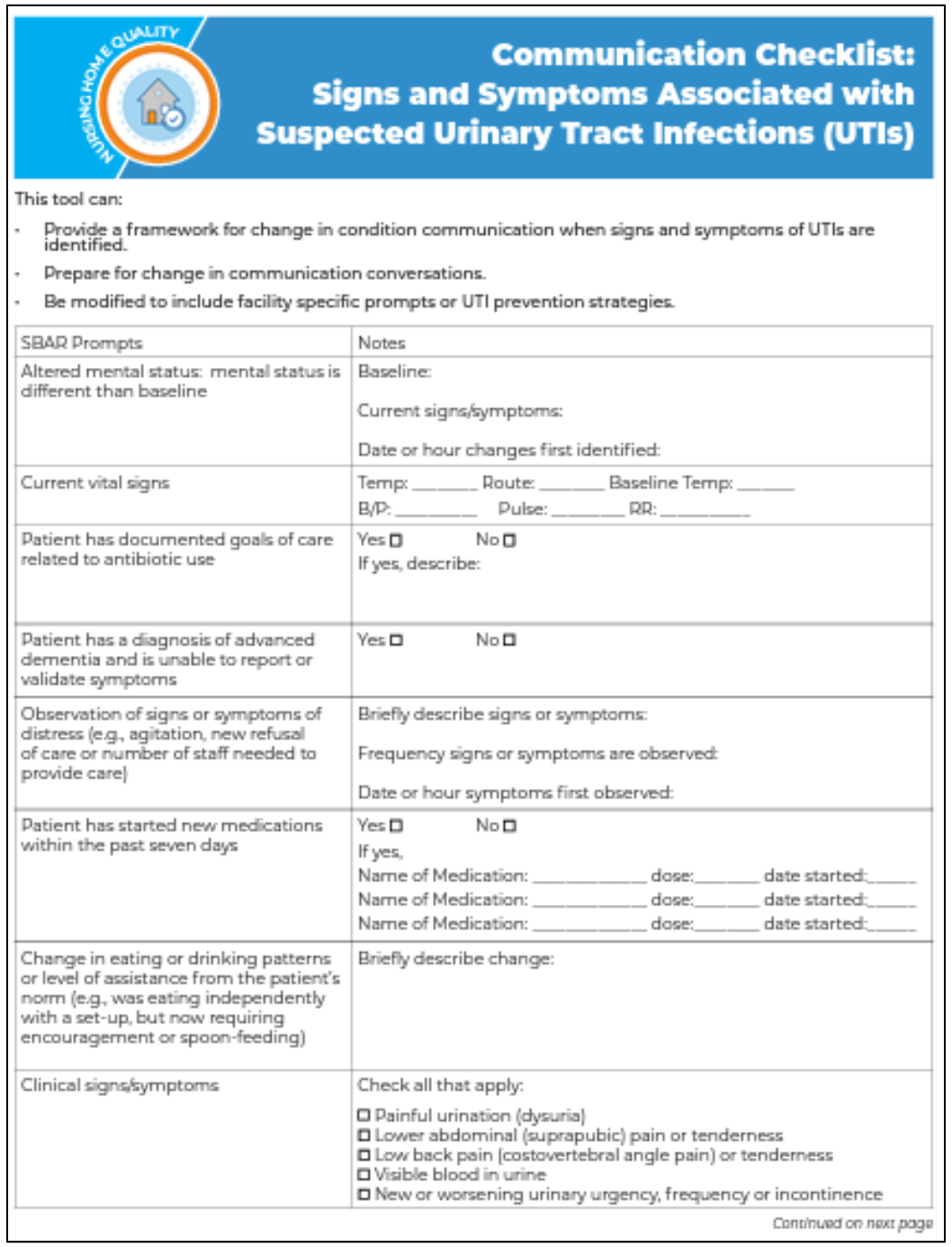
(continued)

S-B-A-R Communication Form

Situation-
Background
Assessment/Appearance
Recommendation/Review and Notify

Four pages that walk you through each system to gather information before calling a medical provider

Also helpful with communication and critical thinking within the facility



Communication Checklist: Signs and Symptoms Associated with Suspected Urinary Tract Infections (UTIs)

This tool can:

- Provide a framework for change in condition communication when signs and symptoms of UTIs are identified.
- Prepare for change in communication conversations.
- Be modified to include facility specific prompts or UTI prevention strategies.

