



Go to the Hospital or Stay Here Decision Guide Affinity Group

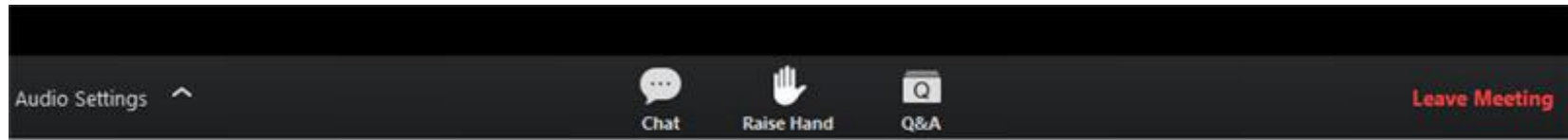
Leadership Commitment to the Guide and its Impact on Avoidable Transfers

November 9, 2022

Health Quality Innovation Network



Logistics – Zoom Webinar



To ask a question, click on the **Q&A** icon.

Raise your hand if you want to verbally ask a question.

Resources from today's session will be posted in **Chat**.

You may adjust your audio by clicking **Audio Settings**.

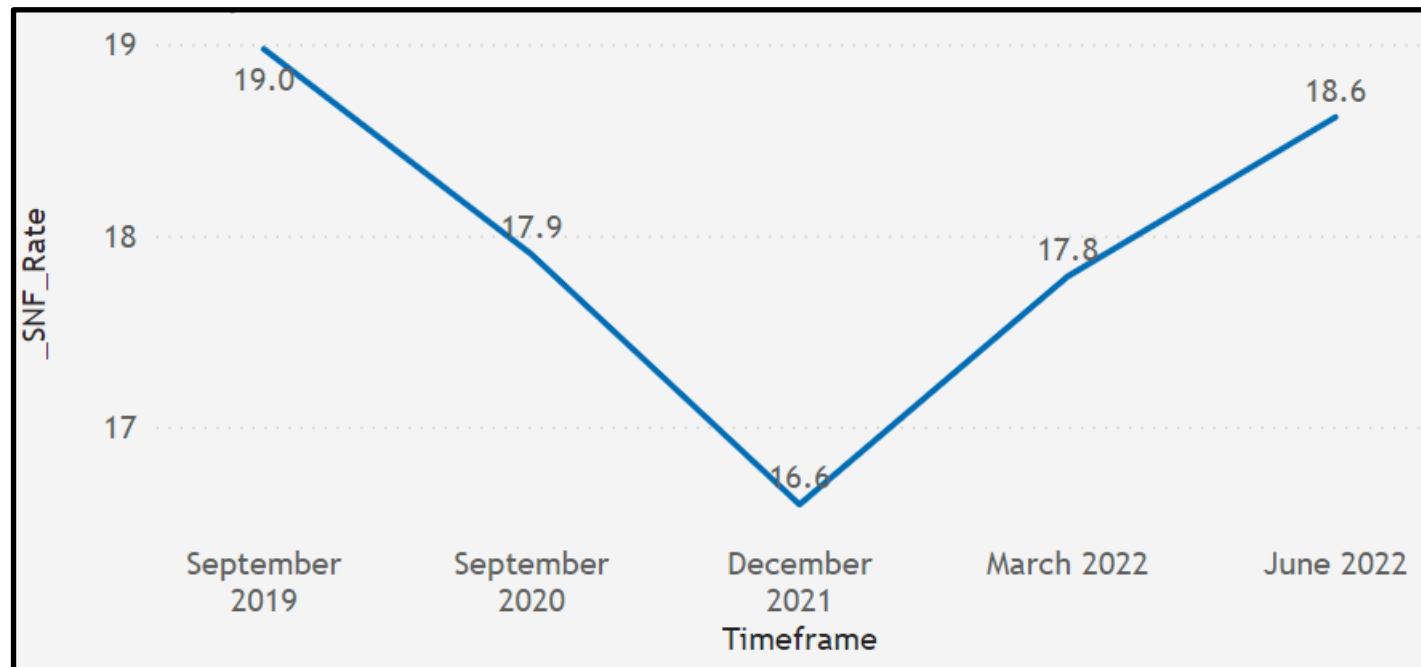
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Karen Southard, RN, MHA, CPHQ
Program Director
The Carolinas Center for Medical
Excellence (CCME)



SNF ED Returns After Hospital Discharge

KS, MO, SC and VA



Who Can Implement the Guide ?



