Reducing Avoidable Emergency Department & Hospitalization Toolkit

This toolkit provides an overview of a quality improvement process to reduce the frequency of avoidable emergency department (ED) visits and hospitalization. As part of a QAPI Performance Improvement Project, this toolkit provides your team with actionable steps to decrease the number of hospital transfers. To assist in organizing and documenting your quality improvement project, utilize Great Plains QIN's Quality Improvement Process Guide.

I. Area for Improvement: Decrease number of outpatient ED visits

Reducing the number of unnecessary hospital transfers is a national priority because ED transfers can result in unnecessary diagnostic tests and interventions, adverse events, increased health care expenditures, and physical and emotional discomfort for both patients/residents and their families. It is estimated that anywhere from 30-70% of ED visits are potentially avoidable.

Research studies on avoidable ED visits for specific settings below:

- **Nursing Homes:** Appropriateness of transferring nursing home residents to emergency departments: a systemic review/ January 2019
- **Clinic/Office:** CMS TCPi Reducing Unnecessary Emergency Department Visits
- **Hospitals:** Trends in the Utilization of Emergency Department Services
- **All Healthcare Settings:** Preventable Emergency Department Visits I AHRQ.gov

II. Root Cause Analysis: Review and select which factors apply

Review 10% of your resident/patient transfers or hospital ED visits for the last 6 months or at a minimum 10 charts to determine the reasons for transfer and if the transfer could have been avoided. Using an excel tracking spreadsheet such as the INTERACT® Hospital Rate Tracking Tool and the Acute Care Transfer Log may be helpful in determining the "who", "what", and "why" for the transfers.

Common reasons for transfer:

1. Inadequate communication during hand-offs from hospital, to nursing home, home health, and assisted living or long-term support services (LTSS)
2. Lack of awareness of nursing home capabilities by hospital discharge staff
3. Early change in resident's condition unrecognized and unreported by staff or family
4. Multiple signs and symptoms without specific clinical diagnosis and effective management
5. Lack of resources necessary to manage the person's condition
6. Inadequate communication between nursing staff and primary care provider
7. No in-person assessment by healthcare provider
8. After hour transfers
9. Family insistence and preferences/family calling 911 without input

10. Inadequate advance care directives
11. Lack of primary care provider/lack of time/appointments and orders to send to ED
12. Lack of transportation/social supports
13. Inadequate chronic care management or gaps in care coordination
14. Events related to infection (respiratory, gastrointestinal, urinary tract, skin/wound): potential sepsis
15. Events related to resident care (falls, abrasions, trauma, dehydration, pressure ulcers, inadequate monitoring, and care delivery)
16. Medication adverse events
17. Potentially Preventable Adverse Events Document I CMS

Many of the strategies in this toolkit reference INTERACT® (Interventions to Reduce Acute Care Transfers) tools and resources. INTERACT® is a quality improvement program that focuses on the management of acute change in condition. It includes clinical and educational tools and strategies for use in everyday practice. Many electronic health records incorporate INTERACT® or similar tools and resources.

Most INTERACT®- Training, Tools, Licensing, and Resources (pathway-interact.com) are free; **however, you do need to register and log in to download the tools/resources and access these pages.** There are tools for several care settings along with implementation guides.

- INTERACT® Version 4.5 Tools for Skilled Nursing
- INTERACT® Version 2.0 Tool for Assisted Living
- INTERACT® Version 1.0 Tools for Home Health Care

Examples of INTERACT® Tools:

- SBAR Communication Form and Progress Note
- Decision Support Tools (Charge in Condition File Cards and Card Path
- Stop and Watch Tool
- Advance Care Planning Tracking Tool
- Acute Change of Condition Cards
- Care Path Cards (acute mental status, dehydration, fever, GI symptoms, respiratory, SOB, CHF, UTI, Fall, etc.)
- Quality Improvement Tools
- Acute Care Transfer Log Checklist
- Calculating Hospitalization Rate Tracking Tool
- Capabilities List
- Hospital Transfer Form

III. Set a Goal: Specific, Measurable, Attainable, Relevant, Time-bound, Inclusive and Equitable

Ensure people and projects reflect your organization's commitment to equity and inclusion. To find out more about being inclusive and equitable in setting goals visit The Management Center.