SBAR Prompts	Notes
Altered mental status: mental status is different than baseline	Baseline: Current signs/symptoms: Date or hour changes first identified:
Current vital signs	Temp: _____ Route: _____ Baseline Temp: _____ B/P: _____ Pulse: _____ RR: _____
Patient has documented goals of care related to antibiotic use	Yes ☐ No ☐ If yes, describe:
Patient has a diagnosis of advanced dementia and is unable to report or validate symptoms	Yes ☐ No ☐
Observation of signs or symptoms of distress (e.g., agitation, new refusal of care or number of staff needed to provide care)	Briefly describe signs or symptoms: Frequency signs or symptoms are observed: Date or hour symptoms first observed:
Patient has started new medications within the past seven days	Yes ☐ No ☐ If yes, Name of Medication: _____ dose:_____ date started:_____ Name of Medication: _____ dose:_____ date started:_____ Name of Medication: _____ dose:_____ date started:_____
Change in eating or drinking patterns or level of assistance from the patient's norm (e.g., was eating independently with a set-up, but now requiring encouragement or spoon-feeding)	Briefly describe change:
Clinical signs/symptoms	Check all that apply: ☐ Painful urination (dysuria) ☐ Lower abdominal (suprapubic) pain or tenderness ☐ Low back pain (costovertebral angle pain) or tenderness ☐ Visible blood in urine ☐ New or worsening urinary urgency, frequency or incontinence

Continued on next page

Today we have given an assortment of options from INTERACT®

Alliant Health Solutions also has created disease-specific Communication Checklists for Suspected UTIs, Delirium/Change in Mental Status, as well as Hypo or Hyperglycemia

AHS Communication Checklist Page

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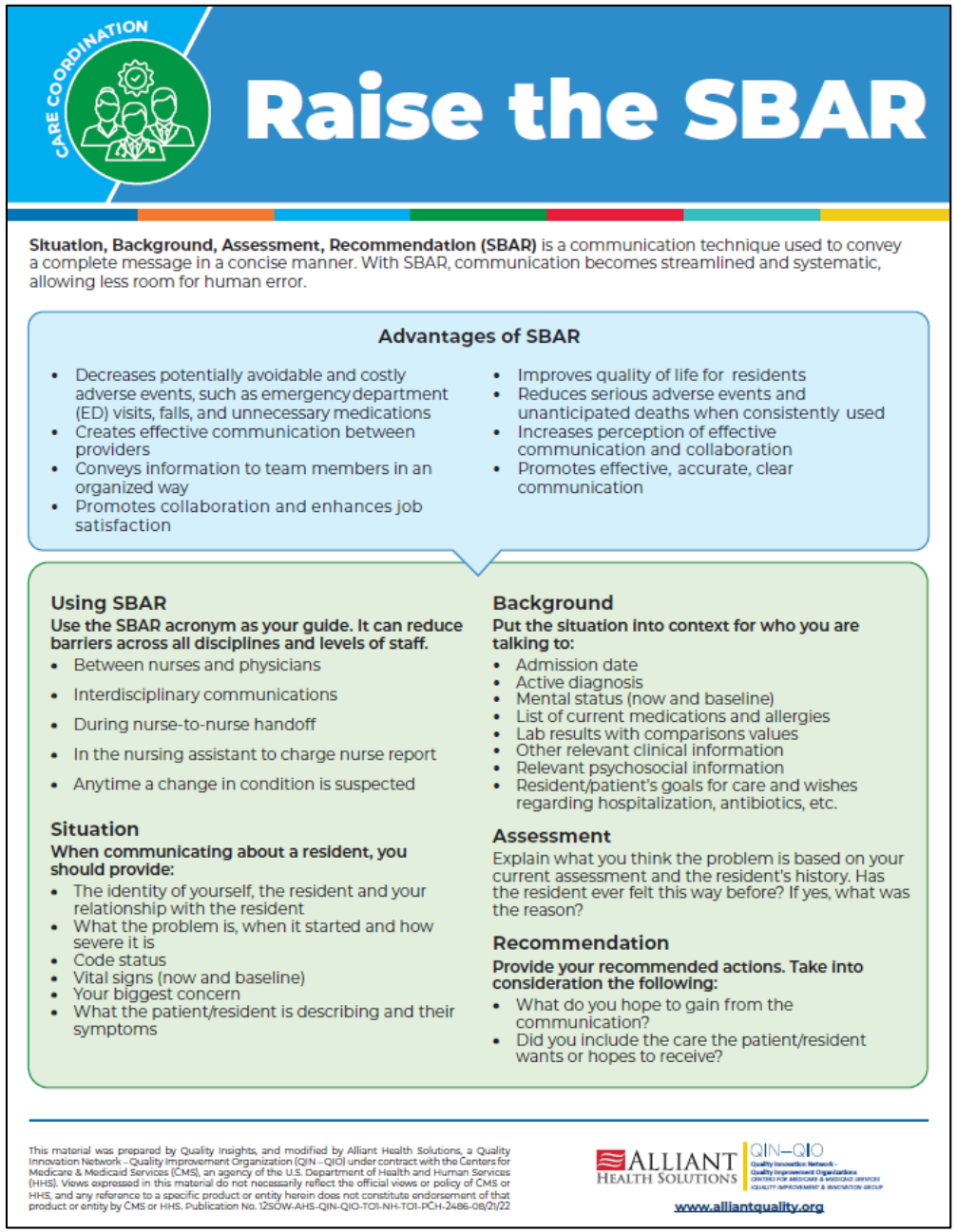