Today's Objectives

- Explain how the Guide can be part of your readmission reduction strategy
- Analyze your last six months of transfers to determine how the Guide can best work for you
- Identify steps to implement the Guide

One More Tool in Preventing ED Transfers and Readmission for Your Toolkit

The Guide provides information in an easy-to-read format about making decisions to stay and be treated at your facility.

It demonstrated a reduction in transfers and readmissions when implemented into your admission, care planning, and change in condition conversations with residents and family.

Use it to provide staff education and review avoidable transfers.

Feedback from over 276 Region IV Nursing Homes

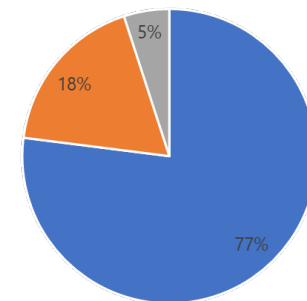
What was the Greatest Benefit

Top: Increased Resident/Family
Knowledge-80%

Families asked more questions
about care in the facility
during care planning sessions

Staff liked having a factual
written resource

Positive Impact on Readmissions after 1 Year



■ Yes ■ No ■ Maybe ■

Polling Question

What is the top reason your facility wants to reduce avoidable ED transfers?

- We want our residents to be treated in our facility with confidence and care
- We want to reduce avoidable readmissions
- We want to remain a preferred continuum-of-care provider
- It is a priority for our quality and business strategy

First Step: What are your Triggers?

Review the last 6 months or 10 transfers to the hospital

<https://pathway-interact.com/wp-content/uploads/2021/08/5-INTERACT-Acute-Care-Transfer-Log-Worksheet-2021.pdf>

What are the common reasons?

Are they Short Stay or LTC?

Patterns in day or time?

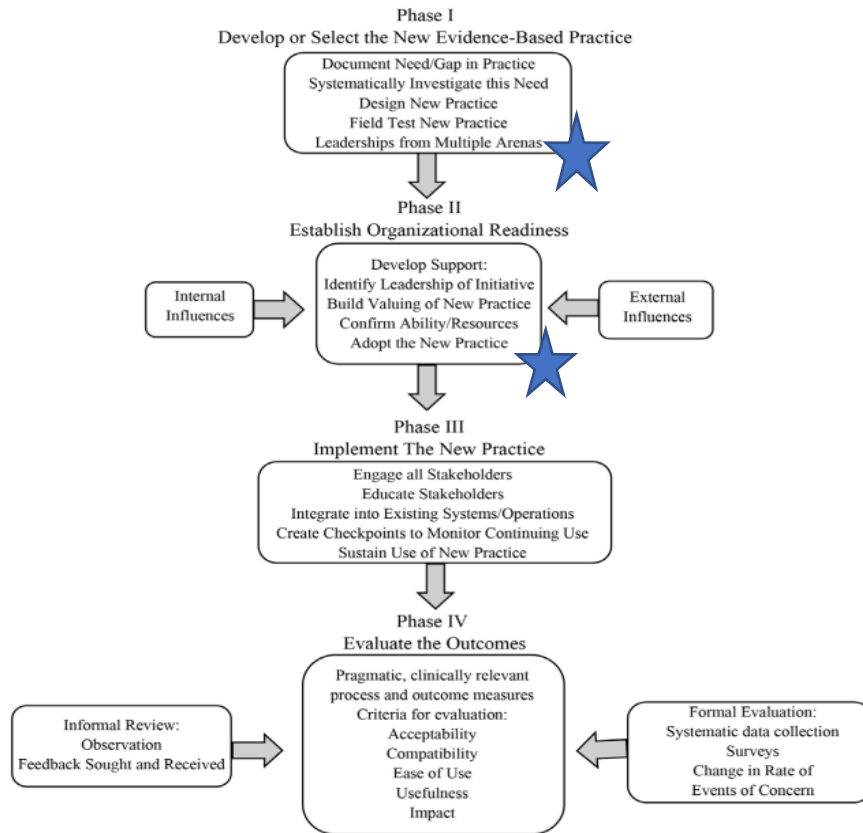
What is the outcome of the transfer?

Digging Deeper

For all Transfers in which the Family insists or Staff panicked look at:

- Review the last 24 hours of resident care, vital signs
- What treatments were attempted
- How soon and who notified the family
- Other measures taken

Phased Approach to Addressing ED Return to Hospital



GO TO THE HOSPITAL OR STAY HERE?

A Decision Guide for Residents, Families, Friends and Caregivers



GO TO THE HOSPITAL OR STAY HERE?

