AHRQ's Safety Program for Nursing Homes: On-Time Preventable Hospital and ED Visits Training

Slide 1: Introduction to Preventable Hospital and ED Visits Reports

SAY:

In this session we will introduce you to the Preventable Hospital and ED Visits electronic reports.

Slide 2: Preventable Hospital and ED Visits Electronic Reports

SAY:

This section will cover each component of Preventable Hospital and ED Visits, which includes the following electronic reports. The electronic reports are:

- Transfer Risk Report – High Risk
- Transfer Risk Report – Medium Risk
- ED Treat and Release Report
- Monthly Transfers by Facility or Nursing Unit
- Monthly Transfers by Provider
- Key Metrics Trend Report

Slide 3: Teaching the Preventable Hospital and ED Visits Electronic Reports

SAY:

This training will provide you with the information you need to teach the reports to the nursing home change team. The training will follow a similar approach to how you should present the reports to the nursing home team:

- **Step 1:** Review the purpose of the report.
- **Step 2:** Describe the content of the report.
- **Step 3:** Discuss the calculation details.

The Facilitator needs to understand the sources of the data in each report, criteria for inclusion of residents in each report, and calculations that create the elements in the report: the column headings and cell content. With this knowledge, the Facilitator can answer questions that may arise about the content and accuracy of the reports.

Nursing home staff need to master enough details about the report to see the value of the reports, judge the accuracy of the reports, and use them to help make care plan decisions.

- **Step 4**: Use quizzes and exercises that are provided for each report to test participants' understanding.

Slide 4: Transfer and Intake Notes Title Slide

SAY:

Now let's begin by going over the *Transfer Note* and *Intake Note.*

Slides 5: Transfer and Intake Notes

SAY:

The *Transfer Note* is a written communication tool between the nursing home and the receiving facility – either hospital or ED. It provides a high-level summary of the reasons for transfer and what treatments (if any) were provided prior to transfer.

All information on the Preventable Hospital and ED Visits electronic reports is based on a standard list of documentation elements used to record information on transfers to and from the nursing home and the hospital or ED. The standard elements are included in the sample *Transfer Note* and *Intake Note*.

Slides 6–7: Transfer Note

SAY:

Nursing homes vary as to how they record the standard elements contained in these notes. The On-Time program does not require the use of the transfer or intake notes, but the elements included in them must be present in the nursing home's electronic medical record (EMR) to generate all components of the reports. Reports also require elements from other data sources, including physician orders, medication records, Minimum Data Set (MDS), and nursing documentation.

The following information is captured in a consistent manner so that data can be used to generate reports:

- Transfer date and time
- Transfer to location (hospital or ED)
- Reason for transfer - grouped according to symptom or condition (cardiac/circulatory/blood, respiratory symptoms, mental disorders/neurological/psychological, gastrointestinal/genitourinary, endocrine/nutritional/metabolic, wound and skin, fall-related and non-fall-related injury, musculoskeletal, other not specified elsewhere) or treatment not available at transferring facility)
- Treatments provided in the nursing home prior to transfer
- Providers who saw the resident (and documented in the EMR) within 24 hours of transfer
- Person authorizing the transfer to hospital or ED

Slides 8–9: Sample Transfer Note

DO:

Instruct trainees to look at the Transfer Note handout. Review the contents and point out special features.

Resident Name:	Transfer Date: Transfer Time:	Transfer to: ☐ Emergency Department ☐ Hospital

Reason for Transfer Out of Facility	
Cardiac/Circulatory ☐ Anemia ☐ Cardiac arrest ☐ Coagulation defect ☐ Chest pain/angina ☐ Dizzy/lightheaded ☐ Hypertension/uncontrolled hypertension ☐ Hypotension ☐ Rule out congestive heart failure ☐ Rule out deep vein thrombosis *Respiratory* ☐ Abnormalities of breathing ☐ COPD ☐ Cough or wheezing ☐ Hypoxia ☐ Shortness of breath ☐ Rule out pneumonia *Mental Disorders/Neurological/ Psych* ☐ Change in mental status (e.g. agitation, anxiety, confusion) ☐ Delirium ☐ Depression ☐ Dementia	☐ Rule out cerebrovascular accident ☐ Seizure/epilepsy/convulsion ☐ Symptoms of decline in cognitive function and awareness ☐ Psychiatric (psychosis, suicidal) *Fall-Related Injury* ☐ Major injury ☐ Minor injury *Non-Fall-Related Injury* ☐ Major injury ☐ Minor injury *Musculoskeletal* ☐ Joint pain/joint disorder ☐ Weakness *Other Changes in Condition, Not Specified Elsewhere:* ☐ Abnormal lab results ☐ Failure to thrive ☐ Fever/possible infection ☐ Functional decline ☐ Malaise/fatigue ☐ Potential surgical complication ☐ Poor intake or nutritional decline ☐ Weight loss

Gastrointestinal/ Genitourinary

- ☐ Abdominal/pelvic pain
- ☐ Diarrhea/gastroenteritis
- ☐ Dysphagia
- ☐ GI bleed
- ☐ G tube
- ☐ Hematuria
- ☐ Nausea or vomiting
- ☐ Renal failure
- ☐ Rule out kidney or urinary tract infection

Endocrine/Nutritional/Metabolic

- ☐ Dehydration
- ☐ Malnutrition
- ☐ Uncontrolled diabetes

Wound and Skin

- ☐ Cellulitis
- ☐ Edema
- ☐ Infected wound or decubitus
- ☐ Jaundice
- ☐ Rash

Treatment Unavailable at Transferring Facility

- ☐ Diagnostics: Radiology, imaging
- ☐ IV access: Meds or fluids
- ☐ Transfusion
- ☐ Catheter insertion/reinsertion

Treatments Prior to Transfer

- ☐ Labs
- ☐ X rays
- ☐ IV fluids
- ☐ Subcutaneous fluids
- ☐ Nasogastric tube
- ☐ Oxygen
- ☐ Respiratory treatment
- ☐ Respiratory suctioning
- ☐ Medication: IV
- ☐ Medications: IM or SQ
- ☐ Medications: PO

Seen by (Within 24 Hours of Transfer)

- ☐ Primary Care Physician
- ☐ Covering Physician
- ☐ Consulting Physician
- ☐ Nurse Practitioner or Physician's Assistant
- ☐ Respiratory Therapist
- ☐ Other

- ☐ Transfer requested by resident/family

Authorized by:

- ☐ Resident's Primary Care Physician/Name________________
- ☐ Other Provider/Name_________________
- ☐ Medical Director/Name_________________
- ☐ Medicare Managed care Organization
- ☐ Outside Clinic or Service

Slides 10–11: Intake Note

SAY:

The *Intake Note* is written to capture standardized information about the hospital or ED visit upon return to the nursing home, to use it in reporting, and to facilitate improved monitoring and management of resident care. The intake note captures important details about the resident's care across settings to assist the nursing home staff in planning the resident's care.

The Intake Note is completed for each resident returning from a hospital admission, ED, or observation stay. It includes the following:

- Admit date and time
- Admit to unit (long-term care, subacute, or rehab)
- Intake type (ED visit, observation stay, or hospital admission)
- Hospital length of stay or hospital admission date
- Treatment received in the ED, if returning from ED
- Discharge diagnoses from hospital (principal diagnosis and secondary diagnoses)
- Surgical procedures received in the hospital, if applicable

Slides 12–14: Sample Intake Note

DO:

Instruct trainees to look at the Intake Note handout. Review the contents and point out special features.

Below is an image of a sample of the first page of an Intake Note. A table showing the full contents follows.