SMART (not IE) Goal Example: *Will reduce ED visits 10% from baseline utilizing the INTERACT® change of condition cards by June 2023.*

SMART(IE) Goal Example: *By March 2023, we will train all staff members on the INTERACT® change in conditions cards with input on training development from staff members representing of all staff (age, gender, race, language, sexual identity/orientation, socioeconomic status, and geography).*

IV. Strategies for Improvement: Analyze barriers discovered during RCA and select strategies to address them

Challenges	Strategies
SECTION 1: Inadequate communication during hand-offs, hospital or discharge setting unaware of caregiver capabilities 	• Conduct QI meeting between NH, hospital, home health or other Long-term support services (LTSS) for Root Cause Analysis (RCA) to determine reasons for transfer back to hospital • Improve communication and warm handoffs between the discharge setting to receiving setting. Ideas that Work: Circle Back Six Simple Question I Circle Back YouTube 6:36 min video I Circle Back Tracking Template • Provide hospital with INTERACT® Nursing Home Capability List so that discharge staff are familiar with what tests and procedures facilities can perform • SNF Best Practices Reducing Potentially Avoidable ER Visits Rehospitalizations I GPQIN • TeamSTEPPS® to enhance communication and patient/resident safety • Readmissions Interview Tool • Project RED (Re-Engineered Discharge) improves the discharge process in a way that promotes resident/patient safety and reduce re-hospitalization rates. Research has shown that RED was effective at reducing readmissions and post hospital emergency department • Nursing Homes can utilize the Improving Nursing Home Discharges Back to the Community Toolkit
SECTION 2: Failure of healthcare staff or family at home to detect and report early changes in patient/resident condition 	• Train staff in the use INTERACT® Change in Condition cards to report changes in patient/resident status early and develop protocols using these evidence-based tools • Examine how patients/residents with changing status are monitored, and how that information is communicated to care givers, medical providers, family (care team) in real time • The INTERACT® Stop and Watch tool is appropriate for all care settings • Ideas That Work - Stop and Watch - 7min YouTube Video • SNF Best Practices Reducing Potentially Avoidable ER visits Rehospitalizations | GPQIN

SECTION 3: Multiple signs and symptoms without clinical diagnosis and effective management; lack of resources to manage patient/resident condition 	• Train nursing staff in structured assessment, evaluation, documentation, and communication of clinical signs and symptoms such as abnormal vital signs, altered mental status, shortness of breath, pain, functional decline, behavioral symptoms, fever, and unresponsiveness. Provide tools, such as the: INTERACT® SBAR for UTI's, COPD, CHF, Pneumonia • Provide evidence-based order sets that address the most common signs and symptoms associated with transfers, such as UTI's, pneumonia, CHF and COPD • SNF Best Practices Reducing Potentially Avoidable ER visits Rehospitalizations | GPQIN
SECTION 4: Inadequate communication between nurses/caregivers, family, and physician 	• Train nurses on structured assessments, evaluations, documentation, and communication strategies such as using the INTERACT® SBAR so that off-site clinicians can make informed transfer choices about transfers • Utilize telehealth to improve off site resident assessment by primary care providers: CMS Telehealth and Telemedicine Toolkit • Use an admissions nurse or advance practice nurse who can assist in making informed choices on new admissions and hospital transfers • Improve daily/shift huddles to address issues early: Huddle Guide Toolkit | HQIN • SNF Best Practices Reducing Potentially Avoidable ER visits Rehospitalizations | GPQIN • TeamSTEPPS® to enhance communication and patient/resident safety
SECTION 5: Family insistence and preference; inadequate or missing advance care planning 	• Use the decision guide, *Go to the Hospital or Stay Here?* when working with patient/resident/ family prior to admission elsewhere to determine preferences and to answer questions about hospital transfers. Discuss current setting capabilities and risks with transfers • Advance Care Planning Resource List • INTERACT® advance care planning tools • Advance Care Planning conversations may be reimbursed by Medicare: End of Life Conversations: Medicare Reimbursement FAQ • SNF Best Practices Reducing Potentially Avoidable ER visits Rehospitalizations | GPQIN

