Dissemination of Resident and Family Decision Guide,
Go to the Hospital of Stay Here? in CMS Region IV

Final Report

March 31st, 2020

Submitted by:
Ruth M. Tappen EdD, RN, FAAN
Christine E. Lynn Eminent Scholar and Professor
Christine E. Lynn College of Nursing
Florida Atlantic University
Boca Raton, Florida

The cost of hospitalizing a nursing home (NH) resident,both in terms of risk to the resident and financial impact on the health care system, is well documented. Quality improvement (QI) programs such as INTERACT™ and Evercare™ have been developed to assist NHs to reduce the number of potentially preventable hospitalizations (PPHs) of NH residents. Some benefit from these programs has been reported but their focus is primarily on early identification and management of acute changes in condition. They do not fully address one of the most intractable reasons for PPHs, resident and family insistence on hospitalization (Lamb et al. 2011) reported by NH staff to be responsible for a significant proportion (15 to 18%) of their PPHs.

Preliminary Work

With support from the Patient Centered Outcome Research Institute (PCORI), Dr. Tappen and her research team conducted interviews of 271 NH residents, families and providers to better understand the reasons for this insistence on readmission. The insights gained from these interviews were combined with their long term care expertise to create a novel patient decision aid *Go to the Hospital or Stay Here? A Decision Guide for Residents, Families, Friends and Caregivers* subsequently pilot tested in 16 South Florida NHs. The Guide was rated helpful or very helpful by 93% of the residents and families who received it. Those who received the Guide (N=95) had a better understanding of the risks and the benefits of rehospitalization, reported less decisional conflict and expressed a greater preference for remaining in the nursing home as opposed to being transferred to acute care when possible (Tappen et al. 2020). A small follow-up grant from PCORI allowed us to commission expert translations into Spanish, Haitian Creole, French, Filipino, Tagalog, and Mandarin Chinese and to create a website www.decisionguide.org where the Guide, audio recordings of the Guide, translations and information about the Guide can be found. We also created a smaller Tri-fold version of the Guide which has proven popular with many facilities.

Current Project

The challenge at this point was that only the most proactive, highly networked facilities would find their way to the Decision Guide website and implement the Guide independently. To widely disseminate this valuable work, $800,000.33 in Federal Civil Money Penalty (CMP) funds were awarded to pursue this purpose supported by the eight states of CMS Region IV, Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and

Tennessee. Contract negotiations with each state and other pre-project activities resulted in start-up of the proposed project in September 2017. A no cost extension to complete data collection and analysis and this report of project activities resulted in a final completion date of March 31st, 2020. This report covers the time period September 2017 to March 31st, 2020.

The goal of the current project was to widely disseminate the Guide, bringing it to the attention of every Medicare-certified NH in the eight states of CMS Region IV.

Project Phases

Phase I.

To accomplish this goal in Region IV, we conducted a two phase project. In Phase I, we edited the Guide and smaller Trifold to conform to CMS specifications and incorporate State Advisors' suggestions. We also developed a package of training resources for the Region IV facilities eventually consisting of 13 training videos that explain the Guide and demonstrate use of the Guide, 4 case studies (a 5th case study was added in Phase II) and a guide to implementation first called the *Implementation Assistant* and now called *Best Practices for Implementing the Guide and Trifold*.

Once these preliminary preparations were completed, we piloted the training package and implementation of the Guide and Trifold in 16 Region IV Medicare-certified nursing homes in Alabama (N=2), Georgia (N=4), Kentucky (N=2), Mississippi (N=2), North Carolina (N=2), South Carolina (N=2), and Tennessee (N=2). Facilities were selected by our State Advisors with the following criteria from CMS in mind:

- include both facilities under 100 beds and those with 101 beds or more
- represent rural, suburban and urban NHs
- include for profit, not-for-pilot and state-funded facilities
- may be state owned, hospital based or free standing

To prepare the pilot nursing homes, an orientation webinar was conducted and a carton of essential materials (sufficient Guides and Trifolds for their current resident population, a CD with the videos, copy of the Implementation Assistant and introductory letter from the Project Director) was sent to each facility prior to an onsite visit from the Project Director and/or Co-Director. During these interactive onsite visits, the following were discussed with the facilities' management team:

- Purpose of the Project:
  - ✓ The NH's hospital readmission concerns
  - ✓ Role of resident and family insistence
  - ✓ CMS policies and penalties
- Pilot homes' role in the Project:
  - ✓ Preparation of staff
  - ✓ Engagement of Providers
  - ✓ Distribution of Guide and/or Trifold to residents and families

- ✓ Use in Care Planning and conversations with residents and families
- ✓ Use of data input forms on website

- Discussion of the NH's plans to roll out the Guide and Tri-fold
- Feedback from participating pilot NHs

The final activities in Phase I involved calls to the pilot NHs to trouble shoot problems encountered and obtain reports of their experiences. The experiences of these Pilot NHs (Best Practices) were incorporated into the workshop presentations made in Phase II and in our final version of the Implementation Assistant now Best Practices for Implementing the Guide and Trifold.

Phase II.

Phase II involved the final planning, conduct of 20 regional workshops, collection of workshop-related data, evaluation of the workshops, final update of project materials and the website, final evaluation of project outcomes and preparation of a final report on the project as a whole.

Planning of the workshops began in the Fall of 2018. In consultation with our State Advisors, sites that could be easily reached by attendees, accommodate the expected audience and the multimedia presentation planned but remain within the budget requirements were selected. The number of workshops per state was determined by the geography of the state and estimated driving distances to the venues. Workshops were held in the following locations:

- Alabama
  - Birmingham
  - Montgomery
- Georgia
  - Alpharetta
  - Macon
  - Savannah
- Florida
  - Boca Raton
  - Plant City
  - Jacksonville
- Kentucky
  - Louisville
  - Kentucky Dam Village
- Mississippi
  - Jackson
  - Oxford
- North Carolina
  - Rocky Mount
  - Thomasville
  - Cullowhee

- South Carolina
    - Greenville
    - West Columbia
- Tennessee
    - Jackson
    - Nashville
    - Morristown

The workshops were interactive, involving participants in discussion of case studies and the vignettes in the training videos. These were incorporated into a three-hour PowerPoint presentation. Content of the presentation included the following:

- Welcome and Introduction to Project and Speakers
- Medicare's Value Based Purchasing, Hospital Readmission Reduction Initiative and Imposition of Penalties
- Issue of Family and Resident Insistence on Hospital Readmission
- Purpose and Development of Resident and Family Decision Guide and Trifold
- Implementation of the Guide/Trifold
    - Preparation of staff
    - Engagement of Providers
    - Distribution and Discussion with Residents and Families
- Staff and Family Education Resources
    - Thirteen training videos
    - Five Case Studies
    - Best Practices for Implementing the Guide and Trifold
- Working with Residents and Families who Insist on Rehospitalization
- Evaluation of Impact of Guide/Trifold use: Website Data Entry
- Website Address and Contact Information

Dr. Tappen led all of the workshops with project team members Dr. Hain or Ms. Southard of South Carolina's QIO or with representatives of the QIOs in several states including Tennessee and Georgia. Every Medicare-certified NH in each of the eight states received a carton of Guides and Trifolds, the videos uploaded onto a CD, Best Practices information sheet and an introductory letter from Dr. Tappen, the Project Director.

Announcement of the workshops was done via email to all the Medicare-certified NHs in the state by the State Advisors, project team and/or the state nursing home associations. Invitees included state ombudsmen, state agency representatives, hospital representatives and state long-term care organization representatives as well as the NHs. Continuing education credit was provided to nurses and nursing home administrators. Participants completed an evaluation of the speakers and the content at the conclusion of the workshop.

Although workshop participants were instructed on procedures for entering their data securely on the decisionguide.org website, few did this. As an alternate procedure, Survey Monkey forms were sent out several times but proved to be equally ineffective. Members of the project team conducted calls to each facility that sent representatives to one of the workshops. Although this yielded a smaller amount of information about each NH's experience with use of the Guide and Trifold, it was the most effective in terms of reaching a substantial proportion of workshop participants.

The results of these efforts are summarized in the next section of this report and detailed in the attached appendices.

Project Objectives

Project Objectives: Process

Phase I Activities:

Project Start-up: An interdisciplinary project team was assembled with representatives of nursing, nursing home administration, QIO leadership, doctoral students and an administrative assistant.

Edit Guide and Trifold: CMS representatives and state agency advisors discussed both the Guide and Trifold, suggested edits and reviewed the modifications made. The final lists of edits that were made to the Guide (version 2.0) may be found in Appendix 1.

Prepare Staff Training and Resident/Family Altogether 13 videos were created. The list of videos suitable for families and residents and a list of those suitable for staff training and their corresponding links are found in Appendix 2. Scripts for most of the videos (two are interviews with Dr. Tappen and Dr. Mims from the Georgia QIO for which there are no scripts) are found in Appendix 3. The videos are too large to append to this report but they may be found on the Project website, www.decisionguide.org or via YouTube links provided in the Appendix.

Prepare Evaluation Forms: Two sets of forms were developed. The first were the data collection forms, developed originally for secure data input on the Project website and later condensed for use via Survey Monkey and calls to the individual NHs that sent representatives to the workshops. The Implementation Assistant document was replaced by the Best Practices document for the workshops. (Appendix 9). These data collection forms may be found in Appendices 4, 5, 6, 7, 8, 10, 11, 12 and 13. The second set of forms were prepared for evaluation of the workshops, one version for nurses' continuing education credit, a second for the nursing home administrators. These may be found in Appendices 14 and 15.

Pilot Entire Package of Materials and Modify as Indicated: This was done with the 16 selected pilot NHs. Videos were edited based on feedback obtained when we showed them during our meetings with these NHs. Calls to the pilot homes after they had

implemented the Guide and Trifold yielded the information used in the first version of what is now our document called Best Practices for Implementing the Guide and Trifold document.

Phase II Activities:

Distribute the Guide and Trifold to all Region IV Medicare-Certified NHs: Working with our contractor (Med-Pass) the packages of modified materials (sufficient Guides and Trifolds for each resident, a CD with the final versions of the 13 videos, revised Best Practices document and cover letter from the Project Director) was sent to every Medicare-certified NH in each state approximately 2-3 weeks before the workshops were held in that state. Med-Pass took responsibility for packaging the materials and mailing them.

Hold Statewide Training Workshops: Twenty workshops were held in the eight states, Alabama (2), Georgia (3), Florida (3), Kentucky (2), Mississippi (2), North Carolina (3), South Carolina (2) and Tennessee (2). A sample PowerPoint presentation (with videos removed to reduce its size) may be found in Appendix 16. Attendance at each workshop may be found in a Table in Appendix 17.

Project Evaluation: Outcomes

Organized Project Team: Team members completed their IRB (i.e. CITI) training as planned. The Stakeholders (State Agency plus CMS representatives) Advisory Committee was convened and meetings were held approximately 10 times annually. Advisory Committee meeting notes may be found in Appendix 18.

Revised Guide and Trifold: The primary revisions (conform to CMS language, emphasize resident and family rights) were done prior to their distribution (Appendix 19). Several minor corrections to the Guide were made at the end of the Project as well. The final version edits were then done in the remaining five languages for both the Guide and the Trifold. The Guide and Trifold may be found in all six languages on the project website www.decisionguide.org.

Create Training Program: Altogether, 13 training videos, five case studies, a PowerPoint presentation and Best Practices document were created. These can be found in Appendices 2, 20, 21 and 9 respectively.

Develop Outcomes Data Collection Forms: These forms include the online NH Survey (Baseline characteristics), Lookback Tool (pre-implementation hospital transfers) and QI Tool (post-implementation hospital transfers and evaluation of their potential preventability) for the pilot NHs and a briefer online version for workshop participants, a condensed Survey Monkey data collection form for workshop participants and, finally, a telephone survey form. (Appendices 4, 5, 6, 7, 8, 10, 11, 12 and 13).

Pilot Study Nursing Home Outcomes: Originally, the plan was to conduct the pilot study in 6 NHs in 3 states but this was increased to16 NHs in 7 states (AL, GA, KY, MS, NC, SC, TN). Three of these NHs lost their top management team within weeks of beginning the pilot study and could not participate. A fourth provided incomplete data and was dropped from the analysis. On average, the remaining 12 NHs achieved a 31.2% reduction in hospital transfers (see Appendix 22 for detailed information about the pilot NHs and the outcomes of the pilot study).

Modify Approach as Indicated: Feedback was obtained from all pilot NHs during the onsite visits and also during the follow-up calls. This feedback informed revisions of the Best Practices document and the videos. We included quotes about their experience and their readmission reduction achievements in the PowerPoint presentation for the workshops.

Distribute Guide, Trifold and Training Materials to all Medicare-certifed NHs in Region IV: As indicated above, this material was sent out 2-3 weeks before the workshops in each state.

Conduct Statewide Trainings: Twenty workshops were conducted across the eight states. Overall they were very well received. Evaluations of the workshops may be found in Appendix 23.

Evaluate Project Effect on Family and Resident response to PPHs (Workshop Outcomes): Effect of Guide use on hospital readmissions and response of residents and families may be found in Appendix 24. Those participants we reached who were able to provide information on either the number of readmissions before and after implementing the Guide or the percent change in readmissions reported a significant reduction in PPHs when the Guide was implemented.

Report to Funding Agency: Quarterly reports have been sent every three months to state funders (SC requires a report every 4 months). This report constitutes the Final Report for the Project.

Summary and Conclusions

In summary, we edited the original Guide and Trifold to conform to CMS language usage and further emphasize the residents' and families' right to participate in decisions about the resident's treatment, produced an Implementation Tool Kit of videos, case studies and the Implementation Assistant and piloted our approach in 16 NHs of CMS Region IV. The 31.2% reduction in hospital readmissions suggested that use of the Guide/Trifold was an effective approach to reducing PPHs.

In the second phase of this project, we shipped these materials to every Medicare-certified NH in CMS Region IV and conducted half day workshops in each of the eight states. Reports from workshop participants further supported the effectiveness of the

Guide and Trifold in reducing resident and family insistence on hospital readmission. The facilities that were fully engaged in implementing the Guide, integrating it into their processes and systems and preparing both staff and providers on the use of the Guide found their residents and families better informed regarding the care that can be provided in the NH, more willing to remain in the NH for treatment when possible and less likely to insist on a medically unnecessary hospital readmission.

References

Lamb G., Tappen R., Diaz S., Herndon L. (2011). Avoidability of hospital transfers of nursing home residents: perspectives of frontline staff. *J Am Geriatr Soc. 59*, 1665-1672.

Tappen, R. Worch, S., Newman, D. and Hain, D. (2020). Evaluation of a Novel Decision Guide "Go to the Hospital or Stay Here?" for Nursing Home Residents and Families: A Randomized Trial. *Research in Gerontological Nursing.*

Appendix 1 – List of Edits

List of Suggested Edits for the Decision Guide

The Decision Guide:

- Title change*: A Decision Guide for Residents, Their Families, Friends, and Caregivers*
- Second photo: Cover the "NuStep" logo with black.
- Pg. 1 changes:
    - Under title "Change in Condition" replace last sentence with: *If this happens, your medical provider has the responsibility to explain the change and the decisions that may need to be made to provide you the best possible treatment.*
    - In middle sentence: take out the apostrophes for "pros" and "cons"
    - Under title "If It's Not An Emergency" change sentence under bullet points to: "You can ask for the results and tell the nurse if you think your doctor, family, a friend or caregiver need to be called." and replace "being sent" to "going".
    - Under title "In An Emergency" sentence edits: "transport you to the hospital emergency department right away unless you have given them a Do Not Hospitalize request." And "a family member, friend or caregiver. You have the right to tell the staff ahead of time who you want called in an emergency."
- Pg. 2 changes:
    - Under title: Reasons to Prefer Being Treated Here: change "skilled facility or rehab center" to "nursing home".
    - Add 2 more bullets: - Physical or Occupational Therapy and - Speech Therapy
    - Last paragraph edits: after "doctors" add: "you do not know."
- Pg. 3. Changes:
    - Under Being Involved in the Decision Title: change wording of the last sentence in that paragraph to: "what treatments are available, the risks and benefits of these treatments, how decisions about your care are being made and how you are involved in making them."
    - Add another bullet: "Caregivers"
    - Add a last sentence: "such as a legal advisor."
    - In the bullets after DNH add: "allow a natural death"
    - Add anther bullet: "(POLST), Medical Orders for Life Sustaining Treatment (MOLST), or similar form that is accepted in your state"
    - At the end of the last sentence, add: "such as a legal advisor."
- Pg. 4. Changes:
    - Change Title: "INFORMATION FOR FAMILY, FRIENDS AND CAREGIVERS OF RESIDENTS WHO CANNOT EXPRESS THEIR WISHES"
    - Change all questions and answers on page 4 to the following:
        1. How can the resident participate in the decision about transfer to the hospital? The resident's wishes always need to be respected. Alternate forms of communication should be considered. If the resident has an advance directive that appoints someone as the health care proxy or durable power of attorney, that person may

make decisions for the resident based on what the resident would want if able to express his/her wishes. Advance directives should also be consulted.

2. If the resident cannot express his or her wishes, should we still tell him or her what is happening? Yes. The resident has the right to know what is happening and should be treated as if he/she understands the situation. Some people may become anxious or frightened if they are moved to an unfamiliar place without explanation. Be sure to use simple, direct words ("You are sick", "Your doctor thinks you should go to the hospital"), a quiet voice and a calm manner when explaining the situation to the resident.
3. How can I (as a family member, friend, or caregiver) be involved in the decision? You may need to complete some legal forms to do this. Ask your doctor, other medical provider or the social worker here for more detailed information. It's best to do this before a question about treatment or hospital transfer comes up.

- Page 5 Changes:
    - Remove question 7 and renumber the remaining questions

- Page 6 Changes:
    - Change the response of question 8 (previously 9) to: "If you are able, you may make the final decision. Consulting with your medical providers, family and friends may help you make a sound decision."
    - Change question 9 (previously 10) and answer to: How much say do I have in making this decision?
      Person-centered care requires that you decide if you are able. People differ in terms of how much information they want and how much of a say they want to have. If for some reason you decide you want to be transferred or stay here against the advice of your medical provider and nurses, you may be asked to sign a form taking responsibility for your decision.
- Pag7 Changes:

    - Change last sent to answer 12 (previously 13) to: Make sure the staff know in advance who you want contacted and how to reach them.
    - Change question number 13 (previously 14) to: Will I be able to continue receiving physical, occupational, or speech therapy if I go to the hospital?
    - In question number 15 (previously 16) change "facility" to "nursing home" in the answer.
- Page 8 Changes:
    - Change title in middle of the page to: COMFORT CARE, PALLIATIVE CARE, AND HOSPICE CARE AS WELL AS ADVANCE DIRECTIVE
    - Change answer to number 2 to: Comfort care or palliative care focuses on easing pain and other symptoms such as nausea, fatigue, depression, breathing problems, constipation or diarrhea that are the result of your illness or the treatment of your illness.
- Page 9 Changes:
    Add another sentence to the answer of question number 6: If you want to change your advance directives, tell your care provider, family, friend or caregiver what changes you would like to make.
- Page 10 Changes: Change "skilled facility" at the bottom of the chart to "nursing home"
- Page 11 Changes:
    - In the Title of the Page, change "Patients" to "Residents" and change "Skilled Facility" to "Nursing Home"
- Page 12 Changes:
    - In the Title of the Page, change "Skilled Facility" to "Nursing Home"
- Page 13 Changes:
    - In the Title of the Page, change "Skilled Facility" to "Nursing Home"
- The back of the book change the information to below:
    - Funding for development of original Guide provided by Patient-Centered Outcomes Research Institute (PCORI). Funding for this updated Guide provided by the Eight States of CMS Region IV (Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee
    - Copyright Florida Atlantic University
    - Visit www.decisionguide.org
    - Version 2.2

Trifold Version:

- Front panel title change*: A Decision Guide for Residents, Their Families, Friends, and Caregivers*
- Replace with first panel title with: **INFORMATION FOR FAMILY, FRIENDS AND CAREGIVERS OF RESIDENTS WHO CANNOT EXPRESS THEIR WISHES**
- Replace first panel questions and answers with:
    - **How can the resident participate in the decision about transfer to the hospital?** *The resident's wishes always need to be respected. Alternate forms of communication should be considered. If the resident has an advance directive that appoints someone as the health care proxy or durable power of attorney, that person may make decisions for the resident based on what the resident would want if able to express his/her wishes.*
    - **If the resident cannot express his or her wishes, should we still tell him or her what is happening?** *Yes. The resident has the right to know what is happening and should be treated as if he/ she understands the situation. Some people may become anxious or frightened if moved to an unfamiliar place without explanation. Be sure to use simple, direct words ("you are sick", "your doctor thinks you should go to the hospital"), a quiet voice and a calm manner when explaining the situation to the resident.*
    - **How can I (as a family member, friend, or caregiver) be involved in the decision?** *You may need to complete some legal forms to do this. Ask your doctor, or other medical provider or the social worker at the facility for more detailed information. It's best to do this before a question about treatment or hospital transfer comes up.*
- Back panel cover changes: Replace with: *Funding for development of original Guide provided by Patient-Centered Outcomes Research Institute (PCORI). Funding for this updated Guide provided by the Eight States of CMS Region IV (Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee) Copyright Florida Atlantic University Visit www.decisionguide.org*
  Version 2.0

- Inside panel first column:
    - Change top sentence in top answer to: *If you have a change in condition, your care provider will explain what decisions need to be made to provide you with the best treatment.*
    - Change wording in top answer to: *doctor, family, friends or caregiver may be called.*
    - Change wording in the third answer to: *to take you to the hospital emergency department.*
    - Change wording in the third answer at the bottom to: *and family, friends or caregiver you have designated.*
    -
- Inside panel middle column:
    - Change wording in top answer to: *potentially dangerous infections or falling in an unfamiliar place.*
    - Change wording in bottom answer to: *Physician or Medical*
- Inside left panel column:
    - Change top sentence in top title below photo to: *AND HOSPICE CARE AS WELL AS ADVANCE DIRECTIVES*
    - Change wording in the Question #4 answer at the bottom to: *your family, friends, caregiver and medical provider from time to time.*

Educational Materials for Residents & Families

Videos

A series of stories illustrating the issues and choices around rehospitalizations that can give residents and families advice and lessons in how they can be handled and, if possible, avoided.

The Usefulness of the Guide

Dr Adrienne Mims shares her perspective as a gerontologist and the family member of a nursing home resident

https://www.youtube.com/watch?v=S69gyJdeQww

A Testimonial from a Nursing Home Resident

Paul, a rehab center resident talks about how the Guide and better information could have helped avoid an unnecessary hospital transfer.

https://www.youtube.com/watch?v=HfmSpm9o5kk&t=6s

Introduction for a new Resident and Family Member

A new resident and a family member are introduced to the Guide

https://www.youtube.com/watch?v=FuTUBR8G4Os

Decision Guide for Resident in Palliative Care

Offering Options: Speaking to a resident on palliative care about the Guide

https://www.youtube.com/watch?v=h_UAVdN5y5M

The Decision Guide in Printed Form

A Social Worker gives the Guide to a short-term rehab resident in printed form

https://www.youtube.com/watch?v=AoLWHS47rUk

DECISION GUIDE LIVE

A full presentation of the content of the Guide

https://www.youtube.com/watch?v=bQLnwgzrgYI&t=671s

Educational Materials for Staff

The Usefulness of the Guide

Dr Adrienne Mims shares her perspective as a gerontologist and the family member of a nursing home resident

https://www.youtube.com/watch?v=S69gyJdeQww

An Introduction from the Project Director

Dr Ruth Tappen describes the development of the Decision Guide

https://www.youtube.com/watch?v=mkVCpQG74E0

A Testimonial from a Nursing Home Resident

Paul, a rehab center resident talks about how the Guide and better information could have helped avoid an unnecessary hospital transfer.

https://www.youtube.com/watch?v=HfmSpm9o5kk&t=6s

Introduction for a new Resident and Family Member

A new resident and a family member are introduced to the Guide

https://www.youtube.com/watch?v=FuTUBR8G4Os

Teaming with Resident to Prevent Hospitalization

A resident's change in condition that can be managed in the nursing home. (Pneumonia)

https://www.youtube.com/watch?v=kQFnsKp7Xp4

Engaging the Resident and Family in the Plan of Care

Resident and family learn how following the recommended diet can prevent another hospitalization. (Salty Fish)

https://www.youtube.com/watch?v=IFVp7uR0YK8

Educational Materials for Staff

Managing an upset resident

How not to do it and how to get it right. (Including a resident calling 911.)

https://www.youtube.com/watch?v=iEJGrg22Fc8

Decision Guide for Resident in Palliative Care

Offering Options: Speaking to a resident on palliative care about the Guide

https://www.youtube.com/watch?v=h_UAVdN5y5M

Decision Guide for Resident in Hospice Care

A Social Worker and Hospice Nurse explain issue of hospitalization when the resident is in hospice care

https://www.youtube.com/watch?v=iEJGrg22Fc8

The Decision Guide in Printed Form

A Social Worker gives the Guide to a short-term rehab resident in printed form

https://www.youtube.com/watch?v=AoLWHS47rUk

The Decision Guide in Tablet Form

A Social Worker gives the Guide to a short-term rehab resident in tablet form

https://www.youtube.com/watch?v=FmB1rmqqM2Q

When Hospitalization is Recommended

A resident experiences a change in condition that would best be managed in a hospital

https://www.youtube.com/watch?v=AoLWHS47rUk

1

The Usefulness of the Guide

Dr. Adrienne Mims shares her perspective as a gerontologist and family member of a nursing home resident.

This was not scripted.

2

An Introduction From the Project Director

Dr. Ruth Tappen describes the development of the Decision Guide.

This was not scripted.

3

The Decision Guide in Tablet Form

How to introduce the video version of the Decision Guide to a resident or family member.

Good morning (afternoon) *Mr. Jefferson*, how are you?

I'm *Goldie Cohen*, the social worker here at *the nursing home*

I want to tell you about the Guide you're about to see in this video.

This Guide has some important information for you about making decisions on going to the hospital or staying here if you become ill, have an accident or your condition changes.

A recent study found that people were unnecessarily being sent back to the hospital when they could have safely been taken care of in the nursing home.

Did you know we can give you antibiotics or intravenous fluids, have an x-ray done or send your blood to the lab to be tested?

So if your condition changes during your stay, we may be able to look after you here, rather than your having to go back to the emergency department or admitted to the hospital.

This Guide explains the care you may be able to receive here if you develop a new h e a l t h problem, like a urinary tract infection or pneumonia and the risks of transferring back to hospital.

When you've seen it, you should think about your preferences for care here or in the hospital and discuss them with your family and your care providers so that your choices are taken into consideration should the situation ever arise.

4

The Decision Guide in Printed Form

How to introduce the printed version of the Decision Guide to a resident or family member.

Social Worker: Good morning *Mr. Jefferson*, how are you?

Resident: I'm fine.

SW: I'm *Goldie Cohen*, the social worker here at *the nursing home*

I have a guide here which has some important information for you. It's about making decisions on going to the hospital or staying here.

This Guide explains the care you may be able to receive here if you develop a new problem, like a urinary tract infection or pneumonia.

(Briefly page through and review the highlights of the Guide with patient & family)

I'm going to leave this with you now for you to look at and think about. You might also want to discuss with your family, a friend or caregiver. Can I hand you your reading glasses?

Do you have any questions for me now

5

Managing an Upset Resident

Effective and Ineffective ways to handle a concerned resident with a minor injury in regard to a transfer to hospital

Scene: **A resident has sprained her right ankle the previous night. The X- ray is normal. The doctor has advised pain medication, rest to the injured limb, icing four to eight times a day for the first 48 hours, splinting the ankle, and elevation of the injured limb above heart level whenever possible to control swelling.**

Situation 1: Inappropriate handling of the situation

(Resident is agitated and wandering around her room with a cell phone in her hand. LPN enters the Resident's room to check how she is doing)

(LPN knocks on the door, hastily as she is walking in)

LPN: Hello, honey, how are you?

(Resident angrily turns away and tries to punch a number into her cell phone.)

LPN: Why aren't you talking to me today, sweetie?

(LPN makes annoyed face)

(Resident sighs in frustration and talks angrily without looking at the nurse, still pacing.)

Resident : Uuhhh! I don't know where they have put me. Why don't you send me to the hospital? My foot is broken.

(LPN stands in front of the Resident, arms akimbo and says impatiently.)

LPN: Ms. *Patricia*, how many times do I have to tell you that your foot is not broken. There is nothing on your X-ray. It's just a sprain. And we are doing everything here they would do in the hospital.

(Resident stares vacantly at the nurse.)

(Nurse looks at the Resident's bed and sees her splint and ice pack on there. LPN goes to bedside, clears the bed swiftly and while doing that says with displeasure:)

LPN: Look at your splint and ice pack, why don't you use these? I doubt if you took your pain medication too.

(Nurse tries to pull Ms. Patricia to her bed.)

LPN: I don't have time for this. Hurry up. You've got to put up your right leg.

(Resident resists to nurse's pulling her to bed and screams with irritation.)

Resident: Ahhh! No, stop, No, stop, leave …..

(Nurse forcefully makes Resident sit on bed and leaves saying,)

LPN: We are trying to make your life easier but you don't do what we tell you.

(Resident dials 911 on her cell phone.)

Resident: 911? I need to go to the hospital.

Situation 2: Appropriate handling of the situation

(Resident seems agitated and is pacing around her room with a cell phone n her hand.)

(LPN enters the Resident's room to check how she is doing. From 5ft away she begins to walk toward her speaking and waving to get her attention but not startle her.)

(LPN knocking on the door)

LPN: Hello, *Mrs. Murray*.

(LPN lifting hand to her face level and approaching slowly)

I am *Claudette Lewis,* I'm here to help you today.

(Extends her hand for handshake with palm facing upward slowly and does handshake using hand-under-hand technique.)

(Pause for discussion)

(LPN speaking slowly)

LPN: Are you alright?

(Resident sounding frustrated)

Resident: I need to go to the hospital. It still hurts.

(LPN nodding her head to show that she validates her pain)

LPN: I can see that you are not comfortable. Why don't you sit down here *(gestures)* and we can talk about this.

(Resident stares blankly at the nurse)

LPN: Let me help you sit down.

(LPN helps her sit down in propped up position on her bed.)

Let's elevate your foot so the swelling decreases. *LPN assesses the ankle. Resident pulls away the right foot.)*

Resident: Ouch!!

