Simple Strategies Stand Up

Recognize and Respond Collaborative Guide

Improving Nursing Home Quality of Care

Quality Improvement Organizations
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CENTERS FOR MEDICARE & MEDICAID SERVICES

HQIN
Health Quality Innovation Network

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Introduction

Thank you for your commitment to improving your residents' quality of life by participating in Health Quality Innovation Network (HQIN) initiatives. Your dedicated leadership instills quality improvement practices that eliminate healthcare-acquired infections (HAIs) and adverse drug events (ADEs), reduce preventable emergency department (ED) visits and readmissions, and improve resident and family satisfaction.

This guide provides background and reference information about HQIN's Recognize and Respond Collaborative to help your team prepare for a successful journey.

Overview

The Health Quality Innovation Network (HQIN)

The HQIN is led by Health Quality Innovators (HQI), the Quality Innovation Network-Quality Improvement Organization (QIN-QIO) for Kansas, Missouri, South Carolina and Virginia. As part of this initiative, nursing homes from all four states will work together to test systems of change in organizational and clinical areas and share experiences and best practices over the course of several months. HQIN improvement consultants and expert faculty will provide consultation and support on content, methods and application of interventions.

The Recognize and Respond Collaborative Overview

The collaborative will use an "all teach, all learn" methodology. Participating nursing home teams will engage virtually with their peers to share learning and Plan-Do-Study-Act (PDSA) cycle test results during peer-to-peer sharing events.

Specifically, the collaborative will strive to instill INTERACT® and TeamSTEPPS® quality and performance improvement practices, and dramatically improve resident satisfaction by focusing on the systems that impact quality, such as communication, leadership, clinical models, quality of life indicators and specific clinical outcomes.

Objectives

The primary objectives of the Recognize and Respond Collaborative are to implement INTERACT® and TeamSTEPPS® concepts, individually test system changes aimed at reducing adverse drug events (ADEs), healthcare-acquired infections (HAIs), preventable emergency department (ED) visits and readmissions, and to collectively share learning.

More specifically:

- Engage in advance care planning
- Utilize care paths
- Implement communication tools
- Track and analyze hospitalization rates
- Track and analyze ED visits
- Recognize and respond to changes in condition

Teams will also set their own goals, aligned with their own needs and those of the overall collaborative.

Methods

Participants will use INTERACT®, TeamSTEPPS® and QAPI as a framework for this collaborative. Each nursing home is expected to select a priority area of focus and develop an aim statement that includes specific goals. Nursing homes may begin by working within a defined population. The ultimate goal is to spread improvement to other populations within or beyond the facility.

Both process and outcome measurement strategies will be used to assess progress toward goals. Participants will implement numerous PDSA cycles. In addition, they will learn how to collect and plot well-defined data that relate to their aim. Data tracking will continue throughout the duration of the collaborative.

Framework

INTERACT® Framework:
INTERACT® is a quality improvement program designed to improve the identification, evaluation and communication about changes in resident status. INTERACT® was first designed in a project supported by the Centers for Medicare & Medicaid Services (CMS). Now, many post acute providers across the U.S. are using INTERACT®.

TeamSTEPPS® Framework:
TeamSTEPPS® is an evidence based set of teamwork tools, aimed at optimizing resident outcomes by improving communication and teamwork skills among health care professionals.

QAPI Framework:
QAPI is the merger of two complementary approaches to quality – quality assurance (QA) and performance improvement (PI). Both involve seeking and using information, but they differ in key ways.

Quality Assurance: A process of meeting quality standards and assuring that care reaches an acceptable level. Nursing homes typically set QA thresholds to comply with regulations. They may also create standards that go beyond regulations. QA is a reactive, retrospective effort to examine why a facility failed to meet certain standards. QA activities do improve quality, but efforts frequently end once the standard is met.

Performance Improvement: Also referred to as quality improvement (QI), this proactive and continuous study of processes is intended to prevent or decrease the likelihood of problems. Using this approach, nursing homes identify areas of opportunity and test new approaches to fix underlying causes of persistent/systemic problems. PI in nursing homes aims to improve processes involved in healthcare delivery and resident quality of life. PI can make high quality even better.