SECTION 6: Infections (urinary tract, pneumonia, C Diff, skin and wound, etc.) All these can lead to sepsis 	• Use the UTI Toolkit for Long-term Care Facilities to access evidence-based strategies for the prevention and management of UTIs • AHRQ Toolkit 3 Common Infections (UTI, Lower Respiratory, Skin and Soft Tissue) • INTERACT® Care Path Cards • CMS Head to Toe Infection Prevention Handbook (ZIP) • Sepsis | CDC • Nile Moss- one families struggle with sepsis - YouTube Video – 1:37 • GPQIN Connecting the Dots Resources (sepsis, antibiotics) • C. diff Guidelines and Prevention Resources | CDC • SNF Best Practices Reducing Potentially Avoidable ER visits Rehospitalizations | GPQIN
SECTION 7: Inadequate fall management, post fall or injury assessment 	• Use post fall criteria in AHRQ's On Time Falls Prevention • Read Chapter 2 of AHRQ's Falls Toolkit for a comprehensive response to falls: Use this Falls Protocol • Use GPQIN Post Fall Huddle Template • Measure orthostatic blood pressures from lying to standing positions. If BP drops >20mm Hg or feeling lightheadedness; this is abnormal • SNF Best Practices Reducing Potentially Avoidable ER visits Rehospitalizations | GPQIN
SECTION 8: Medication Adverse Events, such as behavioral change, falls, gastrointestinal, breathing, heart, balance, mobility, eating and or sleeping changes 	• Alert to potential medication events related to polypharmacy (being on 5 or more medications). Deprescribe when possible • If an untoward change of condition develops after a new medication is prescribed; investigate further BEFORE adding another medication to the regime. Include pharmacist in review • Ensure medication reconciliation is done between transferring care sites • IHI Skilled Nursing Facility Trigger Tool for Measuring Adverse Events | IHI - Institute for Healthcare Improvement • American Geriatric Society Pocket Guide to the Beers Criteria • Medication Errors and Adverse Drug Events | PSNET | AHRQ • Disposal of Unused Medications | US Food & Drug Adm • National Action Plan for ADE Prevention | US Dept HHS • Adverse Events in Nursing Homes | CMS • SNF Best Practices Reducing Potentially Avoidable ER visits Rehospitalizations | GPQIN

V. Measure Your Success: Collect and analyze data for specific measures

Measurement is an important component of a performance improvement program which helps to identify areas of low performance and target future interventions. Both outcome measures and process measures

should be part of the measurement process. In this instance, an outcome measure may be the number of transfers to the ED per month.

Process measures are in response to the findings of root cause analysis and therefore are specific to each organization. They must be measurable either through audits or observation. Examples of process measures include:

- Number of times an SBAR tool is used by nursing staff to communicate a change in condition to the primary care provider and the number of times the involved resident was transferred versus being managed in the nursing home, assisted living or other LTSS
- Number of times staff use a change in condition card each shift and which of the patient/resident were the subject of the card who were later transferred
- Number of times staff use Stop and Watch communication tool

VI. Celebrate Your Success: Promote success and express appreciation when goals are met

- Use a graph to illustrate monthly ED visits, admission, and readmissions. Run Chart Tool | IHI
- Display the graph so that staff are aware of trends
- Highlight patient/residents who were not transferred and instead were managed in the nursing home, home or long-term support service to avoid unnecessary tests and emotional distress
- Ensure that staff realize the many benefits to patients/residents and families when an unnecessary hospital transfer is prevented
- Share your project in your facility and with others via a storyboard: CMS Storyboard Guide for PIPs
- Celebrate when staff make progress towards the goals of increasing activities and resident engagement. Utilize incentives, pizza parties, posters, raffles, small gift cards, and other rewards for excellence
- Ensure that leadership demonstrates gratitude and encouragement during and following your campaign
- Collaborate with nursing homes, hospital, home health, and other long-term support service leadership to congratulate discharge staff and others when avoidable transfers to the ED are reduced

Share Your Success!

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