Resident Name:	Admit Date: Admit Time:	Admit to: ☐ Long-Term Care ☐ ☐ Subacute or Rehab

Intake Type:

- ☐ ED Visit
- ☐ Observation Stay
- ☐ Hospital Admit *(Enter one of the following)*
  - ☐ Hospital Admission Date OR
  - ☐ Hospital LOS

If admitted from one of the following, do not complete this form:

- ☐ Long-Term Care Facility
- ☐ Assisted Living
- ☐ Home

Treatments Received in the ED/HOSP	ED Discharge/Hospital Discharge Diagnoses: Primary & Secondary (*Indicate principal or secondary if more than one hospital discharge diagnosis.)*	Primary	Secondary
Catheter Insertion/ Reinsertion	☐ Anemia	☐	☐
☐ Foley	☐ Angina	☐	☐
☐ Ostomy	☐ Asthma	☐	☐
☐ PEG	☐ Atrial fibrillation	☐	☐
☐ Suprapubic	☐ Acute MI	☐	☐
	☐ Cellulitis	☐	☐
Diagnostics	☐ CHF	☐	☐
☐ EKG	☐ Circulatory problems	☐	☐
☐ CT scan	☐ COPD	☐	☐
☐ Doppler studies	☐ CVA	☐	☐
☐ MRI	☐ Dehydration	☐	☐
☐ Ultrasound	☐ Dementia	☐	☐
☐ X rays	☐ Depression	☐	☐
☐ Other	☐ Diabetes	☐	☐
	☐ Dysrhythmias	☐	☐
IV Access/Insertion and Fluids	☐ Electrolyte imbalance	☐	☐
☐ PICC	☐ Fever	☐	☐
☐ Central	☐ Fall - injury	☐	☐
☐ Peripheral	☐ Gastroenteritis	☐	☐
☐ IV fluids	☐ Genitourinary problems	☐	☐

Labs Obtained
- ☐ Electrolytes
- ☐ Cardiac workup
- ☐ CBC
- ☐ Blood cultures
- ☐ Other

Medications
- ☐ Oral
- ☐ IM or IV
- ☐ Subcutaneous

- ☐ Observation Only

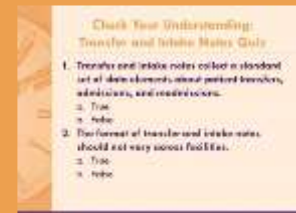
Respiratory
- ☐ Oxygen therapy
- ☐ Respiratory treatment
- ☐ Suctioning

- ☐ Transfusion
- ☐ Other ___________

Surgical Procedure During Hospital Stay
- ☐ Abdominal
- ☐ Cardiac
- ☐ Hip fracture
- ☐ Other fracture
- ☐ Joint replacement
- ☐ Other major surgery, not listed above

	Primary	Secondary
☐ GI bleed	☐	☐
☐ Hypotension	☐	☐
☐ Hypertension	☐	☐
☐ Hypoglycemia	☐	☐
☐ Hyperglycemia	☐	☐
☐ Kidney infection	☐	☐
☐ Medication reaction	☐	☐
☐ Mental status change	☐	☐
☐ Mental disorder/ psychosis	☐	☐
☐ Neoplasm	☐	☐
☐ Pneumonia	☐	☐
☐ Pressure ulcer	☐	☐
☐ Peripheral vascular disease	☐	☐
☐ Respiratory, other nonpneumonia	☐	☐
☐ Renal disease	☐	☐
☐ Seizure	☐	☐
☐ Sepsis/urosepsis	☐	☐
☐ Surgical complications or infection	☐	☐
☐ Syncope	☐	☐
☐ Urinary tract infection	☐	☐
☐ Other_______________	☐	☐

Slides 15–16: Check Your Understanding: Transfer and Intake Notes Quiz



Ask participants to answer the quiz questions independently and then discuss as a group.

1. Transfer and intake notes collect a standard set of data elements about patient transfers, admissions, and readmissions.
   a. True
   b. False

ANSWER: a

2. The format of transfer and intake notes should not vary across facilities.
   a. True
   b. False

ANSWER: b

3. Which of the following would you **not** expect to find in a *Transfer Note*?
   a. The name of the provider authorizing the transfer
   b. The location the patient is being transferred to
   c. The reason the patient is being transferred
   d. The name of the patient
   e. The patient's primary discharge diagnosis
   f. The treatments the patient received in the nursing home prior to transfer
   g. The providers who saw the resident within 24 hours of transfer

ANSWER: e

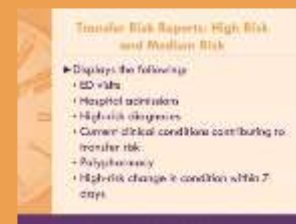
Slide 17: Transfer Risk Reports title slide

SAY:

Now let's begin going over each of the *Transfer Risk* reports.

Slides 18–19: Transfer Risk Reports – High Risk and Medium Risk

SAY:



Transfer Risk reports (High Risk and Medium Risk) provide a weekly snapshot of residents at risk for transfer to a hospital or ED that may be prevented. The report is designed to help nursing home staff see the changes in resident clinical status earlier and identify residents at risk for transfer. To accomplish this goal, the *Transfer Risk* report displays transfer risk factors by resident each week.

The report summarizes risk elements recorded on intake and transfer notes, Minimum Data Set (MDS) assessments, medication profiles, and daily or weekly nurse documentation and applies risk rules to provide a list of residents meeting criteria for high risk for transfer to the hospital or ED. Using the report will enable multidisciplinary teams to better identify and communicate regarding residents at risk for transfer to the hospital and will facilitate proactive management of these residents.

Members of the multidisciplinary team can use the *Transfer Risk* report each week to monitor changes in the resident risk profile and confirm that appropriate interventions are in place, are understood by the entire care team, and are implemented. Specific questions the report may answer include:

- How many residents on the nursing unit are at risk for transfer?
- What are the most frequent risk factors that high-risk residents have?
- Which high-risk changes in residents' conditions are flagging more often than others?
- Which clinical conditions contributing to risk are flagging more often than others?
- How often is polypharmacy seen in residents at risk for transfer?

This weekly report displays resident identifiers, shows Do Not Resuscitate (DNR) or Do Not Hospitalize (DNH) status, and includes information on the following risk factors:

- **ED visits,** including observation stays (number within 7, 30, and 90 days, ED discharge diagnosis);
- **Hospital admissions** (number within 7, 30, and 90 days, discharge diagnosis, and length of stay for most recent hospitalization);
- **High-risk diagnoses** associated with transfer risk (congestive heart failure, myocardial infarction, angina, pneumonia or bronchitis, asthma or chronic obstructive pulmonary disease, urinary tract infection, sepsis or fever or infection, dehydration, circulatory problems [includes vascular disease, venous and arterial ulcer], renal failure, diabetes or hypoglycemia, anemia, or gastroenteritis);
- **Current clinical conditions contributing to transfer risk** (oxygen therapy, catheter or ostomy, stage II or higher pressure ulcer, fall risk, late-loss ADL index score greater than or equal to 12 [based on RUG-III], cognitive impairment, medical conditions [cellulitis, hypertension, deep vein thrombosis, moderate dementia, peripheral neuropathies, quadriplegia, paraplegia, hemiparesis], high-risk medications [insulin, anticoagulants, antibiotics, alpha blockers, antipsychotics, antianxiety medications, sedative-hypnotics, anticonvulsants, antihypertensives, opioids, diuretics];
- Polypharmacy; and
- **High-risk change in condition within 7 days** (CHF or chest pain or MI, pneumonia or bronchitis, mental status change or neurological change, UTI, sepsis or fever or infection, dehydration).

This report can be filtered to display residents at risk for transfer on a single nursing unit or display all residents facilitywide at risk for transfer.

Criteria for identifying residents at risk for transfer are based on the presence of medical diagnoses and conditions associated with preventable hospital and ED visits, polypharmacy, and changes in condition within 7 days associated with high risk for transfer.

Slide 20: Transfer Risk Report Rules – title slide

SAY:

A set of rules is used to determine high and medium transfer risk. We will refer to the following table as we review the rules.

Slide 21: Transfer Risk Report Rules

DO:

Instruct trainees to look at the Rules for High and Medium Transfer Risk table. Review the contents and explain that the table will be a useful tool as the rules are described.

Table 1. Rules for High and Medium Transfer Risk

	Risk Factors					Risk Level	
Row No.	Prior ED Visit or Hospital Admission	Active High-Risk Diagnoses	Clinical Conditions Contributing to Risk	Poly-pharmacy	High-Risk Change in Condition Within 7 Days	High	Medium
1	X	X				X	
2	X		X			X	
3	X			X		X	
4	X				X	X	
5		At least 4 in these 2 categories		X		X	
6		X			X	X	
7				X	X	X	
8	X						X
9			X				X
10				X			X
11					X		X
12		X					

Slides 22–24: Rules for Determining High Transfer Risk

SAY:

High Risk. A resident is considered high risk for a hospital or ED visit based on one of three rules.

Rule 1: ***High risk based on prior hospital or ED visit AND an existing high-risk factor***

Criteria: Resident has prior hospital or ED visits in last 90 days and at least one additional risk factor from the following (Table 1, Rows 1-4):

- Active high-risk diagnosis (one or more)
- Current clinical conditions contributing to risk
- Polypharmacy - 15 or more medications
- High-risk change in condition within 7 days

To illustrate Rule 1:

- A resident with an ED visit within 90 days of report date and active high-risk diagnosis of COPD present within 7 days of report date would trigger Rule 1.
- A resident with hospital admission within 90 days of report date and clinical condition contributing to risk, such as use of oxygen or presence of Foley catheter within 7 days of report date, would trigger Rule 1.

Rule 2: ***High risk based on polypharmacy AND at least 4 risk factors from existing high-risk diagnoses or clinical conditions contributing to risk combined*** *(Table 1, Row 5)*

Criteria: Resident has polypharmacy (more than 15 medications, excluding PRNs) and a minimum of four risk factors from high-risk diagnosis list or clinical conditions contributing to risk combined.