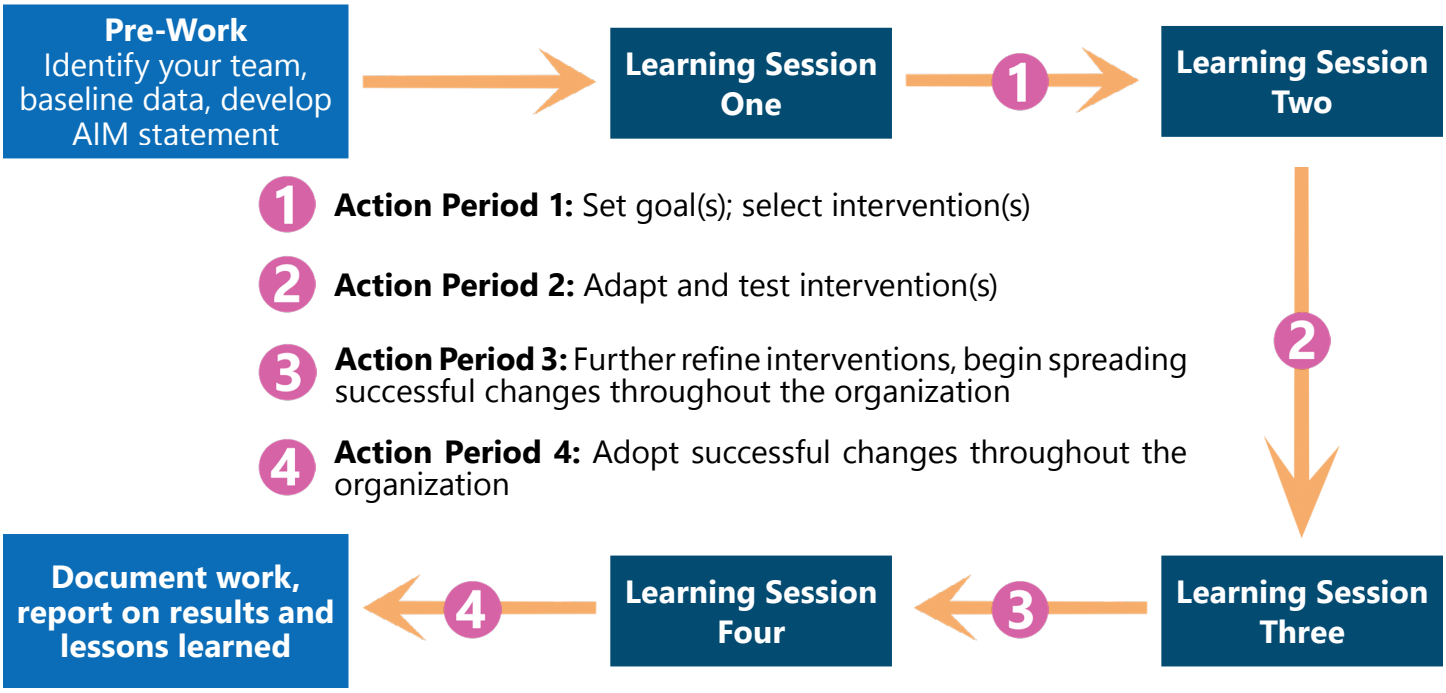
Together, QAPI is a data-driven, proactive approach to improving the quality of life, care and services in nursing homes. QAPI activities involve members at all levels of the organization to identify opportunities for improvement, address gaps in systems or processes, develop and implement an improvement or corrective plan, and continuously monitor effectiveness of interventions.

Breakthrough Collaborative Overview

A "collaborative" is a systematic approach to healthcare quality improvement designed to accelerate learning and widespread implementation of best practices. Participants perform multiple, small, rapid tests of change then share their experiences.

The Institute for Healthcare Improvement (IHI) developed the Breakthrough Series to help healthcare organizations make "breakthrough" improvements in quality while reducing costs. The Breakthrough Series is designed to help organizations close the gap of "what we know" and "what we do" by creating a structure in which interested organizations can easily learn from each other and from recognized experts in topic areas where they want to make improvements.

HQIN will feature the following components of the Breakthrough Series Collaborative Model throughout this initiative.