Raising the SBAR

- Tool to explain how to best use the SBAR communication technique to convey a complete message concisely.
- Communication becomes streamlined and systematic.
- The person you are talking to will receive all the information required to make an informed decision.

Let's Look at the Cycle Breakdown Again

In isolation, individual tools are not likely to have an impact on readmission or ED visit rates. Impact occurs when implemented as part of a quality improvement initiative that includes a plan for sustainability.

- ✓ **Timely identification of changes in condition** – Stop and Watch, Alliant communication checklists, Zone tools
- ✓ **Evaluation prior to communication with a medical provider** – Stop and Watch, SBAR, Communication checklists
- ✓ **Physician alignment with your readmission goals** – capabilities list, communication checklist
- ✓ **Resident or family partnership** – capabilities list, confidence, communication checklist, Decision Guide
- ✓ **Communication between staff, families, residents and physicians** – Stop and Watch, communication checklists
- ✓ **Facility services**– capabilities checklist
- ✓ **Goals of care**– SBAR, capabilities list, Decision Guide and SESSION #3

Learning Objectives

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Use Tomorrow

Current users of Stop and Watch and SBAR:

- Meet with your team and assess processes – are tools used consistently, thoroughly, and by all staff, all shifts, including contracted staff? Identify one area of opportunity to strengthen your processes.
- Review your orientation and annual competency programs – do these programs adequately cover your goals for avoiding readmissions and ensure staff skill and comfort in identifying changes in condition and communicating with patients, families and providers?

New users of Stop and Watch and/or SBAR tools:

- Meet with your team and assess your strengths and opportunities.
- Develop a QAPI project for implementation.

Claiming Credits

Claim CE for NAB or ANCC here:

https://app.smartsheet.com/b/form/0075048c504749489991 5bf5c2c823df

9/20 Readmissions Affinity Group (credit valid until 10/13//22)

Did you attend the live event or watch the recorded version? *

Live

Which series are you claiming credit for today? *

Affinity Group Series

Which Affinity Group Sub Series are you claiming credit for today? *

Care Coordination

Care Coordination Affinity Groups *

Care Coordination-NHs: Detecting and Communicating Change of Condition held on ...

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Continuing Education Information - RECORDING