(Resident looks tense)

I think it's broken. Send me to the hospital.

LPN: We did an X-ray yesterday. The doctor said it's not broken.

(Resident remains silent)

LPN: There is a sprain, though and we are working to heal that.

(LNP places hands gently, lightly on ankle)

(Resident slightly nods her head, indicating yes.)

LPN: I can see the swelling has decreased compared to yesterday.

(Pause for possible response here.)

LPN: You are doing great with the ice pack.

(Taking ice pack in her hand)

LPN: I know it's hard to stay in bed for so long. So, use this splint to support your ankle while you are walking.

(LPN demonstrates splint)

(Resident looks at the nurse)

LPN: Is your pain medication helping you?

(Resident nods her head in agreement.)

LPN: OK. That's good.

(LPN uses hand-under-hand technique slowly.)

LPN: How about moving to a room near the nurse's station? That way we'd get to talk more.

(Resident nods, looks like she'd like that.)

LPN: You think that's a good idea?

(Resident nods her head to indicate yes.)

Resident: Thank you, you are taking good care of me.

(LPN smiles with Resident)

6

Decision Guide for Resident in Palliative Care

A nurse practitioner explains palliative care and the options for deciding whether to go to hospital to resident and her daughter (by telephone).

Scene: **Nurse Practitioner enters the resident's room. Resident is in bed.**

Nurse: Good *afternoon Ms. Daniels ,* I'm *Lakeisha Washington*, the nurse practitioner here at the home*.* How are you feeling today?

Resident: I've seen better days.

Nurse: I have some information I'd like to share with you about your stay here. Do you prefer to make your own healthcare decisions or do you have a family member or friend who helps you make healthcare decisions?

Resident: I don't have anybody close by, my son and his wife live in Philadelphia. He's coming next week to see me. He's the one to talk to if I can't speak for myself. He's a wonderful son.

Nurse: Well, we want to make you as comfortable as possible, so I'd like to share some very important information about your care while you're here. You know you're in palliative care, yes?

Resident: I think so, is it the same as hospice care?

Nurse: Not quite. Hospice care is for those in the final months of their life, 6 months or less in general. Palliative care can continue for many months, even years.
It's care focused on symptom management, to help deal with your pain, breathing problems or other symptoms that might be side effects of your condition. And a lot of these symptoms can be treated here at our care center. In fact, whenever possible we try to avoid unnecessary hospital visits unless it really is something we do provide here.

(Resident indicates agreement – nods)

Nurse: Most folks aren't aware how many medical treatments can be provided right here, in our care facility. If you have a change in your condition that needs additional treatment we may very well be able to treat you here rather than going through the stress of a hospital transfer.

Resident: What kind of treatments are you talking about?

Nurse: One example might be an allergic reaction or dehydration, say. We can deal with those. Also, we can do a lot of the tests and treatments your medical provider might request, such as X-rays, blood tests and other treatments to keep you comfortable.

Resident: Well that sounds good.

Nurse: I have a guide here which should answer a lot of your questions. I'll leave it here for you to look over and you can talk it over with your son when he comes to visit.

You should also let him know your wishes in case at any point he has to make end-of-life care decisions for you. And if you have strong feelings about end-of-life care decisions, there are Advance Directives you can draw up to make sure things go the way you want at that time. Your son can see the Guide on our website if you want to share it with him before he comes.

Resident: I understand.

Nurse: So I'll leave you the guide and we can talk again any time. Would you like me to talk to your son when he comes?

Resident: Yes, thank you.

Nurse: I will do that. In the meantime, call me if you or your son have any questions. Thank you for your time today.

7

Decision Guide for Resident in Hospice Care

Resident is responsible for their own decisions

A social worker explains to a resident in hospice care and his spouse about the options for deciding whether to go to hospital

Scene: **Social Worker and Hospice Nurse approach and enter the resident room. Mr. Lewis in bed, his wife in a chair.**

Social Worker: Good afternoon, *Mr. and Mrs. Lewis*, I'm *Goldie Cohen*, the social worker here and you know David Moro, your hospice nurse. We would like to talk to you for a few minutes. Is this a good time?

Resident: Yes, it is.

SW: How are you feeling today?

Resident: I'm ok today. I didn't like my breakfast. The pancakes were soggy. Who are you again?

(SW pulls up a chair & sits beside patient.)

SW: I am *your social worker.* I'm sorry you didn't like your pancakes. I'll pass on the information to the kitchen for you and maybe they can improve them. Right now, we would like to talk with you and your wife about some important information which could impact your stay with us, related to making choices about going to the hospital or staying here?

Resident: Last time I went to the hospital, I waited for hours in the emergency department and the doctor sent me back here with some new pills.

Hospice Nurse: Well, if something like that happens again, you may be able to receive medical care here. If you have an existing problem, or develop a new problem, like a urinary tract infection or pneumonia, instead of going to the hospital and waiting for hours, you may be able to be treated here. Remind me, do you

make healthcare decisions for yourself, or do you have a family member, a friend, or a Health Care Proxy involved in your care?

Resident: I make my own decisions. If for some reason I couldn't, my wife is my healthcare proxy.

Hospice Nurse: Okay, good. I would like you to be aware that if you are sent to the emergency room or hospital, your hospice care may be discontinued if Hospice does not approve the transfer.

I need to call the hospice doctor to inform him and seek his advice about your care. The hospice doctor will approve the transfer if he thinks you need to be seen at the hospital. Otherwise, you can be taken care of here.

SW: Here is a guide that provides information about the care you can receive here.

(Briefly reviews the highlights of the Guide with patient.)

Resident: Thank you.

SW: I'm going to leave this with you now for both of you to look at and think about. Do you have any questions? Resident shakes his head "No" It was nice talking to you. Thank you.

(Social Worker exits room.)

Resident and Wife: Thank you. Good-bye.

Hospice Nurse: Ho w is your pain? Is the new medication more effective?

Resident: It's much better.

Wife: He's so much more relaxed now that the pain is under control.

8

Engaging the Resident and Family in the Plan of Care

A nurse and nursing assistant explain to a resident the need to comply with treatment guidelines to avoid returning to hospital

Opening Scene: Mr. Petrov in bed and Nursing Assistant Maria is checking his vital signs.

Maria (CNA): Almost done here *Mr. Petrov*. Is anyone coming to visit you today?

Mr. Petrov: Ivan! Maria, no need to call me so fancy. And, yes, since you ask, my sister Anya will be by this afternoon. She's a good woman, always brings me the salt fish. It's a favorite from the mother country. She cooks divine like m y Babushka. I give some to you.

Maria (CNA): That's very kind of you Mr. Petrov. I would love to taste it.

Later at lunchtime…

Scene: **Conference room showing Nurse Jackie reading, Mary eating from a Tupperware style container cautiously**.

(Jackie peers over her book/magazine)

Jackie (RN): Maria, what's wrong with your food? Do you want some yogurt? I've got extra in the fridge.

Maria (CNA): Thanks, I brought something else. I'm just trying this salt fish from Mr. Petrov's sister. She brought him a bunch of it, but it's so salty I can barely get a bite down.

Jackie (RN): I guess it lives up to its name then?

(Maria nods)

Jackie: Doesn't Mr. Petrov have heart failure? Why would his sister bring him salty fish? That can seriously disturb his fluid balance. Is she still here?

(Puts book down and stands up)

Maria (CNA): He said it's something his grandma used to make. Last I saw, she said she would be here all afternoon.

(Jackie exits the room briskly.)

Scene: **Bedside.**
Mr. Petrov in bed eating from a Tupperware style container and holding a bottle of beer with smiling sister sitting next to him on the bed.

(Jackie knocks, pauses and enters while walking into the room slowly.)

Jackie: I see you have a visitor Mr Petrov. It's wonderful when family stops by.

Mr. Petrov: Ah, Jackie, my nurse! This is my darling sister Anya! She bring me the salt fish like my Babushka make. It is a lovely, lovely snack. Come, come she has enough for you to have some.

(Anya brings a large tote into view from the floor.)

Anya: Yes. Nothing is too good for my sweet brother. He always tell me how bland the food they serve here is. There's nothing like a bit of flavor to spice things up.

Jackie: Did you know that salt fish is not good for Mr. Petrov? From what I understand it seems to have a lot of*...(making hand motions)*, well, salt! Mr. Petrov has heart failure. If he eats a lot of salt*)* he would need extra medication to get rid of the excess water in his body that makes it hard for his heart to work. And if it becomes difficult for him to breathe because he has too much water in his body we might have to send him back to the hospital like we did last month. It would be much better for Mr. Petrov if he didn't eat the salt fish.

Anya: Oh, I remember him in hospital. That was very hard, eh Ivan?

(She slaps him gently on the knee.)

I came just before and give you the salt fish that weekend. You don't tell me the salt fish is bad for your heart.

(Anya stands with hands on her hips.)

Mr. Petrov: Anya! It remind me of home and family! You never come except when you bring the salt fish! If I don't ask for it, you don't come at all!

Anya: But, yes, of course I still come see you, you're my only brother I'm going to check with the nurse every time you ask me to make something, because you sneaky sly about the rules for your condition. Maybe I can make something else you can have that reminds you of home. I make good borscht. You like that. Let's ask your nurse.

Jackie: That's beet soup, isn't it? If you don't add salt to it, beet soup is good for Mr. P. I'd be happy to print you out a list of what is good for Mr.Petrov to eat and what may be harmful. Anytime either of you have questions you can always call and ask. I'm glad you understand why we ask you to eat something else.

(Mr. Petrov nods his head in agreement)

Scene fades out.
(Maria is at Mr. Petrov's bedside)
(Nurse Jackie enters after finishing)

Jackie: Good Morning! How is the swelling in your legs today Mr. Petrov? They've been much thinner since we have been careful with your salt restriction.

Maria: Mr. Petrov was just telling me about his sister coming later!

Mr. Petrov: Good Morning, yes, she coming today to visit. She's coming with gifts. And my legs are like that of Russian ballet dancer's the most beautiful girls in the world.

(Mr. Petrov waving one leg in the air)

Jackie: Sounds like you are doing well, I can't wait to see what she brings you, I'll have to stop by later and see her.

9

Teaming with a Resident to Prevent Hospitalization (pneumonia)

An LPN and nurse practitioner manage a resident who does not need a transfer to hospital

Scene: **A discussion at a Nurses Station between NP and CNA, regarding a resident with new symptoms.**

LPN Jessie Simpson: Linda, I just left Mr. Chang's room. He didn't seem quite right. That cough has gotten worse, his skin was damp and he was a little confused about what day it is.

NP Linda Pollack: Thanks Jessie. I'll check on him. While I do that, could you please check his admission notes to be sure we discussed how we will handle a change in health status while he's here?

Cut to: **NP returns to the Nurses Station**

NP: I just saw Mr. Chang. Thanks for being so alert! I think he may have pneumonia but he was adamant "no more hospitals". I spoke with him and his wife and explained that we can start antibiotics, do chest x-rays and a CBC here to determine what's going on. I also spoke with his provider who agreed it would be best if he stays here. It is not in his best interest to move him if we can treat him here.

Cut to: **Primary Care Provider (Doctor) reviewing chart with NP at the Nurses Station**

Doctor: Fortunately, with the antibiotics, oxygen therapy and continued monitoring of his fluids, Mr. Chang should be fine in a week or so. I am glad he and his wife had enough confidence to allow us to treat him here. This is a great example of teamwork within your staff.

NP: Thank you. We monitor our residents carefully for any change in condition.

10

When Hospitalization is Recommended

A staff nurse, charge nurse and doctor manage a resident who needs to be transferred to the hospital

Scene: **Nurse speaking with resident sitting up in bed.**

Nurse: Your leg looks a little swollen today. Wasn't that the one that was bothering you yesterday?

Resident: My legs always bother me…they swell up and then I take my water pill and it goes away.

Nurse: Yes, but this time only one leg looks swollen.

Resident: It's nothing (patient rubs his left chest)

Nurse: Is your chest hurting you?

Resident: It's a little sharp pain, I get those once in a while.

(Resident waves nurse's hand away.)

(Nurse goes back to the nurse's station, reviews the chart, notes that patient is on Coumadin for aortic valve replacement; his last INR level was low.)

Charge RN walks by and notices nurse's frown.

Charge RN: Is everything alright?

Nurse: I'm a little concerned about Mr. Lewis. His leg looks swollen today and I think she's having some pain in her chest. He was complaining of the pain in her leg yesterday, but you know how he is; he never complains and "pooh-poohs" everything. I just looked at her lab results from Monday and her INR is sub-therapeutic.

Charge RN: I think we should call Dr. Dominguez. He might need to go to the hospital.

Nurse: I will, I'll call him right now

Nurse picks up the phone, and dials- reaches the doctor and relays the information.

Dr. Dominguez (on phone): I don't like the fact that he's having chest pain, call the ambulance and send him to St. Vincent's. He needs a chest pain and PE work up.

Nurse: I'll call them now, thank you.

(Nurse hangs up and calls.)

Nurse returns to Mr. Lewis and takes his vitals.

Show Vital signs on monitor with elevated HR, low o2 Sat

Nurse: Mr. Lewis, we need to send you over to the hospital to have your leg looked at, and some blood tests. We are worried about the pain in your chest too. Do you want us to call your daughter?

Resident: Yes, please. I want her to know where I am.

Charge RN calls family member (daughter) who says she'll meet them at the hospital.

11

Introduction for a New Resident and Family Member

How to introduce the Decision Guide video version to a resident or family member.

Good morning (afternoon) Mr. (Mrs., Ms.) name, how are you?
I'm *(your name)*, the/a *(your title)* here at *(facility name)*.
I want to tell you about the guide you're about to see in this video.
This Guide has some important information for you about making decisions on going to the hospital or staying here if you become ill, have an accident or your condition changes.
This Guide explains the care you may be able to receive here if you develop a new problem, like a urinary tract infection or pneumonia and the risks of transferring to hospital.
When you've seen it, you should think about your wishes and preferences and discuss them with your family and your care providers so that your choices are taken into appropriate consideration, should the situation ever arise.
Do you have any questions?
Thank you

12

A Testimonial from a Nursing Home Resident

Paul, a rehab center resident, talks about how the Guide and better information could have helped avoid an unnecessary hospital transfer.

This was not scripted.

13

Decision Guide Live

A video version of the Decision Guide that can be shown on in-house television systems, transmitted electronically or shown on a tablet for those who are unable or would prefer not to read a print version

Part I

Scene 1: A Nursing home or care facility.

A doctor and nurse speak directly to camera

Doctor: Did you know that almost half of transfers to the hospital could be avoided?

We're here to help you understand why these transfers are made and how you can be involved in the decision.

This question comes up if your condition changes *(pause)*: "Go to the hospital or

stay here?”
Now this change could be a fever, shortness of breath, pain, injury from a fall, or a number of other
things.

If this happens, your provider has to explain to you the change and the decisions that need to be made to provide you with the best possible treatment.

Why think about this now? Well, it can be difficult to weigh the pros and cons of a transfer to the
hospital when you are already ill, and it’s not easy to make a decision in the middle of a crisis.

This information we’re about to give you is so that, should it ever happen, you can make an informed decision when it arises.

If it’s not an emergency, the nurse can assess your condition:

- Ask you what happened, how you feel, where it hurts
- Listen to your heart and lungs
- Take your temperature, blood pressure, oxygen level
- Test your blood and urine

You can then ask for the results and whether your doctor or family will be called. If you have any concerns about being sent to the hospital, this is the time to express them.

Remember though, in a life-threatening situation the staff may call 911 to take you to the hospital emergency department right away. They will also call your doctor, or other medical provider, (a nurse practitioner or physician assistant) and a family member, friend or caregiver. You have the right to tell the staff ahead of time who you want called in an emergency.

Scene 2: A Nurses station.

A nurse (1) looks up from a chart and speaks to camera

Nurse 1: Did you know that many of your tests and treatments can be provided here in the facility by our skilled staff.

These could be:
- Medications
- X-rays and blood tests
- Oxygen
- Wound care
- Comfort care, pain relief, fluids, bed rest
- Intravenous fluids in some facilities, and
- Physical or occupational therapy

We can also check on you and report to your doctor or medical provider.

And you can ask your nurse, doctor or other medical provider what else can be done for you here.

These are some of the main reasons someone might prefer to be treated here.

Scene 3: A Nursing home or care facility.

(Nurse 2 walks towards camera speaks directly to it.)

Nurse 2: Of course, we can't do everything.

Hospitals can provide more complex tests and treatments, including:
- Heart monitoring
- Body scans
- Intensive care
- Blood transfusion
- and Surgery

These are the kind of reasons you might have to be treated in the hospital and you should carefully consider all of these factors when you're making your decision.

But there are some risks around going to the hospital.

(Nurse 2 approaches a resident, stops and speaks straight to camera.)

Nurse 2: Being transported to the hospital can be stressful. You're likely to have to explainyour concerns all over again to new nurses and doctors.
You're at greater risk of skin breakdown, exposure to infection and maybe even falling in an unfamiliar place.
So you may feel more comfortable staying here and being cared for by the staff who know you.

Resident: I know. Last year they sent me to the hospital just for intravenous medication. I was supposed to be there just for three or four days but I developed pneumonia, and I had to stay much longer. Since then I really don't like to go to the hospital for this sort of thing. I like to be treated in the place where I live.

Scene 4:
Cut back to the Doctor

Doctor: The main thing is that we want you to be involved in that decision.
You have the right to know what's happening to you, what treatments are available, the risks and benefits of these treatments, how decisions about your care are being made and how you are involved in making them.

So you may want to talk to people about your choices:

- Your Nurses, Doctors and other medical providers, of course, but also:
- Social workers
- Spiritual advisor
- Family members
- Close friends
- Care givers

These are very personal decisions and it's up to you who you talk to and whose opinions you respect.

You can make your preferences known by:

- Talking with the people I've mentioned
- Putting your wishes in writing and telling people where those documents can be found

You can also complete advance directive documents including:

- A Power of Attorney for your healthcare
- A Health care proxy, where you name someone to make health care decisions for you if at any time you can't.

- There's a Living Will, which states your preferences for end of life care
- And there are orders for a DNR (do not resuscitate) or DNH (do not hospitalize) if that is what you would prefer should that time come.
- There are also Physician Orders for Life Sustaining Treatment (POLST) or similar form that is accepted in your state.

Scene 5:
Cut back to Nurse 1

Nurse 1: So what can we do to help you with this process?

If you still have questions, please ask your nurse, social worker, doctor, nurse practitioner or physician assistant to talk with you.

They can take you through the guide and any questions you might have.

They may recommend others talk with you as well and the guide has an extensive Frequently Asked Questions section which goes over may of the questions others have had before.

It also has lots of comments other people have made about this issue.

So remember, it's your care, your decision and we want you to have the best care that you feel is right for you.

Part II

Frequently Asked Questions

A healthcare professional answers family members' questions

A. Questions About Transfers to the Hospital

Scene 1: **A conference table. An adult son and daughter are seated with a social worker.**

Son: So why would the doctor consider sending our mother to a hospital?

Social Worker: Well, if she had an injury or a serious change in condition, that's when your medical provider may consider sending her to a hospital.

Son: What exactly do you mean by a “medical provider”?

Social Worker: It could be a physician (MD), doctor of osteopathy (DO), nurse practitioner (NP) or a physician assistant (PA).

Daughter: When would staying here be the best choice for her?

Social Worker: If we can provide the care she needs, then staying here may be the best choice.

Daughter: And what kind of care can you provide here?

Social Worker: That varies from one facility to another but most can give medications (by mouth or injection), intravenous fluids (but not blood transfusions) and they can do common lab tests, x-rays and make regular checks on your condition.

Son: Are there any other reasons why we would want her to be cared for here?

Social Worker: Several in fact. The staff and routines here are familiar to her. The staff already know her, her health history and her needs.
There’s a lot less disruption to her routine as well if she stays. The transfer itself may be tiring, even stressful and complications may occur in the hospital.

Son: But when would going to a hospital be the best choice?

Social Worker: Hospitals do have more equipment and staff than nursing homes do. They can do more complex lab tests, x-rays and scans, they can monitor her condition more closely, give blood transfusions and do complex procedures like surgery.

Daughter: What’s a hospitalist?

Social Worker: Hospitalists are doctors who specialize in giving hospital care. In many hospitals, it will be a hospitalist that oversees the care, not your primary care provider.

Daughter: Who makes the final decision on whether to send her to a hospital or stay here?

Social Worker: Your doctor, nurse practitioner, or physician assistant will consult with you and your mother before a decision is made.

Son: How much say do we have in this decision?

Social Worker: That’s up to you. People differ in terms of how much they want to know and how much of a say they want to have in this decision. If for some reason you decide she wants (or you want her) to be transferred or stay here against the advice of your medical provider and nurses, you may be asked to sign a form taking responsibility for your decision.

Daughter: What happens if it's an emergency?

Social Worker: If 911 is called she will receive on-the-spot treatment from the EMTs (ambulance crew) and then be sent to the nearest hospital.

Daughter: Can we request a certain hospital?

Social Worker: You can but in an emergency, the EMTs will take her to the closest hospital, as long as it can provide the care she needs. If it isn't an emergency and your preferred hospital is close by, they may be able to take her there.

Son: Will we know where she is? Will she know what's happening to her?

Social Worker: Sometimes, during a 911 emergency, there isn't time to call family members until someone's already on their way to the hospital. Your mother can ask that you be called as soon as possible and both your provider and the nursing home staff have a responsibility to keep you informed.

Daughter: Will she still be able to get physical and occupational therapy if I she's in the hospital?

Social Worker: That depends on why she's gone to the hospital and how sick she is. If therapy has to be discontinued, it can begin again when she's ready.

Daughter: And will she come back here after she's discharged from the hospital?

Social Worker: In most cases, yes, but in some circumstances going to a rehabilitation hospital, a different nursing home or even going home may be the better choice for her.

Son: But will you hold her room for her while she's in the hospital?

Social Worker: Most of the time, a nursing home will hold the room for several days. But these policies vary so you should ask someone at the facility what the policy is if it concerns you.

Daughter: What happens to her personal effects if she's transferred to the hospital?

Social Worker: They can be stored for her here.

Son: So why are we talking about this now?

SW: Well, it's difficult to carefully consider options and your personal preferences in the midst of a crisis, like being sick enough to be sent to the hospital. You may be upset, worried and your mother may be feeling too bad to talk about her preferences with her provider or with you.

Son: Why is this decision so important?

SW: Several reasons. Sometimes residents or their family members get very anxious when

they become ill and they ask for the resident to be sent to hospital when treatment could have been provided here.
There are some risks and discomfort associated with being sent to the hospital. The transfer itself, a new environment, new staff and new routines can all be sources of discomfort. Risks include falls, skin breakdown (pressure sores) and more exposure to infection.

Both the transfer and hospital care are also very expensive. Some of these expenses may not be covered by your insurance. So you may want to ask about this so you can consider all the information when you make your decision.

B. Questions About Comfort Care, Palliative Care, Hospice and Advance Directives

Scene: **A nursing home lounge. A resident's adult son and daughter are seated with a social worker (SW).**

Wife: What exactly is the difference between hospice and palliative care?

SW: The type of care is similar but hospice care is really for those in the final months of their life (usually 6 months or less). Palliative care can continue for many months, even years. Hospice care focuses on pain control and symptom management, as well as emotional and spiritual support.

Wife: So what do you mean by "comfort care"?

SW: Comfort care focuses on symptoms management. It is concerned with easing pain and other symptoms like nausea, fatigue, depression, constipation or diarrhea, or breathing problems that are the result of the illness or the treatment of that illness. Palliative care teams also help people cope with their illness, offering practical solutions and emotional and spiritual care.

Daughter: What happens if my father is getting hospice care when he goes to the hospital?

SW: If he goes to the hospital, he may have to re-qualify for hospice when he returns here. If there's time, the hospice should be called before he's transferred to the hospital.

Daughter: What are Advance Directives? Should he have them?

SW: Advance directives are documents that tell the family, medical provider, hospital, skilled facility or rehab center staff what kind of care he wants to receive if he is unable to be involved in the decision because he's too ill.
He can say he doesn't want certain treatments, like CPR (resuscitation) if his heart stops, or to be put on a breathing machine if he can't breathe on his own. He can also state he wants all the treatment available if comes to that. He can also designate someone (like you, or a sibling or spouse) to make decisions for him if he can't do it himself when the time comes.

Wife: If he does have Advance Directives, will his wishes be honored?

SW: To make sure his wishes are honored, he should review them you and with the staff and his medical provider ahead of time.

Make sure a copy is on his chart at the hospital and here. It's a good idea for you and the medical care provider to have copies of the advance directives ahead of time.

Daughter: Once he's made his wishes known in Advance Directives, can he change his mind?

SW: Yes, he can change your mind and his advance directives at any time.

Information for Family, Friends, and Caregivers of Residents Who Cannot Express Their Wishes

Daughter: What would happen if our father couldn't express his wishes? Say if he had a stroke or something like that?

SW: A resident's wishes always need to be respected. There are alternate forms of communication you could consider. If your father has an advance directive that appoints someone as the health care proxy, that person may make decisions for him based on what he would want if able to express his wishes or he can complete advance directives to let us all know what his wishes are.

Wife: If he couldn't express his wishes, should we still tell him what is happening?

SW: Yes. Every resident has the right to know what is happening and should be treated as if he understands the situation. Some people may become anxious or frightened if moved to an unfamiliar place without explanation. Be sure to use simple, direct words ("you are sick", "your doctor thinks you should go to the hospital"), a quiet voice and a calm manner when explaining the situation to him.

Daughter: How can we be involved in the decision?

SW: You may need to complete some legal forms to do this. We can give you detailed information about how this is done. It would be best to do this before a question about treatment or hospital transfer comes up as well as while your father can still express his own wishes.

Son: Thank you.

Decision Guide Implementation Assistant

Thank you for your interest in the Florida Atlantic University Patient/Family Decision Guide "Go to the Hospital or Stay Here?" (The Guide).
The development of the Guide was funded by the Patient Centered Outcomes Research Institute (PCORI). This Implementation Assistant was designed to assist you in formulating the necessary policies and procedures to implement the Guide. Simply answer these questions and you will have accumulated the necessary information to effectively and efficiently implement the Guide in your facility.

I. Who will decide on the policies and procedures to implement this Guide?

1) Who will decide how to use this Guide in our facility?

☐ One Person?

Name _____

Title _____

OR

☐ Committee?

Who will serve on this committee?

Name _____ Title _____

Name _____ Title _____

Name _____ Title _____

When should this committee meet and how often?

_____

II. POLICY - Which version(s) of the Guide do we want to use?

1) The following versions of the Guide are available:

☐ Printed 8-1/2 x 11" – Full Color – 13 pages*

☐ Printed 8-1/2 x 11" – Black & White – 13 pages

☐ Printed 8-1/2 x 11" – Trifold Brochure – Full Color – Single Page*

☐ Printed 8-1/2 x 11" – Trifold Brochure – Black & White – Single Page

☐ Digital Version – PDF File – Full Color – 13 page version

☐ Digital Version – PDF File – Full Color – Trifold version

☐ MP3 Voice-over File – 13 Page version

☐ YouTube Video Voice-over

Call **800-438-8884 or visit www.med-pass.com** (keyword: decisionguide) to place an order.

All formats in English, Spanish, Creole, French, Filipino, and Chinese can be viewed at **www.decisionguide.org.**

* Items in stock for same day shipping from MED·PASS®

2) Which version and/or combination do we wish to use and why?

_____

_____

_____

_____

_____

3) Cost of Print Versions for our facility:

- ☐ Total Residents in-house: _____
- ☐ **Plus:** Average number of new admissions per month: + _____
- ☐ **Plus:** Extra amount needed to keep on hand for training and misc. purposes: + _____
- ☐ **Equals:** Total Number of Print Versions needed to order: = _____

Please Note: *When reviewing total needed, take into account, if print versions in other languages are needed (e.g., Spanish, Creole, French, Filipino, and Chinese).*

III. PROCEDURE

1) Who will be responsible to order the Guide in the formats we choose?

_____

2) Where will we store the print versions of the Guide?

_____

Who will have access to them? _____

3) If we use the print version (13-page or Trifold), how do we ensure it gets into the hands of every resident/family member of our existing population?

- ☐ Family Council Meeting (show YouTube video?) _____
- ☐ Resident Council Meeting (show YouTube video?) _____
- ☐ Print/online newsletter? (Embed YouTube video?) _____

4) How do we want to use the electronic versions of the Guide?

- ☐ YouTube _____
- ☐ Voice-Over MP3 _____
- ☐ Electronic PDF File _____

5) How do we ensure it gets into the hands of all new residents/families?

☐ Place a physical copy of the Guide in all admission packets? ☐ Y ☐ N

If Yes, who will be responsible to ensure this is done? _____

☐ Hand them directly to patients/families at the first planned care conference?

Who will be responsible to make sure this happens? _____

☐ Hand them directly to patients/families within _____hours of admission?

Who will do this?

- ☐ Nursing
- ☐ Social Services
- ☐ Admissions
- ☐ Intake Coordinator
- ☐ Concierge
- ☐ Internal Case Manager

6) Who will be responsible for creating a staff training program to ensure all relevant staff know about the brochure and can relate the information to residents/families if they ask?

a. Can we incorporate the Decision Guide YouTube Video into our training? ☐ Y ☐ N

b. How do we ensure all <u>new</u> staff members are trained in the use of the GUIDE?

_____

7) Which department will have responsibility to distribute this brochure?

- ☐ Admissions
- ☐ Case Management
- ☐ Social Work
- ☐ Nursing

8) Who will receive training on how to speak with the residents/families about the Guide? _____

_____

_____

9) Who will be responsible to review the brochure with the resident/family member?

_____

_____

_____

10) Can we put the PDF version on our company website? ☐ Y ☐ N

11) Can we put a link to the Decision Guide Website on our website? ☐ Y ☐ N

Directions:
Use the answers from the previous questions to write your own facility policies and procedures to use the Guide. A sample policy statement is provided for your use:

Sample Policy & Procedure

Policy Area: **Hospital Readmission Reduction Plan**	**Subject:** ***Usage of Patient Family Decision Guide (Guide)***
Title of Policy: **Facility Usage of the Decision Guide**	**Number:** **Decision Guide Policy # 001**
Effective Date:	**Page Number:**
Approved Date:	**Approved by:**
Revision Date:	

1. **Rationale or background to policy:**
   As part of the organization's continuing effort to monitor and reduce preventable/ unnecessary hospital readmissions, the creation of policies and procedures for the GUIDE has been deemed necessary to ensure all personnel understand the needs, wants, desires and wishes of our residents and their families. This policy is one of several that shall be created as a result of this facility choosing to properly implement the GUIDE.

