INTERACT Implementation Learning in Action Collaborative Webinar 4: SBAR

February 18, 2016
11:30 am – 12:30 pm EST
AQIN – SC QIO Team:

Sarah Stein Banyai, MPH
Quality Specialist
SStein@thecarolinascenter.org
803.212.7521

Heather Jones, MHA, PTA, CPHQ
Manager Care Coordination
HJones@thecarolinascenter.org
803.212.7584

Marilee Mohr, RN
Quality Specialist
MMohr@thecarolinascenter.org
803.212.7517

Karen Southard MHA, RN
State Program Director, SC-AQIN/QIO
KSouthard@thecarolinascenter.org
803.212.7518
Learning In Action Collaborative

During this 6 month, action oriented, virtual collaborative participants will:

- Receive education, coaching, and resources from experts in the field
- Develop strategies to reduce avoidable hospital readmissions
- Learn about evidence-based INTERACT tools and have the opportunity to implement interventions to reduce hospital readmissions: QI tools, capabilities list, transfer forms, SBAR, and STOP and WATCH
- Build a community of practice with their peers and share successes and challenges
- Learn to use data in a meaningful way to improve care
Welcome

- All webinars will be recorded and can be accessed at
  http://atlanticquality.org/initiatives/care-coordination/care-coordination-sc/

- Meeting norms:
  - Flexibility and understanding with technology
  - Engagement and participation in discussions and peer-to-peer sharing
  - Focused attention
Collaborative Timeline

(All webinars are scheduled on Thursdays from 11:30 am -12:30 pm EST)

October 8, 2015 – Kickoff Webinar #1: Readmission Tracker

October 19-23, 2015 Check in/Coaching call (15-30 min)

November 5, 2015 – Webinar #2: Capabilities List

November 9-13, 2015 Check in/coaching call (15-30 min)

November 19, 2015 – Webinar #3: Transfer Forms

December 7-16, 2015 Check in/coaching call (15-30 min)

January 7, 2016 – Webinar #4: SBAR

January 25-29, 2015 Check in/coaching call (15-30 min)

February 18, 2016 – Webinar #5: Stop and Watch

February 29- March 4, 2015 Check in/coaching call (15-30 min)

March 17, 2016 – Webinar #6: Lessons Learned and Next Steps
The INTERACT Program

Opportunities for You and Your Facility

High

Reduce Preventable Hospitalizations

Improve Quality, Reduce Costs

Low

Shared Savings for Providers

Low

Costs Avoided

$ Cost

High
Where will you be in 5 Years?

- ACO
- NH/HHA
- Value Based Purchasing
- Bundled Payment Model
- Mergers and Acquisitions
Process Improvement Principles

- Resident Focus
- Leadership Involvement
- Team-Based
- Data and QI Tools
- Just Culture
- Prevent Overcorrection
- Staff Empowerment
- Continuous Improvement
INTERACT tools are meant to be used together in your daily work in the nursing home or home health agency.

INTERACT tools will help identify common causes of readmission.

INTERACT aligns with QAPI initiatives.

https://interact2.net/
## Alignment of QAPI and INTERACT

<table>
<thead>
<tr>
<th>QAPI</th>
<th>INTERACT</th>
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</thead>
<tbody>
<tr>
<td>Improves communication</td>
<td>Provides communication tools</td>
</tr>
<tr>
<td>Driven by leadership and empowers staff to be part of the decision making</td>
<td>Leadership sets the charter and works with staff to implement</td>
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<tr>
<td>Standardize practice</td>
<td>Evidence-based tools</td>
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<tr>
<td>Data drives the change</td>
<td>Data helps identifies the opportunity to improve</td>
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<tr>
<td>Provides a system to monitor effectiveness of care</td>
<td>Provides tools to analyze process, provides care paths to deliver care in a consistent manner</td>
</tr>
<tr>
<td>Systemwide improvement</td>
<td>Utilize PDSA cycles and spreads success across the organization</td>
</tr>
<tr>
<td>Organizes the change plan into a performance improvement project</td>
<td>INTERACT is a performance improvement project</td>
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SC Diagnosis-Specific Readmissions