Ongoing Support

- Virtual Coaching Meetings
- Root Cause Analysis
- Data Analysis
- Tools and Resources

Calendar of Events

July 2023

Pre-work
Register for Kick-off and Learning Session 1
Review collaborative resources prior to Learning Session 1

August 22, 2023

Collaborative Kick-off
Overview of Collaborative Expectations and Activities

September 12, 2023

Learning Session 1
Advance Care Planning/Resident and Family Engagement

September 26, 2023

Learning Session 2
Communication

October 10, 2023

Learning Session 3
INTERACT® Care Paths

October 24, 2023

Learning Session 4
INTERACT® QI Tools

November 14, 2023

Collaborative Outcomes
Pulling it all Together and Sustainability

Expectations

HQIN advisors will:

- Provide expertise on clinical content and process improvement, both during and between learning sessions
- Offer coaching to teams
- Provide an electronic mailing list (email list) and other communication venues for shared learning
- Provide resources to participants in order to accelerate spread among nursing homes
- Maintain and safeguard the confidentiality of privileged data or information in compliance with HIPAA regulations—whether written, photographed or electronically recorded and whether generated or acquired by the team—which can be used to identify an individual resident, practitioner, nursing home, health plan or resident population.

Nursing homes are expected to:

- Perform pre-work activities (as outlined, beginning on page 8)
- Connect the collaborative goals to a strategic initiative in the nursing home
- Provide a senior leader to sponsor and actively support the team
- Participate in learning sessions that best meet the home's needs
- Identify performance measures that the team will target, including the recommended performance measures related to collaborative goals
- Implement PDSA cycles to meet the targeted performance measures
- Share data with frontline staff and update them regularly on activities and progress
- Interact during learning sessions by sharing information, including interventions, successes and challenges
- Maintain and safeguard the confidentiality of privileged data or information in compliance with HIPAA regulations—whether written, photographed or electronically recorded and whether generated or acquired by the team—which can be used to identify an individual patient, practitioner, nursing home, health plan or resident population.

Pre-Work

Please complete the following pre-work activities to prepare your facility for participation in the collaborative.

Identify your QI Team

Each facility should form a collaborative team to test and implement system changes. Please identify your team using the Recognize and Respond Team Member Form. (Attachment One)

Step One: Team Leadership Selection – a collaborative team begins with filling key leadership roles.

Senior Leader

Team members will report progress to the senior leader. The ideal senior leader:

- Has ultimate authority to allocate time and resources to achieve team aims
- Has ultimate authority over all areas affected by the change
- Will champion the spread of successful changes throughout the organization

Examples of senior leaders include a nursing home administrator or director of nursing. Nursing homes operated by corporations should identify a senior leader at the building level and are encouraged to name one at the corporate level as well. At a minimum, corporate leadership should be apprised of progress throughout the collaborative.

Team Leader

(i.e., DON, department manager)

- Coordinates, organizes and directs all activity
- Serves as the team champion that spreads successful change throughout the facility
- Attends collaborative activities

Day-to-Day Leader

(i.e., nurse, QA nurse)

- Has clinical understanding of and interest in the selected topics
- Drives the project to ensure change is happening
- Organizes meetings with direction from the team leader
- Attends collaborative activities

Frontline Champion

The ideal frontline champion:

- Is a respected frontline staff member with interest and expertise in the selected areas of focus
- Understands current processes of care
- Has a good working relationship with colleagues and the day to day leader
- Wants to drive improvements in the system

An example of a frontline champion is a nursing assistant. **It is essential to include this role.**

Step Two: Team Member Selection – an effective team is comprised of four to six team members who work well together and combine skills, styles and competencies.

Team members may include:

- Leadership, administrators, DONs
- Nurse practitioners
- Administrative staff
- Frontline staff
- Residents and families

Effective team members should:

- Have critical-thinking skills
- Be motivated to improve systems and processes
- Be creative and innovative
- Communicate well

✓ Work with your Recognize and Respond Team to complete the Preventable ED Visit and **Readmission Self-Assessment** tool

Each item relates to prevention elements that should be in place for a reliable and successful patient safety program to reduce unnecessary transfers.

✓ Work with your Recognize and Respond Team to collect your baseline data

Each facility should collect and analyze internal data to establish a baseline. Baseline data should capture all resident transfers during Q2 2023 (April-June 2023). If your team is unable to capture Q2 data, use June 2023 transfers to establish your baseline. If your team does not have an active tracking tool, implement the INTERACT® Hospital Rate Tracking Tool.