2. **Policy Statement:**
   The purpose of this policy is to establish a clear level of communication regarding the use of the GUIDE between the governance, leadership, staff and other stakeholders in this facility.

3. **Procedure:**
   i) Sample – Based on answers to questions in Implementation Assistant
   ii) Sample – Based on answers to questions in Implementation Assistant
   iii) Sample – Based on answers to questions in Implementation Assistant

ImplementAssist (12/15)

Section I - Contact Information:

1. Your Information

Name		Title (Position)	
Your Email Address		Direct Phone Number	
Nursing Home Name			
Address			
City		State	
County		Zip Code	
Medicare Provider Number			

Section II - Facility Information:

2. Total number of certified beds

3. Do you participate in:

Medicare Select...

Medicaid Select...

4. Does your facility belong to a corporation Select...

a. If yes, name of corporation

b. Number of nursing homes in the corporation

5. Is your facility: For-profit Non-profit Government owned

6. Do you consider your geographic location to be Rural Urban Suburban

7. Is your facility operated by The company that owns it Management Company

8. Does your facility use Electronic Medical (Health) Records Combination of both Paper Medical Records

9. How many hospitals/emergency departments (ED's) do you use for your acute-care transfers? hospital/ED's

10. Do you use a staffing agency for employee shortages? Select...

a. If yes, approximately how many shifts in May 2018?

i. RN

ii. LPN

iii. CNA

Section III - Senior Leadership Team Information:

11. How long has the administrator been at this facility? Years (Use a decimal point if less than 1 year)

12. How long has the Director of Nursing been at this facility? Years (Use a decimal point if less than 1 year)

13. How many hours per month is the Medical Director employed or contracted? Hours

Section IV - Medical Provider Information:

14. How many Primary Care Physicians regularly visit residents in your facility? [ ]

a. On average, how many days per week is at least one primary care physician on site? [ ] days per week

15. Does your facility employ a Nurse Practitioner [Select...]

a. Does your facility contract for Nurse Practitioner services? [Select...] If yes, how many days per week? [ ] days per week

b. Does your facility utilize a nurse practitioner that is employed by your medical director or other physicians? [Yes] If yes, how many days per week? [5] days per week

16. Does your facility employ a Physician Assistant? [Select...]

a. Does your facility contract for Physician Assistant services [Select...] If yes, how many days per week? [ ] days per week

Section V - Resident Profile Information (FOR THIS SECTION ONLY: *Please provide information from 5/1/2018 through 5/31/2018 only):*

17. For the month of May, 2018, what was the total number of resident census days in your facility? [ ]

Formula: 120 bed facility that had a 90% occupancy in May, 2018 = 3,348 days (120 X 31 days X 90%=3,348)

18. In May 2018, how many LONG-TERM CARE residents were: Male [ ] Female [ ]

19. In May 2018, how many SHORT-TERM (Post-Acute Care) residents were: Male [ ] Female [ ]

20. In May 2018, what was the approximate percentage (%) of residents with the following as their primary payer:

a. Medicare (Part A Skilled) [ ] percent
b. Medicaid [ ] percent
c. Medicare Managed Care [ ] percent
d. Private Pay [ ] percent
e. Managed Care [ ] percent

f. Other percent

Total % 0

21. In May 2018, Approximately what percent of your resident population speaks English as their primary language? percent

a. What percent speak a language other than English?

i. Spanish percent

ii. French or Creole percent

iii. Other (please specify) percent Please specify

Total %

22. In May 2018, Resident ethnic groups: percent

a. European American (White, non-Hispanic) percent

b. Black, African American, or Caribbean percent

c. Hispanic percent

d. Asian percent

e. Native American or Pacific Islander percent

f. Other percent

Total %

Section VI - End of Life Care Information:

23. Does your facility provide Hospice Care? Select...

a. If yes, approximately how many residents receive hospice services in a month? residents

24. Does your facility provide Palliative Care or Comfort Care? Select...

a. If yes, approximately how many residents receive palliative or comfort care services in a month? residents

Section VII: Staffing Information: (FOR THIS SECTION ONLY: Please provide information from 5/1/2018 through 5/31/2018 only):

25. Please complete the chart below:

Position	Total Number Employed	Full-Time Equivalents (FTE's)
ADON		
Additional Administrative RN's (This may include unit coordinators, internal or external case managers, MDS nurses, etc.)		
Staff Education Coordinator - RN		
Staff Education Coordinator – Other		
RN's (Long-term care)		
RN's (Short Term/Post-Acute Care)		
LPN's (Long-term care)		
LPN's (Short Term/Post-Acute Care)		
CNA's (Long-term care)		
CNA's (Short Term/Post-Acute Care)		

26. For the Month of MAY 2018, what were the total number of RN hours worked:

Shift	Long-Term Care	Short Term (Post-Acure Care)

Day		
Evening		
Night		

27. For the Month of MAY 2018, what were the total number of LPN hours worked:

Shift	Long-Term Care	Short Term (Post-Acure Care)
Day		
Evening		
Night		

28. For the Month of MAY 2018, what is the CNA hours worked:

Shift	Long-Term Care	Short Term (Post-Acure Care)
Day		
Evening		
Night		

29. For your Long-Term Care Unit(s), does your staff work (please check one):

Licensed Staff ○ 8 Hours ○ 12 Hours ○ Hybrid

Non-licensed staff (CNA) ◉ 8 hours ○ 12 Hours ○ Hybrid

30. For your Post-Acute Care, does your staff work (please check one):

Licensed Staff ○ 8 Hours ○ 12 Hours ○ Hybrid

Non-licensed staff (CNA) ○ 8 hours ○ 12 Hours ◉ Hybrid

31: Do you a utilize consistent assignment staffing philosophy in your nursing home? (•) Yes ( ) No

Appendix 6 - Pilot 3 Month Look-back Tool Online Form

QI TOOL FOR 3 MONTH LOOK-BACK

Three Month Look-back Entry

Resident Code *
** Required field*

Resident Age

Resident Gender
- ☐ Male
- ☐ Female

Days in Facility:

Original Admission Date: mm/dd/yyyy

Date of Discharge: mm/dd/yyyy

Resident was discharged to: Select…

Original Admission Date: mm/dd/yyyy

Number of Previous Hospitalizations:

Comments:

QI TOOL FOR PROJECT PERIOD

Primary Information

Resident Code *
** Required field*

Resident Age

Resident Gender
- ☐ Male
- ☐ Female

Is this Resident?
- ☐ Long-term care
- ☐ Post-actue care

A. Long-term Care Resident

Most Recent Admission Date: mm/dd/yyyy

Date of Discharge: mm/dd/yyyy

Resident was discharged to: Select…

Original Admission Date: mm/dd/yyyy

Number of Previous Hospitalizations:

If resident was discharged to the hospital, please complete the QI form below:

Section A

Reason for Resident Transfer to Hospital

(Please check all that apply)

- ☐ **911 Emergency** *(please specify)*
  - ☐ True emergency requiring immediate transfer
  - ☐ Exacerbation of existing condition that has become critical
  - ☐ Resident or family member has placed a 911 call
- ☐ This was a planned transfer (e.g. transfusion)
- ☐ Physician preference/insistence
- ☐ Resident preference/insistence
- ☐ Family preference/insistence
- ☐ Other (please describe):

Additional Factors that contributed to the transfer

(Please check all that apply)

- ☐ Advance directives not in place
- ☐ Discharged from the hospital too soon
- ☐ Facility could not provide necessary treatment, equipment or care.
- ☐ Other resources to provide care in the facility were not available (please describe)

(Box opens if checked)

(Box opens if checked)

Is the resident receiving the following type of care?

- [ ] Hospice
- [ ] Comfort measures
- [ ] Palliative
- [ ] None of the above

Actions Taken Prior to Transfer

(Please check all that apply)

Medical Evaluation

- [ ] None
- [ ] Telephone Consultation with medical provider
- [ ] NP or PA Visit
- [ ] Physician Visit
- [ ] RN Consultation
- [ ] Other (please describe)

Testing Done Prior to Transfer

- [ ] None
- [ ] Ultrasound
- [ ] X-ray
- [ ] Blood Work
- [ ] Urinalysis and/or culture
- [ ] Vital Signs
- [ ] EKG
- [ ] Venousdoppler
- [ ] Other (please describe)

Interventions

- [ ] New or Change in Medication
- [ ] Oxygen
- [ ] Counselling/Teaching/Support
- [ ] IV or Subcutaneous Fluids
- [ ] Assessment
- [ ] Other (please describe)
- [ ] Increase Oral Fluids
- [ ] Monitoring

Were Advance Directives in place?

(Please check all that apply)

- [ ] Living Will
- [ ] Healthcare Proxy/Surrogate
- [ ] POLST, MOLST or POST
- [ ] DNR
- [ ] DNH
- [ ] DNI
- [ ] Full code
- [ ] None of the above
- [ ] Other (please describe)

Before transfer were Advance Directives…

(Please check all that apply)

- [ ] Discussed with Resident
- [ ] Discussed with Family
- [ ] Discussed with medical provider
- [ ] Sent to hospital with resident

Was the Transfer...

Discussed with Resident
- [ ] Yes
- [ ] No

If yes, please describe what was discussed:

If not, please select the reasons why not below:

- [ ] Cognitive Incapacity
- [ ] Acute Behavioural Changes
- [ ] Unresponsive
- [ ] Not primary decision maker
- [ ] Resident/Family Request/Preference
- [ ] Other *(Please describe)*

Was the Transfer...

- [ ] Discussed with Family
  - [ ] Yes
  - [ ] No

If yes, please describe what was discussed:

If not, please select the reasons why not below:

- [ ] Unable to reach family
- [ ] Resident requested family not be called
- [ ] No family to contact

	☐ Other *(Please describe)*	

Was the Decision Guide...

(Please check all that apply)

Given to any of the following on Admission

- ☐ Resident
- ☐ Family
- ☐ Designated Caregiver/significant other
- ☐ None of the above

If yes, was there discussion with the resident and/or family about the Guide prior to this change in condition?:

- ☐ Yes
- ☐ No

Please provide a brief summary of the conversation with the resident and/or family and how/why it resulted in transfer to the hospital:

Section B

What was the outcome of the Transfer?

(Please check all that apply)

- ☐ Returned to NH, not admitted
- ☐ Standard hospital admission
- ☐ Admitted under observation status
- ☐ Died in Emergency Department
- ☐ Other (please describe)

If admitted, how long was the Resident in the hospital: ***days***

What was the admitting diagnosis?

- ☐ Acute renal failure
- ☐ Anemia
- ☐ Asthma
- ☐ Cancer
- ☐ CHF *(congestive heart failure)*
- ☐ Cellulitis
- ☐ COPD *(chronic obstructive pulmonary disease)*
- ☐ DVT *(deep vein thrombosis)*
- ☐ Fracture *(Please specify site)*
- ☐ Pneumonia/Respiratory Virus
- ☐ UTI *(Urinary tract infection)*
- ☐ Sepsis
- ☐ Stroke
- ☐ Other (please describe)

Section C

Change in Condition and Other Factors that Contributed to Hospital Transfer

(Please check all that apply)

New or Worsening Symptoms or Signs

- ☐ Abdominal Pain
- ☐ Abnormal vital signs *(low/high BP; high respiratory rate)*
- ☐ Altered mental status
- ☐ Behavioral symptoms *(e.g. Aggression)*
- ☐ Bleeding (other than GI)
- ☐ Cardiac Arrest
- ☐ Chest Pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Edema (new or worsening)
- ☐ Fever
- ☐ Feeding/swallowing difficulty
- ☐ Function decline
- ☐ GI bleeding
- ☐ Loss of consciousness *(syncope)*
- ☐ Nausea/vomiting
- ☐ Pain
- ☐ Respiratory Distress
- ☐ Seizure
- ☐ Skin wound or ulcer
- ☐ Stroke/TIA/CVA
- ☐ Trauma *(fall/accident/fracture)*
- ☐ Unresponsive
- ☐ Urinary Complication
- ☐ Weight loss
- ☐ Other (please describe)

Abnormal Labs or Test Results

- ☐ Blood sugar (high)
- ☐ Blood sugar (low)
- ☐ EKG
- ☐ Hemoglobin or hematocrit
- ☐ INR
- ☐ Kidney function
- ☐ Pulse oximetry
- ☐ Urinalysis or urine culture
- ☐ White blood cell count *(High)*
- ☐ X-ray
- ☐ Other Electrolytes
- ☐ Imaging
- ☐ Other (please describe)

Diagnosis *(or presumed diagnosis)*

- ☐ Acute renal failure
- ☐ Anemia
- ☐ Asthma
- ☐ Cancer
- ☐ CHF *(congestive heart failure)*
- ☐ Cellulitis
- ☐ COPD *(chronic obstructive pulmonary disease)*
- ☐ DVT *(deep vein thrombosis)*
- ☐ Fracture
- ☐ Pneumonia/Respiratory Virus
- ☐ UTI *(Urinary tract infection)*
- ☐ Sepsis
- ☐ Stroke
- ☐ Other (please describe)

Section D

In retrospect, do you think this transfer could have been prevented?

- ☐ Yes. *(Please describe why)*
- ☐ No. *(Please describe why not)*

If Yes, please check all that apply

- ☐ New signs, symptoms, or other change might have been detected earlier
- ☐ Changes in the resident's condition might have been communicated better among facility staff, with physician/NP/PA, or other health care providers
- ☐ The condition might have been managed safely in the facility with available resources
- ☐ Resources were not available to manage the change in condition safely or effectively despite staff willingness to manage in the facility

  (check all that apply) below
  - ☐ On-site primary care clinician
  - ☐ Pharmacy services
  - ☐ Staffing
  - ☐ Lab or other diagnostic tests
  - ☐ Other *(please describe)*
- ☐ Resident and family preferences for hospitalization might have been discussed earlier

- [ ] Advance directives and/or palliative or hospice care might have been put in place earlier
- [ ] Discharged from the hospital and sent to nursing facility too soon
- [ ] Other *(please describe)*

As a result of this review, have you identified any opportunities for improvement?

- [ ] Yes. *(Please describe)*
- [ ] No.

Would more discussion of the information in the Decision Guide have affected the decision to transfer?

- [ ] Yes. *(Please describe why)*
- [ ] No.

Final comments or notes

B. Post-acute Care Resident

Original Admission Date: mm/dd/yyyy
(Related to this post-acute episode)

Date of Discharge: mm/dd/yyyy

Resident was discharged to: Select…

Number of Previous Hospitalizations:
(During this episode)

Section I - Contact Information

1. Your Information

Name		Title (Position)	
Your Email Address		Direct Phone Number	
Nursing Home Name			
Address			
City		State	
Medicare Provider Number		Zip Code	

Section II - Facility Information

1. Total number of beds

2. Do you participate in:

Medicare Select...

Medicaid Select...

3. Does your facility belong to a corporation Select...

a. If yes, name of corporation

b. Approximate number of nursing homes in the corporation

4. Is your facility: ○ For-profit ○ Non-profit ○ Government owned

5. Is your facility operated by ○ The company that owns it ○ Management Company

6. Do you consider your geographic location to be ○ Rural ○ Urban ○ Suburban

7. Does your facility use

○ Electronic Medical (Health) Records

○ Paper Medical Records

○ Combination of both

Which form of the guide are you using? ○ Full Guide ○ Both ○ Trifold

Which of the following formats are you using?

a) Full Paper Guide ○ Colour ○ Black & White

b) Trifold ○ Colour ○ Black & White

c) Electronic

○ Closed circuit TV ○ Tablet

Do you use online programs for staff training? ○ Yes ○ No

Section III - Senior Leadership Team Information:

8. How long has the administrator been at this facility? _____ Years (Use a decimal point if less than 1 year)

9. How long has the Director of Nursing been at this facility? _____ Years (Use a decimal point if less than 1 year)

10. How many **hours per month** is the Medical Director employed or contracted? _____ Hours

Section IV - Medical Provider Information:

11. How many Primary Care Physicians regularly visit residents in your facility? _____

a. On average, how many days per week is at least one primary care physician on site? _____ days per week

12. Does your facility employ a Nurse Practitioner Select...

a. Does your facility contract for Nurse Practitioner services? Select... If yes, how many days per week? _____ days per week

b. Does your facility utilize a nurse practitioner that is employed by your medical director or other physicians? Yes If yes, how many days per week? 5 days per week

13. Does your facility employ a Physician Assistant? Select...

a. Does your facility contract for Physician Assistant services Select... If yes, how many days per week? _____ days per week

Section V - Resident Profile Information

14. In the last month, what was the average number of residents in your facility? _____

What was the average (per cent) occupancy rate? _____ %

What was your hospital transfer rate? _____

15. On average, how many LONG-TERM CARE residents did you have last month: _____

16. On average, how many SHORT-TERM (Post-Acute Care) residents did you have last month: _____

17. In the last month, approximately what percent of your resident population spoke English as their primary language? _____ percent

18. In the last month, what was the ethnic breakdown of your residents: percent

a. European American (White, non-Hispanic) _____ percent

b. Black, African American, or Caribbean _____ percent

c. Hispanic _____ percent

d. Asian _____ percent

e. Native American or Pacific Islander _____ percent

f. Other ____ percent

Total % ____

Section VI - End of Life Care Information:

19. Does your facility provide Hospice Care? Select...

a. If yes, approximately how many residents receive hospice services in a month? ____ residents

20. Does your facility provide Palliative Care? Select...

a. If yes, approximately how many residents receive palliative care services in a month? ____ residents

21. Does your facility provide Comfort Care? Select...

a. If yes, approximately how many residents receive comfort care services in a month? ____ residents

Section VII: Staffing Information

22.

Total number of licensed nurse staff hours per resident per day	
RN hours per resident per day	
LPN/LVN hours per resident per day	

Nurse aide hours per resident per day	
Physical therapist staff hours per resident per day	

BEST PRACTICES
For Implementing the Guide and Trifold

ENGAGING RESIDENTS AND FAMILIES

Preadmission

- Share the Trifold during interview with prospective resident/family

On Admission

- Most facilities provide the Guide on Admission
- Use during discussion of resident's condition and the care you will be providing
- Send the smaller Trifold with monthly bill to reach all family members

Family Meetings and Care Conferences

- Refer to Guide during care conferences
- Family and resident councils & family/social events such as holiday cookouts

Advanced Care Planning/Changes in Level of Care

- Use the Guide to start difficult conversations
- Discuss when change in condition occurs (care you can provide in your facility)
- Discuss when resident and/or family are considering palliative or hospice care

FAQs: Use of the Guide in Your Facility

How can I obtain the materials?

You can purchase the Guides and Trifolds from MED-PASS or download materials from the website www.decisionguide.org to print. Or use them electronically. They are available in English, Spanish, Chinese, Tagalog, French and Creole.

Who should give out the Guide?

Every organization will choose a different approach but most prefer the clinical staff member who will be discussing care and treatment goals during admission and lead care planning conferences with the resident and family.

Should I give the Guide out more than one time?

You should not give multiple copies of the Guide to a resident. Best practice has been using the Trifold only as an introduction before admission or to inform families. The full size Guide should be referenced during ongoing conversations about care. Consider placing it in your admission packet. Most important is to make sure it is kept by the bed of the resident.

We already address admissions back to the hospital, why do I need the Guide?

The Guide is based on research, best practices and lessons learned by many professionals in long term care. It is organized to address why residents and their families should think about this ahead of time, compare nursing home and hospital capabilities, suggest with whom they can discuss this, address end of life care, present FAQs and include quotes from real residents, families and providers. The Guide supports your discussions with residents and families and directly addresses resident and family insistence on a potentially preventable hospitalization.

Is the Guide intended to help reduce transfers to the hospital?

Yes, the intent of the Guide is to help residents and families better understand the options and the capabilities of most skilled nursing facilities. It is a new tool for you to add to your current transfer reduction plan.

STAFF EDUCATION

Facility Leadership Meetings

- Introduce at leadership and staff meetings
- Reinforce use of the Guide during unit-based and facility-wide staff meetings
- Embed the Guide and videos into staff orientation

Quality Improvement

- Use the information in the Guide to assess where you need to improve your efforts to address resident/family insistence on transfer
- Evaluate improvement in resident and family insistence on potentially preventable transfers
- Use in a QAPI project

Procedures & Referral Source

- Involve your Medical Director and all covering providers
- Share with referring hospitals

FAQs: Preparing Your Staff

How should I educate my staff on the Guide?

Most facilities have provided this education in three steps. First, in a leadership meeting discuss how the Guide and Trifold will be integrated into your current system and processes to reduce potentially preventable hospitalizations. Second, present the Guide, its purpose and use, in a general staff meeting. Third, work with your unit, and individual staff members to ensure effective implementation.

Which training materials are best for staff education and ongoing QI?

It is essential to share the Guide with staff and cover the different components of its content. Short training videos are available on YouTube and the website www.decisionguide.org. They are divided into groups based on the target audience: staff or resident/family. The education should be ongoing. Use of the case studies, videos and the Guide itself to address resident and family insistence on transfer should be a part of every facility's QI goals.

Why share the Guide with my referring hospitals and Medical Staff?

Value Driven Healthcare is about being most efficient with the resources used during an episode of care. Avoidable transfers create stress on the resident and increase the cost of care. Hospitals and Providers can collaborate on improving systems and processes to reduce avoidable transfers. Share and use the Guide when participating in readmission meetings with your hospitals and medical staff. Involve them in helping to educate residents and families about the care skilled nursing facilities can provide in managing many changes in condition.

For more information contact:
Florida Atlantic University
Ruth M. Tappen, EdD, RN, FAAN
777 Glades Rd, Boca Raton, FL 33431
Phone: 561-297-2613
Email: rtappen@health.fau.edu
Project Email: nurtappen@health.fau.edu

Appendix 10 - Workshop 3 Month Look-back Tool

3 MONTH LOOK-BACK

Three Month Look-back Entry

Please complete this form ONLY if the resident was transferred to the hospital in the last 3 months

Resident Code
This code is automatically generated

Resident Age

Resident Gender
- ☐ Male
- ☐ Female

Date of hospital transfer: mm/dd/yyyy

Resident Ethnic Group
- ☐ European American (White, non-Hispanic)
- ☐ Black, African American, or Caribbean
- ☐ Hispanic
- ☐ Asian
- ☐ Native American or Pacific Islander
- ☐ Other

Is the Resident
- ☐ Long-term care
- ☐ Post-acute care

Is the Resident on
- ☐ Hospice care
- ☐ Palliative care
- ☐ Comfort measures
- ☐ None of the above

Was the discharge due to resident or family insistence?
- ☐ Yes
- ☐ No

Was the discharge within 30 days of admission to the nursing home?
- ☐ Yes
- ☐ No

Was this a planned transfer?
- ☐ Yes
- ☐ No

Were Advance Directives in place?
- ☐ Yes
- ☐ No

Save (Not complete)

Submit (Complete)

Go to next entry

For Three Month Look-back entries no further information is required, thank you

Appendix 11 - Workshop QI Tool

QI TOOL FOR PROJECT PERIOD

Primary Information

Please complete this form ONLY if the resident was transferred to the hospital

Resident Code
This code is automatically generated

Resident name or internal reference
This will not be visible to the project but is for internal reference only

Resident Age

Resident Gender
- ☐ **Male**
- ☐ **Female**

Is this Resident?
- ☐ **Long-term care**
- ☐ **Post-acute care**

Date of Transfer: mm/dd/yyyy

Was the discharge within 30 days of admission to the nursing home?
- ☐ Yes
- ☐ No

Resident Ethnic Group
- ☐ European American (White, non-Hispanic)
- ☐ Black, African American, or Caribbean
- ☐ Hispanic
- ☐ Asian
- ☐ Native American or Pacific Islander
- ☐ Other

Is the resident receiving:

- ☐ Hospice care
- ☐ Palliative Care
- ☐ Comfort measures
- ☐ None of the above

Section A

Reason for Resident Transfer to Hospital

(Please check all that apply)

- ☐ **911 Emergency** *(please specify)*
  - ☐ True emergency requiring immediate transfer
  - ☐ Resident or family member has placed a 911 call
- ☐ This was a planned transfer (e.g. transfusion)
- ☐ Facility could not provide necessary treatment, equipment or care.
- ☐ Physician request
- ☐ Resident request
- ☐ Family request
- ☐ Other (please describe):

(Box opens if checked)

Section B

Was the Decision Guide given to any of the following on Admission?

(Please check all that apply)

- ☐ Resident
- ☐ Family
- ☐ Designated Caregiver/significant other
- ☐ None of the above

If yes, was there discussion with the resident and/or family about the Guide prior to this change in condition?:

- ☐ Yes
- ☐ No

Please provide a brief summary of the conversation with the resident and/or family and how/why it resulted in transfer to the hospital:

Were Advance Directives in place?

- ☐ **Yes**
- ☐ **No**

Please check any of those below that were in place

- ☐ Full Code
- ☐ DNR
- ☐ DNH
- ☐ DNI
- ☐ POLST, MOLST, POST or similar
- ☐ Living Will
- ☐ Healthcare Proxy/Surrogate form

Before transfer were Advance Directives…

(Please check all that apply)

- ☐ Discussed with Resident
- ☐ Discussed with Family
- ☐ Discussed with medical provider
- ☐ Sent to hospital with resident

Was the Transfer Discussed with Resident?

- ☐ Yes
- ☐ No

If not, please select the reasons why not below:

- ☐ Cognitive Incapacity
- ☐ Acute Behavioral Changes
- ☐ Unresponsive
- ☐ Not primary decision maker
- ☐ Resident/Family Request/Preference
- ☐ Other *(Please describe)*

Was the Transfer Discussed with Family?

- ☐ Yes
- ☐ No

If not, please select the reasons why not below:

- ☐ Unable to reach family
- ☐ No family to contact
- ☐ Resident requested family not be called
- ☐ Other *(Please describe)*

Section C

What was the outcome of the Transfer?

(Please check all that apply)

- ☐ Returned to NH, not admitted
- ☐ Admitted under observation status
- ☐ Standard hospital admission
- ☐ Died in Emergency Department
- ☐ Other (please describe)

Section D

In retrospect, do you think this transfer could have been prevented?

- [ ] Yes. *(Please describe why)*
- [ ] No. *(Please describe why not)*

If Yes, please check all that apply

- [ ] Resident and family preferences for hospitalization might have been discussed earlier
- [ ] Advance directives and/or palliative or hospice care might have been put in place earlier
- [ ] Discharged from the hospital and sent to nursing facility too soon
- [ ] New signs, symptoms, or other change might have been detected earlier
- [ ] Changes in the resident's condition might have been communicated better among facility staff, with physician/NP/PA, or other health care providers
- [ ] The condition might have been managed safely in the facility with available resources
- [ ] Resources were not available to manage the change in condition safely or effectively despite staff willingness to manage in the facility
  (check all that apply)
  - [ ] On-site primary care clinician
  - [ ] Pharmacy services
  - [ ] Staffing
  - [ ] Lab or other diagnostic tests
  - [ ] Other *(please describe)*
- [ ] Other *(please describe)*

Would more discussion of the information in the Decision Guide have affected the decision to transfer?

- [ ] Yes. *(Please describe why)*
- [ ] No.

As a result of this review, have you identified any opportunities for improvement?

☐ Yes. *(Please describe)*

☐ No.

Final comments or notes

Save (Not complete)

Submit (Complete)

Go to next entry

Thank you for completing this form

Appendix 12 - Calls to Individual Nursing Homes Form

Facility Name/State		
Name of NH contact		
Date		
Name of caller		

1	Are you using the Guide? (Yes / No)	
1a	If Yes, have your residents and family members found it helpful? (Yes / No)	
1b	If Yes, in what ways?	
1c	If Not, then why not?	
2	Can you give me an example of how the Guide has helped you prevent a readmission? *(please try to get a story)*	
3a	How many readmissions have you had in the three months PRIOR to using the Guide? *(If the answer is "I don't know" please enter X)*	
	Number:	
3b	How many readmissions have you had in the first three months USING the Guide? *(If the answer is "I don't know" please enter X)*	
	Number:	
	Note: Did you know most facilities so far have seen substantial reductions in readmissions if using the Guide as recommended?	
4a	Are you completing the 3 month Look Back and QI tools online? (Yes / No) *If you are, we can send you a report of your results.*	
4c	If you are not, would you like some technical support to get started? (Yes / No)	

Revised: 5/29/2019

Reducing Readmissions Webinar

A CMS-Supported Project

How to Reduce Avoidable Hospitalizations Due to Resident and Family Insistence Webinar

Welcome!
We would like to thank you for attending our CMS-Supported Webinar
Please take a few minutes to complete our Survey of Webinar Participants

Click the OK Button to start survey

1. Please share your contact information

Name	
Facility Name	
Your title/position	
Email	
Phone	
State	-- select state --
City	
On average, what was your LONG-TERM CARE census last month?	
On average, what was your SHORT-TERM (Post-Acute Care) census last month?	

2. Are you using the Guide?

- ◯ **Yes**
- ◯ **No**

3. If Yes, how have your residents and family members found it helpful?

4. If No, why aren't you using it?

5. **Please give us an example of how using the Guide helped you prevent a readmission?**

6. **How many readmissions did you have in the first three months PRIOR to using the Guide?**

- ◯ **Don't know**
- ◯ **Number of readmissions**

7. **How many readmissions have you had in the first three months SINCE you began using the Guide?**

- ◯ **Don't know**
- ◯ **Number of readmissions**

8. **Are you completing the 3 month Look Back and QI tools online?**

- ◯ **Yes**
- ◯ **If you are unable to complete the online tools, what are the barriers? How can we help?**

9. **If you would like some technical support or other help to get started, what is the best way we can contact you?**

10. **Additional Comments.**

Thank you for completing our survey!