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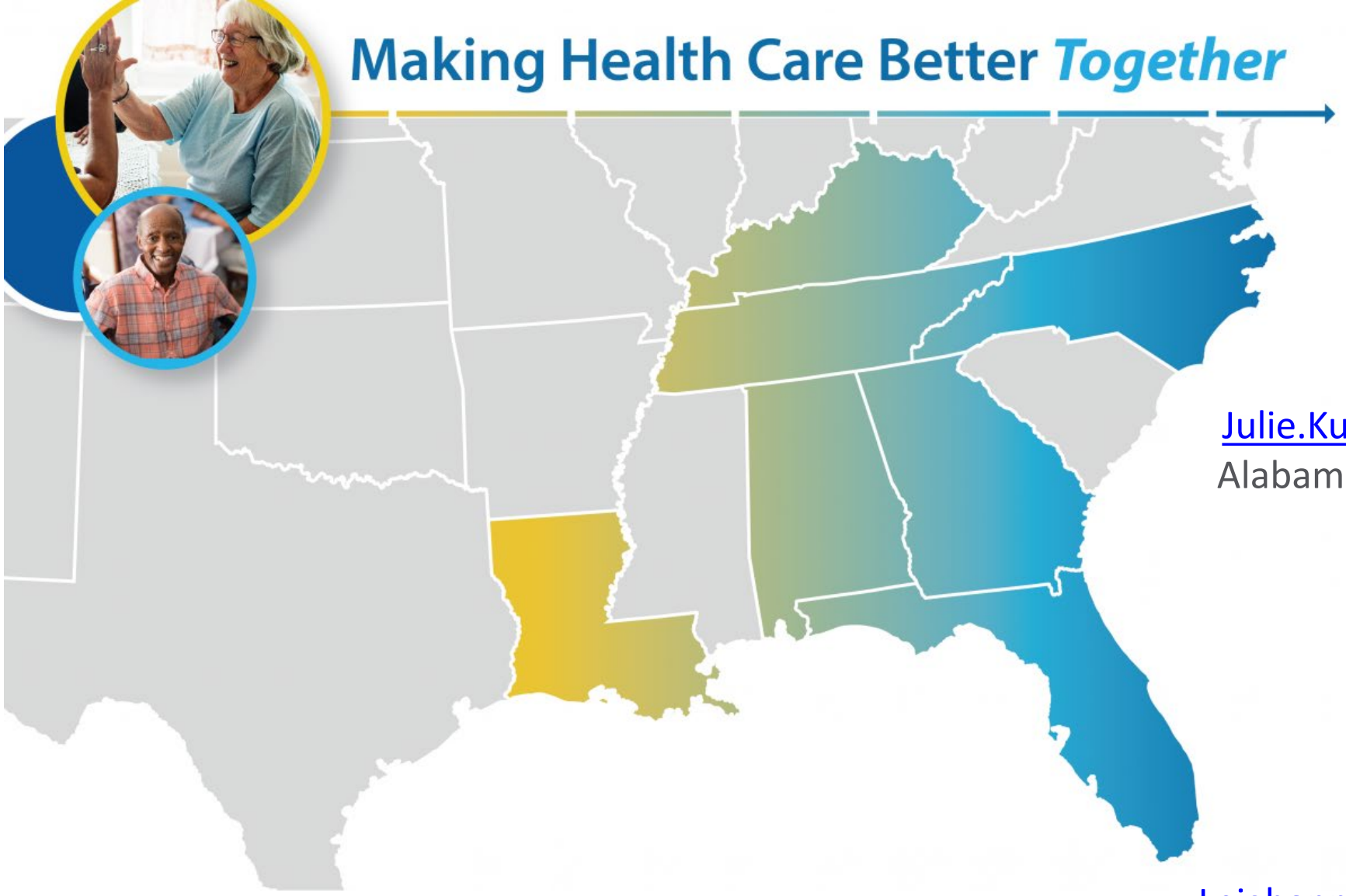

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Nursing Home and Partnership for Community Health:
CMS 12th SOW GOALS

OPIOID UTILIZATION AND MISUSE

Promote opioid best practices

•

Reduce opioid adverse drug events in all settings

PATIENT SAFETY

Reduce hospitalizations due to c. diff

•

Reduce adverse drug events

•

Reduce facility acquired infections

CHRONIC DISEASE SELF-MANAGEMENT

Increase instances of adequately diagnosed and controlled hypertension

•

Increase use of cardiac rehabilitation programs

•

Reduce instances of uncontrolled diabetes

•

Identify patients at high-risk for kidney disease and improve outcomes

CARE COORDINATION

Convene community coalitions

•

Reduce avoidable readmissions, admissions to hospitals and preventable emergency department visits

•

Identify and promote optimal care for super utilizers

COVID-19

Support nursing homes by establishing a safe visitor policy and cohort plan

•

Provide virtual events to support infection control and prevention

•

Support nursing homes and community coalitions with emergency preparedness plans

IMMUNIZATION

Increase influenza, pneumococcal, and COVID-19 vaccination rates

TRAINING

Encourage completion of infection control and prevention trainings by front line clinical and management staff

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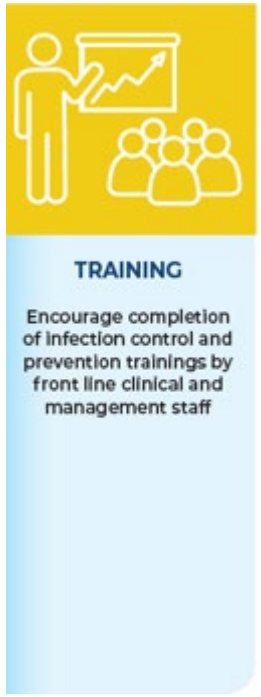
Scan the QR Codes or Click the Links to Complete the Assessments!

CMS requested Alliant Health Solutions, your QIN-QIO, to work with select nursing homes to understand emerging healthcare needs in nursing homes. Alliant Health Solutions will be engaging nursing home leadership on each of these key areas to ensure plans are in place to achieve and maintain health quality and equity. Be on the look out for communications from Alliant Health Solutions!

Nursing Home Emergency Preparedness Program (NH EPP) Self-Assessment

Nursing Home Infection Prevention (NHIP) Initiative Training Assessment



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https://bit.ly/AHS_NHEPPAssessment

https://bit.ly/NHIPAssessment

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Questions?

Making Health Care Better *Together*

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