To illustrate Rule 2:

- A resident with a medication profile indicating 16 active medications during the report week, active high-risk diagnoses of pneumonia and renal failure, and presence of oxygen therapy and Foley catheter use during the report week would trigger Rule 2.
- A resident with medication profile indicating 15 active medications during the report week, active high-risk diagnosis of UTI, presence of Stage III pressure ulcer, and two medical conditions (cellulitis and hypertension) would trigger Rule 2.

Rule 3: ***High risk based on high-risk change in condition within last 7 days*** *(Table 1, Rows 6–7)*

Criteria: Resident has at least one high-risk change in condition within last 7 days AND at least one active high-risk diagnosis or polypharmacy.

To illustrate Rule 3:

- A resident with new cough within 7 days of report date and active high-risk diagnosis of CHF would trigger Rule 3.
- A resident with new or worsened urinary incontinence documented within 7 days of report date and two active high-risk diagnoses (renal failure and diabetes) would trigger Rule 3.

Slide 25: Rules for Determining Medium Transfer Risk

SAY:

The resident is at medium risk for hospital or ED visit if **one** of the following four conditions is true:

- Prior hospital or ED visit within 90 days of report date (Table 1, Row 8)
- At least one current clinical condition contributing to risk (Table 1, Row 9)
- Polypharmacy (Table 1, Row 10)
- At least one high-risk change in condition within 7 days (Table 1, Row 11)

Note: Having an active high-risk diagnosis alone is not sufficient to categorize a resident as at risk for transfer (Table 1, Row 12).

Slide 26: Sample Transfer Risk Report – High Risk

DO:

Instruct trainees to look at Transfer Risk Report handout. Review the report contents and point out special features.

Resident Name and Advance Directive Status			# ED Visits Within:			ED Discharge Diagnosis	# Hospital Admits Within:			Hospital Discharge Diagnosis		High-Risk Diagnoses Associated With Transfer Risk													Current Clinical Conditions Contributing to Transfer Risk									Polypharmacy	High-Risk Change in Condition (Based on Assessment Data Within 7 days of Report Date)					
	Age	DNR,DNH, MOLST, or POLST Order in Place	0-7 Days	8-30 Days	31-90 Days	For Most Recent ED Visit	0-7 Days	8-30 Days	31-90 Days	For Most Recent Hospital Stay	LOS for Most Recent Hospitalization	Congestive Heart Failure	Myocardial Infarction	Angina	Pneumonia or Bronchitis	Asthma or COPD	Urinary Tract Infection	Sepsis or Fever or Infection	Dehydration	Circulatory Problems*	Renal Failure	Diabetes or Hypoglycemia	Anemia	Gastroenteritis	Oxygen Therapy	Catheter or Ostomy Present	Stage II or > Pressure Ulcer	Fall Risk	Late-Loss ADL Score ≥12	Cognitive Impairment	Medical Conditions**	High-Risk Medications***	Medication Total ≥15	CHF or Chest Pain or MI	Pneumonia or Bronchitis	Mental Status Change or Neurological Symptoms	Urinary Tract Infection	Sepsis or Fever or Infection	Dehydration
Resident A	79				2	Fever - unknown origin			1	MI	5		X								X	X						X			1	X		1	1				1
Resident B	81	1			1	Urinary tract infection		1		Cellulitis	10	X		X			X		X	X						X		X	X		2	X	X	1			1	1	
Resident C	82			1		Anemia		1	1	COPD	4				X	X			X				X		X					X	1	X	X		2	2		1	
Resident D	80			1		Gastroenteritis			1	GI bleed	3							X	X				X	X				X	X		2	X						1	1
Resident E	76						1		1	Altered mental status	2											X							X		1		X			2			
Resident F	84	1																	X		X					X	X	X					X						1
Total Residents		2	0	2	2		1	2	4			1	1	1	1	1	1	1	4	1	2	2	2	1	1	2	1	4	3	1	5	4	4	2	2	2	1	3	3

Slide 27: Reviewing Transfer Risk Report Calculation Details

DO:

Review the calculation details with Facilitator trainees.

SAY:

When On-Time technical specifications are included in facility EMRs, the software performs various calculations to display the relevant information. We will review how the different fields are determined.

Advanced Directive Status. If the resident has an advanced directive, such as DNR, DNH, Physician Orders for Life-Sustaining Treatment (POLST), or Medical Orders for Life-Sustaining Treatment (MOLST), in place, an "X" will display; otherwise, the cell is left blank.

ED Visits Within Last 90 Days. This section displays the number of ED visits that occurred in the following timeframes:

- 0-7 days
- 8-30 days
- 31-90 days

If no ED visits occurred in the past 90 days, the field is blank.

ED Discharge Diagnosis. This is the ED discharge diagnosis associated with the ED visit nearest and prior to or on the report date. If multiple diagnoses are in the medical record, the diagnosis designated as "primary" will be displayed. If no "primary" designation is made, the diagnosis listed first will be displayed. If no diagnosis is in the medical record, the cell will be blank.

Hospitalizations Within Last 90 Days. This section displays the number of hospitalizations that occurred in the following timeframes:

- 0-7 days
- 8-30 days
- 31-90 days

If no hospitalizations have occurred in the past 90 days, the field is blank.

Hospital Discharge Diagnosis. This is the hospital discharge diagnosis associated with the hospital admission nearest and prior to or on the report date. If multiple diagnoses are in the medical record, the diagnosis designated as “primary” will be displayed. If no “primary” designation is made, the diagnosis listed first will be displayed. If no diagnosis is in the medical record, the cell is blank.

Length of Stay (LOS) for Most Recent Hospitalization. This is the number of days of the most recent hospitalization. If no hospitalization occurred in the past 90 days, the cell is blank.

Active High-Risk Diagnoses. Certain medical diagnoses are associated with preventable hospital and ED visits. Specifically, the following 12 diagnoses are considered high risk:

- CHF
- Chest pain or MI
- Pneumonia or bronchitis
- Asthma or COPD
- UTI
- Sepsis or fever or infection
- Dehydration
- Circulatory problems
- Renal failure
- Diabetes
- Anemia
- Gastroenteritis

If the ICD-9-CM codes (2012) for the above diagnoses are noted in the medical record, an “X” will display; otherwise, the cell is blank. [Check that everyone knows about ICD-9 codes.]

Clinical Conditions That Contribute to High Risk. Displays an “X” if medical conditions and treatments are noted in the medical record.

- ***Oxygen therapy.*** If there is a physician’s order for oxygen (including PRN) within the 7 days prior to the report date, an “X” will display.
- ***Presence of catheter or ostomy.*** If there is a physician’s order for Foley catheter, suprapubic catheter, or ostomy in the 7 days prior to the report date, an “X” will display.

- ***Presence of stage 2 or greater pressure ulcer.*** If there is a pressure ulcer stage 2, 3, 4, or unstageable recorded as present within 7 days of the report date, an "X" will display; otherwise, the cell is blank.
- ***Fall risk (based on On-Time Fall Risk indicator or facility-defined source).*** If there is a fall recorded for the resident in the 7 days prior to the report date, an "X" will display.
- ***Late-loss ADL Score ≥12.*** The late-loss ADL score is computed by adding the MDS self-performance values for items G0110A1 (Bed Mobility) + G0110B1(Transfer) + G0110H1 (Eating) + G0110L (Toileting). If the MDS codes are within 7 days of the report and the total is greater than or equal to 12, an "X" will display.
- ***Cognitive impairment.*** If MDS item C0500 is coded any value (0-7), an "X" will display for cognitive impairment. If no value is recorded for C0500, items B0700 coded as 1, 2, or 3 or C0700 coded as 1 or C1000 coded as 1, 2, or 3 will indicate cognitive impairment.
- ***Certain medical conditions (with sample ICD-9-CM diagnosis codes).*** This is a count of the number of medical conditions listed below present or considered active within 7 days and prior to the report date. For example, if only cellulitis and moderate dementia were indicated as present and active, the number 2 would display.
    - Cellulitis (682.0-9)
    - Hypertension (401.0-9)
    - Deep vein thrombosis (453.40)
    - Moderate dementia (290.0)
    - Peripheral neuropathies (356.0-.9)
    - Quadriplegia (344.0)
    - Paraplegia (334.1)
    - Hemiparesis (342.8; 438.2)

- ***High-risk medications.*** If any of the following medications are in use within 7 days of the report, an "X" will display:

    - Insulin
    - Anticoagulants
    - Antibiotics
    - Alpha blockers
    - Antipsychotics
    - Antianxiety

- Sedative-hypnotics
- Anticonvulsants
- Antihypertensives
- Opioids
- Diuretics

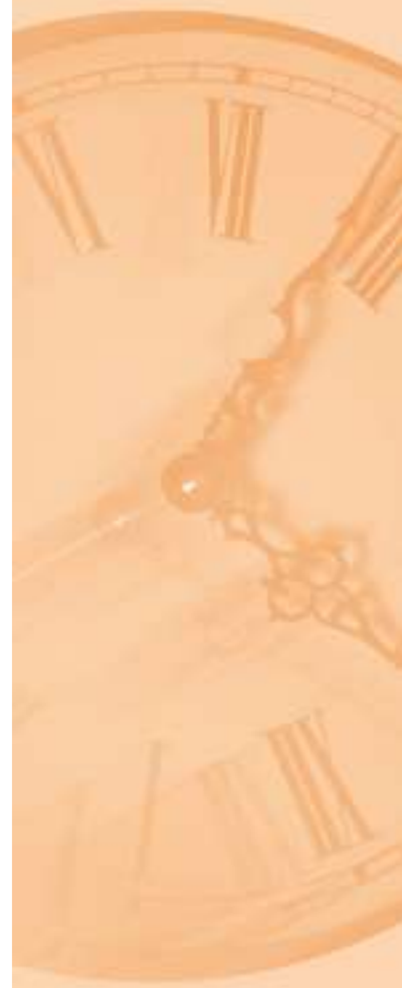
Polypharmacy. Polypharmacy is considered the use of 15 or more medications and is treated as a risk factor for hospital or ED visits. The count of medications includes over-the-counter medications but excludes medications ordered to be given on a PRN basis.