For more information please go to our website
http://decisionguide.org/

If you need to order more materials or have any questions please email:
ftappen@health.fau.edu

Please select END SURVEY to complete

PROGRAM EVALUATION FOR CONTINUING EDUCATION

Program Title: How to Reduce Avoidable Hospitalizations Due to Resident and Family Insistence: A CMS-Supported Project

LOCATION:

Evaluation Analysis (Nursing) May 2019 Range 1 to 4 (Excellent = 4 Good = 3 Fair = 2 Poor = 1)			
Q#	**Question**	**Mean**	**N**
1.	This program enhanced my professional skills and/or knowledge.		
2.	The objectives were related to the overall purpose/goal of the program:		
	The content met the stated objectives: The participant will:		
3.	Provide reasons why there is concern about the occurrence of avoidable hospitalizations of nursing home residents.		
4.	Provide an overview of the CMS Nursing Skilled Facility 30-day All Cause Readmission Measure		
5.	Describe the development of the Resident and Family Decision Guide, Go to the Hospital or Stay Here?		
6.	Describe effective strategies for introducing the Guide to Residents and		
7.	Describe effective strategies for training staff on use of the Guide.		
8.	Presenters: The presenters were effective in conveying information:		
9.	The activity will help me engage patients and families as partners in their		
	Environment:		
10.	The teaching methods (lecture, overheads, video etc.) were effective.		
11.	The information provided was current and accurate as reflected by the		
12.	The time (contact hours) allocated was adequate for the material presented.		
13.	The information presented was at an appropriate educational level.		
14.	The facility (lighting, ventilation, etc.) was conducive to learning.		
		Percent	**N**
16.	Based upon your participation in this activity, do you intend to change your practice behavior? (Select One)		
a)	I do plan to implement changes in my work practice based on the information		
b)	My current work practice has been reinforced by the information presented		
c)	I need more information before I will change my work practice		
17. •	Was the content of this activity fair, balanced, objective and free of commercial bias? (Select one)		
a)	Yes		
b)	No		

Evaluation Analysis (Nursing - Florida)

LOCATION: FLORIDA

PROGRAM EVALUATION FOR CONTINUING EDUCATION

Program Title: How to Reduce Avoidable Hospitalizations Due to Resident and Family Insistence: A CMS-Supported Project

Q#	Question (Range for Responses 1 to 4)	Mean	N
1.	This program enhanced my professional skills and/or knowledge.		
2.	The objectives were related to the overall purpose/goal of the program:		
	The content met the stated objectives: The participant will:		
3.	Provide reasons why there is concern about the occurrence of avoidable hospitalizations of nursing home residents.		
4.	Provide an overview of the CMS Nursing Skilled Facility 30-day All Cause Readmission Measure		
5.	Describe the development of the Resident and Family Decision Guide, Go to the Hospital or Stay Here?		
6.	Describe effective strategies for introducing the Guide to Residents and Families.		
7.	Describe effective strategies for training staff on use of the Guide.		
	Presenters: The presenters were effective in conveying information:		
8.	Dr. Ruth Tappen		
9.	Dr. Debra Hain		
	Other Presenter (please specify name):		
	Environment:		
10.	The teaching methods (lecture, overheads, video etc.) were effective.		
11.	The information provided was current and accurate as reflected by the content.		
12.	The time (contact hours) allocated was adequate for the material presented.		
13.	The information presented was at an appropriate educational level.		
14.	The facility (lighting, ventilation, etc.) was conducive to learning.		
15. Additional Comments and/or Suggestions:			

NATIONAL ASSOCIATION OF LONG TERM CARE ADMINISTRATOR BOARDS

Participant Program Evaluation

Program: How to Reduce Avoidable Hospitalizations Due to Resident and Family Insistence: A CMS-Supported Project

NAB/NCERS Approval Number: 20200129-3.00-A50276

Sponsoring Organization: Florida Atlantic University

Program date: January 30, 2019

Location: Boca Raton, Florida

Scale:

5=Excellent

4=Good

3=Average

2=Needs Improvement

1=Unsatisfactory

Rate the following aspects of the program:

_____ Learning objectives we met

_____ Content material was engaging

_____ Appropriateness of topic and content to long term care

_____ Usefulness of the knowledge/skills acquired

_____Instructor's knowledge of materials/topic

_____Instructor's presentational skill

_____Overall program rating

This program has been approved for Continuing Education by NAB/NCERS. NCERS strives to approve quality programs whose content can reasonably contribute to the professional development of long term care administrators. Should you have any confidential comments concerning this program, please direct

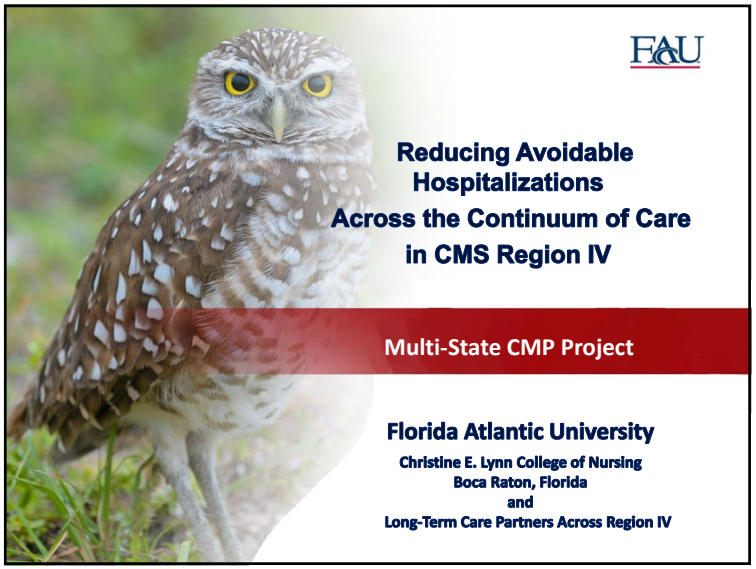
CHRISTINE E. LYNN COLLEGE OF NURSING
FLORIDA ATLANTIC UNIVERSITY

WELCOME

- For CEU credit be sure to **sign in** at the Registration Desk before the workshop starts, complete and hand in the EVALUATION at the end of the workshop. **Sign out** at the end of the workshop.
- Connect your cellphone to the WIFI: Brookland Banquet Password: FAU
- Download the **Poll Everywhere App** from your app store to your cellphone if you want to participate in the presentation. Enter **ruthtappen962** in the username input to join the presentation. Go to the app store to find it.

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

1



Reducing Avoidable Hospitalizations Across the Continuum of Care in CMS Region IV

Multi-State CMP Project

Florida Atlantic University
Christine E. Lynn College of Nursing
Boca Raton, Florida
and
Long-Term Care Partners Across Region IV

2

FLORIDA ATLANTIC UNIVERSITY

FOR CEU CREDIT

- Be sure to SIGN-IN and remember to SIGN-OUT at the end of the Workshop.
- Enter ALL information on registration forms.
- Make sure your LICENSE NUMBERS are accurate and complete

Making Waves

3

FLORIDA ATLANTIC UNIVERSITY

Disclaimer

The developers and presenters of this workshop have no conflicts of interest to declare.

Making Waves

4

CHRISTINE E. LYNN COLLEGE OF NURSING
FLORIDA ATLANTIC UNIVERSITY

- 1. Alabama
- 2. Florida
- 3. Georgia
- 4. Kentucky
- 5. Mississippi
- 6. North Carolina
- 7. South Carolina
- 8. Tennessee

CMS Region IV Initiative

5

FLORIDA ATLANTIC UNIVERSITY

Project Team

- Ruth M. Tappen
- Debra Hain
- Karen Southard
- Lesley Decker
- Russell Crisp
- Armiel Suriaga
- Sarah Worch
- Linda Carr
- Osmay Cardoso

Making Waves

6

Presenter

Ruth M. Tappen, Ed.D., R.N., F.A.A.N
Principal Investigator
Christine E. Lynn Eminent Scholar in Nursing & Professor
Florida Atlantic University, College of Nursing
Boca Raton, FL

7

Presenter

Debra J Hain,
PhD, ARNP, AGPCNP-BC, FAANP, FNKF
Professor
MSN Coordinator: AGNP Concentration
Blake Distinguished Professor
Christine E Lynn College of Nursing

8

Presenter

Karen Southard, RN, BS, MHA

Acting State Program Director for South Carolina

The Carolinas Center for Medical Excellence

9

FLORIDA ATLANTIC UNIVERSITY

Presenter

Beth Hercher
QI Advisor
Qsource QIN-QIO

Making Waves

10

FLORIDA ATLANTIC UNIVERSITY

Presenter

Jennifer Judson RN BSN
Special Innovation Project Lead
Palliative Care

Making Waves

11

FLORIDA ATLANTIC UNIVERSITY

Presenter

Leighann Sauls
State Program Director for North Carolina
Alliant Quality QIN-QIO

Making Waves

12

FLORIDA ATLANTIC UNIVERSITY

Presenter

Sarah Sutherland RT (R) MBA

Q Source QIN-QIO

Making Waves

13

FLORIDA ATLANTIC UNIVERSITY

Now Let's Find Out Who Is In Our Audience

Please Go To Your
Poll Everywhere App

Making Waves

14

WHO IS OUR AUDIENCE?

- Nursing Home Administrators
- Nursing Administration//Management
- Medical Provider (MD, DO, NP, PA)
- Other Nursing Home Professionals and Staff
- Long Term Care Partners (State Agency, Ombudsmen, and so forth)

Poll Everywhere — Start the presentation to see live content. Still no live content? Install the app or get help at PollEv.com/app

15

CHRISTINE E. LYNN COLLEGE OF NURSING
FLORIDA ATLANTIC UNIVERSITY

Learning Objectives

- Provide an overview of current CMS Value-based Programs
- Discuss avoidable and unavoidable transfers that result in admission
- Discuss the evidence behind the Decision Guide
- Describe effective strategies to implement the Decision Guide
- Evaluate the effectiveness of the Guide

16

CHRISTINE E. LYNN COLLEGE OF NURSING
FLORIDA ATLANTIC UNIVERSITY

SNF VBP Program

The Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM) is used in the SNF VBP Program. The SNFRM estimates the risk-standardized rate of unplanned hospital readmissions within 30 days for:

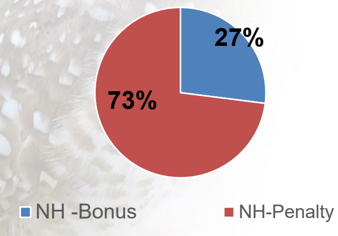
People with fee-for-service Medicare who had been inpatients at PPS, critical access, or psychiatric hospitals.

Any cause or condition.

17

CHRISTINE E. LYNN COLLEGE OF NURSING
FLORIDA ATLANTIC UNIVERSITY

2018 CMS NH Readmission Program



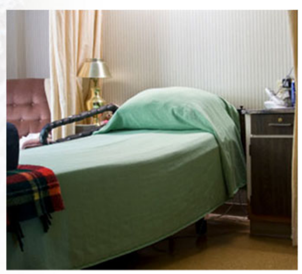
NH National Performance Year 1

kwwsv=22zzz1prghuqkhdowkfduh1frp2duwlfoh2534;445;2QHZV24;445<<63

18

CHRISTINE E. LYNN COLLEGE OF NURSING
FLORIDA ATLANTIC UNIVERSITY

- Loss of Medicare revenue
- Potential penalty up to 2%
- Publicly reported on CMS Nursing Home Compare
- Potential loss of market share
- Reputation



What does a Readmission to the Hospital Cost You?

19

CHRISTINE E. LYNN COLLEGE OF NURSING
FLORIDA ATLANTIC UNIVERSITY

- Unnecessary tests
- Potential for Hospital Acquired Infection
- Delirium
- Loss of ADLs
- Pressure Ulcers
- Falls
- Malnutrition
- Death

The Effect of Frequent Transfers to the Hospital on the Resident

20

CHRISTINE E. LYNN COLLEGE OF NURSING
FLORIDA ATLANTIC UNIVERSITY

Readmission rates decline when hospitals develop skilled nursing facility networks

September 5, 2017, Columbia University's Mailman School of Public Health

HEALTH

Medicare cuts payments to nursing homes whose patients keep ending up in the hospital

By Jordan Rau Kaiser Health News Dec 4, 2018

Impact of Change: Everyone is in the Game

21

CHRISTINE E. LYNN COLLEGE OF NURSING
FLORIDA ATLANTIC UNIVERSITY

- Staff or facility cannot provide the care that is needed
- Fear of litigation
- Failure to properly communication to the physician
- **Resident or family insist**

Why Do Nursing Homes Send Patients to the Hospital?

22

CHRISTINE E. LYNN COLLEGE OF NURSING
FLORIDA ATLANTIC UNIVERSITY

Are Readmissions a Top Priority in Your Facility?

Poll Everywhere

23

ARE READMISSIONS A PRIORITY IN YOUR FACILITY?

YES

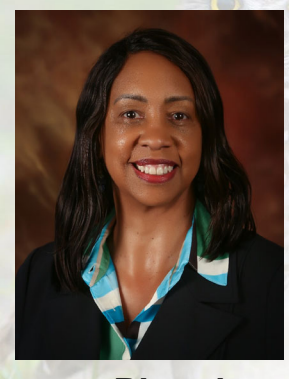
NO

NOT SURE

Poll Everywhere Start the presentation to see live content. Still no live content? Install the app or get help at PollEv.com/app

24

CHRISTINE E. LYNN COLLEGE OF NURSING
FLORIDA ATLANTIC UNIVERSITY



"Having the conversation early during a resident's admission and allowing them to make their wishes known helps to avoid crisis transfers to the hospital"

Planning Ahead For Care Decisions

25

CHRISTINE E. LYNN COLLEGE OF NURSING
FLORIDA ATLANTIC UNIVERSITY

Introducing…

the Guide

"Should I Go to the Hospital or Stay"

26

FLORIDA ATLANTIC UNIVERSITY

Guide Development: PCORI Study Findings

271 People in LTC were interviewed:

- 96 residents (75% long stay and 25% short stay)
- 75 family members
- 100 providers (staff, medical providers)

Making Waves

27

FLORIDA ATLANTIC UNIVERSITY

Lessons Learned

- Short-stay individuals want to be called patients
- Long-stay individuals want to be called residents
- Advance care planning terminology unfamiliar to them unless they'd been involved personally in these decisions
- Few references to dying with dignity: no residents, no staff, only 5 family members mentioned this

Making Waves

28

FLORIDA ATLANTIC UNIVERSITY

Lessons Learned (cont)

- 77% of residents had not thought about this before
- 50% of family and staff had not thought about this before

Making Waves

29

FLORIDA ATLANTIC UNIVERSITY

Lessons Learned: Preferences

How many preferred, other things being equal, to remain in the NH vs be transferred to the hospital:

- Residents evenly divided into three groups: remain in NH, go to hospital, depends on severity
- Families either chose remain in NH or be transferred
- Staff overwhelmingly preferred remain in NH
- No ethnic group or religious differences found

Making Waves

30

FLORIDA ATLANTIC UNIVERSITY

Three Family and Resident Decision Styles

- Deliberative
  - Talk with others
- Emotional
  - Based on feelings
- Delegated
  - Turned over to son, daughter, trusted provider

Making Waves

31

FLORIDA ATLANTIC UNIVERSITY

FEATURES

Formatting:

Large print

Increased number of pages

Colorful

Attracts attention, easier to find amid resident room clutter

Address as Adults

No cartoons, used photos taken in South Florida NHs

Making Waves

32

FLORIDA ATLANTIC UNIVERSITY

Features (cont)

- Begin with necessary information
  - The “nice” information, such as the quotes, are at the end
- Watch reading level
  - Currently is 5th grade but some long words were kept
- Accommodate differences in decision styles
  - e.g. the decision tree vs. narrative

Making Waves

33

FLORIDA ATLANTIC UNIVERSITY

Residents’ Positive and Negative Comments about NHs

Positive	Negative
Familiar	Under Staffed
Comfortable	Under Equipped
Personal Knowing	Occasionally rough handling
Responsive	Rude CNA’s

Making Waves

34

FLORIDA ATLANTIC UNIVERSITY

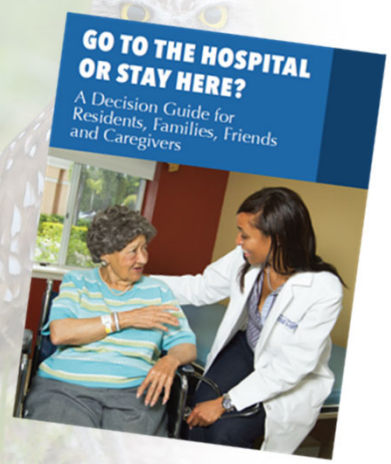
Positive and Negative comments about Hospital Stays

Positive	Negative
Better Staffed	Impersonal
Better Equipped	High Risk (especially infection)
Doctors Available	Don’t Listen
Test Results Quickly Available	

Making Waves

35

FLORIDA ATLANTIC UNIVERSITY



Making Waves

36

37

Šl#z dqwwr eh
involved 100%."
(Patient)

"We do our
best to keep
them here. We
gr whvwv iluvw#
the proper
assessment,
diagnostic tests,
z kdwhyhu z h
can do here
ehiruh z h
z rxog wudqvihu
to the hospital."
(Nurse)

1

Did you know that almost half of transfers to the hospital may be avoidable?

This Guide will help you understand why these transfers are made and how you can be involved in the decision.

CHANGE IN CONDITION

The question of sending you to the hospital or keeping you here may come up if your condition changes. This change could be a fever, shortness of breath, pain, an injury from a fall, or other change in your condition. If this happens, your medical provider has the responsibility to explain the change and the decisions that may need to be made to provide you the best possible treatment.

WHY THINK ABOUT THIS NOW?

This information is being provided to you so that you can make an informed decision if the question of going to the hospital arises.

Lw fdq eh gliilfxow wr z hljk wkh surv dqg frqv ri d wudqvihu wr wkh krvslwdoz khq |rx ehfrp h loruwr ghflgh z kdwwuhdwp hqw you prefer in the middle of a crisis.

IF IT IS NOT AN EMERGENCY

Liwklvlvqrwdq hp hujhqf|/wkh qxuvh z looodvvhvv |rxu frqglwlrq=

- Dvn |rx z kdwkdsshqhg/krz |rx ihho/z khuh lw#kxuwv
- Listen to your heart and lungs
- Take your temperature, blood pressure, oxygen level
- Test your blood and urine

You can ask for the results and tell the nurse if you think your doctor, family, a friend or caregiver need to be called. If you have concerns about going to the hospital, this is the time to express them.

IN AN EMERGENCY

In a life threatening situation, the staff may call 911 to transport |rx wr wkh krvslwdo hp hujhqf| ghsduwp hqw uljkw dz d| xqohvv |rx kdyh jlyhq wkhp d G r Q rw K rvslwdol}h uhtxhvw1 Wkh| z loo also call your doctor or other medical provider (such as nurse practitioner or physician assistant) and a family member, friend or caregiver. You have the right to tell the staff ahead of time z kr |rx z dqw fdoohg lq dq hp hujhqf|1

38

"It depends on
z kdw lv jrlqj
on, the severity
of the illness.
Give me a run
grz q rq z kdw
the hospital can
do for me and
z kdw wkh| fdq
do for me here."
(Patient)

ŠL#grqŴz dqwwr
push the panic
button and send
her to a hospital
if it can be kept
under control
here." (Son)

2

REASONS TO PREFER BEING TREATED HERE

P dq| whvwv dqg wuhdwp hqwv fdq eh surylghg lq wkh qxuvlqj krp h=

- Medications
- X-rays
- Blood tests
- Oxygen
- Wound care
- Checking on you and reporting to your doctor or other medical provider
- F rp iruw fduh +sdlq uholhi/径xlgv/ehg uhvw,
- LY +lqwudyhqrxv, ioxlgv lq vrp h idflolwlhv
- Physical or Occupational Therapy
- Speech Therapy

\rx fdq dvn |rxu qxuvh/grfwru ru rwkhu p hglfdo surylghu z kdw else can be done for you here.

REASONS TO PREFER BEING TREATED IN THE HOSPITAL

Hospitals can provide more complex tests and treatments lqfoxglqj=

- Heart monitoring
- Body scans
- Intensive care
- Blood transfusion
- Surgery

THERE ARE ALSO RISKS TO GOING TO THE HOSPITAL

Being transported to the hospital can be stressful. You are likely to have to explain your concerns to nurses and doctors you gr qrw nqrz 1 \rx duh dovr dw juhdwhu ulvn iru vnlq euhdngrz q/ exposure to infections or falling in an unfamiliar place. You may feel more comfortable staying here and being cared for e| vwdii z kr nqrz |rx1 \rx vkrxog fduhixoo| frqvlghu doo idfwruv z khq p dnlqj |rxu ghflvlrq1

39

"They (resident
and family)
can only make
an informed
decision if they
have all the
information."
(Doctor)

3

BEING INVOLVED IN THE DECISION

\rx kdyh wkh uljkw wr nqrz z kdw lv kdsshqlqj wr |rx/z kdw wuhdwp hqw#duh dydlodeoh/wkh ulvnv dqg ehqhilwv ri wkhvh wuhdwp hqw/krz ghflvlrqv derxw |rxu fduh duh ehlqj p dgh dqg krz |rx duh lqyroyhg lq p dnlqj wkhp 1

\rx p d| z dqw wr wdon wr wkh iroorz lqj shrsoh derxw |rxu fkrlfhv=

- Nurses
- Doctors and other medical providers
- Vrfldo z runhuv
- Spiritual advisor
- Family members
- Close friends
- Caregivers

Wkhvh duh yhu| shuvrqdo ghflvlrqv1 LwŴv xs wr |rx z kr |rx wdon wr dqg z krvh rslqlrqv |rx uhvshfw1

\rx fdq p dnh |rxu suhihuhqfhv nqrz q e|=

- Wdonlqj z lwk wkh shrsoh dwwhg deryh
- Sxwwlqj |rxu z lvkhv lq z ulwlqj dqg whoolqj shrsoh z khuh the documents can be found
- F rp sohwlqj dgydqfh gluhfwlyh grfxp hqwv lqfoxglqj=
  - Srz hu ri dwwruqh| iru khdowk fduh
  - Health care proxy (naming someone to make health care decisions for you if you cannot)
  - Olylqj z loo +vshflilhv |rxu suhihuhqfhv iru hqg ri#olih care)
  - Uhtxhvw iru d G Q U +gr qrw uhvxvflwdwh, wr doorz d natural death or DNH (do not hospitalize) order
  - Physician Orders for Life Sustaining Treatment
  - (POLST), Medical Orders for Life Sustaining Treatment (MOLST), or similar form that is accepted in your state

WHAT CAN WE DO TO HELP YOU WITH THIS PROCESS?

Li |rx wkloo kdyh txhvwlrqv/sohdvh dvn |rxu qxuvh/vrfldo z runhu/grfwru/ qxuvh sudfwlwlrqhu ru sk|vlfldq#dvvlvwdqw wr wdon z lwk |rx1 Wkh| p d| uhfrp p hqg rwkhuv wdon z lwk |rx dv z hoo/vxfk dv d dnjdodgylvru1

40

INFORMATION FOR FAMILY, FRIENDS AND CAREGIVERS OF RESIDENTS WHO CANNOT EXPRESS THEIR WISHES

"I usually ask khu/z kdwgr |rx think? I explain and go over hyhu|wklqj z lwk her." (Husband)

"Letting the idp lo| nqrz / making sure wkh| duh dz duh of the tests being done, the results, ghilqlwho| khosv#z lwk#wkh decisions. Her z hoo0ehlqj lv my primary concern." (Sister)

1. **How can the resident participate in the decision about transfer to the hospital?**

   The resident's wishes always need to be respected. Alternate forms of communication should be considered.

   If the resident has an advance directive that appoints someone as the health care proxy or durable power of attorney, that person may make decisions for the resident based on what the resident would want if able to express his/her wishes. Advance directives should also be consulted.

2. **If the resident cannot express his or her wishes, should we still tell him or her what is happening?**

   Yes. The resident has the right to know what is happening and should be treated as if he/she understands the situation. Some people may become anxious or frightened if they are moved to an unfamiliar place without explanation. Be sure to use simple, direct words ("You are sick", "Your doctor thinks you should go to the hospital"), a quiet voice and a calm manner when explaining the situation to the resident.

3. **How can I (as a family member, friend, or caregiver) be involved in the decision?**

   You may need to complete some legal forms to do this. Ask your doctor, other medical provider or the social worker here for more detailed information. It's best to do this before a question about treatment or hospital transfer comes up.

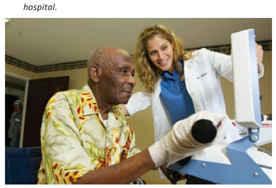
FAQs (Frequently Asked Questions)

ABOUT TRANSFERS TO THE HOSPITAL

1. **What is a "medical provider"?**
   Your medical provider may be a physician (MD), doctor of osteopathy (DO), nurse practitioner (NP) or physician assistant (PA).
2. **Why would my doctor or other medical provider consider sending me to a hospital?**
   If you experience an injury or a serious change in condition, your medical provider may recommend you go to a hospital for treatment.
3. **When would staying here be the best choice for me?**
   If we are able to provide the care you need, then staying here may be the best choice.
4. **What kind of care can be provided here?**
   This varies from one facility to another but most are able to give you medications by mouth or injection, IV (intravenous) fluids except blood transfusions, order common lab tests and x-rays, and make periodic checks on your condition.
5. **What other reasons would I have for preferring to be cared for here?**
   There are several reasons. The staff and routines are familiar to you. The staff already know you, your health history and your needs and there is less disruption to your routine if you stay here. The transfer itself may be tiring, even stressful for you. You may be at greater risk for complications in the hospital.
6. **When would going to a hospital be the best choice for me?**
   Hospitals have more equipment and staff than nursing homes. They can do more complex lab tests, x-rays and scans, monitor your condition more closely, give blood transfusions and do complex procedures such as surgery.

FAQs (Frequently Asked Questions) *continued*

7. **What is a hospitalist?**
   Hospitalists are doctors who have specialized in providing hospital care. In many hospitals, it will be a hospitalist that will oversee your care, not your primary care provider.
8. **Who will make the final decision as to whether I should be sent to a hospital or stay here?**
   If you are able, you may make the final decision. Consulting with your medical providers, family and friends may help you make a sound decision.
9. **How much say do I have in making this decision?**
   Person-centered care requires that you decide if you are able. People differ in terms of how much information they want and how much of a say they want to have. If for some reason you decide you want to be transferred or stay here against the advice of your medical provider and nurses, you may be asked to sign a form taking responsibiity for your decision.
10. **What happens if it's an emergency?**
    If 911 is called, you will receive on-the-spot treatment from the EMTs (ambulance crew) and then be sent to the nearest hospital.



FAQs (Frequently Asked Questions) *continued*

11. **Can I request a certain hospital?**
    You may make this request but in an emergency, the EMTs will take you to the closest hospital if it can provide the care you need. If it is not an emergency and your preferred hospital is close by, they may be able to take you there.
12. **Will my family, friends, or caregiver know where I am? Will they know what is happening to me?**
    Sometimes during a 911 emergency, there isn't time to call family members, friends or caregivers until you are on your way to the hospital. You can ask that they be called as soon as possible. Both your medical provider and nursing home staff have a responsibility to keep them informed. Make sure the staff know in advance who you want contacted and how to reach them.
13. **Will I be able to continue receiving physical, occupational, or speech therapy if I go to the hospital?**
    That depends on why you are going to the hospital and how sick you are. If therapy has to be discontinued, it will begin again when you are ready.
14. **Will I return here after I am discharged from the hospital?**
    In most cases, you will return here but in some instances going to a rehabilitation hospital, assisted living facility, a different nursing home or even going home may be the better choice for you.
15. **Will the facility hold my room for me while I'm in the hospital?**
    Most of the time, the nursing home will hold your room for several days. But these policies vary so you should ask someone at the nursing home what their policy is and how it will affect you.
16. **What happens to my personal belongings if I am transferred to the hospital?**
    Your personal belongings can be stored for you here.
17. **Why are we talking about this now?**
    It is difficult to carefully consider options and your personal preferences in the midst of a crisis, such as being sick enough to be sent to the hospital. You may be upset, worried, or feeling too bad to talk about your preferences with your medical provider and your family, friends or caregiver at that time.

FAQs (Frequently Asked Questions) *continued*

"It's my lungs. There's nothing they can do for me any more so Lz rxog udwkhu vwd| khuh z khuh wkh| nqrz p h and I can be comfortable. Lw#z rxog eh different if, z khq wkh| z huh ilqlvkhg/wkh| could say 'you can get up out of that chair and go to the ball'. But that is not going to happen." (Patient)

8

18. Why is this decision so important?

There are several reasons why this decision is important. Sometimes residents, their family members, friends or caregivers become very anxious when a resident becomes ill and ask that the person be sent to the hospital when treatment could be provided here. There are some risks and discomfort associated with being sent to the hospital. The transfer itself, a new environment, new staff and new routines can be sources of discomfort. The risks include falls, skin breakdown (pressure sores) and more exposure to potentially dangerous infections. Both the transfer and hospital care are very expensive. Some of these expenses may not be covered by your insurance. You may want to ask about this so that you can consider this information in making your decision.

COMFORT CARE, PALLIATIVE CARE, AND HOSPICE CARE AS WELL AS ADVANCE DIRECTIVES

1. What is the difference between hospice and palliative care?

Hospice care and palliative care are similar but hospice care is intended for those who are in the final months of their life (usually 6 months or less) while palliative care can continue for many months, even years. hospice care focuses on pain control, symptom management, emotional and spiritual support.

2. What is "comfort care"?

Comfort care or palliative care focuses on easing pain and other symptoms such as nausea, fatigue, depression, breathing problems, constipation or diarrhea that are the result of your illness or the treatment of your illness. Palliative care teams also help you cope with your illness, providing practical solutions, emotional and spiritual care. The goal is to preserve your peace, comfort and dignity as much as possible.

3. What happens if I am getting hospice care when I go to the hospital?

If you go to the hospital, you may have to re-qualify for hospice after returning here. If there is time, hospice should be called before you are transferred to the hospital.

45

4. What are advance directives? Should I have them?

Advance directives are documents that tell your health care providers what kind of care you want to receive if you are unable to be involved in the decision. You can say you don't want certain treatments such as CPR (resuscitation) if your heart stops, to be put on a breathing machine if you can't breathe on your own, or if you want a feeding tube if you cannot eat. You can also state that you want all the treatment available if that is your preference. You can designate someone to make decisions for you if you cannot (or do not want to) do it yourself.

5. If I have advance directives, will my wishes be honored?

To make sure that your wishes are honored, review them with the staff, your family, a friend, or care provider ahead of time. Be sure a copy is on your chart at the hospital and available here as well. It's a good idea to give copies of your advance directives to your family, a friend, or caregiver and medical care provider ahead of time. You can update your advance directives at any time.