SC overall readmission rate is 11.7%
New Payment Models Related to Quality

Star Rating for SC HHA

- 0% 2% 2% 8% 21% 51% 11% 2% 2%
- 1 Star 1.5 Star 2 Star 2.5 Star 3 Star 3.5 Star 4 Star 4.5 Star 5 Star
HHA Admissions and Return to ER after Discharge from Hospital

- Admitted while under HHA:
  - South Carolina: 16.10%
  - Nation: 15.90%

- Discharged from hospital, Return to ER no Readmission:
  - South Carolina: 13.00%
  - Nation: 12.20%

https://www.medicare.gov/HomeHealthComparison
Tracking in Real Time

- Track and trend transfer measures using QI Tool
- Conduct root cause analysis using QI Tool
  - Analyze transfers
  - Look for common patterns
- Choose interventions based on your findings
Building Partnerships

Engaging Your Hospitals – Communication Tool

Readmission Champion

NH/HHA Capability List

Share your QI Goals

Host or join a community care transitions meeting
Communication Tools

Capabilities List

• Standardized, pre-populated checklist of nursing home/home health capabilities for decisions about transfers back into facility

• Distribute to EDs and hospital discharge planners

• Marketing and education tool

https://interact2.net/tools_v4.html
Using the Tool in Different Ways

• Combines the QI Review for readmission and compare to your capabilities list – gaps?

• Allows you to build a business case for service line expansion within the facility

• Establishes a quality scorecard using the most frequent admission DRG/readmission QI review tool and facility capabilities list

• Targets both internal and external education to staff and other providers
SBAR Develops Professional Team

- Advances the professionalism of the nurse
- Increases confidence and respect among team members
- Enhance critical thinking
- Increase clinical competency
- Empowers staff → Valued/Contributor to the Team
Evaluation of SBAR

• Review the SBAR completed form
• Gain feedback from Medical Leadership
• Trend deficits in clinical assessment skills
• Involve staff development in developing ongoing education
Today’s Tool: STOP and WATCH
Design of the Tool

• Designed for Nursing Home, Assisted Living, or Home Health Agency

• Any staff or family member can use the tool

• Helps to alert skilled care team that someone sees a subtle change to individual

• Prescriptive in the implementation of the tool for any setting

• Has been shown to have a dramatic impact on reducing readmissions
**Stop and Watch**

**Early Warning Tool**

If you have identified a change while caring for or observing a resident, 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.

- Seems different than usual
- Talks or communicates less
- Overall needs more help
- Pain – new or worsening; Participated less in activities
- Ate less
- No bowel movement in 3 days; or diarrhea
- Drank less
- Weight change
- Agitated or nervous more than usual
- Tired, weak, confused, or drowsy
- Change in skin color or condition
- Help with walking, transferring, toileting more than usual

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

*Patient/Resident*
<table>
<thead>
<tr>
<th>Communication Tools</th>
<th>Use</th>
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<tbody>
<tr>
<td>Stop and Watch</td>
<td>Certified Nursing Assistants, other direct care staff (rehabilitation, environmental services, dietary, others); consider providing to families</td>
</tr>
<tr>
<td>Early Warning Tool</td>
<td>• Regular evaluation of and recognition of changes in residents’ condition</td>
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<tr>
<td></td>
<td>• Monitoring residents at high risk for hospital transfer on a specific schedule for a defined period of time (e.g. every shift for the first 3 days after admission from the hospital)</td>
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<td>• Reporting changes to licensed nurses</td>
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<td>• Documentation in medical record <em>(or other location)</em></td>
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STOP and Watch – All Staff Support Tool

- Physician
- Nurse
- Nursing Assistant
- Support Staff
- Ancillary Staff
Hardwiring STOP and Watch