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

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.

Sample page



"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)

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Page 3 of the Guide

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

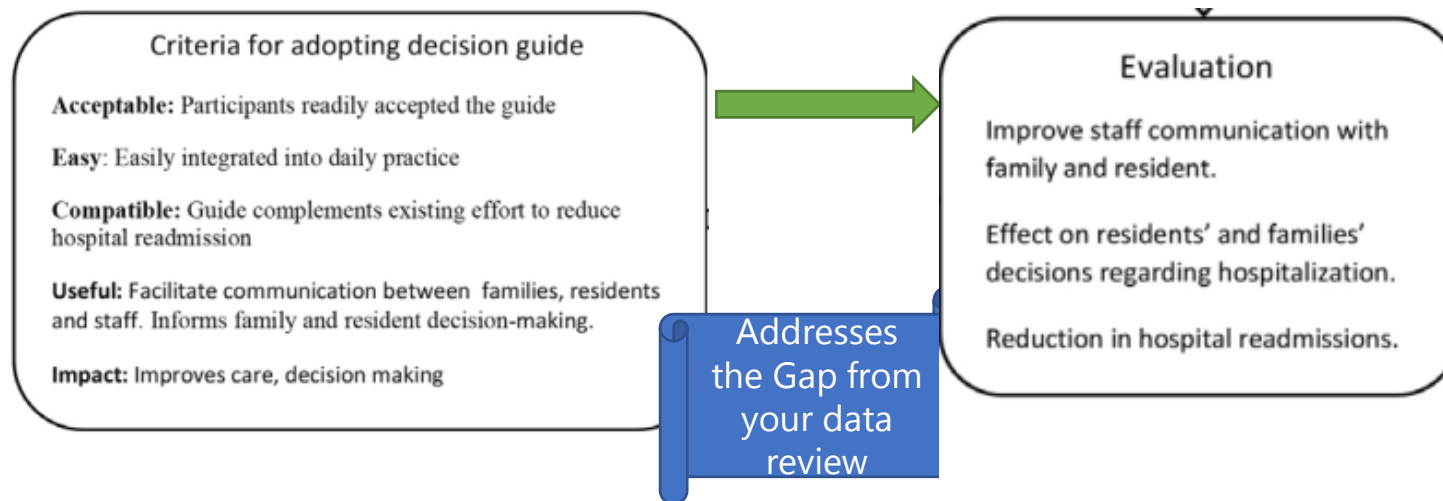
Hospitals can provide more complex tests and treatments including:

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

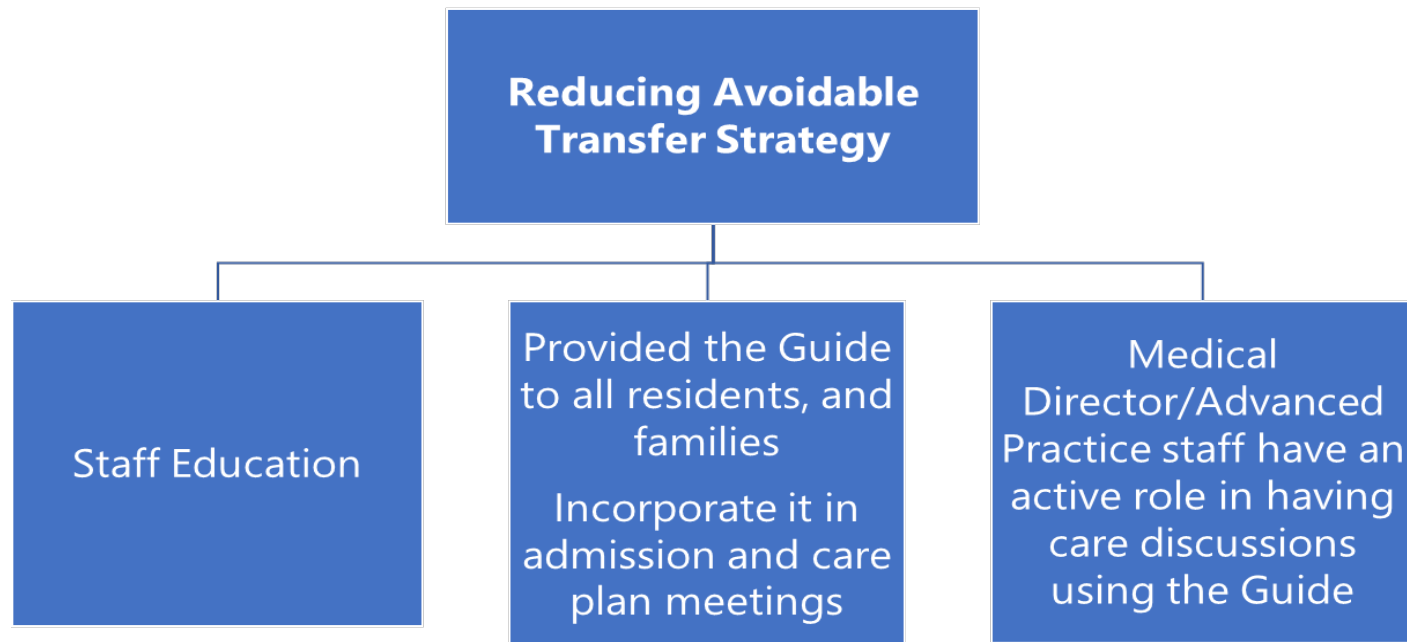
THERE ARE ALSO RISKS TO GOING TO THE HOSPITAL