High-Risk Change in Condition. Certain clinical conditions or symptoms are associated with high risk for transfer. These symptoms and clinical condition elements are captured from multiple data sources within the facility's electronic medical record and represent changes that occurred in a resident's clinical condition within 7 days of report date.

Electronic data sources such as nurse documentation, 24-hour reports, electronic medication administration records, and physician orders provide information more quickly than MDS assessments and enable clinicians to recognize resident changes sooner.

The high-risk change in condition elements are grouped into six categories, as shown on the risk report:

- CHF or chest pain or MI
- Pneumonia or bronchitis
- Mental status or neurological symptoms
- UTI
- Sepsis, fever, or infection
- Dehydration



Slides 28–30: Documentation Elements and High-Risk Change in Condition

DO:

Use the Documentation Elements and High-Risk Change in Condition (HRCC) handout to review scoring details for the HRCC category with Facilitator trainees.

SAY:

The HRCC section of the Transfer Risk Report includes a display of the number of times various symptoms and procedures associated with HRCC are documented in the EMR during the report week. Each time a symptom or procedure is documented in the medical record in the past 7 days, a point is added to the associated HRCC and the sum displays.

This score can indicate the severity of the risk factor and the likeliness that this condition could lead to a transfer. For example, a resident experiencing two or three symptoms under CHF/Chest Pain/MI (e.g., shortness of breath, edema, and fatigue) may be at higher risk for transfer to the ED or hospital for this reason than a resident with only one of those symptoms.

Table 2 lists documentation elements potentially associated with each high-risk condition; these elements are captured during routine electronic documentation and stored in the EMR. If there are no documented symptoms for a resident at transfer risk for a specific HRCC during the report week, no value will display and the column will be blank. Of note, some symptoms (e.g., nausea) may contribute to more than one HRCC.

Table 2. High-Risk Change in Condition and Documentation Elements

	Documentation Element	CHF/ Chest Pain/MI	Pneumonia/ Bronchitis	Mental Status Change	UTI	Sepsis/ Fever/ Infection	Dehydration
1	Cardiopulmonary						
2	Shortness of breath (SOB): Unrelieved or new SOB at rest; unable to lie flat	1					
3	SOB: Labored breathing		1				
4	Wheezing and chest tightness at rest	1					
5	Inability to sleep without sitting up	1					
6	Chest pain: New or unrelieved	1					
7	Chest pain: With inspiration or coughing		1				
8	Cough: New or worsening cough	1	1				
9	Sputum production: New or increased		1				
10	Dizzy/lightheaded upon standing	1					
11	Edema: Worsening edema lower extremities or worsening edema generalized	1					
12	Fatigue: Easily fatigued/weakness	1					
13	Difficulty swallowing						1
14	Gastrointestinal						
15	Diarrhea (recurrent for last 24 hours)						1
16	Nausea or vomiting (recurrent for last 24 hours)	1					1
17	Genitourinary						
18	Abdominal pain: Lower				1		
19	Hematuria				1		
20	Incontinence: New or worsened				1		
21	Urination: Painful or burning or increased urgency/frequency				1		

	Documentation Element	CHF/ Chest Pain/MI	Pneumonia/ Bronchitis	Mental Status Change	UTI	Sepsis/ Fever/ Infection	Dehydration
22	Infection						
23	IV fluids given					1	1
24	Blood cultures obtained					1	
25	Mental or Behavior						
26	Agitation: New or worsened			1			
27	Anxiety: New or worsened	1		1			
28	Confusion or disorientation: New or worsened			1			
29	Depressive symptoms: New or worsened	1		1			
30	Inattention or lack of focus or withdrawn or distracted or not attending activities			1			
31	Nutrition						
32	Appetite: Poor or loss of appetite	1	1	1	1		1
33	Decreased oral intake over the last 24 hours		1	1	1		1
34	Diuretic use						1
35	Vital Signs						
36	Orthostatic hypotention						1
37	Weight loss 5% ≤30 days; 10% ≤180 days						1
38	Weight gain of >5 lb in 3 days	1					
39	Fever: Temp >102°F	1	1	1		1	1
40	Fever: Temp >100°F		1		1	1	
41	Fever: Two or more temps >99°F					1	
42	Fever: Increase in temp >2 degrees above baseline				1	1	

Slides 31–33: Check Your Understanding: Transfer Risk Reports Quiz

DO:

Ask participants to answer the quiz questions independently and then discuss as a group.

1. High-risk diagnoses must be documented in the medical record as being active within 7 days of the report.

   a. True
   b. False

ANSWER: b

2. If there is no MDS ADL score for bed mobility (G01101A) within 7 days of the report date, the late-loss ADL score will not display.

   a. True
   b. False

ANSWER: a

3. A resident with the number 3 displayed under UTI in the High-Risk Change in Condition section of the *Transfer Risk* report would mean:

   a. This resident has had three UTIs this year.
   b. This resident has had a UTI for 3 days during the report week.
   c. This resident's record contains documentation of three different signs and symptoms of a potential UTI.
   d. UTI is this resident's third most common high-risk change in condition.

ANSWER: c

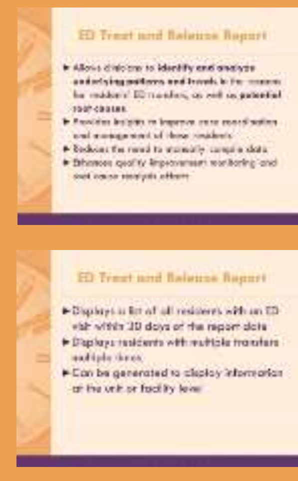
Slide 34: ED Treat and Release Report title slide

SAY:

Now let’s look at the next report.

Slides 35–36: ED Treat and Release Report

SAY:



This monthly report helps the facility understand trends in resident transfers to the ED with subsequent return to the nursing home, without hospital admission. The report allows clinicians to analyze frequencies of reasons for transfer and potential root causes (e.g., treatment unavailable at facility, treatments prior to transfer) during the month that may provide insight to improve care coordination and management of these residents. The report reduces the need to manually compile these data and enhances quality improvement monitoring and root cause analysis activities.

The report can be used to answer the following questions:

- How many residents had an ED visit and returned to the nursing home during the report month?
- For the residents who appear on the report, which reasons for transfer are cited most often?
- Are any patterns seen with reason for transfer this month compared with previous months?
- How many residents were transferred for diagnostic services not available at the nursing home?
- How many residents were transferred to receive IV fluids or to gain IV access?
- Did every resident transferred for a respiratory reason receive oxygen within 24 hours of transfer time? How many received a respiratory treatment? How many were suctioned? How many were seen by a respiratory therapist?
- How many residents were seen by the primary care provider (physician, nurse practitioner, or physician's assistant) within 24 hours of transfer?
- How many residents had prior ED visits within the same report month? How many had ED visits within 3 days? 30 days?
- How many residents with an ED visit also flagged as at high risk for transfer during the same month?