6. Once I have expressed my wishes in advance directives, can I change my mind?

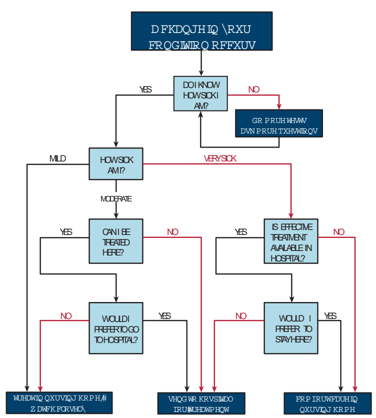
Yes, you can change your mind and your advance directives at any time. If you want to change your advance directives, tell your care provider, family, friend or caregiver what changes you would like to make.

9

46

Decision Tree

GO TO THE HOSPITAL OR STAY HERE?



47

Continuing the Conversation...

What Residents Say About Going to the Hospital or Staying in the Nursing Home When a Change in Condition Occurs

11

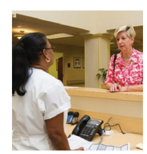
ŠLp dnh p | rz q ghflvlrqv1Ldp fdsdeoh dw wklv srlqw dqg grqŴw need anybody else."

"I listen to the doctor, listen to the nurses and then I come to my rz q ghflvlrqĭ

ŠP | vrq dqg wkuhh gdxjkwhuv z rxog khos p h p dnh wkh ghflvlrq1 Z h z rxog wdon lw#ryhuĭ

ŠLz rxog ohdyh lw wr wkh shrsoh z kr z run khuh/p | grfwruv dqg wkh qxuvhv1Wkh| nqrz p ruh derxw lw wkdq Lgr1Wkh| mxvw whoo p h li I have to go."

ŠLkdyh kdg lqvwdqfhv z khq Lkdyh vwd|hg khuh dqg rwkhuv z khq L qhhghg wr jr wr wkh krvslwdo1Lz rxog udwkhu vwd| khuh1Lkdyh ehhq kdss| khuh dqg ehhq wuhdwhg yhu| z hooĭ



48

12

What the Families Say about Going to the Hospital or Staying in the Nursing Home When a Change in Condition Occurs

ŠWklv zrxog eh vrphwklqj zh zrxog glvfxvv1 Li L wkrxjkw vkh qhhghg wr jr wr wkh krvslwdo/ li vkh zrxog jhw wkh ehvw wuhdwphqw there, I am more likely to recommend it to her.” (Daughter)

ŠQr rqh zdqww wr vhh d sduhqw lq wkh krvslwdoÙ lwuhdoo| wuhvvhv p h rxwexwLuhdol}hg vkh zdv lq jrrg kdqgv1 Vkh zdv lq lqwhqvlyh fduh exwfdp h rxwdqg lv edfn wr qrup doqrz 1Ś +Vrq,

ŠL wklqn idp lolhv vkrxog nqrz zkdw lv kdsshqlqj/ wkdw lv yhu| lp sruwdqw1 L zdqw wr eh lq wkh orrs1 Wkh p rvw lp sruwdqw wklqj wr p h lv wkh krqhvw| ri wkh vwdii/ wkhp ehlqj dyhoz lwk p h derxw wkh problem. Then I could make the correct decision. He has to be frp iruwdeoh z lwk wkh ghflvlrq1Ś +Z lih,

ŠOrug nqrzv/ zkdwhyhu wkh| wklqn wkh| fdq fxuh/ wkdw zrxog eh alright.” (Husband)

ŠLi lwz dv fdqfhu z khuh wkhuh lv qr fxuh/ wkhq qr txhvwlrq z h z rxog z dqw krvslfh wr frp h khuh1 Exw li lwz dv d vhulrxv lqihfwlrq L wklqn he should go to the hospital to be treated.” (Wife)

ŠL zdqw wr eh ixoo| lqyroyhg lq wkh ghflvlrq/ z dqw wr nqrz doo wkh facts. Absolutely.” (Brother)

ŠP | eurwkhu kdv srz hu ri dwwruqh| exw z h#doop dnh wkh ghflvlrqv concerning him together.” (Daughter)

ŠL#z rxog z dqw wr nqrz krz vhulrxv lw#lv dqg z kdw rxwfrp h lv h{shfwhg1Ś +Olihorqj iulhqg z kr lv khdowk fduh vxuurjdwh,

ŠLi lw z dv mxvw p lqru/ wkhq wkh qxuvlqj krp h fdq wdnh fduh ri lw1 Here they can do oral antibiotics, things like that. Depends on z kdw lw lv1Ś +Vwhsgdxjkwhu,

ŠL#z rxog glvfxvv lw#z lwk p | kxvedqg exw L dp p ruh lqyroyhg ehfdxvh L dp khuh hyhu| gd|1Ś +G dxjkwhu0lq0odz ,

49

What Care Providers Say About Going to the Hospital or Staying in the Nursing Home When a Change in Condition Occurs

13

“We try treating the patient in the facility prior to transfer. We whoo wkh sdwlhqw/ Ñz h can take care of this khuh iru qrz1 Exw z h kdyh wr z dwfk lw dqg li it’s not getting better, z h z loovhqg |rx wr wkh hospital’.” (Doctor)

ŠP rvw orqj whup uhvlghqwv z dqw wr eh lqyroyhg lq wkh ghflvlrq because they prefer to be treated here. Rehab patients, too, if they are making good progress.” (Nurse)

ŠP rvw idp lolhv z dqw wr kdyh d yrlfh1 Sdwlhqwv/ wrr/ li wkh| fdq1Ś (Doctor)

“Some families are very involved; others just leave it to the facility dqg wkh grfwru exw z dqw wr eh nhsw lqirup hg1Ś +Q xuvh,

“The doctor is usually the gatekeeper.” (Administrator)

ŠVrp hwlp hv z h vd| |rx qhhg wr jr dqg wkh| vd| qr Ù wkdw lv wkhlu fkrlfh1Wkh| kdyh d uljkw wr lqvlvw rq z kdw wkh| ihho lv ehvw diwhu |rx have explained it to them, reassured them.” (Nurse)

ŠWkh ehqhilw ri wkhp vwd|lqj khuh lv wkdw wkh| nqrz wkh vwdii1Ś +Q xuvh,

“It’s about the resident. I prefer they be treated here if possible. We try to respect their preferences, get the doctors involved and the idp lo| dv z hoo1Ś +Dgp lqlvwudwru,

ŠWkh| p ljkw eh p ruh frp iruwdeoh khuh1 Exw li z h fdqÚw p dqdjh wkh sdlq ru li wkh| qhhg vrp h gldjqrvwlf whvw ru surfhgxuh z h fdqÚw gr khuh/ wkh| wuxo| qhhg wr jr wr wkh krvslwdo1Ś +Vrfldo z runhu,

50

Funding for development of original Guide provided by Patient-Centered Outcomes Research Institute (PCORI).
Funding for this updated Guide provided by the Eight States of CMS Region IV (Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee)

Visit z z z 1ghflvlrqjxlgh1ruj Version 2.0

FAU
FLORIDA ATLANTIC UNIVERSITY

51

CHRISTINE E. LYNN COLLEGE OF NURSING
FLORIDA ATLANTIC UNIVERSITY

A Resident’s Thoughts on the Guide Book: Video

52

FLORIDA ATLANTIC UNIVERSITY

Reducing Avoidable Hospitalizations Across the Continuum of Care in CMS Region IV

Phase I

- Develop training materials
- Pilot materials and Guide implementation in 16 NHs

Phase II

- Conduct 20 workshops in CMS Region IV
- Evaluate outcomes of using the Guide
- Evaluate the Project and report to the eight states of Region IV

Making Waves

53

CHRISTINE E. LYNN COLLEGE OF NURSING
FLORIDA ATLANTIC UNIVERSITY

Region IV Pilot Results

- 100% distributed the Guide to residents and families
- 95% residents and families found it helpful
- 75% read it several times
- 50% shared it with other families and friends

54

FLORIDA ATLANTIC UNIVERSITY

One of the Pilot Homes told us….

"We are very focused on educating our residents and families about the care we can provide and choices they have. The Guide supplements the conversations we have during admissions"

Mississippi Pilot Home

Making Waves

55

CHRISTINE E. LYNN COLLEGE OF NURSING
FLORIDA ATLANTIC UNIVERSITY

Pilot: Impact on Avoidable Transfers

- Facilities who used the Guide consistently in conversations with the residents and families during admission and care plan meetings reported increased questions regarding the level of care they can provide
- Several homes with robust, integrated readmission reduction programs found use of the Guide helped improve their readmission rates
- The Guide is an essential element of a comprehensive system-wide readmission reduction program

56

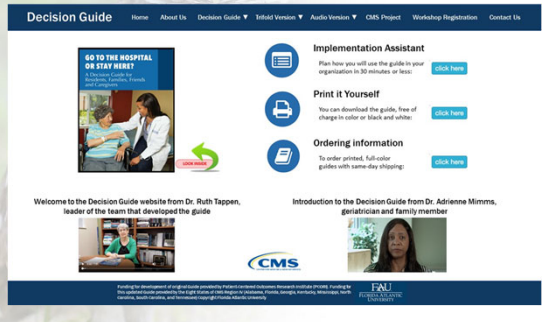
CHRISTINE E. LYNN COLLEGE OF NURSING
FLORIDA ATLANTIC UNIVERSITY

Program Materials

57

CHRISTINE E. LYNN COLLEGE OF NURSING
FLORIDA ATLANTIC UNIVERSITY

www.decisionguide.org



The Project Website

58

FLORIDA ATLANTIC UNIVERSITY

Getting Started

First Steps:

- Meet with your leadership team
- Provide facility-wide staff preparation
- Monitor and reinforce at unit and team level
- Embed in orientation

Making Waves

59

CHRISTINE E. LYNN COLLEGE OF NURSING
FLORIDA ATLANTIC UNIVERSITY

- Review the Guide and plan when it will be introduced to the Resident and Family
- Highlight how your facility is working to prevent avoidable transfers and readmissions to the hospital
- Review some recent transfers that could have been prevented-use a training video to emphasize learning
- Use a case study to engage staff in the discussion

Educating Staff In 30 Minutes

60

CHRISTINE E. LYNN COLLEGE OF NURSING
FLORIDA ATLANTIC UNIVERSITY

Sample Case Study

Incorporating Avoidable Admission/Readmission into Staff Education

61

FLORIDA ATLANTIC UNIVERSITY

Case Studies

- Case Study 1. Anxious Post Acute Resident (C. Difficile)
- Case Study 2. Concerned Resident with Abdominal Tenderness
- Case Study 3. Resident with Probable Pneumonia
- Case Study 4. No Advance Directives

Making Waves

62

CHRISTINE E. LYNN COLLEGE OF NURSING
FLORIDA ATLANTIC UNIVERSITY

Decision Guide Video Menu 1/3

1. The Usefulness of the Guide 2:26

Dr Adrienne Mimms Dr Adrienne Mimms shares her perspective as a gerontologist and the family member of a nursing home resident.
Suitable for Residents, Family and NH Professionals

2. An Introduction from the Project Director 3:06

Dr Ruth Tappen describes the development of the Decision Guide
Suitable for Residents, Family and NH Professionals

3. A Testimonial from a Nursing Home Resident 1:54

Paul, a rehab center resident talks about how the Guide and better information could have helped avoid an unnecessary hospital transfer.
Suitable for Residents, Family and NH Professionals

4. Introduction for a new Resident and Family Member 6:01

A new resident and a family member are introduced to the Guide
And others

63

CHRISTINE E. LYNN COLLEGE OF NURSING
FLORIDA ATLANTIC UNIVERSITY

Decision Guide Video Menu 2/3

5. Teaming with Resident to Prevent Hospitalization 1:49

A resident's change in condition that can be managed in the nursing home. (Pneumonia)
Suitable for training NH staff in handling and educating residents on the Guide

6. Engaging the Resident and Family in the Plan of Care 3:43

Resident and family learn how following the recommended diet can prevent another hospitalization. (Salty Fish)
Suitable for training NH staff in handling and educating residents on the Guide

7. Managing an upset resident 3:16

How not to do it and how to get it right.
(Including a resident calling 911.)
Suitable for training NH staff in handling and educating residents on the Guide

8. The Decision Guide for a Resident in Palliative Care 4:01

Offering Options: Speaking to a resident on palliative care about the Guide
Suitable for training NH staff in handling and educating residents on the Guide

64

CHRISTINE E. LYNN COLLEGE OF NURSING
FLORIDA ATLANTIC UNIVERSITY

Decision Guide Video Menu 3/3

9. The Decision Guide for a Resident in Hospice Care 3:10

A Social Worker and Hospice Nurse explain issue of hospitalization when the resident is in hospice care.
Suitable for training NH staff in handling and educating residents on the Guide

10. The Decision Guide in Printed Form 1:39

A Social Worker gives the Guide to a short-term rehab resident in printed form.
Suitable for training NH staff in handling and educating residents on the Guide

11. The Decision Guide in Tablet Form 2:16

A Social Worker gives the Guide to a short-term rehab resident in tablet form.
Suitable for training NH staff in handling and educating residents on the Guide

12. When Hospitalization is Recommended 3:21

A resident experiences a change in condition that would best be managed in a hospital.
Suitable for training NH staff in decision making with regard to hospitalization

65

FLORIDA ATLANTIC UNIVERSITY

Where Can You Find the Videos?

1. In your packet you will find a CD with all 12 videos.
2. You Tube: search for *Decision Guide.*
3. They will be posted on our website under project training materials shortly.

Making Waves

66

CHRISTINE E. LYNN COLLEGE OF NURSING
FLORIDA ATLANTIC UNIVERSITY

Second Step: Start Using the Guide

Engaging Residents and Families in the Guide

67

CHRISTINE E. LYNN COLLEGE OF NURSING
FLORIDA ATLANTIC UNIVERSITY

- The value of communication- listening, assessing and comforting
- Distressed Residents can be very insistent

How the Guide can Help Improve Quality of Care in Your Facility: Distressed Resident Video

68

CHRISTINE E. LYNN COLLEGE OF NURSING
FLORIDA ATLANTIC UNIVERSITY

- Encouraging residents to care for themselves and make good decisions helps avoid complications and prevent hospitalizations
- Respecting resident choice but offering alternatives so they can enjoy what matters to them
- Engaging with residents to understand what is important in their life

Partners in Planning Care: Salt Fish Video

69

CHRISTINE E. LYNN COLLEGE OF NURSING
FLORIDA ATLANTIC UNIVERSITY

Map out your Process, consider at least 3-4 opportunities to use the Guide in conversations with Residents and Families.

Polling: Pick the ways you might use the Guide:

- 1. Admission process
- 2. Interview with prospective residents and families
- 3. Family care plan meeting
- 4. Advance directive conversation
- 5. When a patient's condition is changing

Engaging Residents and Families in Using the Guide

70

Pick the ways you might use the Guide.

Admission Process	A
Interview with perspective residents and families	B
Family care plan meeting	C
Advanced directive conversation	D
When a patient's condition is changing	E

Poll Everywhere — Start the presentation to see live content. Still no live content? Install the app or get help at PollEv.com/app

71

CHRISTINE E. LYNN COLLEGE OF NURSING
FLORIDA ATLANTIC UNIVERSITY

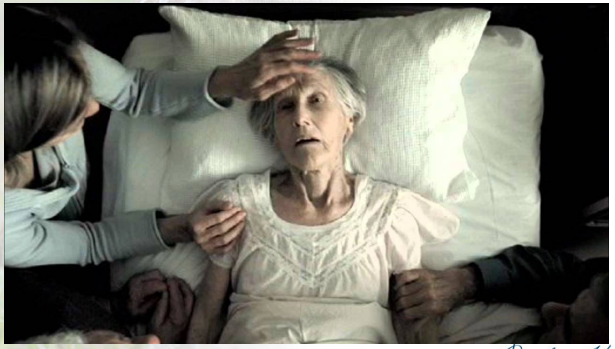
- Advanced Care Planning
- Palliative Care
- Hospice

Resident looks for Reassurance and Information about Care Options: Palliative Care Video

72

FLORIDA ATLANTIC UNIVERSITY

Handling Difficult Discussions



Making Waves

73

FLORIDA ATLANTIC UNIVERSITY

Family Case Study

- Mrs. Miller was an 99 year old female resident of a LTC facility. She had a history of dementia, heart failure, osteoarthritis and hypertension
- One day she becomes lethargic and more confused
- After assessing the resident, the NP called her son to discuss next steps
- Her son wants her to go to the hospital despite multiple efforts to change his mind and consider hospice care. "I want her to live to 100"
- She was transferred to the hospital and one week later returned with multiple pressure wounds and a substantial decline in her health
- Two days later she died

Making Waves

74

FLORIDA ATLANTIC UNIVERSITY

Ask, Tell, Ask

- Can help healthcare professionals tailor information or advice to what families and residents want to hear
  - **Ask** what they know and what they want to know
  - **Tell** them what they want to know
  - **Ask** if they understand and what else they want to know

Making Waves

75

FLORIDA ATLANTIC UNIVERSITY

Ask

- Permission to have the conversation
- Understanding of their loved ones condition
- What they hope to accomplish/what their loved one would want

Making Waves

76

FLORIDA ATLANTIC UNIVERSITY

Tell

- Simple information that the person wants to know about their loved ones' condition
- Share information that the healthcare provider (i.e. physician, nurse practitioner) wants them to know such as treatment options
- Use language they can understand (limit medical jargon)

Making Waves

77

FLORIDA ATLANTIC UNIVERSITY

ASK

- Confirm understanding by having them repeat back what was said in their own words
- If they have any questions or if they want to know anything else

Making Waves

78

FLORIDA ATLANTIC UNIVERSITY

Could the story be different?

Healthcare professional	Family
Would it be okay if we discuss your mother's health condition?	Yes it would
What do you know about your mother's health condition?	I know she has dementia but she is not that bad
Ok let's go over your mother's health condition	Ok
People with dementia can have a sudden change in their mental status and this can make them confused. Often it is caused by infection which I think your mother has. We would prefer to treat her here because people her age do better here with medications we can give. Can you tell us what we can do when there is a change in condition?	Well you can give medicine here or send them to the hospital

79

FLORIDA ATLANTIC UNIVERSITY

Healthcare professional	Family
That is correct, can you tell me what your mother would want?	She does not like hospitals so I guess stay here
Would you like for me to tell you what we can do about her condition?	Yes, I don't want anything too bad to happen to my mother
We will give her antibiotics, monitor her condition and make her comfortable	Ok
Is there anything else you want to know? We know she didn't want to go to the hospital so if she does not get better with in 24-48 hours after the antibiotics , we can contact you and discuss other options that fit with your mothers wishes Of course we will contact you if there are any changes	What happens if she gets worse? Ok, but I want to know if there are any changes

80

FLORIDA ATLANTIC UNIVERSITY

Mom Has Altered Mental Status

Daughter tells other family members mom's condition has changed and wants to know if she should have the nursing home staff send her to the hospital

Family members in another city reply "oh come on mom was fine two weeks ago when we saw her"

What should you do?

Making Waves

81

FLORIDA ATLANTIC UNIVERSITY

Recognizing and Responding to Emotion

Daughter "I can't believe this is happening to my mother. I am worried she needs to go to the hospital"

Acronym NURSE	Statement
N Name the emotion	I can see that you are worried about your mother
U Understanding the emotion	This must be difficult to hear especially when you are so far away
R Respect	I know you want to do the best for your mother
S Support	I am here to support you so we will do the best thing for your mother
E Explore the emotion	Can you tell me what you think is best for your mother

Making Waves

82

FLORIDA ATLANTIC UNIVERSITY

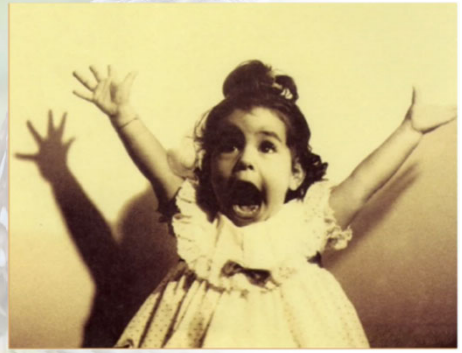
Think outside the box……

Use of technology to improve Communication

Making Waves

83

CHRISTINE E. LYNN COLLEGE OF NURSING
FLORIDA ATLANTIC UNIVERSITY



Data Collection

84

CHRISTINE E. LYNN COLLEGE OF NURSING
FLORIDA ATLANTIC UNIVERSITY

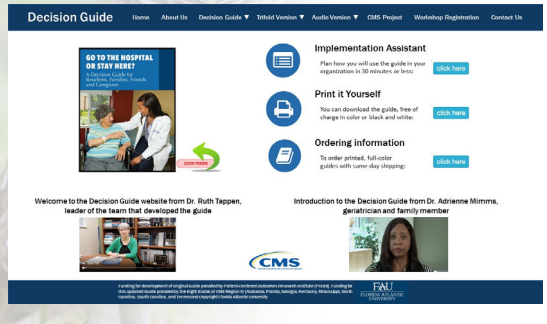
- It helps you understand how to better achieve your hospital transfer reduction goals
- You can identify and trend common elements that trigger avoidable transfers
- Your own data can be used to review your transfer pattern and identify opportunities for improvement
- The data helps us further refine and enhance the tools you need to support these goals

Why Data Matters

85

CHRISTINE E. LYNN COLLEGE OF NURSING
FLORIDA ATLANTIC UNIVERSITY

Go to the decisionguide.org website and register



Getting Started

86

CHRISTINE E. LYNN COLLEGE OF NURSING
FLORIDA ATLANTIC UNIVERSITY

7 Sections- best completed by DON or NHA
Contact Information

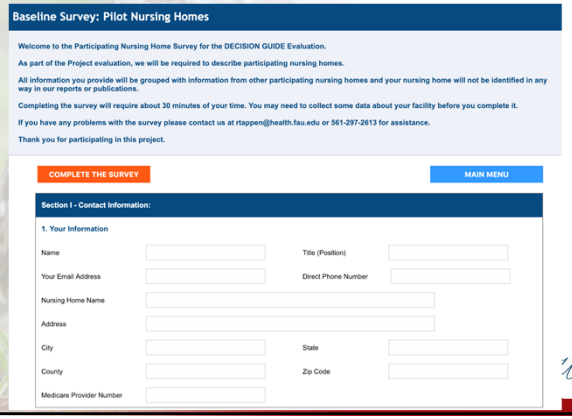
- Facility characteristics
- Senior Leadership Information
- Medical Provider Information
- Resident Profile Information
- End of Life Care Information
- Staffing Information

Step I. Complete the Baseline Survey

87

FLORIDA ATLANTIC UNIVERSITY

Baseline Survey



88

FLORIDA ATLANTIC UNIVERSITY

Baseline Survey

Section II - Facility Information:

2. Total number of certified beds

3. Do you participate in: Medicare Select... Medicaid Select... Dually Certified Select...

4. Does your facility belong to a corporation Select...

a. If yes, name of corporation

b. Aproximate number of nursing homes in the corporation

5. Is your facility: For-profit Non-profit Government owned

6. Is your facility operated by The company that owns it Management Company

7. Do you consider your geographic location to be Rural Urban Suburban

8. Does your facility use Electronic Medical (Health) Records / Paper Medical Records / Combination of both

89

FLORIDA ATLANTIC UNIVERSITY

Baseline Survey

9. Which form of the guide are you using? Full Guide Both Trifold

10. Which of the following formats are you using? Full Guide Both Trifold

11. Which of the following formats are you using?

a) Full Paper Guide Colour Black & White

b) Trifold Colour Black & White

c) Electronic Closed circuit TV Tablet

12. Do you use a staffing agency for employee shortages? Select...

Section III - Senior Leadership Team Information:

13. How long has the administrator been at this facility? Years (Use a decimal point if less than 1 year)

14. How long has the Director of Nursing been at this facility? Years (Use a decimal point if less than 1 year)

15. How many hours per month is the Medical Director employed or contracted? Hours

90

FLORIDA ATLANTIC UNIVERSITY

Baseline Survey

Section IV - Medical Provider Information:

16. How many Primary Care Physicians regularly visit residents in your facility?

a. On average, how many days per week is at least one primary care physician on site? days per week

17. Does your facility employ a Nurse Practitioner Select...

a. Does your facility contract for Nurse Practitioner services? Select...

b. Does your facility utilize a nurse practitioner that is employed by your medical director or other physicians? Select...

18. Does your facility employ a Physician Assistant? Select...

a. Does your facility contract for Physician Assistant services Select...

Making Waves

91

FLORIDA ATLANTIC UNIVERSITY

Baseline Survey

Section V - Resident Profile Information

19. In the last month, what was the average number of residents in your facility?

What was the average (per cent) occupancy rate? %

What was your 30 day hospital readmission rate last month?

What was your all-cause hospital readmission rate last month?

20. On average, how many LONG-TERM CARE residents did you have last month:

21. On average, how many SHORT-TERM (Post-Acute Care) residents did you have last month:

22. In the last month, approximately what percent of your resident population spoke English as their primary language? percent

23. In the last month, what was the ethnic breakdown of your residents: percent

a. European American (White, non-Hispanic) percent

b. Black, African American, or Caribbean percent

c. Hispanic percent

d. Asian percent

e. Native American or Pacific Islander percent

f. Other percent

Total %

92

FLORIDA ATLANTIC UNIVERSITY

Baseline Survey

Section VI - End of Life Care Information:

23. Does your facility provide Hospice Care? Select...

a. If yes, approximately how many residents receive hospice services in a month? residents

24. Does your facility provide Palliative Care? Select...

a. If yes, approximately how many residents receive palliative care services in a month? residents

25. Does your facility provide Comfort Care? Select...

a. If yes, approximately how many residents receive confort care services in a month? residents

Section VII: Staffing Information:

26. Please complete the chart below:

Total number of licensed nurse staff hours per resident per day	Total Number Employed
RN hours per resident per day	
LPN/LVN hours per resident per day	
Nurse aide hours per resident per day	
Physical therapist staff hours per resident per day	

93

CHRISTINE E. LYNN COLLEGE OF NURSING
FLORIDA ATLANTIC UNIVERSITY

Captures your previous 3 months transfers for comparison purposes

Three Month Look-back Entry

Resident Code [Control]

Original Admission Date: [Control] mm/dd/yyyy

Date of the Discharge: [Control] mm/dd/yyyy

Resident was discharge To: [Control]

Number of Previous Hospitalizations: [Control]

Comments:

[Control]

Step 2. The 3 Month Look Back Tool

94

FLORIDA ATLANTIC UNIVERSITY

Three-month Look-back

Three Month Look-back Entry

Please complete this form ONLY if the resident was transferred to the hospital in the last 3 months

Resident Code

Facility Reference Code or Name (for facility use only)

Resident Age

Resident Gender: Male / Female

Date of hospital transfer

Resident Ethnic Group: Select...

Is the Resident? Long-term care / Post-acute care

Is the Resident on Hospice care / Comfort measures / Palliative care / None of the above

Was the discharge due to resident or family insistence? Yes / No

Was the discharge within 30 days of admission to the nursing home? Yes / No

Was this a planned transfer? Yes / No

Were Advance Directives in place? Yes / No

Save (Not complete)

Submit (Complete)

Go to next entry

95

CHRISTINE E. LYNN COLLEGE OF NURSING
FLORIDA ATLANTIC UNIVERSITY

- Captures characteristics of the resident prior to the transfer
- Addresses discussions held, interventions attempted
- Focuses on Reason for transfer
- Looks at outcome of the transfer
- Provides for Internal analysis of the transfer

"We found this to be concise and easy to use- the information gave us a deeper look into where we could improve" NC Pilot Home

Step 3. Quality Improvement Tool

96

FLORIDA ATLANTIC UNIVERSITY

QI Tool

Primary Information

Please complete this form ONLY if the resident was transferred to the hospital

Resident Code
This code is automatically generated

Facility Reference Code or Name
(for facility use only)

Resident Age ____ years

Resident Gender
- Male
- Female

Resident Ethnic Group
- European American (White, non-Hispanic)
- Asian
- Black, African American, or Caribbean
- Native American or Pacific Islander
- Hispanic
- Other

Is the resident receiving:
- Hospice
- Comfort measures
- Palliative
- None of the above

Is this Resident?
- Long-term care
- Post-acute care

Date of Transfer ____ mm/dd/yyyy

Was the discharge within 30 days of admission to the nursing home?
- Yes
- No

Making Waves

97

FLORIDA ATLANTIC UNIVERSITY

QI Tool

Section A

Reason for Resident Transfer to Hospital:

(Please check all that apply)

- **911 Emergency** (please specify)
  - True emergency requiring immediate transfer
  - Resident or family member has placed a 911 call
- This was a planned transfer (e.g. transfusion)
- Facility could not provide necessary treatment, equipment or care

Additional Factors that contributed to the transfer
(Please check all that apply)
- Physician Request
- Resident Request
- Family Request
- Other:

Making Waves

98

FLORIDA ATLANTIC UNIVERSITY

QI Tool

Section B

Was the Decision Guide given to any of the following on Admission?
- Resident
- Family
- Designated Caregiver/significant other
- None of the above

If yes, was there discussion with the resident and/or family about the Guide prior to this change in condition?: Yes No

Please provide a brief summary of the conversation with the resident and/or family and how/why it resulted in transfer to the hospital:

Were Advance Directives in place? Yes No

Please check any of those below that were in place
- Full code
- POLST, MOLST or POST
- DNR
- Living Will
- DNH
- Healthcare Proxy/Surrogate
- DNI

Before transfer were Advance Directives...
(Please check all that apply)
- Discussed with Resident
- Discussed with medical provider
- Discussed with Family
- Sent to hospital with resident

Making Waves

99

FLORIDA ATLANTIC UNIVERSITY

QI Tool

Was the Transfer discussed with Resident Yes No

If not, please select the reasons why not below:
- Cognitive Incapacity
- Not primary decision maker
- Acute Behavioural Changes
- Resident/Family Request/Preference
- Unresponsive
- Other (please describe)

Was the Transfer discussed with Family Yes No

If not, please select the reasons why not below:
- Unable to reach family
- No family to contact
- Resident requested family not be called
- Other (please describe)

Section C

What was the outcome of the Transfer? (Please check all that apply)
- Returned to NH, not admitted
- Admitted under observation status
- Standard hospital admission
- Died in Emergency Department
- Other (please describe)

Making Waves

100

FLORIDA ATLANTIC UNIVERSITY

QI Tool

Section D

In retrospect, do you think this transfer could have been prevented?