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.

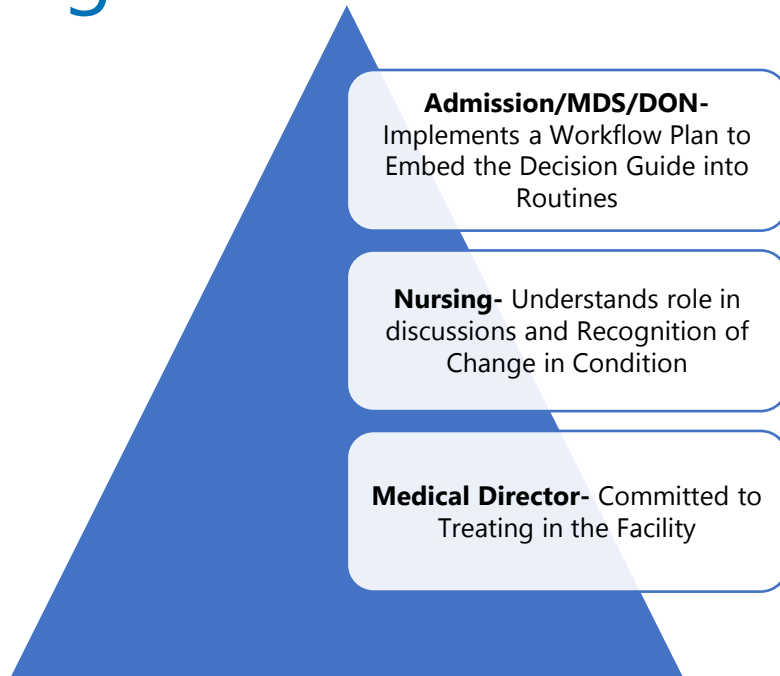
Decision Guide: Is the Change Right for Your Facility?



Strategy for Success



Engage and Empower Your Team to Lead the Charge



Decision Guide Suggested Workflow



Decision Guide FAQ's

BEST PRACTICES For Implementing the Guide and Trifold

ENGAGING RESIDENTS AND FAMILIES

Preadmission

- Share the Trifold during interview with prospective resident/family

On Admission

- Most facilities provide the Guide on Admission
- Use during discussion of resident's condition and the care you will be providing
- Send the smaller Trifold with monthly bill to reach all family members

Family Meetings and Care Conferences

- Refer to Guide during care conferences
- Family and resident councils & family/social events such as holiday cookouts

Advanced Care Planning/Changes in Level of Care

- Use the Guide to start difficult conversations
- Discuss when change in condition occurs (care you can provide in your facility)
- Discuss when resident and/or family are considering palliative or hospice care

[http://www.decisionguide.org/docs/latest/BestPractices_FINAL%20\(1\).pdf](http://www.decisionguide.org/docs/latest/BestPractices_FINAL%20(1).pdf)

Create a Timeline for Implementation

Month 1

- Conduct ED transfer analysis and plan strategy with leadership
- Order/Copy the Guide Materials
- Decision Guide lead assigns roles for implementation
- Weekly planning for implementation
- Share the reason for implementing the Guide with the staff