The report displays a list of residents who transferred to the ED for treatment and returned to the nursing home. Any resident with an ED visit date within 30 days of the report date displays on the report. Residents with multiple transfers in the month will display multiple times. The report may be run for the entire facility or for a single unit. It displays the following:

- ED visit (date and discharge diagnosis)
- Reason for transfer (cardiac/circulatory, respiratory, mental/psych/neurological, GI/GU, endocrine/metabolic/ nutrition, wound and skin, injury (fall related or non-fall related), musculoskeletal, abnormal labs or anemia, fever/possible infection, malaise/fatigue, possible surgical complication)
- Reason for transfer: treatment not available at facility (diagnostics, IV access, transfusion, catheter insertion/reinsertion)
- Authorized by (primary care physician, covering provider, medical director, Medicare managed care organization, outside clinic or service)
- Nursing home treatment 24 hours prior to transfer (labwork or x rays, IV fluid/subcutaneous fluids, oxygen, respiratory treatment or suctioning, medications (IV, IM, SQ, or PO)
- Seen by – within 24 hours prior to transfer (primary physician, covering physician, consulting physician, nurse practitioner or physician’s assistant, respiratory therapist, other)
- Prior ED visit (within 3 or 30 days)
- Prior hospital discharge (within 7 or 30 days)

Slide 37: Sample ED Treat and Release Report

DO:

Instruct trainees to look at ED Treat and Release Report handout. Review the report contents and point out special features.

Facility Name:			
Month:			
Average Daily Census	30	Total Transfers (Obs, ED)	13
Resident Days (Including Bed Holds)	900	Total Residents (Obs, ED)	12

	ED Visit		Reason for Transfer													Reason for Transfer: Treatment Unavailable at Facility				Authorized by:					Nursing Home Treatments 24 Hours Prior to Transfer								Seen By (Within 24 Hours Prior to Transfer)						Prior ED Visit		Prior Hospital Discharge	
	ED Visit Date	ED Discharge Diagnosis	Cardiac/Circulatory	Respiratory	Mental/Psych/Neurological	Gastrointestinal/Genitourinary	Endocrine/Metabolic/Nutrition	Wound or Skin Issues	Fall-Related Injury	Non-Fall-Related Injury	Musculoskeletal	Abnormal Labs or Anemia	Fever/Possible Infection	Malaise/Fatigue	Potential Surgical Complication	Diagnostics: Radiology, Imaging	IV Access: PICC, Central, Periph; Meds or Fluids	Transfusion	Catheter Insertion/Reinsertion	Primary Care Provider	Covering Provider	Medical Director	Medicare Managed Care Org	Outside Clinic or Service	Labwork Obtained	X Rays Obtained	IV Fluid/Subcutaneous Fluids	Oxygen	Respiratory Treatment	Respiratory Suctioning	Medications: IV or IM or SQ	Medications: PO	Primary Care Provider	Covering Provider	Consulting Physician	Nurse Practitioner or PA	Respiratory Therapist	Other	0-3 Days	4-30 Days	0-7 Days	8-30 Days
Resident A	11/11/2013	Angina	X																	X								X				X	X									
Resident B	11/20/2013	UTI			X															X												X				X					1	
Resident C	11/15/2013	Anemia										X		X				X			X				X											X						1
Resident D	11/13/2013	COPD		X									X									X						X	X											1		
Resident G	11/2/2013	Gastro-enteritis				X	X					X									X				X			X					X									
Resident G	11/11/2013	Fracture							X												X																			1		
Resident J	11/20/2013	G tube replacement				X													X		X																			1		
Resident P	11/10/2013	Dehydration				X	X					X		X						X					X	X										X				3		1
Resident R	11/1/2013	Pneumonia		X								X	X				X			X					X	X		X	X			X				X						
Resident T	11/30/2013	Asthma		X									X										X					X	X				X						1			1
Resident Y	11/30/2013	Laceration								X										X																						
Total reasons		21	1	3	1	3	2	0	1	1	0	4	3	2	0																											
% Total reasons			5	14	5	14	10	0	5	5	0	19	14	10	0																											

Slide 38: ED Treat and Release Calculation Details

DO:

Review the calculation details with Facilitator trainees.

SAY:

When On-Time technical specifications are included in facility EMRs, the software performs various calculations to display the relevant information. We will review how the different fields are determined.

ED Visit Date. This is the date the resident was admitted to the ED.

ED Discharge Diagnosis. This is the ED discharge diagnosis associated with the ED Visit Date. If no diagnosis is in the medical record, the cell will be blank.

Reason for Transfer. If any of the following conditions are documented in the Transfer Note, an "X" will display:

- ***Cardiac/Circulatory.*** If any of the following conditions are documented under "Cardiac/Circulatory" on the *Transfer Note*, an "X" will display in this column:
    - Anemia
    - Cardiac arrest
    - Coagulation defect
    - Chest pain/angina pectoris
    - Dizzy/lightheaded
    - Hypertension/uncontrolled hypertension
    - Hypotension
    - Rule out congestive heart failure
    - Rule out deep vein thrombosis

- ***Respiratory.*** If any of the following conditions are documented under "Respiratory" on the *Transfer Note*, an "X" will display in this column:

    - Abnormalities of breathing
    - COPD
    - Cough or wheezing
    - Hypoxia
    - Shortness of breath
    - Rule out pneumonia

- ***Mental/Psych/Neurological.*** If any of the following conditions are documented under "Mental/Psych/ Neurological" on the *Transfer Note*, an "X" will display in this column:

    - Change in mental status (agitation, anxiety, confusion)
    - Delirium
    - Depression
    - Dementia
    - Rule out cerebrovascular accident
    - Seizure/epilepsy/convulsion
    - Symptoms of decline in cognitive function and awareness
    - Psychiatric (psychosis, suicidal)

- ***Gastrintestinal/Genitourinary.*** If any of the following conditions are documented under "Gastrointestinal/ Genitourinary" on the *Transfer Note*, an "X" will display in this column:

    - Abdominal/pelvic pain
    - Diarrhea/gastroenteritis
    - Dysphagia
    - Gastrointestinal bleed
    - G tube
    - Hematuria
    - Nausea or vomiting
    - Renal failure
    - Rule out kidney or urinary tract infection

- ***Endocrine/Metabolic/Nutrition.*** If any of the following conditions are documented under "Endocrine/Metabolic/ Nutrition" on the *Transfer Note*, an "X" will display in this column:

    - Dehydration
    - Malnutrition
    - Uncontrolled diabetes

- ***Wound and Skin.*** If any of the following conditions are documented under "Wound and Skin" on the *Transfer Note*, an "X" will display in this column:

    - Cellulitis
    - Edema
    - Infected wound or decubitus
    - Jaundice
    - Rash

- ***Fall-Related Injury:.*** If any of the following conditions are documented under "Fall-Related Injury" on the *Transfer Note*, an "X" will display in this column:

    - Major injury
    - Minor injury

- ***Non-Fall-Related Injury.*** If any of the following conditions are documented under "Non-Fall-Related Injury" on the *Transfer Note*, an "X" will display in this column:

    - Major injury
    - Minor injury

- ***Musculoskeletal.*** If any of the following conditions are documented under "Musculoskeletal" on the *Transfer Note*, an "X" will display in this column:

    - Joint pain/joint disorder
    - Weakness

- ***Abnormal Labs or Anemia.*** If "Abnormal lab results" or "Anemia" is checked on the *Transfer Note*, an "X" will display in this column.
- ***Fever/Possible Infection.*** If "Fever/possible infection" is checked on the *Transfer Note*, an "X" will display in this column.
- ***Malaise/Fatigue.*** If "Malaise/fatigue" is checked on the *Transfer Note*, an "X" will display in this column.

- ***Potential Surgical Complication.*** If "Potential surgical complication" is checked on the *Transfer Note*, an "X" will display in this column.
- ***Treatment Unavailable at Transferring Facility.*** If any of the following are noted on the Transfer Note, an "X" will display in this column:

    - Diagnostics: Radiology, imaging
    - IV Access: Meds or fluids
    - Transfusion
    - Catheter insertion/reinsertion

Authorized by: The clinician who authorized the transfer, as recorded on the *Transfer Note*, is displayed here. Options include:

- Resident's primary care physician
- Other provider
- Medical director
- Medicare managed care organization
- Outside clinic or service

Treatment Prior to Transfer. If any of the following are documented on the *Transfer Note* or in physician orders as having been supplied in the 24 hours prior to transfer, an "X" will display.

- Labs
- X rays
- IV fluids
- Subcutaneous fluids
- Nasogastric tube
- Oxygen
- Respiratory treatment
- Respiratory suctioning
- Medications: IV
- Medications: IM or SQ
- Medications: PO

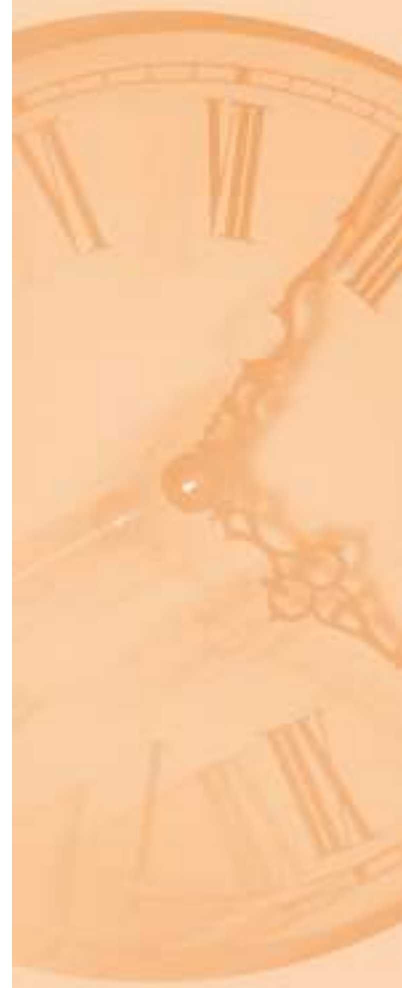
Seen by (Within 24 Hours of Transfer). If the resident was seen by a clinician within 24 hours of the transfer, as recorded on the *Transfer Note* or in the EMR system, an "X" will display.