Action Period

Action Period Resources

INTERACT® Quality Improvement Program

- Tools to assist with implementation of a comprehensive, robust patient safety program
- Quality improvement tools
- Communication tools
- Decision support tools
- Advance care planning tools

TeamSTEPPS® for Long-Term Care

- Tools to assist with implementation of a teamwork system that improves collaboration and communication within your community

HQIN Improvement Consultants and Expert Faculty

The HQIN team is here to support your efforts throughout the entire collaborative. Contact your quality improvement advisor directly or email us at ***ltc@hqi.solutions***.

Measurement Strategy

Current nursing home quality indicators are presented as a mix of structural, process and outcome measures, each with its own set of advantages and disadvantages.

Structural Measures: Structural quality indicators have the advantage of being relatively easy to measure. Unfortunately, a pretty, well-maintained nursing home does not necessarily result in quality care. However, there often is a positive correlation. And for most customers these quality indicators are your first impression.

Although important, structural quality measures should be thought of as "necessary but not sufficient" (Castle & Ferguson, 2010). Staffing level is a good example. Intuitively, we think higher levels of caregivers improve the quality of care. Experience shows us this is not always the case. We see that staffing levels are important, but how staff are used may be more important.

Process Measures: Process measures track how day-to-day operations impact progress toward the goal.

Considering the Recognize and Respond Collaborative, the team could track a variety of processes by implementing the following:

- SBAR for identifying and communicating changes in resident condition
- A clinical decision guide to assist staff in decision-making processes
- A thorough resident pre-admission assessment checklist
- Staff huddles

Outcome Measures: Outcome measures examine whether the team is achieving its ultimate goal. For example, if the team wants to reduce falls, it would include an outcome measure tracking the number of residents who fall. We recommend that all Nursing Home Quality Care Collaborative (NHQCC) participants choose at least one of the following recommended outcome measures. Teams should choose measures that match their priority area of focus.

Recommended Outcome Measures (from CASPER reports):

- Percent of Short-Stay Residents Who Were Re-Hospitalized after a Nursing Home Admission
- Percent of Short-Stay Residents Who Have Had an Outpatient Emergency Department Visit
- Number of Hospitalizations per 1,000 Long-Stay Resident Days
- Number of Outpatient Emergency Department Visits per 1,000 Long-Stay Resident Days
- Percent of Residents Experiencing One or More Falls with Major Injury
- Percent of Residents with a Urinary Tract Infection

Defining Your Focus and Measures

Current nursing home quality indicators are presented as a mix of structural, process and outcome measures, each with its own set of advantages and disadvantages.

Before Learning Session 1, **your team should identify a priority area of focus, build your aim statement, identify your population of focus and identify your measure(s).**

It is important to note that your team can track a process and outcome measure related to the same intervention. For example, your team chooses to implement staff huddles to improve shift-to-shift reporting between clinical team members. With that, you can track the use of the tool (process measure) along with the number of residents transferred to the ED per month (outcome measure).

Use the following sections to guide your team discussion. Record preliminary decisions on the Priority Area of Focus Worksheet (Attachment Two).

Choose a Priority Area of Focus

- In this collaborative, the "area of focus" should be a targeted organizational or clinical system related to patient safety and resident transfers that you want to improve.
- Although your nursing home may have many priorities, we encourage you to limit your team to just one area of focus at a time.
  - You might reach your goal in that area, then move on to a second one, or you might continue to work on the same one throughout the collaborative. There will be opportunities to update, refine and change your area of focus.

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How to Make Your Selection

- Select your priority area of focus by reviewing your Recognize and Respond Self-Assessment, current readmission or ED visit data metrics and other available internal data. Where are your opportunities for improvement?
  - The focus area should be a system that will directly contribute to the success of the collaborative goals of implementing INTERACT® and TeamSTEPPS® concepts to improve resident safety and reduce unnecessary ED visits and rehospitalizations

A good priority area of focus has both:

- Room for improvement
- A likely significant impact on your ability to deliver quality care and support quality of life for your residents

Involve senior leaders (both at your nursing home and at the corporate level, if applicable), and your medical director in the selection decision. You will need support at all levels to make the improvements you desire.

Once you have determined which area of focus will be your priority for the start of the collaborative, you can develop an aim statement.