- ○ Yes, please describe why
- ○ No, please describe why not

if yes, please check all that apply:

- ☐ Resident and family preferences for hospitalization might have been discussed earlier
- ☐ Advance directives and/or palliative or hospice care might have been put in place earlier
- ☐ Discharged from the hospital too soon
- ☐ New sign, symptom, or other change might have been detected earlier
- ☐ Changes in the resident's condition might have been communicated better among facility staff, with physician/NP/OA, or other health care providers
- ☐ The condition might have been managed safely in the facility with available resources
- ☐ Resources were not available to manage the change in condition safely or effectively despite staff willing to manage in the facility (check all that apply)
  - ☐ On-site primary care clinician
  - ☐ Pharmacy services
  - ☐ Staffing
  - ☐ Lab or other diagnostic tests
  - ☐ Other (describe)
- ☐ Other (describe)

101

FLORIDA ATLANTIC UNIVERSITY

QI Tool

Would more discussion of the information in the Decision Guide have affected the decision to transfer?

- ○ Yes, please describe
- ○ No

As a result of this review, have you identified any opportunities for improvement?

- ○ Yes, please describe
- ○ No

Final comments or notes

Save (Not complete)

Submit (Complete)

Go to next entry

LOG OUT

102

CHRISTINE E. LYNN COLLEGE OF NURSING
FLORIDA ATLANTIC UNIVERSITY

"Should I Go to the Hospital or Stay"

Integrating the Guide into Your System Processes

103

CHRISTINE E. LYNN COLLEGE OF NURSING
FLORIDA ATLANTIC UNIVERSITY

When the Guide is Helpful

- Admission (Provide the Guide)
- Prior to Admission and/or with Billing (Trifold)
- Family Care Plan Meeting (Discuss the Guide)
- During Advanced Care Plan meeting (Discuss the Guide)

104

CHRISTINE E. LYNN COLLEGE OF NURSING
FLORIDA ATLANTIC UNIVERSITY

Everyone can help prevent a Readmission!

- Embed the Guide in your discussion about readmissions- early recognition of change in resident condition
- Use of the Guide aligns with Stop and Watch and Change in Condition
- Also consider using the Guide with the Advanced Care Plan Tracker

105

CHRISTINE E. LYNN COLLEGE OF NURSING
FLORIDA ATLANTIC UNIVERSITY

Approximately what percentage of your transfers in the last year were due to family insistence?

- 75% or more
- 50-74%
- 25-73%
- 10-24%
- Less than 10%

Let's Take One More Poll

106

Approximately what percentage of your transfers in the last year were due to family insistence?

75% or more
50% - 74%
25% - 49%
10% - 24%
Less than 10%

Poll Everywhere — Start the presentation to see live content. Still no live content? Install the app or get help at PollEv.com/app

107

CHRISTINE E. LYNN COLLEGE OF NURSING
FLORIDA ATLANTIC UNIVERSITY

Dc#Dgp lwlrqv2Uhdgp lwlrqv#lq#qrw#Suhyhqwdeoh

The goal is not to avoid the necessary transfers, but to...

- Educate staff on the level of care that can be provided
- Use your data to show avoidable transfers and opportunities to improve
- Enhance assessment and communication among members of the care team
- Educate and assure residents and families that you can provide care when condition changes
- Assist residents and families in planning for advanced illness

108

CHRISTINE E. LYNN COLLEGE OF NURSING
FLORIDA ATLANTIC UNIVERSITY

The Guide is a written tool to use in conjunction with your other discussions and strategies to prevent avoidable transfers

The Medical Director and clinical staff need to be engaged in the Guide implementation and continued use

The facilities who took the time to embed the Guide into their readmission improvement program reported more favorable results

Some facilities had a presentation to families and residents during council meetings or family social events, found them very successful

Many put the Trifold into the monthly bill

More Lessons Learned from the Pilot NHs

109

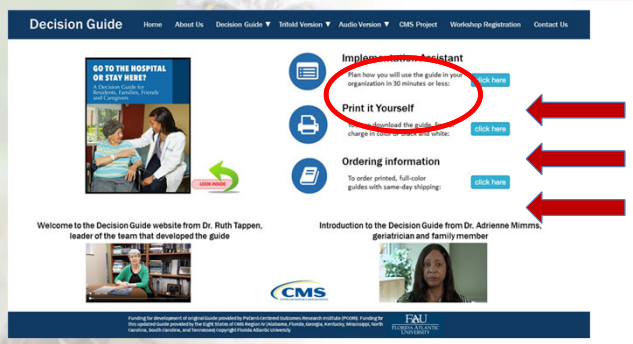
CHRISTINE E. LYNN COLLEGE OF NURSING
FLORIDA ATLANTIC UNIVERSITY

Also consider.....

- Resident trust in staff- Do they know me here?
- Many families think we are still rest homes!
- Hospitals can point fingers for readmissions- need to partner and improve care coordination
- Families have lots of questions that are not always asked. Use Ask-Tell-Ask

110

CHRISTINE E. LYNN COLLEGE OF NURSING
FLORIDA ATLANTIC UNIVERSITY



Implementation Assistant: Summary of Best Practices

111

CHRISTINE E. LYNN COLLEGE OF NURSING
FLORIDA ATLANTIC UNIVERSITY

Staff Leadership Meeting

- Introduce at leadership meeting
- Unit-based and facility-wide staff meetings
- Embed into orientation

Quality Improvement

- Use the information in the Guide to assess where you need to improve your measures to address resident/family insistence on transfer
- Evaluate improvement in resident and family insistence on potentially preventable transfers

Procedures & Referral Sources

- Involve your Medical Director and all covering providers
- Share with referring hospitals

Staff Education

112

CHRISTINE E. LYNN COLLEGE OF NURSING
FLORIDA ATLANTIC UNIVERSITY

How should I educate my staff on the Guide?

- Most facilities have provided the education in 3 ways:
  - First, during a leadership team meeting discuss how the value of The Guide will be used.
  - Second, with the clinical staff during staff meetings on unit to educate them on the contents, process of when to use The Guide and the value it brings to your current processes.
  - Third, in a general staff meeting because it is important that everyone understand how avoidable these transfers can be prevented.
- The Guide pairs well if you are using the STOP and WATCH or Change in Condition INTERACT tools.

FAQs - Staff Education

113

CHRISTINE E. LYNN COLLEGE OF NURSING
FLORIDA ATLANTIC UNIVERSITY

Which training materials are best for staff education and ongoing QI?

- It is essential to share the Guide with staff and cover the different components of the content.
- Short Training videos are available on You Tube or the website www.decisionguide.org and are divided into recommended groups based on the target audience.
- The education should be ongoing and use of the case studies and videos to address resident and family insistence on transfer should be a part of every facility's QI goal.

FAQs - Staff Education

114

CHRISTINE E. LYNN COLLEGE OF NURSING
FLORIDA ATLANTIC UNIVERSITY

Why share the Guide with my referring hospitals and Medical Staff?

- Value Driven Healthcare is about being most efficient with the resources used during an episode of care.
- Avoidable transfers create stress on the resident and increase the cost of care.
- Hospitals and Providers collaborate on improving systems and processes to reduce avoidable transfers.
- Share and use the Guide when participating in readmission meetings with your hospitals and Medical Staff. Involve them in helping to educate residents and families about the care skilled nursing facilities can provide in managing many changes of condition.

FAQs - Staff Education

115

CHRISTINE E. LYNN COLLEGE OF NURSING
FLORIDA ATLANTIC UNIVERSITY

Preadmission
- Interview with prospective resident/family (Trifold)

Admission
- During discussions about the resident's condition and care you will be providing (the Guide)
- To reach all families, send the Trifold with monthly bill

Family Care Meetings
- Care conference goal setting (the Guide)
- Family and resident councils & facility events

Advanced Care Planning
Changes in Level of Care
- Discuss when change in condition occurs (what can you provide in your facility?)
- Discuss when resident placed on palliative or hospice care

Family and Resident Intervention

116

CHRISTINE E. LYNN COLLEGE OF NURSING
FLORIDA ATLANTIC UNIVERSITY

How can I obtain the materials?

- You can purchase them from Med-Pass or download materials from the website www.decisionguide.org to print or use electronically.

Who should give out the Guide?

- Every organization will choose a different approach but most prefer the clinical staff member who will be discussing the care and treatment goals during admission and lead care planning conferences with the resident and family.

FAQs:Family and Resident Intervention

117

CHRISTINE E. LYNN COLLEGE OF NURSING
FLORIDA ATLANTIC UNIVERSITY

Should I give the Guide out more than one time?

- You should not give multiple copies of the Guide to a resident.
- Best practice has been using the trifold only as an introduction before admission or helping to inform families.
- However the Guide should be referenced during ongoing conversations about care.
- Consider placing it in an admission packet.
- Most important is to make sure it is kept by the bed of a resident.

FAQs:Family and Resident Intervention

118

CHRISTINE E. LYNN COLLEGE OF NURSING
FLORIDA ATLANTIC UNIVERSITY

We already cover admissions back to the hospital with our resident and family education, why do I need the Guide?

- The Guide is based on research, best practices and lessons learned by many professionals in long term care.
- It is organized to address why residents and their families should think about this ahead of time, compare nursing home and hospital capabilities, suggest with whom they can discuss this, address end of life care, present FAQs and include quotes from real residents, families and providers.
- The Guide supports your discussions with residents and families and directly addresses resident and family insistence on a potentially preventable hospitalization.

FAQs:Family and Resident Intervention

119

CHRISTINE E. LYNN COLLEGE OF NURSING
FLORIDA ATLANTIC UNIVERSITY

Is the Guide intended to help reduce transfers to the hospital?

- Yes, the intent of the Guide is to help residents and families better understand the options and the capabilities of most skilled nursing facilities.
- It is a new tool for you to use to minimize potentially avoidable hospitalizations.

FAQs: Family and Resident Intervention

120


FAU
Thank You
Florida Atlantic University
Christine E. Lynn College of Nursing
Boca Raton, Florida
rtappen@health.fau.edu

Appendix 17 - Total Workshop Attendance

Workshop Attendance					
Date	**Location**	**Administrators Credit**	**Nurses Credit**	**Others Non-Credit**	**Total Head Count ***
30-Jan	Boca Raton, FL	21	40	9	77
7-Feb	Plant City, FL	12	31	12	61
8-Feb	Jacksonville, FL	22	23	11	42
10-Feb	Alpharetta, GA	**	**	**	82
28-Feb	Greenville, SC	13	3	4	21
1-Mar	West Columbia, SC	10	8	9	29
5-Mar	Jackson, TN	19	34	11	66
6-Mar	Nashville, TN	14	30	9	56
7-Mar	Morristown, TN	18	22	6	46
14-Mar	Macon, GA	0	3	1	7
15-Mar	Savannah, GA	5	8	3	17
21-Mar	Jackson, MS	6	22	9	39
22-Mar	Oxford, MS	20	33	6	59
4-Apr	Birmingham, AL	24	48	4	65
5-Apr	Montgomery, AL	18	39	2	54
10-Apr	Louisville, KY	23	29	12	61
11-Apr	Kentucky Dam Village, KY	5	15	7	26
23-Apr	Rocky Mount, NC	47	72	20	128
24-Apr	Thomasville, NC	36	99	17	143
25-Apr	Cullowhee, NC	10	36	7	45
TOTALS		**323**	**595**	**159**	**1124**

* Please note that some people did not sign in, others signed in but did not need continuing education credit and still others signed for both administration and nursing so these figures cannot be summed across the columns

** 118 people scanned electronically, only 82 people allowed in room, Nursing and Administrator are not determinable because Georgia Health Care Assoc provided credit.

5/20/2019

Appendix 18 - CMS Advisory Committee Meeting Minutes

December 2017 Meeting Minutes:

- Is technology in nursing homes (NH) going to be an issue to show the videos?
- Do nursing homes have wifi? Yes 90% of them do.
- Should we have DVD or YouTube for the nursing homes? DVD costs $, we can embed the YouTube video on their websites
- Video
- Pilot nursing home selection criteria:
    - For and not for profit
    - Rural and urban
    - Chair independent
- New regulations begin Nov 28th: quality of life and NH residents' rights
- May want to amend the Guide (DNR vs DNH)
- Send a link that explains DNR and DNH
- Edits to the Guide on pg. 4: where it targets one disease is a concern, other diseases should be mentioned
- Edit to page 9: Advance Directives, resident choice, honored
- Admissions packet to include trifold
- Use in all settings across continuum of care (hospital, hospice & health)

January 2018 Meeting Minutes:

- Discussion of changes to the Guide since the first Advisory Committee Meeting in December:
    1. Title Change to reflect support from other than family members (i.e. friends and caregivers)
    2. Change of disease specific section to "Info for residents who cannot express their wishes"
    3. Added speaking to a legal advisor in addition to providers, family, friends and caregivers.
- Preferred terminology to use for nursing home? Are facilities referring to themselves more as nursing facility? Stephanie Davis says the term everyone using is nursing home.
- Preferred terminology ER or ED? ED used more. A suggestion of "hospital emergency department" to differentiate from Urgent Care Clinics.
- Emphasis on resident and right of the resident's involvement in the decision.
- Focus on person-centered care, resident rights. A discussion of new requirements and regulations for person-centered care.
- Some of the quotes: was not sure of the rationale for being in the Decision Guide. Could they be reframed as "conversation starters"?
- The Guide was discussed with the Advisory Group and they liked the quotes because stakeholders can identify with the information. They should stay in the Guide. Could explore transitioning into this section using a different title such as "conversation starters".

- Discussion of the 30 day threshold for returning to a skilled provider versus going back to the hospital post discharge, i.e. “don’t have to start all over in the system”.
- Summed up going to the hospital if an acute intervention is
- needed versus back to a skilled facility.
- The Decision Tree is well liked. Someone suggested providing instructions for using it. Suggestion to keep it simple, no more instructions.
- There’s a January 18th deadline for providing comments on the Guide for those who could not attend the meeting.

February 2018 Meeting Minutes:

- Going over the Guide for edits: POLST is described, but MOLST should be included as well and described
- On page 2 add speech therapy
- On page 7 FAQs #13 add speech therapy
- On the photo page, take out the nametag of the therapist
- Page 1 change in condition “medical provider?” “care provider?” choose
- Page 5 Question #5 period is missing
- Page 6 question #7 hospitalist, primary care, medical provider, personal effects change to personal belongings
- Page 2 “belongs” should be “belong”
- Make facility form separate pages
- Do pilots have to meet every criteria? There is 1 NH that has low readmissions and is rural
- Diverse cross section of facilities dementia unit not required but would like a few
- Many do not have family counsels, not required criteria
- Rehab therapists under contract in facilities without rehab
- Collect pilot data for 3 months after visit
- After 90 days complete form online pre and post start
- NH with low readmissions could offer “Best Practices” info with us
- Rural facility (with several buildings) low readmissions
- Should consider them
- Each state selects based on basic criteria, want a very good cross section
- University will receive all candidates and decide
- Prefer facilities who are eager to participate
- Baseline survey = basic demographics and statistics of facilities has been made shorter
- Total # of licensed beds differs from certified beds, certified but not licensed
- We do everything by “certification”
- We’re going to ask both
- #6 urban, rural, suburban (suggest dropdown)
- #7 suggest time frames (is entered directly)
- #9 does it really matter? Most are under contract some full time
- Change # of hours in the building
- #13 why care how many ER’s used
- How many local hospitals NHs sending patient to?

March 2018 Meeting Minutes:

- Facilities refer to comfort care vs hospice
- Palliative, hospice, comfort care/measures some facilities use all 3 terms
- Some specialties would say they're all different
- Palliative care is billable, not comfort care
- All 3 should be listed
- Rural vs metro
- Bundle payments and preferred provider agreements can determine how many
- Hospitals provide different services based on need of resident vs closest hospital
- Do we need to provide option of other than male and female
- Politically correct term is other (self designation)
- Has not seen other; what's on MDS?
- To look at MDS, be as inclusive as possible, ethnicity should be reported
- QI Tool only completed for transferred residents
- Be consistent with hospice and palliative care and differentiate both
- Residents have a right to refuse recommended advice

April 2018 Meeting Minutes:

- The report revealed pushback from hospital association keeping language about things that can happen in the hospital vs. the nursing home
- Does not want to imply that going to the hospital is bad
- NHs are expecting to hear from us and others are requesting to participate
- Georgia NH association says that all facilities are excited
- Participating NHs are for and not for profit
- The smallest NH is 38 bed capacity to the largest that is over 200 bed capacity
- States will decide where workshops will be held in the state
- Referring to the Guide: should the word say "or stay here" instead of "nursing home"?
- Script continues to reference "here" instead of "nursing home"
- Consider specifying or decide if inclusive of other facilities
- It's possible you might have to change your concerns you could be at greater risk of skin breakdown, etc.
- Conversation with resident: change to less definitive cause and effect
- Under FAQs "speech therapy" added to Guide needs to be added to the scripts
- Avoid using "confused" use either "anxious" or "upset" instead
- Include the daughter from the beginning of the script
- Begin to speak, wave hand and approach after invited in then handshake
- Webinar for pilots will be either May 9th or 16th
- Baseline survey: purpose descriptive statistics for analysis; info provides picture for outcomes analysis
- For conferences and publications need correlations
- Employee shortages an issue worth investigating, will be posted to Decision Guide website
- Facility information certified by licensed bed?
- Certified nursing assistants needed
- #22 facilities might be hesitant to answer

- #'s 23, 24, 25 hours worked, not ratio
- Please eliminate 22-25 "comfort measures" vs hospice and palliative care
- NPs contracted or employed have average days/week onsite resident
- Staffing data available
- % of English and non-English speakers
- Seeking original date resident was admitted to NH – need instructions
- Need specific time period to get accurate data

May 2018 Meeting Minutes:

- Workshops will be planned for the end of the year
- Number of workshops will start in Florida
- Where should the workshops be held? Locations and venues…
- Think about CE credits if people would want that for attending. Yes, people would want CEUs, FAU not provider in each state
- Multiple disciplines, not just nursing (social work, Amins, etc.)
- GA. – CEUs not important
- KY. – Can set up CEUs, would want to create a course, register, certificate CEUs can attend if Amdin has license in KY, otherwise, no. Objectives, course description, presentation, evaluation
- FL. – would want CEUs (CE broker) not able to offer a commitment to doing it in FL
- MS. – would need to offer CEUs go to different boards NHA, social work, nursing if provides materials
- NC – Admins CEUs to encourage participation
- SC – thinks CEUs would be great but not sure how to get them, would garner more attendance
- TN – would want to offer CEUs but have to seek approval from NHA board, nursing too difficult, don't grant each entity an opportunity, complicated and will check
- Overview of forms
- Implementation Assistant shortened
- Baseline shortened – efficient for data analysis to see Guide helped facility
- Lookback March, April, May
- Project June, July, August
- QI tool for entry
- Decision Guides sent to printer
- States can see how pilots did in Sept/October
- Finished videos being edited
- Forms have been completed
- Webmaster is uploading them to website

July 2018 Meeting Minutes:

- Project Update: overarching theme: everyone going to implement differently based on demographics and location
- Champions: corporate, concierge, admins, DONs, Admissions
- Video Comments:

    - Received great feedback from pilot facilities
    - Talked about video and how will use each one
    - Rough cuts available until we're done with editing
    - Case studies will be sent out
    - Video comments collated into one document
    - New video where staff talks to resident and family member about what's in the Guide
    - Palliative care video will be redone
- Website is live and open for data entry
- In mid-July will ask how data entry is going

August 2018 Meeting Minutes:

- Pilot update: phone calls were made to Jefferson, Trinity Ridge, Magnolia, Abbeville, AG Rhodes and The Oaks
- Workshop planning:
    - Workshops will be for 3.5 hours
    - From 9-12:30
    - There will be QIOs and State NH agencies
    - NC they will be held in end of November or end or March
    - GA they will be held in end of November or end or March (preferred)

September 2018 Meeting Minutes:

- QI tool – behind on entering data
- Some are on top of it doing the data entry, others are just starting
- Too soon to analyze outcome data
- QI – Why do they get sent back to the hospital?
- States want to know if it is mandatory?
- Follow-up call #2 has it been shared with other providers?
- How are you educating families and residents?
- Hospital partners – readmission rates
- Are hospitals invited to attend workshops? We should utilize this material and let the hospitals know about this initiative

October 2018 Meeting Minutes:

- Barry students are evaluating pilot data
- Follow-up with Eagle, plans to start November 1st, if we want
- Ask more follow-up questions. Willing to do a retrospective data?
- If Guide was not given out during the project period, cannot do retrospective data
- Eliminate Eagle Health
- Ask Magnolia to do the lookback
- Driftwood needs to the QI
- Ridgetop changed its name to Stone Ridge
- The videos will be edited again
- Training workshop outline: will discuss best practices learned from pilot

- In the next 90 days, contract NH Administrators that package is coming
- Make an announcement in newsletters about the QAPI and QIOs
- List serve reach out to hospital associated as an FYI

November 2018 Meeting Minutes:

- NAB approved for each state
- Nursing more complex – docs submitted to program committee
- Additional requirements in some states
- Pre-posttests, word clouds, poll everywhere will be used to engage participants instead of just lecture
- Press release, save the date, once contracts have been approved

January 2019 Meeting Minutes:

- We have a busy few months ahead with the planning of the upcoming workshops
- Move AL workshop to first week of April break
- Other states' workshops are confirmed
- All states' contracts have been approved

February 2019 Meeting Minutes:

- Video production scripts have been edited and finalized
- We will be shooting the videos next month
- The Decisions Guide Booklet feedback
    - Looks good
    - Some simple grammar corrections
- Press release will be planned and launched in the coming months

March 2019 Meeting Minutes:

- Video production
    - Reshooting second half of Decision Guide (FAQs) and anxious resident videos
    - Feedback for the video deadline is April 27th
- April 16-20 conference
- Decision Guide final edits
- FAU press release at CMS, April Washington needs to be reviewed
- Map that shows Region IV states and partnering organizations in each state
- 1 page to be distributed
- We will send out press release draft
- CMS officer works with FAU press after finalized

April 2019 Meeting Minutes:

- Report on Workshops:
  - AL: 125 Birmingham, 63 Montgomery
  - KY: 66 Louisville, 67 Gilbertsville
  - NC: 126 Rocky Mount, 162 Thomasville, 53 Cullowhee
  - GA: did well with their 1st Workshop
- Report on Webinars: Have been having informal conversations and need to offer Webinars because people have missed the Workshops. Will be scheduling 4 Webinars two will happen April 18th and 25th, and May 2nd and 9th for one hour from 1-2pm. It will be more condensed from the 3-hour Workshop presentation. We will be using Zoom. We will be setting up the registration now on our website. We can make flyers edits to send out called Webinar Flyers which will:
  - Make it 1 page
  - Make it say CMS Region IV not Medicare Region IV
  - Please say "Due to Civil Money Penalty Grant"
  - Section Research Initiative change to: be a part of this CMS Region IV initiative
- Webmaster just finished the registration link and it was checked and is working
- Emailing "Save the Date" Flyer for Webinar – state representatives will do
- Attendance: The most difficult problem with equipment compatibility at one workshop. Poll everywhere doesn't always work if wifi doesn't work. When we do it manually we people to raise our hands to count for the 4 polls. We can't do a lot with this data, but people are saying that there is a major percentage.
- Evaluations: NAB rate from 1-5 and is easier to see the average
- Nursing: it's a much more complicated evaluation and we used the Florida State Board for the first 3 in Florida, GHCA did the CE for theirs but they didn't send any data. So this is from AXIS who provides continuing ed in all the other states.
- The Quarterly report went out with the detailed rosters
- A poll question was created, How will they use the Guide.
- A question came up about legal liability with somebody is kept in the facility and has GIRD and the video does raise this concern. We didn't find any reports and Medicare data and didn't find any place where there could be a problem with legal liability. The wording was fixed so there haven't been issue there.
- Concern about getting people on the website and enter their data. We're calling and sending a note to help people from the Workshop to help out with this.

May 2019 Meeting Minutes:

- Graph from pilots: there are challenges with starting from zero, but this Was prepared for CMS for their summer publications. This will give you an idea of the average decrease overall for the 13 pilot which is 31%. We are still trying to contact 2 NHs to confirm some numbers, because there are some anomalies, there are some instances that can create some anomalies such as one resident who has seven readmissions in three months.
- The people in Cullowhee were very pleased that we visited West of Asheville in North Carolina
- the numbers are split into those who wanted CEUs for NAB and nursng and some who are not seeking credit so the numbers don't add across the main table but the actual head count is correct and there are no duplicates there.
- Total webinar attendance was 251
- we added a fifth webinar because we had technical issues with the third webinar

- We are editing the website and our PowerPoint so we can have it uploaded to our website. We have edited out the polls and not sure if we will be including the link to the YouTube videos or embedding them. We will be working with people who assisted with the presentations because they may want to add more information. The webinar is more self explanatory whereas the workshop power points were set up needing explanations. We would like the version on our website to be totally self-explanatory.
- Evaluations NAB (evaluation range 1 to 5)
- We could enter this information into SurveyMonkey but the sheet we use has only 5 main questions in information needed

June 2019 Meeting Minutes:

- There is concern about overloading the nursing homes with requests for data
- Really want the NH to know what data we needed to reassure them that the reports would be beneficial. If we have duplicates we can mark them so they're not counted twice because there may be more than one person being contacted from attending workshops
- The pilot nursing homes did complete the data request and the reports were very helpful
- We have uploaded the PowerPoint to the website
- The new version is now completely self-explanatory for those who cannot attend the Workshops

July 2019 Meeting Minutes:

- Will plan to send out Survey Monkey to get feedback
- We are creating a form so that we can make calls to the workshop participants and get feedback since we are not getting many who are actually using the website to provide their feedback
- The workshops attendance is doing great, so once we can capture the feedback we will be able to put together the data
- Creating a Data Input form for the workshop participants
- Planning on having more webinars in the coming months

August 2019 Meeting Minutes:

- Survey Monkey update

  We sent out a Survey Monkey and we have received much feedback, so we will be planning on sending out another in the near future.
- Calls to Workshop Participants
- Data Input Forms have been sent via email. These are the forms that the workshop participants will complete after attending a Workshop. This will give us good feedback from the NH participants and their suggestions moving forward. Some of the comments are “It is such a

wonderful tool. We've had pretty good feedback on it at family council meetings." "The decision guide opens the conversation about what we can do here."

- Sample Comments
- Preliminary pattern is similar to the Pilot study with the NHs saying that the Guide is a helpful tool and both with staff training and providing awareness of the services that they can provide in the facility for the resident.
- Update Webinar

  Participation was good, as we continue to encourage all participants to complete the online survey we will gather more data from their input.

September 2019 Meeting Minutes:

- There will be another webinar on October 3rd at 2:00 PM
- SurveyMonkey was done however there were poor responses
- making calls more effective
- North Carolina still needs follow up calls done
- For those nursing homes an facilities that used the guide 67% did say they were communicating with the community hospitals
- going over the qualitative data
  - these were comments that were given by the participants they were not questions that were asked of them
  - seemed like the guide was very helpful
  - it is also good to know about the cost of transportation to the hospital and how high the ambulance fees can be
- We asked people how they were implementing the guide. 137 people who took the time to speak to our callers very similar to the pilot nursing homes
- There should be more numbers with all the interest from companies with relation to reducing hospitalization
- we will put together more stories that relate directly to the use of the guide
- We had one director of nursing who came to the webinar and she used it and shared how it worked for her with other webinar participants
- Suggest to send SurveyMonkey for the third time a lot of people do not have the time to take calls and discuss the guide implementation and would rather do it on SurveyMonkey
- We will go ahead and send out a SurveyMonkey in September and another one in October
- The QIOs will be opening in November

October 2019 Meeting Minutes:

- We are planning on updating the website and adding more user-friendly information to it
- Some changes that we have already made:
  - Made some of the images and fonts larger
  - Added an order form
  - Added the Trifold
  - Changed some of the Menu bar options
  - Change Training to Educational Resources

- There should be a relatable quote on the home page that indicates that there are less hospitalizations.
- Keep the color consistent with the colors that are in the Guide
- The photo of the Guide is a good size, however the Trifold should be larger
- Center the "Trifold" title
- The Trifold photo should be linked so that when it is clicked on it'll go right to the PDF file of the Trifold
- We are wrapping up calls to the facilities in North Carolina
- We won't be having a November meeting. Next meeting will be December.
- Will send the Guide a week ahead of time so that Committee members have time to review it and give feedback

December 2019 Meeting Minutes:

- Feedback on last edits for the Decision Guide
    - Only a few spacing issues
    - A word "Hospice" needs a capital "H"
- The Trifold looks good and doesn't require any changes
- We will be doing a final updated version to the Guide booklet and trifolds in the following languages:
    - English
    - Spanish
    - Haitian Creole
    - French
    - Tagalog
    - Chinese
- The website home page has been redesigned and a updated
- Added a quote on the home page that related to the Guide and how it has helped with the understanding that the facility can take care of changes in conditions in the nursing home.
- We are almost complete with the feedback calls for the North Carolina nursing homes

March 2020 Meeting Minutes:

- The Decision Guide website is the top website when searched through Google
- The Decision Guide booklets and trifold translations edits have been completed and will uploaded to the website and sent to MedPass the printer
- We are all done with the calls to the nursing homes
- Now we are on the clean-up and analysis phase
- We will working on completing the Final report that is due upon completion of the project (3/31/2020)
- This is our last State Advisory Committee meeting, and we appreciate all the feedback that has been provided by each of the states throughout this project.

GO TO THE HOSPITAL OR STAY HERE?

A Decision Guide for Residents, Families, Friends and Caregivers

Did you know that almost half of transfers to the hospital may be avoidable?

This Guide will help you understand why these transfers are made and how you can be involved in the decision.

CHANGE IN CONDITION

The question of sending you to the hospital or keeping you here may come up if your condition changes. This change could be a fever, shortness of breath, pain, an injury from a fall, or other change in your condition. If this happens, your medical provider has the responsibility to explain the change and the decisions that may need to be made to provide you the best possible treatment.

WHY THINK ABOUT THIS NOW?

This information is being provided to you so that you can make an informed decision if the question of going to the hospital arises.

It can be difficult to weigh the pros and cons of a transfer to the hospital when you become ill or to decide what treatment you prefer in the middle of a crisis.

IF IT IS NOT AN EMERGENCY

If this is not an emergency, the nurse will assess your condition:

- Ask you what happened, how you feel, where it hurts
- Listen to your heart and lungs
- Take your temperature, blood pressure, oxygen level
- Test your blood and urine

You can ask for the results and tell the nurse if you think your doctor, family, a friend or caregiver need to be called. If you have concerns about going to the hospital, this is the time to express them.

