Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

Comagine Health

Quality Improvement Review of Transfers; Drivers of Admissions and Readmissions

Transfers to the emergency department and hospital admissions/readmissions are sometimes necessary to provide the appropriate level of care needed to address a resident's current health status. However, data show that a percentage of emergency department visits and hospital admissions/readmissions are potentially preventable, and these transitions can be highly disruptive for frail individuals. It is important to gather information related to any transfer and analyze it for gaps in your processes and systems related to care and communication among care team members, including external care providers. Uncovering patterns or trends provides the opportunity for improvement that enhances the quality of care and reduces potentially preventable transfers.

Explore the Issue: Review of Transfers/Readmissions – Questions to Ask

- What are our current rates for emergency department visits and hospital admissions/readmissions? How do they compare to the state and national averages?
- What critical team conversations happen after a resident is transferred? How do we involve the resident/family in these conversations?
- How do we determine if the transfer (change in condition-related) was preventable or not?
- What patterns have we identified through tracking?

Conduct a Performance Improvement Project (PIP): Suggested Steps

Step 1: Determine the key areas for improvement: (*Refer to questions listed above under "Explore the Issue")*

- Complete a review of the medical records for 10 residents who were transferred to the emergency department or admitted to the hospital. ***NOTE:*** You can choose a different number or timeframe based on your facility's usual patterns of transfer and readmission. The point is to select a meaningful amount to allow you to identify any trends.
- Study the assessment notes/documentation conducted by the nurse and other staff who cared for the resident. Review other areas, such as lab work and notes from the hospital. Note any diagnostic reasons or other data of interest (e.g., staff involved, medical director, time of day, etc.)
- Determine if there were missed opportunities that could have resulted in treating the resident early on or prevented the issue that led to the hospital transfer.

Step 2: Create a goal that focuses on the key area you have identified as needing improvement. *Consider both knowledge and process gaps.*

For example:

- If process is an issue, consider what kind of tools are needed to guide the nurse and other staff that provide care to ensure appropriate actions are taken at first sign of change in condition to prevent hospitalization. Also, consider any workflow challenges that may impact the implementation.
- Consider what type of information needs to be provided to new and current nursing staff. Did they know the correction action or procedure, how to perform it or who was supposed to perform it?

Step 3: Consider all the factors that may have been involved in a transfer or readmission. Identify all reasons why a transfer or readmission occurred by using the **Root Cause** for the problem (applying the "5 Whys" technique).

- Was the transfer/readmission preventable? Use a tool like the **INTERACT Quality Improvement Tool for Review of Acute Care Transfers** that will let you drill down into individual cases. This site also features additional tools to track and review your trends under the "Quality Improvement" section.
- Does the issue(s) stem from the facility process, staff training /education or both?
- Don't assume staff are on the same page with drivers of readmissions – impressions may differ from data.

Step 4: Why is it important to address your facility's specific prevention process issues?
Improving the process to prevent hospital readmissions will help to reduce certain outcomes that affect the quality of life for a resident, such as unnecessary trips to the emergency department. It will also improve clinical outcomes and coordination of care through better and more timely communication of a resident's status and response to interventions when a change in condition occurs.

Step 5: Brainstorm to develop your Plan-Do-Study-Act (PDSA) cycle

- What exactly are we going to do? List action steps. *Refer to the* ***Examine Your Practices*** *section below for ideas on processes some facilities have used.* Some suggestions include:
  - Once factors have been identified as patterns for the organization, choose which of these to work on over the next quarter. *For example,* if pain is an issue, you can pilot the use of these tools to help with assessing pain with residents.
    - **Pain Assessment in Advanced Dementia (PAINAD)**
    - **Palliative Care Toolkit**
  - Incorporate a post-readmission interview to incorporate resident/family caregiver input.
  - If using Point Click Care, determine if facility can benefit by purchasing additional option to track ED visits (abaqis® quality management system).
- Set a timeline for the PDSA process.
- Evaluate each part of the process. ***NOTE:*** Change takes time, so ideally test for six months to make sure the process is ingrained.
- Were the results the desired outcomes? Is the outcome consistent with the expectations set?
- How will we know that change is an improvement?

Step 6: Implement and evaluate your **Plan-Do-Study-Act (PDSA) cycle**

- What changes to the process are we going to make based on our findings?
- How are we going to sustain all processes and continue to build a culture of safety (i.e., turnover in leadership or caregiver staff)?
- How will we communicate to all staff, residents, families and affiliations our quality-of-care improvements? (e.g., checklist)

Examine Your Practices: Peer Insights to Consider

- **Use all the data sources available to help track and understand transfers and readmissions.** PointClickCare® has hospitalization and emergency department tabs, providing relevant and actionable data. The abaqis® quality management system is also something used by centers to support quality improvement.
  - Interview staff, providers, residents and family members to learn more about what was done and what could be done better to prevent future transfers.
  - Talk to your hospital partners to gather more information about the transfer or admission/readmission.
  - The **Hospital Guide to Reducing Medicaid Readmissions Toolbox** can be used as a guide to develop the types of questions you want to ask.