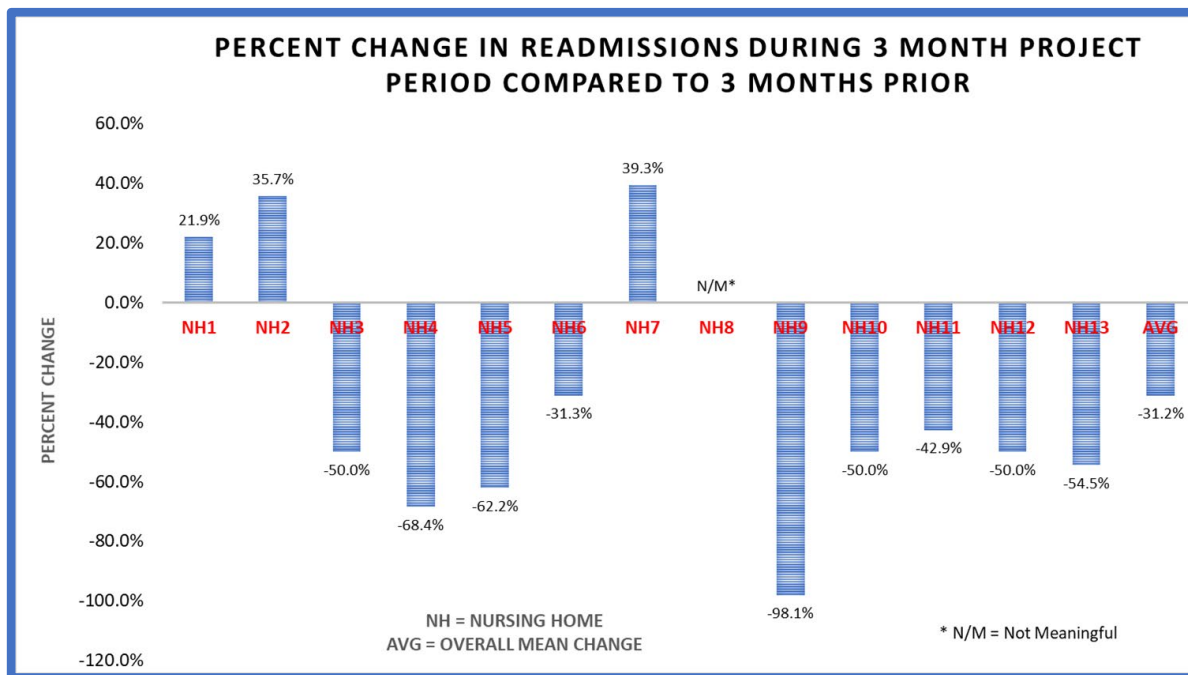
Month 2

- Map out workflow and post on staff bulletin boards
- Hold staff training
- Reminder in shift huddles
- Monitor process
- Discuss in Leadership meetings

Month 3

- Start monitoring the impact on transfers to ED
- On-going education for staff
- Share results in leadership meetings

The Guide Can Improve Your ED Transfers within 3-months of Implementation



Resources For The Guide

Download the FAQs for Discussion and Planning

Start selecting case studies for education

Consider the training videos to address the gaps identified in your review

Case Studies

- 1. Anxious Resident – Possible C. Difficile**
An 88-year-old post acute patient feels they should go back to the hospital. [click here](#)
- 2. Abdominal Tenderness**
A resident with CHF, hypertension and anxiety suffers abdominal tenderness. [click here](#)
- 3. Pneumonia**
Resident admitted after hip surgery – family feels she would be better in hospital. [click here](#)
- 4. Advance Directives**
Resident with pancreatic cancer has change in condition. [click here](#)
- 5. Advanced Dementia**
Resident's son insists his 99-year-old mother go to the hospital [click here](#)

Videos



The Usefulness of the Guide



An Introduction from the
Project Director



A Testimonial from a Nursing
Home Resident



Let's Get Started- November

Action for the next 30 days:

- ✓ Review the last 6 months of transfers to the hospital- Categorize the frequency, reason, and outcome of the transfer.
- ✓ Share the data with leadership and discuss the plan to implement the Guide focusing on the most frequent reason for transfers to the hospital.
- ✓ Develop your implementation timeline and track your progress.
- ✓ Identify key Decision Guide Champion.



■ Integrating a New Hospital Transfer Decision Guide into Long-Term Care Practice: Application of Implementation Science Models

Authors: Tappen, Ruth; Southard, Karen; Hain, Debra; Kaye, Suzie; Adonis-Rizzo, Marie Tamara

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Join us for the next Affinity Group session:

**December 7th
1:00 p.m. EST**

***Designing your Workflow and
Educating Staff***

[Webinar Registration - Zoom](#)



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