IN AN EMERGENCY

In a life threatening situation, the staff may call 911 to transport you to the hospital emergency department right away unless you have given them a Do Not Hospitalize request. They will also call your doctor or other medical provider (such as nurse practitioner or physician assistant) and a family member, friend or caregiver. You have the right to tell the staff ahead of time who you want called in an emergency.

"I want to be involved 100%." (Resident)

"We do our best to keep them here. We do tests first, the proper assessment, diagnostic tests, whatever we can do here before we would transfer to the hospital." (Nurse)

"It depends on what is going on, the severity of the illness. Give me a run down on what the hospital can do for me and what they can do for me here."
(Resident)

"I don't want to push the panic button and send her to a hospital if it can be kept under control here."
(Son)

REASONS TO PREFER BEING TREATED HERE

Many tests and treatments can be provided in the nursing home:

- Medications
- X-rays
- Blood tests
- Oxygen
- Wound care
- Checking on you and reporting to your doctor or other medical provider
- Comfort care (pain relief, fluids, bed rest)
- IV (intravenous) fluids in some facilities
- Physical or Occupational Therapy

* Speech Therapy

You can ask your nurse, doctor or other care provider what else can be done for you here.

REASONS TO PREFER BEING TREATED IN THE HOSPITAL

Hospitals can provide more complex tests and treatments including:

- Heart monitoring
- Body scans
- Intensive care
- Blood transfusion
- Surgery

THERE ARE RISKS IN GOING TO THE HOSPITAL

Being transported to the hospital can be stressful. You are likely to have to explain your concerns to nurses and doctors you do not know. You are also at greater risk for skin breakdown, exposure to infections or falling in an unfamiliar place. You may feel more comfortable staying here and being cared for by staff who know you. You should carefully consider all factors when making your decision.

BEING INVOLVED IN THE DECISION

You have the right to know what is happening to you, what treatments are available, the risks and benefits of these treatments, how decisions about your care are being made and how you are involved in making them.

You may want to talk to the following people about your choices:

- Nurses
- Doctors and other medical providers
- Social workers
- Spiritual advisor
- Family members
- Close friends
- Caregivers

These are very personal decisions. It's up to you to choose who you talk to and whose opinions you respect.

You can make your preferences known by:

- Talking with the people listed above
- Putting your wishes in writing and telling people where the documents can be found
- Completing advance directive documents including:
  - Power of attorney for healthcare
  - Health care proxy (naming someone to make health care decisions for you if you cannot)
  - Living will (specifies your preferences for end of life care)
  - Request for a DNR (do not resuscitate) to allow a natural death or DNH (do not hospitalize) order
  - Physician Orders for Life Sustaining Treatment (POLST), Medical Orders for Life Sustaining Treatment (MOLST), or similar form that is accepted in your state

WHAT CAN WE DO TO HELP YOU WITH THIS PROCESS?

If you still have questions, please ask your nurse, social worker, doctor, nurse practitioner or physician assistant to talk with you. They may recommend others talk with you as well, such as a legal advisor.

"They (resident and family) can only make an informed decision if they have all the information." (Doctor)

INFORMATION FOR FAMILY, FRIENDS AND CAREGIVERS OF RESIDENTS WHO CANNOT EXPRESS THEIR WISHES

"I usually ask her, what do you think? I explain and go over everything with her." (Husband)

"Letting the family know, making sure they are aware of the tests being done, the results, definitely helps with the decisions. Her well-being is my primary concern." (Sister)

1. **How can the resident participate in the decision about transfer to the hospital?**
   The resident's wishes always need to be respected. Alternate forms of communication should be considered.
   If the resident has an advance directive that appoints someone as the health care proxy or durable power of attorney, that person may make decisions for the resident based on what the resident would want if able to express his/her wishes. Advance directives should also be consulted.

2. **If the resident cannot express his or her wishes, should we still tell him or her what is happening?**
   Yes. The resident has the right to know what is happening and should be treated as if he/she understands the situation. Some people may become anxious or frightened if they are moved to an unfamiliar place without explanation. Be sure to use simple, direct words ("You are sick", "Your doctor thinks you should go to the hospital"), a quiet voice and a calm manner when explaining the situation to the resident.

3. **How can I (as a family member, friend, or caregiver) be involved in the decision?**
   You may need to complete some legal forms to do this. Ask your doctor, other medical provider or the social worker here for more detailed information. It's best to do this before a question about treatment or hospital transfer comes up.

FAQs
(Frequently Asked Questions)

ABOUT TRANSFERS TO THE HOSPITAL

1. **What is a "medical provider"?**
   Your medical provider may be a medical doctor (MD), doctor of osteopathy (DO), nurse practitioner (NP) or physician assistant (PA).
2. **Why would my doctor or other medical provider consider sending me to a hospital?**
   If you experience an injury or a serious change in condition, your medical provider may recommend you go to a hospital for treatment.
3. **When would staying here be the best choice for me?**
   If we are able to provide the care you need, then staying here may be the best choice.
4. **What kind of care can be provided here?**
   This varies from one nursing home to another but most are able to give you medications by mouth or injection, IV (intravenous) fluids except blood transfusions, order common lab tests and x-rays, and make periodic checks on your condition.
5. **What other reasons would I have for preferring to be cared for here?**
   There are several reasons. The staff and routines are familiar to you. The staff already know you, your health history and your needs and there is less disruption to your routine if you stay here. The transfer itself may be tiring, even stressful for you. You may be at greater risk for complications in the hospital.
6. **When would going to a hospital be the best choice for me?**
   Hospitals have more equipment and staff than nursing homes. They can do more complex lab tests, x-rays and scans, monitor your condition more closely, give blood transfusions and do complex procedures such as surgery.

FAQs (Frequently Asked Questions) *continued*

7. **What is a hospitalist?**

   Hospitalists are doctors who have specialized in providing hospital care. In many hospitals, it will be a hospitalist who will oversee your care, not your personal medical provider.

8. **Who will make the final decision as to whether I should be sent to a hospital or stay here?**

   If you are able, you may make the final decision. Consulting with your medical providers, family and friends may help you make a sound decision.

9. **How much say do I have in making this decision?**

   Person-centered care requires that you decide if you are able. People differ in terms of how much information they want and how much of a say they want to have. If for some reason you decide you want to be transferred or stay here against the advice of your medical provider and nurses, you may be asked to sign a form taking responsibiity for your decision.

10. **What happens if it's an emergency?**

    If 911 is called, you will receive on-the-spot treatment from the EMTs (ambulance crew) and then be taken to the nearest hospital.

FAQs (Frequently Asked Questions) continued

11. **Can I request a certain hospital?**

    You may make this request but in an emergency, the EMTs will take you to the closest hospital if it can provide the care you need. If it is not an emergency and your preferred hospital is close by, they may be able to take you there.

12. **Will my family, friends, or caregiver know where I am? Will they know what is happening to me?**
    Sometimes during a 911 emergency, there isn't time to call family members, friends or caregivers until you are on your way to the hospital. You can ask that they be called as soon as possible. Both your medical provider and nursing home staff have a responsibility to keep them informed. Make sure the staff know in advance who you want contacted and how to reach them.

13. **Will I be able to continue receiving physical, occupational, or speech therapy if I go to the hospital?**
    That depends on why you are going to the hospital and how sick you are. If therapy has to be discontinued, it will begin again when you are ready.

14. **Will I return here after I am discharged from the hospital?**

    In most cases, you will return here but in some instances going to a rehabilitation hospital, assisted living facility, a different nursing home or even going home may be the better choice for you.

15. **Will the facility hold my room for me while I'm in the hospital?**

    Most of the time, the nursing home will hold your room for several days. But these policies vary so you should ask someone at the nursing home what their policy is and how it will affect you.

16. **What happens to my personal belongings if I am transferred to the hospital?**

    Your personal belongings can be stored for you here.

17. **Why are we talking about this now?**

    It is difficult to carefully consider options and your personal preferences in the midst of a crisis, such as being sick enough to be sent to the hospital. You may be upset, worried, or feeling too bad to talk about your preferences with your medical provider and your family, friends or caregiver at that time.

FAQs (Frequently Asked Questions) continued

"It's my lungs. There's nothing they can do for me any more so I would rather stay here where they know me and I can be comfortable. It would be different if, when they were finished, they could say 'you can get up out of that chair and go to the ball'. But that is not going to happen." (Resident)

18. Why is this decision so important?

There are several reasons why this decision is important. Sometimes residents, their family members, friends or caregivers become very anxious when a resident becomes ill and ask that the person be sent to the hospital when treatment could be provided here. There are some risks and discomfort associated with being sent to the hospital. The transfer itself, a new environment, new staff and new routines can be sources of discomfort. The risks include falls, skin breakdown (pressure sores) and more exposure to potentially dangerous infections. Both the transfer and hospital care are very expensive. Some of these expenses may not be covered by your insurance. You may want to ask about this so that you can consider this information in making your decision.

COMFORT CARE, PALLIATIVE CARE, AND HOSPICE CARE AS WELL AS ADVANCE DIRECTIVES

1. What is the difference between hospice and palliative care?

Hospice care and palliative care are similar but hospice care is intended for those who are in the final months of their life (usually 6 months or less) while palliative care can continue for many months, even years. Hospice care focuses on pain control, symptom management, emotional and spiritual support.

2. What is "comfort care"?

Comfort care or palliative care focuses on easing pain and other symptoms such as nausea, fatigue, depression, breathing problems, constipation or diarrhea that are the result of your illness or the treatment of your illness. Palliative care teams also help you cope with your illness, providing practical solutions, emotional and spiritual care. The goal is to preserve your peace, comfort and dignity as much as possible.

3. What happens if I am getting hospice care when I go to the hospital?

If you go to the hospital, you may have to re-qualify for hospice after returning here. If there is time, hospice should be called before you are transferred to the hospital.

4. What are advance directives? Should I have them?

Advance directives are documents that tell your health care providers what kind of care you want to receive if you are unable to be involved in the decision. You can say you don't want certain treatments such as CPR (resuscitation) if your heart stops, to be put on a breathing machine if you can't breathe on your own, or if you want a feeding tube if you cannot eat. You can also state that you want all the treatment available if that is your preference. You can designate someone to make decisions for you if you cannot (or do not want to) do it yourself.

5. If I have advance directives, will my wishes be honored?

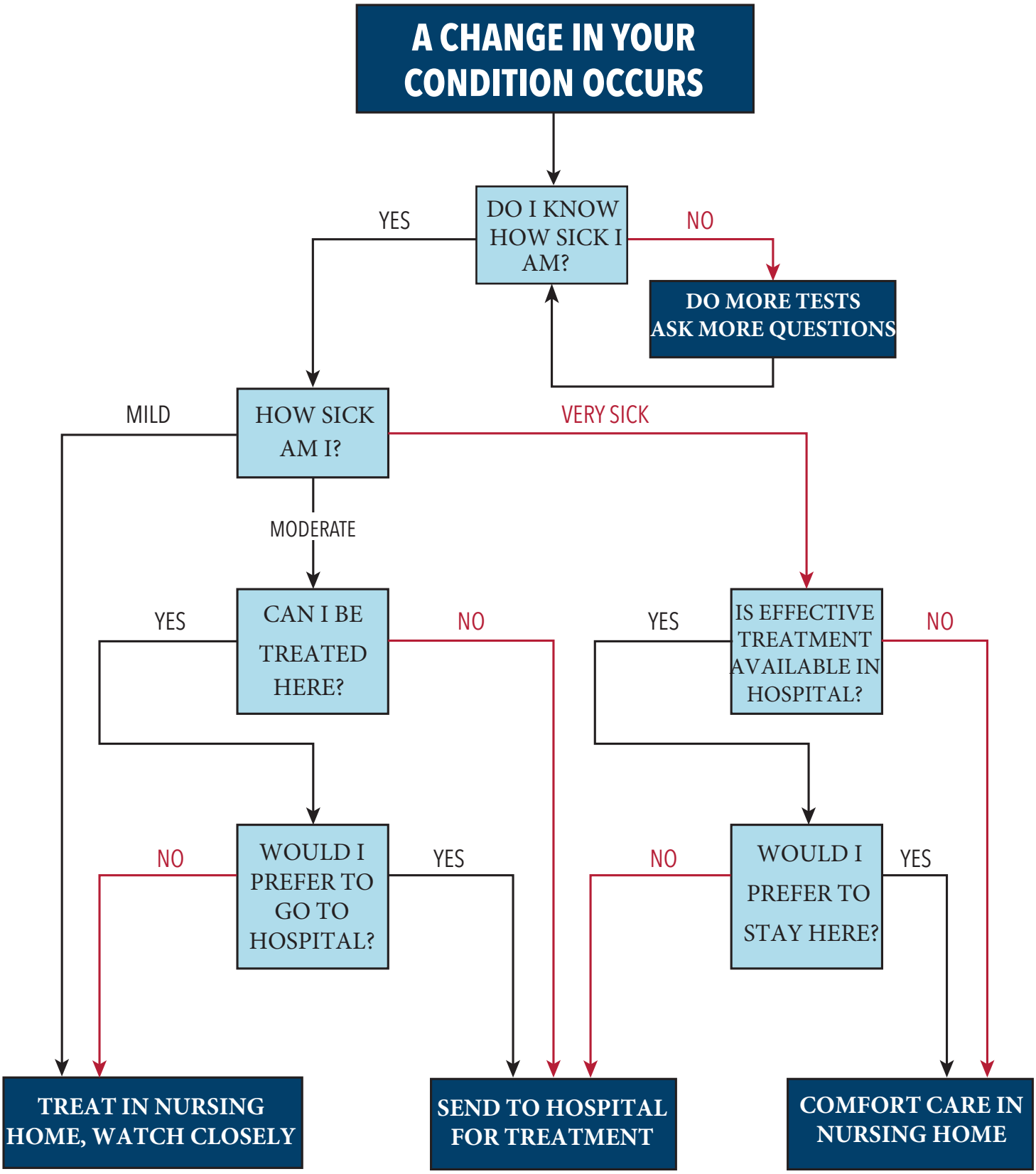
To make sure that your wishes are honored, review them with the staff, your family, a friend, or care provider ahead of time. Be sure a copy is on your chart at the hospital and available here as well. It's a good idea to give copies of your advance directives to your family, a friend, or caregiver and medical care provider ahead of time. You can update your advance directives at any time.

6. Once I have expressed my wishes in advance directives, can I change my mind?

Yes, you can change your mind and your advance directives at any time. If you want to change your advance directives, tell your care provider, family, friend or caregiver what changes you would like to make.

Decision Tree

GO TO THE HOSPITAL OR STAY HERE?



Continuing the Conversation...

What Residents Say About Going to the Hospital or Staying in the Nursing Home When a Change in Condition Occurs

"I make my own decisions. I am capable at this point and don't need anybody else."

"I listen to the doctor, listen to the nurses and then I come to my own decision."

"My son and three daughters would help me make the decision. We would talk it over."

"I would leave it to the people who work here, my doctors and the nurses. They know more about it than I do. They just tell me if I have to go."

"I have had instances when I have stayed here and others when I needed to go to the hospital. I would rather stay here. I have been happy here and been treated very well."

What the Families Say about Going to the Hospital or Staying in the Nursing Home When a Change in Condition Occurs

"This would be something we would discuss. If I thought she needed to go to the hospital, if she would get the best treatment there, I am more likely to recommend it to her." (Daughter)

"No one wants to see a parent in the hospital – it really stresses me out but I realized she was in good hands. She was in intensive care but came out and is back to normal now." (Son)

"I think families should know what is happening, that is very important. I want to be in the loop. The most important thing to me is the honesty of the staff, them being level with me about the problem. Then I could make the correct decision. He has to be comfortable with the decision." (Wife)

"Lord knows, whatever they think they can cure, that would be alright." (Husband)

"If it was cancer where there is no cure, then no question we would want hospice to come here. But if it was a serious infection I think he should go to the hospital to be treated." (Wife)

"I want to be fully involved in the decision, want to know all the facts. Absolutely." (Brother)

"My brother has power of attorney but we all make the decisions concerning him together." (Daughter)

"I would want to know how serious it is and what outcome is expected." (Lifelong friend who is health care surrogate)

"If it was just minor, then the nursing home can take care of it. Here they can do oral antibiotics (pills), things like that. Depends on what it is." (Stepdaughter)

"I would discuss it with my husband but I am more involved because I am here every day." (Daughter-in-law)

What Care Providers Say About Going to the Hospital or Staying in the Nursing Home When a Change in Condition Occurs

"We try treating the resident in the facility prior to transfer. We tell the patients, 'we can take care of this here for now. But we have to watch it and if it's not getting better, we will send you to the hospital'." (Doctor)

"Most long term residents want to be involved in the decision because they prefer to be treated here. Rehab patients, too, if they are making good progress." (Nurse)

"Most families want to have a voice. Patients, too, if they can." (Doctor)

"Some families are very involved; others just leave it to the facility and the doctor but want to be kept informed." (Nurse)

"The doctor is usually the gatekeeper." (Administrator)

"Sometimes we say you need to go and they say no – that is their choice. They have a right to insist on what they feel is best after you have explained it to them, reassured them." (Nurse)

"The benefit of them staying here is that they know the staff." (Nurse)

"It's about the resident. I prefer they be treated here if possible. We try to respect their preferences, get the doctors involved and the family as well." (Administrator)

"They might be more comfortable here. But if we can't manage the pain or if they need some diagnostic test or procedure we can't do here, they truly need to go to the hospital." (Social worker)

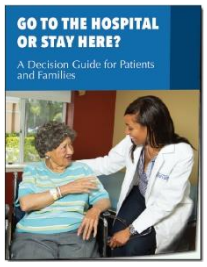
Funding for development of original Guide provided by Patient-Centered Outcomes Research Institute (PCORI). Funding for this updated Guide provided by the Eight States of CMS Region IV

Visit *www.decisionguide.org*

Version 2.2

FAU

FLORIDA ATLANTIC UNIVERSITY



Decision Guide Case Study No. 1
Anxious Resident: Possible C. Difficile

Brief Background

Mr. St. John is an 89-year-old male admitted for post-acute care following a 5-day inpatient admission for pneumonia. The hospital discharge planner reported he was "clinically stable".

In the Hospital

- Pneumonia was treated with IV antibiotics; changed to oral antibiotics on the day of transfer
- Mr. St. John required continuous oxygen to maintain pulse ox greater than 93%
- Mr. St. John developed severe diarrhea on the day prior to discharge. A stool specimen was sent for C. difficile toxin assay, results were pending at time of discharge.

Change in Condition

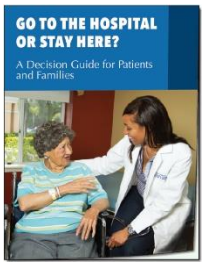
- The day after admission to the nursing home, the CNA reported to the nurse that Mr. St. John did not want to get out of bed for breakfast and seemed more tired and weaker than the previous day
- The nurse assessed the resident and found:
  - Mr. St. John was lethargic but could be easily aroused and knew his name/date/location
  - Mr. St. John reported 4 episodes of diarrhea overnight. He had no appetite and was feeling too weak to get out of bed. His abdomen had hyperactive bowel sounds and was diffusely tender
  - Lung sounds were clear, no cough

Actions Taken

- The nurse called the physician who said she would be able to see Mr. St. John within 2 hours and requested:
  - Bloodwork be done immediately (CBC and basic metabolic panel)
  - IV fluids immediately
  - Probiotic with p.o. antibiotic order
  - Call the hospital for results of the stool specimen sent for C. difficile
- The physician arrived 2 hours later and went to Mr. St. John's room with the nurse. They found him to be weak but awake and orientated to name, place, and date.
- Mr. St. John was sitting on the edge of the bed, appearing very anxious as he loudly stated to them: "I want to go back to the hospital...I feel like I have been getting sicker by the minute since I came here… I can't stay here, I don't want to die."

Case Study Analysis for Discussion:

1) Using the information learned from the Guide, what would be your response to Mr. St. John?
2) Discuss actions you could take to prevent hospital readmission?
3) What do you think the key points are when engaging in discussion with the physician before seeing Mr. St. John?
4) When do you think it is appropriate to discuss readmission issues with Mr. St. John? (at the time of admission or when an acute change happens)?
5). What key points about hospital readmission do you think are important to discuss with Mr. St. John?



Decision Guide Case Study No. 2
Abdominal Tenderness

Brief Case History

Robert Timmons is an 86-year-old male who has lived independently in the community for the past 7 years. His medical diagnoses include:

- Congestive Heart Failure (CHF)
- Hypertension
- Anxiety

Hospitalization

- His most recent hospitalization was one week ago for severe anemia of unknown origin. Mr. Timmons was discharged to your post-acute care facility after a 6-day hospital stay. Upon admission to your facility, he tells you he has "never trusted nursing homes" because he knows "many people" that have died in them. He wants you to know that if anything "happens" he prefers to go to the local hospital because they can take better care of people

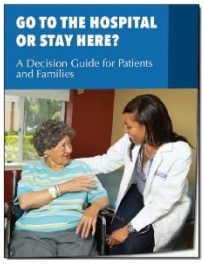
Change in Condition

- One week after admission to the facility, the CNA on the unit notes that he doesn't seem to have an appetite. She told the nurse Mr. Timmons did not eat breakfast and refused to touch his lunch. Upon assessing the patient, the nurse discovered the patient had tenderness in his lower abdomen when palpated, bowels sounds were hyperactive in lower quadrant, afebrile, no nausea or vomiting.
- The physician is given a detailed assessment of the patient's condition and asks the nurse to closely monitor the patient. She adds that her nurse practitioner is coming to the facility that afternoon to evaluate Mr. Timmons.
- The patient asks if something is wrong and if he should be transferred to the hospital right now.

Case Study Analysis for Discussion:

1) Discuss what your response to Mr. Timmons' question would be?
2) What actions can the nurse and other facility staff take to establish this patient's trust and enhance his post-acute care experience?
3) Using the Decision Guide as a tool, what is your next course of action in this case?

4) When would it be appropriate to discuss readmission issues with the Mr. Timmons?
5) What would be the key points you would discuss about hospital readmission?
6) Using information learned in the Decision Guide, are there additional actions that could be taken to prevent hospital readmission? with the Mr. Timmons at this time?



Decision Guide Case Study No. 3
Probable Pneumonia

Brief Case History

Mrs. Hong is an 81-year-old retired school teacher who was admitted to the hospital with acerbation of COPD. Her past medical history includes advanced COPD (oxygen dependent), osteoarthritis, coronary artery disease, and congestive heart failure (CHF). She was transferred to your post-acute facility 5 days ago for rehab with the ultimate goal to return to living independently in the community in her single family home. She has never been admitted to post-acute care before and her family is very anxious about the quality of care she will receive. They expressed some concern about her being able to live independently and asked what they should do. The hospital case manager told your admissions nurse that Mrs. Hong's family believes "nursing homes" are where people go to die and they don't want their mother to die or to suffer. When asked about DNR status, the family state "we don't want her to suffer and doesn't DNR mean you will do nothing"?

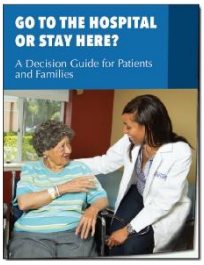
Change in Condition

Two days after admission to your facility:

- The CNA notes that Mrs. Hong isn't herself early in the morning, that she is somewhat anxious, more short of breath, dyspneic and appears to be mildly confused.
- Mrs. Hong is not interested in breakfast and did not go to therapy.
- The Nurse Practitioner (NP) assessed the patient and concluded the patient has pneumonia that can be treated with antibiotics at the facility, but expressed concerns about Mrs. Hong's advanced COPD and her ability to care for herself at home.
- The nurse practitioner called the family who said they think Mrs. Hong should go to the hospital because "at least they can do something about her condition" and address her living arrangements (get her some help in the home).

Case Study Analysis for Discussion:

1) Knowing this family is anxious, and using the Decision Guide as a tool, what is your next course of action in this case?
2) What key points would you discuss with Mrs. Hong and her family about their request for rehospitalization?
3) Hospice care for her advanced COPD may be the best option for Mrs. Hong. Using the Guide, what would you say to Mrs. Hong and her family?
4) Using the Guide, what would be your response to the family about their statement "DNR means you won't do anything to help her".
5) Using information learned in the Decision Guide, what other actions could be taken to help prevent a hospital readmission?



Decision Guide Case Study No. 4
No Advance Directives

Brief Case History

- Maria Rodriquez is a 67-year-old woman with cancer of the pancreas who has been at home receiving palliative care for the past 3 months.
- Her family moved to another state and you are not aware of any friends having come to visit her.
- Mrs. Rodriguez has no advance directives, but clearly has advanced cancer and death is most likely to occur within next 6 months. Her medical team (physician and nurse practitioner) have stated they don't want to provide aggressive care for her but rather make sure she does not suffer and has good quality of life and death with dignity.

Change in Condition:

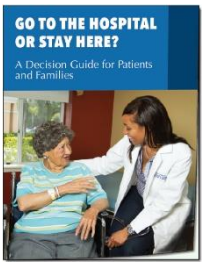
Four days after admission to your facility:

- Mrs. Rodriguez began doing "poorly," walking less, eating less, and seeming more "distant" when staff talk with her.
- Her physician discussed the findings of the RN's physical assessment and then ordered laboratory tests and a chest x-ray, but none of the results indicated an acute change in condition.
- On her fifth day in your facility, Mrs. Rodriguez became very short of breath. Her family was notified and they insisted on admitting her to the hospital.

Case Study Analysis for Discussion:

1) What would you say to the family when they insist on sending Mrs. Rodriguez to the hospital?
2) Using the Guide, what are key points you would discuss with Mrs. Rodriquez and her family about going to the hospital? And with the medical team?
3) What other actions can you take to keep the resident comfortable and her family reassured she is getting the care she needs?
4) Under what circumstances would you support a hospital admission?
5) What do you think about recommending hospice care with the physician and nurse practitioner? If the providers agree, what would you discuss with Mrs. Rodriquez and her family?
6) Is it appropriate to discuss readmission issues with the resident at this time?

7) Given this patient has no advance directives and using information learned in the Decision Guide, what other actions could be taken to avoid hospital admission?



Decision Guide Case Study No. 5
Advanced Dementia

Brief Case History

Mrs. Monroe is a 99 year-old female resident with advanced dementia whose son is the health care surrogate. Because of his job, he has not come to visit his mother for the last two years but he is frequently in contact with staff at the nursing home to inquire about his mother.

Mrs. Monroe's dementia has continued to progress to where she is totally dependent for ADLs, non-ambulatory requiring a wheelchair, and has limited speech. Her health history includes heart failure, hypertension, urinary incontinence, and osteoarthritis.

Change in Condition

Over the past 24 hours, Mrs. Monroe has experienced increased confusion most likely related to a urinary tract infection. She is lethargic but responds nonverbally to stimuli. You contact the nurse practitioner who orders a Complete Blood Count (CBC) with differential, a Basic Metabolic Profile (BMP), and Urine Analysis (UA) with a Culture and Sensitivity (C&S). She requested vital signs every 15 minutes and told you she would be there in 30 minutes.

As part of the protocol, the nurse practitioner contacted the son to inform him Mrs. Monroe had experienced a change in condition. He requested she go to the hospital where "she will get better care". The nurse practitioner informed the son that she could treat his mother in the nursing home with antibiotics and that going to the hospital was not in his mother's best interest. He angrily insisted that his mother go the hospital because he wanted her to "live to 100".

Actions Taken

The NP was able to convince Mrs. Monroe's son to wait until they received the results of the lab work but in the meantime she would start antibiotics. However, within an hour of the phone call, Mrs. Monroe's son called back and said he didn't want to wait and that the NP should send his mother to the hospital immediately. Mrs. Monroe's son has a good relationship with you, so the NP asks for your assistance in talking with him.

Case Study Analysis for Discussion

1. Knowing Mrs. Monroe's son has not seen his mother in two years, how can you give him a clearer picture of her overall condition?
2. What key points would you discuss with her son about hospitalization for someone like his mother who has advanced dementia? How can you use the Guide in this discussion?
3. How would the discussion and outcomes have been different if Mrs. Monroe had advance directives in place? How could you use the Guide to initiate a conversation about advance directives once this crisis has been resolved?
4. How can your facility ensure that advance directives have been discussed with every resident before a crisis arises?
5. Hospice care for someone with advanced dementia and a decline in cognitive and physical function may be the best option. Using the Guide, discuss what would you say to her son about this as an option. When is the best time to discuss the benefits of hospice care?
6. Using the Guide, what steps could you take to prevent hospitalization for someone like Mrs. Monroe in the future?

Appendix 21 - PowerPoint Training Program

CHRISTINE E. LYNN COLLEGE OF NURSING
FLORIDA ATLANTIC UNIVERSITY

How to Implement The Decision Guide

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

1

FLORIDA ATLANTIC UNIVERSITY

*This presentation provides ways that you can use the **Decision Guide**, as well as comments and data from Region IV Nursing Homes who used Guide.*

Making Waves

2

FLORIDA ATLANTIC UNIVERSITY

Benefits of the Guide

- It provides factual information about the care that can be provided in your facility
- It addresses questions about that care in the right setting and the available choices when a resident's condition changes
- Our study demonstrated that facilities who include the Guide in their readmission strategy significantly reduced avoidable transfers

Making Waves

3

FLORIDA ATLANTIC UNIVERSITY

Nursing Homes Using the Guide: Strategy and Success

Reducing Avoidable Transfer Strategy

- **Staff Education** — Training Videos, Case Studies, Presentations.
- Provide the Guide to all residents, families and incorporated in admission and care plan meetings
- Medical Director/ Advanced Practice staff have an active role in having care discussions using the Guide

Making Waves

4

FLORIDA ATLANTIC UNIVERSITY

Use of the Guide can also Support QAPI

QAPI - Improving avoidable Readmissions
The Guide as a Tool

- Provides factual information on whether to go or not go to the hospital
- Supports ongoing education for all staff on ways to prevent "panic transfers to the ED"
- Identifies areas for organizational improvement

Making Waves

5

FLORIDA ATLANTIC UNIVERSITY

The Guide Complements Interact

FACILITIES THAT USE BOTH REPORT INCREASED REDUCTION IN FAMILY INSISTED TRANSFERS!