- During general orientation to all staff
- Select your method for using the tool- EMR, hard copies for the support and ancillary staff
- Outline and reinforce the communication process especially for your support and ancillary staff
- Involve your Medical Director and Covering Physicians in the design and education
- Review the STOP and Watch events daily and record the patients and frequency, and who noted the change.
- Discuss the findings at morning meeting and also at care planning conference
Case Study for Nursing Home

Mrs. Jones is an 89 year old lady who is currently in Lovely Day Nursing Home for rehab services after being discharged from the local hospital for a recurrent flair up of Congested Heart Failure. (2nd readmission within 30 days) Previously, Mrs. Jones was admitted to the hospital for the same diagnosis but went home and returned to the hospital within 10 days.

Mrs. Jones, is quiet, likes to sleep in till 9am and tends to cough at times, she may have a little SOB on activities, but can do all of her own ADL with little assistance. She does like to take her meals in the room but will go the activities room for BINGO.

Based on the Case Study what would you communicate to your care team, your support staff and your patient
**Communication Tools**

**Stop and Watch Early Warning Tool**

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**Patient/Resident**

<table>
<thead>
<tr>
<th>Your Name</th>
<th>Date and Time (am/pm)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reported to</td>
<td>Date and Time (am/pm)</td>
</tr>
<tr>
<td>Nurse Response</td>
<td>Date and Time (am/pm)</td>
</tr>
<tr>
<td>Nurse’s Name</td>
<td></td>
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</tbody>
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**Tips to Implement: PDSA**

**P** – Begin with one team

**D** – Educate staff and MDs, reinforce in daily huddle

**S** – Data to collect:
- # of times tool is used
- # of times hospital transfer averted

**A** – Huddle with staff.

What is working? What needs to be modified? If no modification, then spread to other shifts.
Engaging Family and Patient in Care

- Caregivers should use Stop and Watch
- HHA Aides and PT spend time with the patient
- Role of Telehealth

https://youtu.be/QDXCPncbyRo
Patient Education and Stop and Watch-HHA

- Stop and Watch will activate the Patient and Care Giver Engagement Scores
- Triggers questions that care givers may not ask
- QI: Trend and evaluate Stop and Watch triggers
  - Enhance current patient education material
  - Adapt your Teach Back to include some of the more frequent triggers for readmission
Case Study for Home Health

Mrs. Jones has been discharged from Lovely Day Nursing Home to Always There Home Health Agency. Upon your first visit to the home the nurse reviews Mrs. Jones medication with her and her daughter who lives with her. You go over her follow up physician appointment. On exam Mrs. Jones does have mild inspiratory wheezing, but no rales. Her breathing is normal at 20 and she complains of no pain.

Self Care: Mrs. Jones is to weigh herself upon rising and call the agency for a 3 pound weight gain. She has her medications in a pill box and takes them according to her written directions.

Based on the Case Study what would you spend more time educating your patient on?
STOP and Watch Tool for HHA

Implement and Hardwire:

Modify the tool and replace patient information section with HHA contact information

Laminate the tool and make it a refrigerator magnet for easy access and a constant reminder
Communication Tools

Tips to Implement: PDSA
P – Begin with a core team of caregivers
D – Educate staff and caregivers
S – Data to collect:
   # of times tool is used
   # of times transfer to hospital averted
A – Huddle with staff. What is working?
   What needs to be modified?
   If no modification, then spread to other staff
**Action Items:**

- Schedule a follow-up call with the AQIN-SC team
- Track and review hospital readmission data and transfer data using the QI tools
- Share your Capabilities List with your hospitals
- Educate staff on SBAR tool and begin collecting data on utilization
- Register for INTERACT Implementation Webinar #6 –

**Next Steps – Readmission Tracker –**

*March 17, 2016*

[https://qualitynet.webex.com](https://qualitynet.webex.com)
Thank you!

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