Options include:

- Resident's primary care physician
- Covering provider
- Consulting physician
- Nurse practitioner or physician's assistant
- Respiratory therapist
- Other

Prior ED Visit. If another ED visit occurred 0-3 days or 4-30 days prior to the ED transfer date, and is prior to the report date, the number of ED visits for each timeframe will display.

Prior Hospital Discharge. If a hospital admission occurred 0-7 days or 8-30 days prior to the ED transfer date and is prior to the report date, the number of hospitalizations for each timeframe will display.



Slides 39–41: Check Your Understanding: ED Treat and Release Report Quiz

DO:

Ask participants to answer the quiz questions independently and then discuss as a group.

1. Nursing homes must use the On-Time *Transfer Note* to generate the *ED Treat and Release* report.

    a. True
    b. False

ANSWER: b

2. The *ED Treat and Release* report contains information on ED transfers without an inpatient visit for the 30 days prior to the report run date.

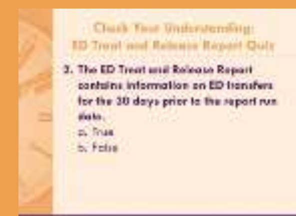
    a. True
    b. False

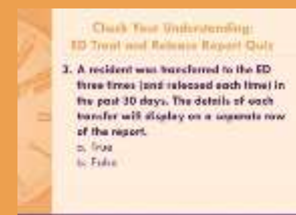
ANSWER: a

3. A resident was transferred to the ED three times (and released each time) in the past 30 days. The details of each transfer will display on a separate row of the report.

    a. True
    b. False

ANSWER: a





Slide 42: Monthly Summary by Facility or Nursing Unit Title Slide

SAY:

Now let's look at the next report.

Slides 43–44: Monthly Summary by Facility or Nursing Unit

SAY:

The *Monthly Summary* provides counts of hospital and ED visits for the month by unit or by facility for residents who were residing at the facility prior to their hospitalizations or ED visits. The report helps clinicians understand the overall picture of reasons for transfer and discharge diagnoses for all transfers.

A facilitywide or unit-based team can use the report to answer questions such as:

- What is the most frequent reason for transfer to ED for the facility, for each nursing unit?
- What is the most frequent reason for hospitalization for the facility, for each nursing unit?
- What is the most frequent discharge diagnosis from the ED? From the hospital?
- How many discharge diagnoses were “potentially preventable”?

The report displays numbers of total transfers and total residents with reasons for transfer and potentially preventable discharge diagnoses. Reasons for transfer follow:

- Mental disorder/psych
- Cardiac/circulatory symptoms
- Pneumonia/respiratory symptoms
- Gastrointestinal/genitourinary symptoms
- Endocrine/nutritional/metabolic
- Musculoskeletal/joint symptoms
- Wound or skin issues
- Fall-related injury
- Non-fall-related injury
- Abnormal labs
- Fever/possible infection
- Malaise/fatigue
- Potential surgical complication
- Treatment unavailable at facility

Potentially preventable discharge diagnoses follow:

- Congestive heart failure
- Pneumonia
- Urinary tract infection
- Sepsis or fever or infection
- Skin ulcers or cellulitis
- Dehydration or metabolic problems
- COPD
- Asthma
- Circulatory problems
- Hypertension
- Gastroenteritis
- Angina pectoris
- Fall/trauma
- Anemia
- Diabetes

Information to populate the report is derived from the On-Time *Transfer Note*, *Intake Note*, or other documentation elements within the facility's EMR system.

Slide 45: Sample Monthly Summary by Facility or Nursing Unit Report

DO:

Instruct trainees to look at the Monthly Summary by Facility or Nursing Unit report handout. Review the report contents and point out special features.

Facility:			
Month:			
Average Daily Census	30	TOTAL Transfers (In/Out, No Returns)	23
Resident Days (Including Bed Holds)	900	Total Residents Transferred	20

		Reason for Transfer														Discharge Diagnosis: Potentially Preventable															Discharge Dx: All Other			
Transfers That Result in Observation Stays or ED Visits or Hospital Visits	Total Counts	Mental Disorders/Neuro Symptoms /Psych	Cardiac /Circulatory Symptoms	Pneumonia /Respiratory Symptoms	Gastrointestinal/ Genitourinary	Endocrine /Nutritional / Metabolic	Musculoskeletal /Joint Symptoms	Wound or Skin Issues	Fall-Related Injury	Non-Fall-Related Injury	Abnormal Lab Results	Fever /Possible Infection	Malaise/Fatigue	Potential Surgical Complication	Treatment Unavailable at Facility	Congestive Heart Failure	Pneumonia	Urinary Tract Infection	Sepsis or Fever or Infection	Skin Ulcers or Cellulitis	Dehydration or Metabolic	Chronic Obstructive Pulmonary Disease	Asthma	Circulatory Problems	Hypertension or Renal Failure	Gastroenteritis	Angina Pectoris	Falls /Trauma	Anemia	Diabetes	Myocardial Infarction	Cerebrovascular Accident	GI Bleed	Other
Observation Stays	9%																																	
# Observations	2				2													1								1								
# Residents	2				2													1								1								
ED Visits	48%																																	
# ED Visits	11			2	1				2	1	3	1			1				2		3		2					2	1	1				
% Total Transfers				18%	9%				18%	9%	27%	9%			9%				18%		27%		18%					18%	9%	9%				
# Residents	10			2	1				2	1	2	1			1				2		2		2					2	1	1				
Top 5 (Rank Order)				2	3				2	3	1	3			3				2		1		2					2	3	3				
Hospital Visits	13%																																	
# Hospital Visits	3		2	1												2	1																	
% Total Hospital Visits			67%	33%												67%	33%																	
# Residents	3		2	1												2	1																	
Top 5 (Rank Order)			1	2												1	2																	
Transfers Out, No Return	9%																																	
# Transfers	2		1								1																							
% Total Transfers			50%								50%																							
# Residents	2		1								1																							
Top 5 (Rank Order)			1								1																							
Transfers In/Out Prior Month	22%																																	
# Transfers	5		2					3																										
% Total Transfers			40%					60%																										
# Residents	3		1					2																										
Top 5 (Rank Order)			2					1																										
Unit Totals																																		
TOTAL Transfers (In/Out, No Returns)	23	0	5	3	3	0	0	3	2	1	4	1	0	0	1	2	1	1	2	0	3	0	2	0	0	1	0	2	1	1	0	0	0	0
Total Residents	20	0	4	3	3	0	0	2	2	1	3	1	0	0	1	2	1	1	2	0	2	0	2	0	0	1	0	2	1	1	0	0	0	0

Slide 46: Monthly Summary by Facility of Nursing Unit Report Calculation Details

DO:

Review the calculation details with Facilitator trainees.

SAY:

When On-Time technical specifications are included in facility EMRs, the software performs various calculations to display the relevant information. We will review how the different fields are determined.

Average Daily Census. This is the average daily census for the facility, or if the report is generated for a single unit, it is the average daily census for the specified unit.

Resident Days (Including Bed Holds). This is the average daily census for the facility multiplied by the number of days in the month. Residents on a bed hold are counted as active residents.

Total Transfers. This is the number of transfers, including observation stays, ED visits, and hospital admissions, within the report month.

Total Residents Transferred. This is the total number of residents with an observation stay, a hospital visit, or an ED visit. If a resident has more than one type of transfer or multiple transfers of the same type within the month, he or she is listed only once.

Total Observation Stays and # Residents. This is the total number of transfers categorized on the Intake Note as an "Observation Stay" and the total number of unique residents returned to the facility after an observation stay.

Total ED Visits and # Residents. This is the total number of transfers categorized on the Intake Note as an "ED Visit" and the total number of unique residents returned to the facility after an ED visit.

Total Hospital Visits and # Residents. This is the total number of transfers categorized on the Intake Note as readmitted to the nursing home after a hospitalization and the total number of unique residents returned to the facility after a hospitalization.

Observation Stays - Reason for Transfer/Discharge Diagnosis. The number of times each reason for transfer or discharge diagnosis is recorded for observation stays is displayed. If a reason for transfer is not recorded as associated with any observation stays, the cell is blank.