- **Get curious about the causes/drivers of transfers and readmissions.** Map the processes involved in care and response to a change in condition to compare what is actually happening to what is expected to happen (identify the gaps). Explore opportunities for improvement using a fishbone diagram or a cause-and-effect diagram. INTERACT® provides quality improvement tools to help understand causes and identify patterns.
- **Share the data and discuss patterns discovered related to transfers and readmissions with ALL staff, not just leadership or QAPI staff.** Ask frontline staff what they think the top reasons are for transfers and compare their answers with the data. Talk about the care provided, tools and resources available, and understanding of roles with identifying changes in condition early and communicating concerns. It's a learning opportunity to teach your staff what to look for and how you could avoid transfer.
- **Be mindful of behaviors and unmet needs.** What is the resident's behavior actually telling you? Teach your staff to focus on recognizing signs and symptoms that may go unspoken and changes in vital signs that should be brought to the nurses' attention that may be helpful in detecting changes in condition early. Consider using tools designed for residents who are non-verbal and who have dementia (i.e., pain tools). These highlight behaviors that may warrant a follow-up to assess and explore possible treatment strategies. Understand when your residents are "stoic" and won't tell you about changes in their signs and symptoms or complain about pain or other things that should be brought to your attention. For verbal residents, the nurse can assess and educate the resident about goals to avoid unnecessary transfers. Let them know we want to work with them to alleviate their symptoms, but we need to know about the symptoms to do this.
- **Establish systems that support identification of risks for transfers and hospital readmission.** For most centers, the majority of transfers occur within the first few days of admission, when staff don't know the resident very well. Can you also identify changes to act on for residents inclined to "tough it out" before a transfer is required? What conditions should be monitored closely? Know what should be responded to with urgency.

Resiliency

Though difficult, crisis can lead us to innovation. It demands we leave our comfort zone and "the way we've always done things" to develop new solutions for problems and re-examine our priorities. As new waves of COVID-19 are revisiting many communities, we may feel we have returned to square one; however, we are not in the same place. We have different tools at our disposal and experience under our belt that we didn't have before, leaving us better poised to meet these challenges. In a quality review of our system – once an emergency subsides (with COVID-19 management or otherwise), how do we critically examine our actions and responses to learn from them and become more resilient for whatever comes next?

Explore the Issue: Organizational Resiliency and Sustainability - Questions to Ask

- What have we learned from this whole experience about keeping our organization resilient?
- How have we celebrated successes in the middle of this prolonged crisis?
- How could we formalize the lessons and approaches we've learned?

Link the Concepts: Systemic Approaches to Recovery and Organizational Resiliency

- Awareness of how individuals and communities **respond to and process through disaster and crisis** can help us better identify opportunities to support resilience. As COVID-19 is not a discrete event and no clear end point is in sight, it's important to recognize that while your team may again be experiencing similar waves of grief, disillusionment and other emotions, experiences may differ from earlier stages of the pandemic, so our responses have to evolve and adapt.
- COVID-19 has created an environment described as volatile/uncertain/complex/ambiguous (VUCA). As leaders, we must acknowledge that things are volatile and will be for some time. There's no going back to the way things were. We are tasked to learn how to function and eventually thrive in this new environment. While challenging, uncertainty allows us freedom from practices that no longer serve us or our residents.

- You've made changes to your system to meet new needs as a result of COVID. Where does it make sense for your organization to re-establish certain conventions and where should it lean further into changes, adaptations and ongoing improvement to better respond to the current environment? A commitment to being a learning organization fosters a culture of safety. Continual learning and improvement results in organizational resilience, allowing your facility to anticipate and respond to what is needed to move forward.

Assess the Approach: Actions for Leadership

- Find an opportunity to examine and reorganize your systems during recovery periods. Use the consensus framework of 10 leadership imperatives in this **Guidance for Health Care Leaders During the Recovery Stage of the COVID-19 Pandemic** as a reference.
- **The fishbone and driver diagrams** can be useful tools. Similar to examining drivers for a process or problem we need to improve, you can use them for an outcome we'd like to influence, such as organizational resiliency.
- Given the notion that "every system is perfectly designed to get the results it gets", if the results we've experienced over the past months are not what we'd expected or planned for, where are opportunities to revisit our system design to improve resiliency? What critical conversations should take place in our team to decide what we keep, what we discontinue going forward and how we can innovate?
    - Peers offered the following resiliency insights: One facility shared that their vice president conducts rounds to check in with and personally thank staff, which has made a significant impact. Celebrate staff in creative ways. Some facilities brought in food, like a taco/food truck on certain days, to show appreciation. Use agency staff to allow staff to take vacation. It costs less to put money toward agency staff than it does to replace a staff person who is burned out from not taking time off. Talk about resiliency often – have a little space carved out in meetings and in conversation with staff. Keep in mind that sometimes a comment from left field can bring about a unique change opportunity.

Put to the Test: Next Steps

1. Bring the *Questions to Ask* back to your QAPI or leadership team.
2. Complete a review of the medical records for the last resident to be transferred to the emergency department or admitted to the hospital. Identify potential areas to strengthen your practices related to early identification and intervention to prevent a future transfer.
3. Review/formalize the lessons and approaches you have learned during the crisis. Identify drivers, strategies, change ideas and post-crisis opportunities that can help you build and sustain your organizational resiliency.
4. Share resources/this summary of practice ideas.

Resources

1. Pain Assessment in Advanced Dementia (PAINAD)
2. Palliative Care Toolkit
3. INTERACT Quality Improvement Tool for Review of Acute Care Transfers
4. Hospital Guide to Reducing Medicaid Readmissions Toolbox
5. Prioritization Worksheet for Performance Improvement Projects
6. Centers for Medicare & Medicaid Services State Operations Manual
7. Guidance for Health Care Leaders During the Recovery Stage of the COVID-19 Pandemic
8. Zunin/Meyers, as cited in Training Manual for Mental Health and Human Service Workers in Major Disasters, U.S. Department of Health and Human Services (2000)
9. IHI Quality Improvement Essentials Toolkit

This material was prepared by Comagine Health, a Medicare Quality Innovation Network-Quality Improvement Organization under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. Views expressed in this material do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a specific product or entity herein does not constitute endorsement of that product or entity by CMS or HHS. 12SOW-T1-21-QIN-094