Developing an Aim Statement

The Model for Improvement provides structure for implementing a QAPI performance improvement plan (PIP). This model couples three fundamental questions with PDSA cycles:

1. What are we trying to accomplish?
2. How will we know that a change is an improvement?
3. What changes can we make that will result in an improvement?

Question 1 is answered in an aim statement. An aim statement is a concise written statement describing what the team expects to accomplish in the collaborative. It provides guidance for the team's specific improvement efforts.

Pre-Work Documentation

- Priority Area of Focus
- Working Draft of Aim Statement
- Population of Focus
- Recommended Outcome Measures
- Recommended Outcome Measures (from CASPER reports):
  - Percent of Short-Stay Residents Who Were Re-Hospitalized after a Nursing Home Admission
  - Percent of Short-Stay Residents Who Have Had an Outpatient Emergency Department Visit
  - Number of Hospitalizations per 1,000 Long-Stay Resident Days
  - Number of Outpatient Emergency Department Visits per 1,000 Long-Stay Resident Days
  - Percent of Residents Experiencing One or More Falls with Major Injury
  - Percent of Residents with a Urinary Tract Infection

For example, if you selected reducing the number of residents transferred to the ED as your priority area of focus, an aim statement could be as follows:
ABC Nursing Home will decrease the number of residents who require a preventable outpatient emergency department visit among long-stay residents by implementing best practices for assessment and communication of resident status, resulting in the rate of long-stay resident ED visits being reduced by 25%.

Teams make better progress when they have an unambiguous, specific aim. Setting numerical targets clarifies the aim, helps create tension for change and directs measurement. For example, an aim to "ensure that 100% of CNAs will be trained to use the Stop and Watch Early Warning Tool within one month of orientation" will be more effective than "improve staff communication."

Involve Senior Leaders in the Discussion. Senior leaders must align the aim with strategic goals of the organization. They must also provide support personnel and resources from information systems, finance and reimbursement, staff development and training, etc.

Base your aim on data and organizational needs. Examine data within your organization. Refer to the collaborative priority area of focus worksheet and focus on issues that matter at your nursing home. There will be time to refine your aim statement during learning sessions.

Defining a Population of Focus

It is recommended that teams select discrete units, wings or resident areas that will be affected by the changes being made, rather than including all residents at the outset of the collaborative.

Selecting and Testing Changes

The final pre-work phase is to select your first evidence-based strategies, or other best practices or change ideas, to test as you work toward your goal. At its most basic level, the Model for Improvement has two parts: three fundamental questions and the PDSA cycle. The third question addresses how to select changes:

1. What are we trying to accomplish?
2. How will we know that a change is an improvement?
3. What changes can we make that will result in improvement?

Collaborative learning sessions, peer interaction and self-study materials will help generate additional ideas for changes to test.

Test with the PDSA Cycle

Use the PDSA cycle to rapidly test and refine the change you select. Tests can be as quick as one time, one shift, one staff person or one resident.

Multiple cycles of testing help you gain the most information and ensure that when you roll out changes more broadly, you have a better chance of successful implementation, spread and sustainability.

Attachment One:
Recognize and Respond Team Member Form

Team Role	Name and Credentials	Title
Senior Leader, Facility Level		
Senior Leader, Corporate (if applicable)		
Team Leader		
Day-to-Day Leader		
Frontline Champion		
Other Team Member		
Other Team Member		
Other Team Member		
Other Team Member		

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Attachment Two:
Priority Area of Focus Worksheet

Priority Area of Focus:

Working Draft of Aim Statement:

Population of Focus: _____

Recommended Outcome Measures:

- ☐ Percent of Short-Stay Residents Who Were Re-Hospitalized after a Nursing Home Admission
- ☐ Percent of Short-Stay Residents Who Have Had an Outpatient Emergency Department Visit
- ☐ Number of Hospitalizations per 1,000 Long-Stay Resident Days
- ☐ Number of Outpatient Emergency Department Visits per 1,000 Long-Stay Resident Days
- ☐ Percent of Residents Experiencing One or More Falls with Major Injury
- ☐ Percent of Residents with a Urinary Tract Infection
- ☐ Other: _____

Potential Issues in Collecting Data for the Recommended Measures:

Additional Process Measures Selected:

Potential Issues in Collecting Data for the Recommended Measures:

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