Observation Stays – Reason for Transfer/Discharge Diagnosis/# of Residents. The number of residents with observation stays associated with each reason for transfer and discharge diagnosis is displayed. If a reason for transfer is not recorded as associated with any observation stays, the cell is blank.

ED Visits - Reason for Transfer/Discharge Diagnosis. The number of times each reason for transfer or discharge diagnosis is recorded for ED visits is displayed. If a reason for transfer is not recorded as associated with any ED visits, the cell is blank.

ED Visits – Reason for Transfer/Discharge Diagnosis/# of Residents. The number of residents with ED visits for each reason for transfer and discharge diagnosis listed is displayed. If a reason for transfer is not recorded as associated with any ED visits, the cell is blank.

ED Visits - % Total Transfers. The percent total for each transfer reason and discharge diagnosis is displayed.

Numerator: Transfer reason count or discharge diagnosis count (x100)
Denominator: Total number of ED visits

ED Visits - Top 5 (Rank Order). This is the top five reasons for transfer and the top five discharge diagnoses with "1" equaling the highest percentage of each. The rank order takes into account any ties by allowing categories with the same percent frequency to be ranked the same.

Hospitalizations - Reason for Transfer/Discharge Diagnosis. The number of times each reason for transfer or discharge diagnosis is recorded for hospitalizations is displayed. If a reason for transfer is not recorded as associated with any hospitalizations, the cell is blank.

Hospitalizations – Reason for Transfer/Discharge Diagnosis/# of Residents. The number of residents with hospitalizations associated with each reason for transfer or discharge diagnosis is displayed. If a reason for transfer is not recorded as associated with any hospitalizations, the cell is blank.

Hospitalizations – % Total Hospitalizations. The percent total for each transfer reason and discharge diagnosis is displayed.

Numerator: Transfer reason count or discharge diagnosis count (x100)
Denominator: Total number of hospitalizations

Hospitalizations - Top 5 (Rank Order). This is the top five reasons for transfer and the top five discharge diagnoses with "1" equaling the highest percentage of each. The rank order takes into account any ties by allowing categories with the same percent frequency to be ranked the same.

Facility/Unit Totals. This is the total for each transfer reason and for each discharge diagnosis.

Slides 47-50: Check Your Understanding: Monthly Summary Reasons for Transfer and Discharge Diagnosis

DO:

Ask participants to answer the quiz questions independently and then discuss as a group.

1. A resident who has never been at the nursing home is admitted from the hospital. This resident would not be listed on the *Monthly Summary* report.

   a. True
   b. False

ANSWER: a

2. A resident who had been to the hospital for an ED visit and a hospital stay in the previous 30 days would be counted in ED Visits - # of Residents but not in Hospitalizations - # of Residents because the ED visit occurred earlier in the month.

   a. True
   b. False

ANSWER: b

3. The *Monthly Summary* report displays the count of observations, hospital visits, and ED visits for which period?

   a. For the 30 days prior to the day the report is run
   b. For the calendar month the user requests
   c. For the prior 7 days
   d. For the prior 14 days

ANSWER: a

4. The *Monthly Summary* would be useful for:

   a. Detecting any trends in reasons for transfer across nursing units.
   b. Understanding the most frequent discharge diagnosis on each nursing unit.
   c. Investigating root cause analysis of potentially preventable hospital and ED visits.
   d. All of the above.

ANSWER: d

Slide 51: Monthly Summary by Provider Report title slide

SAY:

Now let’s look at the *Monthly Summary by Provider* report.

Slide 52: Monthly Summary by Provider Report

SAY:

The *Monthly Summary by Provider* report provides nursing home management with information on the number of residents transferred to the hospital or ED during the month by each primary care provider (PCP). It also shows the number of residents authorized for transfer by the PCP and the number authorized for transfer by a covering physician or consultant.

Further investigation of these hospital and ED visits can help staff determine whether the visits were for potentially preventable conditions, the time of day/day of week the transfers occurred, and whether the transfer order was made by the PCP or a covering provider.

If a trend is detected, facility leadership, including the director of nursing and medical director, can work with providers to review individual cases, educate providers on the nursing home's capabilities, and invite providers to participate in root cause analysis of preventable hospital and ED visits.

The report displays the number of ED visits, observation stays, hospitalizations, and total transfers for each of the facility's PCPs. Each transfer is counted only once at the highest level of care provided. For example, if an ED visit results in a hospitalization, the transfer is counted as one hospitalization, not as an ED visit and a hospitalization.

Slide 53: Sample Monthly Summary by Provider Report

SAY:

Instruct trainees to look at the Monthly Summary by Provider report handout. Review the report contents and point out special features.

Primary Care Provider	Authorizing Provider	ED Visits	Observation Stays	Hospitalizations	Total Transfers
Brown, B.	PCP	2	0	1	
Brown, B.	Covering MD	4	1	0	
Total					8
White, W.	PCP	1	0	1	
Total					2
Franklin, B.	PCP	2	1	1	
Franklin, B.	Medical Director	1	0	0	
Franklin, B.	Managed Care Case Manager	1	0	0	
Total					6

Slide 54: Monthly Summary by Provider Report Calculation Details

DO:

Review the calculation details with Facilitator trainees.

SAY:

When On-Time technical specifications are included in facility EMRs, the software performs various calculations to display the relevant information. We will review how the different fields are populated.

Primary Care Provider. The report displays the name of each primary care provider who has had a patient with at least one observation stay, ED visit, or hospital admit (associated with a prior transfer).

Authorizing Provider. This is the provider type who authorized the transfer. Options include the resident's primary care provider, a covering provider, the facility's medical director, a representative from a Medicare managed care organization, or a clinician from an outside clinic or service. If several residents belonging to a single PCP are authorized for transfer by several different authorizing providers, all authorizing providers are listed.

ED Visits. This is the number of ED visits for each provider who had transfers within the report month that did not result in an observation stay or hospitalization (i.e., was a treat and release from the ED).

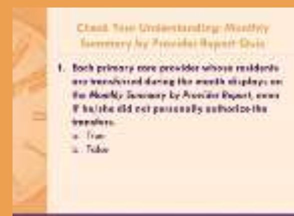
Observation Stays. This is the number of observation stays for each provider who had transfers within the report month that resulted in observation stays.

Hospitalizations. This is the number of hospital admissions for each provider who had transfers within the report month that resulted in hospital admissions.

Total Transfers. This is the total number of observation stays, ED visits, and hospital admissions for each provider who had residents transferred within the report month.

Slides 55-56: Check Your Understanding: Monthly Summary by Provider Report Quiz

DO:



Ask participants to answer the quiz questions independently and then discuss as a group.

1. Each primary care provider whose residents are transferred during the report month will display on the *Monthly Summary by Provider* report even if he or she did not personally authorize the transfer.

   a. True
   b. False

ANSWER: **a**

2. For a hospital admission to be counted on the *Monthly Summary by Provider* report, there has to be a prior transfer associated with the admission.

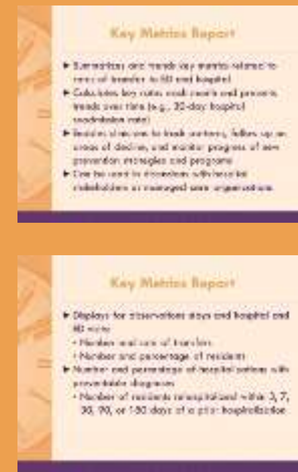
   a. True
   b. False

ANSWER: **a**

Slide 57: Key Metrics Report title slide

SAY:

Now let's look at the *Key Metrics* report.



Slides 58–59: Key Metrics Report

SAY:

The *Key Metrics* report summarizes and trends key metrics related to rates of transfer to the ED and hospital. Key rates are calculated each month and trended over time (e.g., 30-day hospital readmission rate).

Management teams and clinicians can use the report to track patterns, follow up on areas of decline, and monitor progress of new prevention strategies and programs. In addition, these data can be used in discussions with hospital stakeholders or managed care organizations to highlight areas for potential improvement in care management.

This report displays the total number of transfers from nursing home to hospital or ED and the total number of residents transferred from the nursing home to acute care. It also displays the following:

- Observation Stays - number of observation stays, observation stay rate, number of residents with observation stays, percentage of residents in observation stays;
- ED visits – number of ED visits, ED visit rate, number of residents transferred to the ED, percentage of residents transferred to the ED;
- Hospitalizations – number of readmissions to the nursing home from the hospital, number of hospitalizations with preventable diagnoses, percentage of hospitalizations with preventable diagnoses, hospitalization rate, number of residents hospitalized, percentage of residents hospitalized; and
- Hospital readmissions (all cause in last 180 days) - number of residents readmitted with previous hospital discharge in last 3, 7, 30, 90, and 180 days.

Slides 60–61: Sample Key Metrics Report

SAY:

Instruct trainees to look at the Key Metrics Report handout. Review the report contents and point out special features.

Transfer to Hospital and ED Key Metrics Trend Report	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Unit Name:												
Monthly Census (ADC)	30	28	35	35	31	30	30	23	24	27	32	30
Resident Days (Including Bed Holds)	900	840	1,050	1,050	930	900	900	690	720	810	960	900
Total Transfers From Nursing Home to ED or Hospital	24	14	14	14	16	25	11	11	12	11	3	15
Total Residents Transferred From Nursing Home to ED or Hospital	19	10	14	9	20	14	14	10	10	10	3	17
Following information based on returns to nursing home												
Observation Stays												
# Observation Stays	2	3	1	0	3	5	5	2	1	0	0	3
Observation Stay Rate: # Observation Stays/1,000 Resident Days	2.2	3.6	1.0	0.0	3.2	5.6	5.6	2.9	1.4	0.0	0.0	3.3
# Residents in Observation Stays	2	3	1	0	1	3	4	2	1	0	0	2
Residents in Observation Stays/Monthly Census (ADC) (%)	7%	11%	3%	0%	3%	10%	13%	9%	4%	0%	0%	7%
ED Visits (Treat and Return to Nursing Home)												
# ED Visits	10	8	3	10	11	5	3	4	3	5	0	10
ED Visit Rate: # ED Visits/1,000 Resident Days	11.1	9.5	2.9	9.5	11.8	5.6	3.3	5.8	4.2	6.2	0.0	11.1
# Residents to ED	9	4	3	8	10	3	2	3	2	3	0	10
Residents to ED/Monthly Census (ADC) (%)	30%	14%	9%	23%	32%	10%	7%	13%	8%	11%	0%	33%
# Residents With >1 ED Visit in Last 30 Days	1	1	1	1	1	1	1	1	1	1	1	1

Transfer to Hospital and ED Key Metrics Trend Report	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Hospital Visits												
# Hospital Visits (Admissions to Nursing Home From Hospital)	12	3	10	4	2	15	3	5	8	6	3	2
# Hospital Visits With Preventable Discharge Diagnosis	4	0	8	4	2	1	1	1	3	4	2	1
Hospital Visits With Preventable Discharge Diagnosis/Total Hospital Visits (%)	33%	0%	80%	100%	100%	7%	33%	20%	38%	67%	67%	50%
Hospital Visit Rate: # Hospital Visits/1,000 Resident Days	13.3	3.6	9.5	3.8	2.2	16.7	3.3	7.2	11.1	7.4	3.1	2.2
# Residents Hospitalized (Residents Readmitted to Nursing Home From Hospital)	8	3	10	1	9	8	8	5	7	7	3	5
Residents Hospitalized/Monthly Census (ADC) (%)	27%	11%	29%	3%	29%	27%	27%	22%	29%	26%	9%	17%
Hospital Readmissions (All Cause)												
# Residents Readmitted With Previous Hospital Discharge in Last 3 Days	1	1	3	0	3	0	0	0	0	1	0	0
# Residents Readmitted With Previous Hospital Discharge in Last 7 Days	1	1	3	0	4	0	0	0	3	1	0	0
# Residents Readmitted With Previous Hospital Discharge in Last 30 Days	3	1	5	0	4	0	2	1	4	1	0	0
# Residents Readmitted With Previous Hospital Discharge in Last 90 Days	4	1	5	0	4	0	2	1	7	3	0	0
# Residents Readmitted With Previous Hospital Discharge in Last 180 Days	5	1	6	1	5	0	5	1	7	5	0	0

Slide 62: Key Metrics Report Calculation Details

DO:

Review the calculation details with Facilitator trainees.

SAY:

When On-Time technical specifications are included in facility EMRs, the software performs various calculations to display the relevant information. We will review how the different fields are populated.

The report displays 12 months of data for a single unit or facilitywide.

Monthly Census. This is the average monthly census for the facility, or if the report is generated for a single unit, it is the average monthly census for the specified unit.

Resident Days (Including Bed Hold). This is the average daily census for the facility multiplied by the number of days in the month. Residents on a bed hold are counted as active residents.

Total Transfers From Nursing Home to ED or Hospital. This is the total number of transfers (observation stays + ED visits + hospitalizations) having dates during the report month.

Total Residents Transferred From Nursing Home to ED or Hospital. This is the total number of residents transferred with observations stays, ED visits, and hospitalizations during the report month.

Observation Stays

- ***Number of Observation Stays.*** This is the number of observation stays that occurred during the month.
- ***Observation Stay Rate.*** This is the number of observation stays multiplied by 1,000/number of resident days.

- ***Number of Residents in Observation Stays.*** This is the number of unique residents who had an observation stay during the month.
- ***Percentage of Residents in Observation Stays.*** This is the (number of residents in observation stays/monthly census) x 100.

ED Visits (Treat and Return to Nursing Home)

- ***Number of ED Visits.*** This is the number of ED visits that occurred during the month.
- ***ED Visit Rate.*** This is the number of ED visits multiplied by 1,000/number of resident days.
- ***Number of Residents to ED.*** This is the number of unique residents who had an ED visit during the month.
- ***Percentage of Residents to ED.*** This is the (number of residents with ED visits/monthly census) x 100.
- ***Number of Residents With >1 ED Visit in Last 30 Days.*** This is the number of residents with more than one ED visit during the month.

Hospital Visits

- ***Number of Hospital Visits*** This is the number of hospital admissions that occurred during the month.
- ***Number of Hospital Visits With Preventable Discharge Diagnosis.*** This is the number of hospital readmissions with preventable diagnoses (CHF, pneumonia, UTI, sepsis/fever/infection, skin ulcers or cellulitis, dehydration, COPD, asthma, circulatory problems, hypertension, gastroenteritis, angina, falls/trauma, anemia, and diabetes). Residents who do not return during the same month they left are counted in the month in which they return.
- ***Percentage of Hospital Visits With Preventable Discharge Diagnosis/Total Hospital Visits (%).*** This is the (number of hospitalizations with preventable diagnosis/total number of hospitalizations) x 100.
- ***Hospital Visit Rate.*** This is the number of hospitalizations multiplied by 1,000/number of resident days.
- ***Number of Residents Hospitalized.*** This is the number of unique residents who had a hospitalization during the month.
- ***Percentage of Residents Hospitalized/Monthly Census (ADC) (%).*** This is the (number of residents with a hospitalization/monthly census) x 100.

Hospital Readmissions (All Cause)

- ***Number of Residents Hospitalized With a Previous Hospitalization in the last 3 Days.*** This is the number of residents who were hospitalized during the month who also had a previous hospitalization in the prior 3 days. For example, Mr. Jones was transferred to the hospital and admitted on 3/10/15. On 3/8/15, he had just returned to the nursing home from a prior hospitalization. He had only been back at the facility for 2 days before he was transferred to the hospital.
- ***Number of Residents Hospitalized With a Previous Hospitalization in the Last 7 Days.*** This is the number of residents who were hospitalized during the month who also had a previous hospitalization in the prior 7 days.
- ***Number of Residents Hospitalized With a Previous Hospitalization in the Last 30 Days.*** This is the number of residents who were hospitalized during the month who also had a previous hospitalization in the prior 30 days.
- ***Number of Residents Hospitalized With a Previous Hospitalization in the Last 90 Days.*** This is the number of residents who were hospitalized during the month who also had a previous hospitalization in the prior 90 days.
- ***Number of Residents Hospitalized With a Previous Hospitalization in the Last 180 Days.*** This is the number of residents who were hospitalized during the month who also had a previous hospitalization in the prior 180 days.

Slides 63–66: Check Your Understanding: Key Metrics Report Quiz

DO:

Ask participants to answer the quiz questions independently and then discuss as a group.

1. The *Key Metrics* report is run for the previous 12 months. One resident who returned from the hospital yesterday has had two prior hospitalizations – one 3 weeks ago and one 4 months ago. This resident will be counted in the following categories:

   a. # of residents hospitalized with a previous hospitalization in last 3 days
   b. # of residents hospitalized with a previous hospitalization in last 7 days
   c. # of residents hospitalized with a previous hospitalization in last 30 days
   d. # of residents hospitalized with a previous hospitalization in last 90 days
   e. # of residents hospitalized with a previous hospitalization in last 180 days
   f. b and c
   g. c and e
   h. None of the above

ANSWER: g

2. The total number of transfers will always equal the number of residents transferred.

   a. True
   b. False

ANSWER: b

3. A resident goes to the hospital in March and does not return until April. The number of hospitalizations for the month of March includes this resident.

   a. True
   b. False

ANSWER: a

4. A resident goes to the hospital in March and does not return until April. The number of hospitalizations in March with preventable diagnosis includes this resident.

   a. True
   b. False

ANSWER: b