INTERACT
- Quality improvement program
- Tools and resources to help identify, evaluate, and manage changes in condition

plus

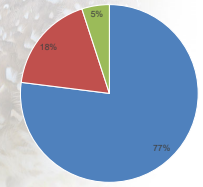
Decision Guide
- To inform residents and families of treatments provided in nursing home.
- Elicit questions on sensitive issues like end of life care

Making Waves

6

FLORIDA ATLANTIC UNIVERSITY

Since you implemented The Guide, have you seen a reduction in readmissions?



Making Waves

7

FLORIDA ATLANTIC UNIVERSITY

Getting the Guide

- Download and print your guide www.decisionguide.org

or

- Purchase the Guide from Med Pass at

https://www.med-pass.com/index.php/go-to-the-hospital-or-stay-here-guide-25-pack.html for the booklet,
and
https://www.med-pass.com/index.php/go-to-the-hospital-or-stay-here-brochure-25-pack.html for the trifold

Making Waves

8

CHRISTINE E. LYNN COLLEGE OF NURSING
FLORIDA ATLANTIC UNIVERSITY

Access Program Materials at www.decisionguide.org

9

FLORIDA ATLANTIC UNIVERSITY

Getting Started

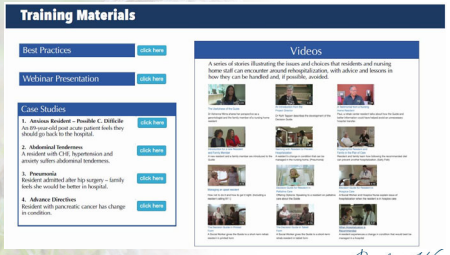
- Use the Best Practices Guide for Implementation for planning rollout
  http://www.decisionguide.org/docs/ImplementationAssistant
- Training Videos and Case Studies are useful for staff education
- Share the Guide with your Medical Staff, Leadership and Nursing staff
- Many facilities use the Guide itself for staff education

Making Waves

10

FLORIDA ATLANTIC UNIVERSITY

Decision Guide Training Videos

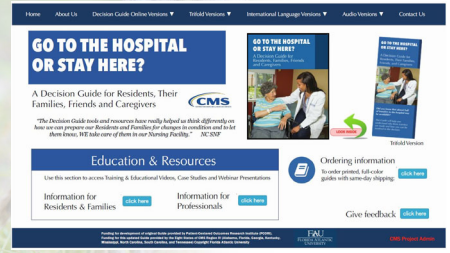


Making Waves

11

FLORIDA ATLANTIC UNIVERSITY

Project Website



Incorporating Avoidable Admission/Readmission into Staff Education

Making Waves

12

FLORIDA ATLANTIC UNIVERSITY

What We Have Learned- Impact on Staff

- *Educational tool for staff nurses*
- *Great for retraining staff*
- *Helps staff initiate difficult conversations e.g. end of life care decision*
- *Strengthens staff confidence in decisions and the follow-up measures necessary when a change in a resident's condition occurs.*

Making Waves

13

CHRISTINE E. LYNN COLLEGE OF NURSING
FLORIDA ATLANTIC UNIVERSITY

- **Highlight how your facility is working to prevent avoidable transfers and readmissions to the hospital**
- **Review the Guide and plan when it will be introduced to the Resident and Family**
- **Review some recent transfers that could have been prevented-use a training video to emphasize learning**
- **Use a case study to engage staff in the discussion**

Educating Staff In 30 Minutes

14

FLORIDA ATLANTIC UNIVERSITY

What We Have Learned Staff Experience

The guide is a useful tool for clinicians (Physicians, Nurse Practitioners, and Nurses) to use during resident/family-clinician conversations related to going to the hospital or staying in the nursing home. Covers important facts on hospital transfers, transitional care, hospice care, and advance directives.

"One more tool in our toolbox"

NHA-Georgia

Making Waves

15

FLORIDA ATLANTIC UNIVERSITY

Helping Families Use the Guide

Educational tool for residents and families to inform them on the treatment options that can be performed in the nursing home.

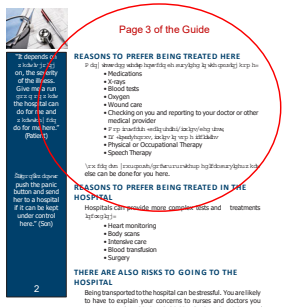
"In a crisis, family members panic, staff panic. Just stop and think what we can do here. The guide is a great educational tool."

NHA, Alabama

Making Waves

16

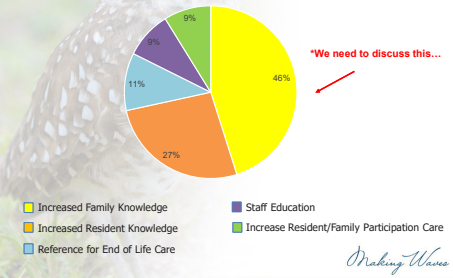
Sample page



17

FLORIDA ATLANTIC UNIVERSITY

What Nursing Homes said about the Guide's Effectiveness: Has the Guide been helpful in reducing avoidable transfers back to the hospital?



Making Waves

18

FLORIDA ATLANTIC UNIVERSITY

Distributing the Guide

Have the guide available in the resident's room.

"We have the Guide in a binder at each resident's bedside. We find quite frequently that the copies of the Guide are removed-so people are reading the Guide."

Executive, Nursing Home, Alabama

Making Waves

19

CHRISTINE E. LYNN COLLEGE OF NURSING
FLORIDA ATLANTIC UNIVERSITY

"It gives family members a better understanding of what questions to ask regarding nursing home services provided at this facility. It helps them (families) in structured meetings to ask questions about services." [NHA, Tennessee]

20

FLORIDA ATLANTIC UNIVERSITY

What We Have Learned: Helps with the End of Life Plan of Care Discussion

Helps to set resident/family goals for care and support discussion of their expectations such as the quality of care for the resident versus quantity of care.

"The Guide is very colorful and laid out in easy to read facts with resident and family quotes from interviews. It opens that dialogue for residents and families to have discussions around end of life care. DON, Alabama

Making Waves

21

FLORIDA ATLANTIC UNIVERSITY

Successful Implementation Strategies

- Include in admission packet
- Use in conversation with families/residents
- Staff education on readmissions
- Use during care planning meetings
- Introduce during resident council meetings
- Sharing with hospital staff

For additional strategies, see Best Practices for Guide Implementation on our website http://decisionguide.org/

Making Waves

22

FLORIDA ATLANTIC UNIVERSITY

Working With Your Hospital

- Distribute the guide to case managers at local hospitals.
- Provide workshops to reinforce information-also support networking between nursing home personnel and hospital personnel
- Create your own slogan for using the decision guide for your facility.

Making Waves

23

Thank You

Florida Atlantic University
Christine E. Lynn College of Nursing
Boca Raton, Florida

For more information contact:
Florida Atlantic University
Ruth M. Tappen, EdD, RN, FAAN
777 Glades Rd, Boca Raton, FL 33431
Phone: 561-297-2613
Email: rtappen@health.fau.edu
Project Email: nurtappen@health.fau.edu

24

Appendix 22 - Pilot Study Nursing Home Outcomes

Characteristics of the Participating Facilities.

The 16 pilot study NHs were located in seven of the 8 CMS Region IV states: Alabama (2), Georgia (4), Kentucky (2), Mississippi (2), North Carolina (2), South Carolina (2) and Tennessee (2). All of the participating facilities were Medicare and Medicaid certified. Seven were located in a rural area, six in an urban area and one in a suburban area. The average tenure of the Administrator was 9.74 years (SD 10.38) range 5-30 years. Average tenure of the Director of Nursing was much shorter with an average of 2.2 years (SD 2.87) range of .10-8 years. The Medical Directors' average tenure was 17 years (SD 6.94), range 8-32 years. Average nurse practitioner days per week were .70 (SD 1.4) with a range of 0-4.5 days per week.

Four of the original 16 NHs dropped out before the pilot study was completed. Three dropped out within weeks of the onsite visit due to a change in top management team. The fourth NH failed to complete their online data reports.

A comparison of the characteristics of the NHs who completed the study versus those that did not yielded no statistically significant differences (see Table 1) using Fisher's exact test for categorical and ANOVA for continuous variables.

Outcomes.

Based on the facilities' reports, the average number of transfers per facility dropped from 27 to 18.58 (See Figure 1 and Table 2). Three of the reporting NHs experienced an increase over this time period while nine experienced a decrease (Figure 1). The average change across the 12 reporting facilities was a decrease of 31.2% in the number of transfers.

In terms of the total number of acute hospital transfers per 1000 residents day across the 12 NHs, as can be seen in Table 3, there was a statistically significant decrease in the average proportion of acute hospital transfers per 1000 resident days [$t(11)=1.92$, $p=.042$, Cohen's $d=1.91$]. The average number of acute hospital transfers decreased from 2.84 (1.74) prior to intervention to of 1.72 (1.51) post intervention per 1000 resident days.

Data on the effects of using the Guide and/or Trifold is available from 12 of the original 16 NHs selected to participate in this pilot study. While there were no statistically significant differences in characteristics between those who dropped out and those who completed the study, it is evident from the data that the NHs who completed the study reported higher levels of RN hours, were more likely to have a nurse practitioner seeing residents, had a Director of Nursing with a longer tenure and a Director with a shorter tenure. Size of the facility, for profit or not for profit status and location in a rural area did not differ across these two groups (completers vs. non-completers).

On average, the NHs who completed the study reported a substantial drop in number of hospital readmissions when they implemented the Guide. Their comments reflect some of the reasons why this occurred: residents and their families did not know the services available in today's NHs, the Guide and Trifold provides this information in a clearer manner that repeated their right to have a part in this important decision and, finally, staff have used the Guide to help them initiate often difficult conversations about end-of-life care.

Table 1.

Pilot Study: Comparison of Completers vs. Non-Completers

Continuous Variables*	Completed		Did not complete		*f*	*p*
	M	SD	M	SD		
Number of Beds	120.33	57.37	105.00	37.42	.24	.62
Tenure of Administrator Years	10.4	10.85	8.25	10.96	.05	.83
Tenure of Director Nursing Years	2.61	3.01	.30	.28	1.09	.32
Medical Director Hours	16.22	5.33	22.00	14.14	1.15	.31
RN Hours	1539.22	762.17	951.27	550.70	1.99	.18
Nurse Practitioner Days Per Week	.85	1.59	0.00	0.00	.52	.48

Category Variables**	Completed		Did Not Complete		*p*
	Yes	No	Yes	No	
For Profit	7	5	2	2	.32
Rural	6	6	1	3	.41

Note: All comparisons are non-significant at $p \leq .05$

*Analysis of Variance

**Fisher's Exact Test

Table 2.

Percent Change in Readmissions Reported by Pilot Study Nursing Homes

Nursing Home ID Number	Number of Transfers 3 Months Prior to study	Number of Transfers Project Period 3 months	Per Cent Change From Baseline
1	14	8	-42.9%
2	32	39	21.9%
3	42	57	35.7%
4	12	6	-50.0%
6	12	6	-50.0%
7	11	5	-54.5%
8	32	22	-31.2%
9	38	12	-68.4%
10	37	14	-62.2%
11	14	7	-50.0%
12	52	1	-98.1%
13	28	46	64.3%
Average	27	18.58	-31.2%

Figure 1.

Percent Change in Number of Hospital Readmissions: 3 Month Project Period Compared to 3 Months Prior to Intervention

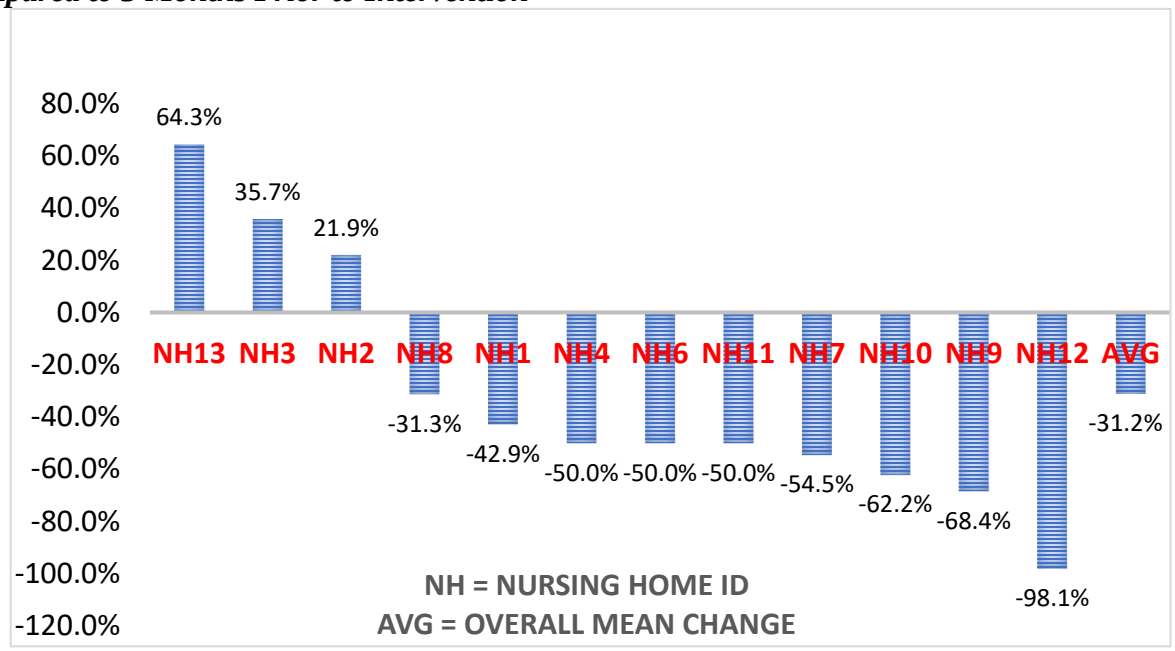


Table 3.

Pre and Post Intervention Differences in Acute Hospital transfer Rates Per 1000 Resident Days

	Pre Intervention		Post Intervention				
	M	*SD*	*M*	*SD*	*t(11)*	*p*	*Cohen's D*
Acute Hospital Transfers	2.84	1.74	1.72	1.51	1.92	.042*	1.91

Note. Hospital transfers reported per 1000 resident days

1-tailed p-value reports

*$p \leq .05$

Table 4.

Pilot Nursing Home Characteristics*

N = 16

	Mean	SD	Range	
			Minimum	Maximum
Overall Nursing Home Rating (Scale 1 to 5)	3.50	1.36	1	5
Health Inspection Ratings	3.38	1.36	1	5
Staffing Ratings	2.88	.96	1	4
Quality Measures Ratings	3.31	1.25	1	5
Average Resident Days	102.75	49.25	33.9	241.7
RN Minutes Resident Days	28.69	10.42	11	51
LPN Minutes Resident Days	64.19	17.62	30	93
Nurse Aide Minutes Resident Days	152.38	18.59	131	198

**From Nursing Home Compare Data*

Qualitative Responses from Pilot Study Participants.

1. How and at what point in a resident's stay are you distributing the Guide/Trifold to residents? To families?

   "Face to face, on admission for new residents and by mail with monthly bill to families." – SC

   "Upon admission, and those who are here they have been distributed to as a hand out." – AL

   "At orientation [admission] and we held a cook-out for residents and families." – TN

   "The Decision Guide booklet is given to new admissions and the Trifold was sent to families at the end of June with the billing statements and a letter." – MS

   "We started distributing the trifold right away with a letter at the first meeting with the resident and family members." – NC

   "Directly on admission. They then have a discharge book which goes with them which includes medical information, function level, etc. and the Decision Guide is included in this." – NC

   "Trifold is mailed to families and full version given out on admission." - KY

2. Are follow-up discussions and/or referrals to information in the Guide/Trifold occurring during a resident stay?

   "Through household meetings and with their Care Plan." – AL

   "Family meetings held at a household level have been very helpful." – AL

   "We do a 72 hr post admission follow-up with residents and family. This is a good time to review the guide another time and answer any questions they might have." – AL

   "We mailed out the brochure to the families with a letter and on 1st of August we held a family night." – KY

   "What this pilot program has done is reminded us of and brought to the forefront many of the issues we deal with daily, so the topics have been helpful as "bullet points", much like a checklist of areas that we need to focus on. The training modules, videos, etc truly overlap with so much of what we do here, but it helps create the important need for consistency." – GA

   "We follow up again to discuss with family at 48 hr care plan meetings." - NC

3. Have you found the Guide/Trifold useful in reducing hospital readmissions?

"Just having another tool to reinforce what we do is helpful, it brings some level of consistency to training, brings up points that remind us of why we are here doing what we do." – MS

"Since we started to rollout the guide we have noticed that some patients that might have insisted on leaving sooner than recommended are showing encouraging signs of allowing us to continue their treatment here, ie : completing antibiotic therapy for UTI's etc, instead of stopping their meds when they feel better AMA, [against medical advice] and going home prematurely, then winding up getting another infection, having to go back to the hospital and then winding up back here again. It's all about them trusting that we can take care of them here so we are opening the conversations more and that is a positive step." – AL

"It will improve the re-hospitalization rate. Sometimes families insist but if they are comfortable that you are focusing on their family member's care then they are more comfortable with them staying in the facility." – TN

4. What has been the response of residents and their families to the Guide/Trifold?

"The trifold has been particularly useful in opening the door for families to talk about this issue." – SC

"Very popular. Families were unsure initially but were very glad to know that the nursing home was not going to send residents to the hospital unless it was strictly necessary. Residents were glad to know what can actually be done right here." – SC

"Most of the families thanked us, said it was good to know this information, they were glad to know that some of the conditions can be treated here, and that at other nursing facilities this was not known. However when we conducted our Resident Council meeting, we had a number of attendees that met this with a little hesitation, some stating that they were not totally comfortable/some skeptical that nurse assessments would be appropriate under some conditions." – MS

"I think that (especially) for very long term residents and their families, they have a certain amount of comfort level with us, so they felt good about having this information re-affirming what we can do here." – TN

"It gives them peace of mind and some additional confidence in what we do."– TN

"Families have been very appreciative of the information, they found it very helpful." – KY

"It's been very helpful. Families have learned a lot they didn't know." – KY

"Overall, we have had very positive feedback." - NC

WORKSHOP POLL RESULTS

WORKSHOP LOCATION	Q: Who is the Audience				
	NH Admin	Nursing Admin/Mgt	Medical	Other	LT Care Partners
Boca Raton, FL					
Tampa, FL					
Jacksonville, FL					
Alpharetta, GA	89	0	0	11	0
Greenville, SC					
West Columbia, SC	13	50	0	38	0
Jackson, TN	33	55	0	3	0
Nashville, TN	21	64	0	14	0
Morristown, TN	24	41	6	24	6
Macon, GA	28	28	0	0	43
Savannah, GA	27	60	7	0	7
Jackson, MS					
Oxford, MS	33	42	0	0	25
Birmingham, AL	26	63	5	5	0
Montgomery, Al	42	42	0	8	8
Louisville, KY	29	33	0	19	19
Gilbertsville, KY	29	50	0	7	14
Rocky Mount, NC					
Thomasville, NC					
Cullowhee, NC	25	8	8	58	0

WORKSHOP LOCATION	Q: Are Admisions a Priority?				
	Yes	No	Unsure		
Boca Raton, FL					
Tampa, FL					
Jacksonville, FL					
Alpharetta, GA					
Greenville, SC	79	0	21		
West Columbia, SC	100				
Jackson, TN	100				
Nashville, TN	92	8			
Morristown, TN	100				
Macon, GA	100				
Savannah, GA	93		7		
Jackson, MS					
Oxford, MS	100				
Birmingham, AL	90	10			
Montgomery, Al	93		7		
Louisville, KY	100				
Gilbertsville, KY	100				
Rocky Mount, NC					
Thomasville, NC					
Cullowhee, NC					

WORKSHOP LOCATION	Q: Pick the ways you might use the Guide				
	A: Admin Process	**B:** Interview with prosp. Resident	**C:** Family care mtg	**D:** Adv. Directive conv.	**E:** Patient's condition changing
Boca Raton, FL	-	-	-	-	-
Tampa, FL	30	40	20	10	0
Jacksonville, FL	31	0	36	26	5
Alpharetta, GA	30	10	36	8	16
Greenville, SC					
West Columbia, SC					
Jackson, TN					
Nashville, TN	38	79	34	3	17
Morristown, TN	29	5	33	12	21
Macon, GA	29	5	33	12	21
Savannah, GA	25	15	35	10	15
Jackson, MS					
Oxford, MS	31	9	34	16	9
Birmingham, AL	36	16	34	8	6
Montgomery, Al	44	7	32	7	10
Louisville, KY	30	5	33	18	15
Gilbertsville, KY	36	6	30	18	9
Rocky Mount, NC					
Thomasville, NC					
Cullowhee, NC					

WORKSHOP LOCATION	Q: Approx. what % of your transfers in the last year were due to family insistence?				
	A: 75% or more	**B:** 50-74%	**C:** 25-49%	**D:** 10-24%	**E:** Less than 10%
Boca Raton, FL	5	9	32	32	23
Tampa, FL	33	0	0	67	0
Jacksonville, FL	0	8	31	31	31
Alpharetta, GA	0	15	31	46	8
Greenville, SC	0	23	46	30	0
West Columbia, SC	0	31	46	15	8
Jackson, TN	0	8	52	24	16
Nashville, TN	8	17	67	8	0
Morristown, TN	0	20	30	35	15
Macon, GA			100		
Savannah, GA	0	20	20	20	20
Jackson, MS					
Oxford, MS	0	20	40	20	20
Birmingham, AL	0	30	22	30	17
Montgomery, Al	0	25	17	50	8
Louisville, KY	6	18	41	18	18
Gilbertsville, KY	0	36	9	18	36
Rocky Mount, NC					
Thomasville, NC					
Cullowhee, NC	8	17	50	25	0

Report: Alabama Workshops – Nursing Attendees

Location/Date		1. This program enhanced my professional skills and/or knowledge	2. The objectives were related to the overall purpose/goal of the program	3. Provide reasons why there is concern about the occurrence of avoidable hospitalizations of nursing home residents.	4. Provide an overview of the CMS Nursing Skill Facility 30-day All Cause Readmission	5. Describe the development of the Resident and Family Decision Guide, Go to the Hospital or Stay	6. Describe effective strategies for introducing the Guide to Residents and Families.	7. Describe effective strategies for training staff on the use of the Guide	8. Presenters: the presenters were effective in conveying information	9. The activity will help me engage patients and families as partners in their care	10. The teaching methods (lecture, overheads, video etc.) were effective	11. The information provided was current and accurate as reflected by the content.	12. The time (contact hours) allocated was adequate for the material presented.	13. The information presented was at an appropriate educational level.
Birmingham	Mean	3.49	3.67	3.67	3.54	3.64	3.69	3.54	3.61	3.56	3.59	3.69	3.74	3.67
	N	51	51	51	51	51	51	51	51	51	51	51	51	51
	Std. Deviation	.556	.478	.478	.558	.486	.468	.505	.547	.552	.595	.468	.446	..478
Montgomery	Mean	3.47	3.75	3.81	3.74	3.84	3.88	3.78	3.78	3.77	3.69	3.81	3.81	3.84
	N	32	32	32	32	32	32	32	32	32	32	32	32	32
	Std. Deviation	3.47	3.75	3.81	.514	.374	.336	.491	.420	.430	.471	397	.397	.369

Report: Alabama Workshop NAB Attendees

LOCATION		Obj Met	Engaging	Approp LTC	Usefulness	Instr. Knowledge	Presentators skills	Overall
Birmingham	Mean	4.61	4.39	4.67	4.56	4.56	4.50	4.42
	N	18	18	18	18	18	18	18
	Std. Deviation	.502	.608	.485	.511	.616	.618	.600
Montgomery	Mean	4.31	4.31	4.62	4.31	4.62	4.38	4.46
	N	13	13	13	13	13	13	13
	Std. Deviation	.751	.751	.650	.751	.650	.961	.660

Report: Florida Workshops – Nursing Attendees

Location/Date		1. This program enhanced my professional skills and/or knowledge	2. The objectives were related to the overall purpose/goal of the program	3. Provide reasons why there is concern about the occurrence of avoidable hospitalizations of nursing home residents.	4. Provide an overview of the CMS Nursing Skill Facility 30-day All Cause Readmission	5. Describe the development of the Resident and Family Decision Guide, Go to the Hospital or Stay	6. Describe effective strategies for introducing the Guide to Residents and Families.	7. Describe effective strategies for training staff on the use of the Guide	8. Presenters: the presenters were effective in conveying information	9. The activity will help me engage patients and families as partners in their care	10. The teaching methods (lecture, overheads, video etc.) were effective	11. The information provided was current and accurate as reflected by the content.	12. The time (contact hours) allocated was adequate for the material presented.	13. The information presented was at an appropriate educational level.
Boca	Mean	3.36	3.28	3.67	3.51	3.62	3.67	3.59	3.69	.10	3.64	3.72	3.62	3.77
	N	39	39	39	39	39	39	39	39	39	39	39	39	39
	Std. Deviation	1.013	1.234	.530	.790	.544	.530	.549	.521	.641	.628	.560	.782	.485
Plant City	Mean	3.46	3.23	3.81	3.73	3.85	3.85	3.73	3.73	.00	3.65	3.81	3.58	3.62
	N	26	26	26	26	26	26	26	26	26	26	26	26	26
	Std. Deviation	.761	1.451	.402	.452	.368	.368	.452	.827	.000	.562	.402	.945	.852
Jacksonville	Mean	3.13	2.60	3.33	3.13	3.60	3.47	3.47	3.47	.00	3.47	3.40	3.27	3.60
	N	15	15	15	15	15	15	15	15	15	15	15	15	15
	Std. Deviation	.915	1.724	.724	.834	.507	.640	.640	.640	.000	.743	1.056	1.100	.507
Total ALL Workshops to date	Mean	3.36	3.40	3.64	3.51	3.71	3.66	3.58	3.65	2.19	3.50	3.64	3.57	3.66
	N	212	212	212	212	212	212	212	212	212	212	212	212	212
	Std. Deviation	.874	1.037	.529	.678	.466	.524	.557	.570	1.838	.692	.562	.715	.592

Report: Florida Workshop NAB Attendees

LOCATION		Obj Met	Engaging	Approp LTC	Usefulness	Instr. Knowledge	Presentators skills	Overall
Boca Raton	Mean	4.65	4.82	4.65	4.65	4.76	4.59	4.59
	N	17	17	17	17	17	17	17
	Std. Deviation	.606	.393	.862	.702	.562	.795	.618
Plant City	Mean	4.56	4.69	4.75	4.50	4.56	4.63	4.50
	N	16	16	16	16	16	16	16
	Std. Deviation	.629	.602	.447	.632	.512	.619	.632
Jacksonville	Mean	4.60	4.13	4.87	4.53	4.73	4.53	4.47
	N	15	15	15	15	15	15	15
	Std. Deviation	.507	.743	.352	.743	.594	.640	.640
Total All Workshops to date	Mean	4.45	4.35	4.65	4.47	4.69	4.45	4.48
	N	154	154	154	154	154	154	154
	Std. Deviation	.616	.719	.621	.668	.489	.785	.618

Report: Georgia Workshops – Nursing Attendees

Location/Date		1. This program enhanced my professional skills and/or knowledge	2. The objectives were related to the overall purpose/goal of the program	3. Provide reasons why there is concern about the occurrence of avoidable hospitalizations of nursing home residents.	4. Provide an overview of the CMS Nursing Skill Facility 30-day All Cause Readmission	5. Describe the development of the Resident and Family Decision Guide, Go to the Hospital or Stay	6. Describe effective strategies for introducing the Guide to Residents and Families.	7. Describe effective strategies for training staff on the use of the Guide	8. Presenters: the presenters were effective in conveying information	9. The activity will help me engage patients and families as partners in their care	10. The teaching methods (lecture, overheads, video etc.) were effective	11. The information provided was current and accurate as reflected by the content.	12. The time (contact hours) allocated was adequate for the material presented.	13. The information presented was at an appropriate educational level.
Macon	Mean	3.75	4.00	4.00	3.75	4.00	3.75	3.75	4.00	4.00	4.00	3.75	4.00	3.75
	N	4	4	4	4	4	4	4	4	4	4	4	4	4
	Std. Deviation	.500	.000	.000	.500	.000	.500	.500	.000	.000	.000	.500	.000	.500
Savannah	Mean	3.50	3.50	3.63	3.63	3.63	3.63	3.63	3.50	3.63	3.50	3.50	3.50	3.50
	N	8	8	8	8	8	8	8	8	8	8	8	8	8
	Std. Deviation	.535	.535	.518	.518	.518	.518	.518	.535	.518	.535	.535	.756	.535
Total ALL Workshops to date	Mean	3.36	3.40	3.64	3.51	3.71	3.66	3.58	3.65	2.19	3.50	3.64	3.57	3.66
	N	212	212	212	212	212	212	212	212	212	212	212	212	212
	Std. Deviation	.874	1.037	.529	.678	.466	.524	.557	.570	1.838	.692	.562	.715	.592

Report: Georgia Workshop NAB Attendees

LOCATION		Obj Met	Engaging	Approp LTC	Usefulness	Instr. Knowledge	Presentators skills	Overall
Alpharetta	Mean	4.20	4.15	4.60	4.50	4.65	4.45	4.50
	N	20	20	20	20	20	20	20
	Std. Deviation	.616	.671	.598	.761	.489	.605	.688
Macon	Mean	5.00	5.00	5.00	5.00	5.00	5.00	5.00
	N	1	1	1	1	1	1	1
	Std. Deviation	.	.	.	.	.	.	.
Savannah	Mean	5.00	4.67	5.00	5.00	5.00	5.00	5.00
	N	3	3	3	3	3	3	3
	Std. Deviation	.000	.577	.000	.000	.000	.000	.000
Total All Workshops to date	Mean	4.45	4.35	4.65	4.47	4.69	4.45	4.48
	N	154	154	154	154	154	154	154
	Std. Deviation	.616	.719	.621	.668	.489	.785	.618

Report: Kentucky Workshops – Nursing Attendees

Location/Date		1. This program enhanced my professional skills and/or knowledge	2. The objectives were related to the overall purpose/goal of the program	3. Provide reasons why there is concern about the occurrence of avoidable hospitalizations of nursing home residents.	4. Provide an overview of the CMS Nursing Skill Facility 30-day All Cause Readmission	5. Describe the development of the Resident and Family Decision Guide, Go to the Hospital or Stay	6. Describe effective strategies for introducing the Guide to Residents and Families.	7. Describe effective strategies for training staff on the use of the Guide	8. Presenters: the presenters were effective in conveying information	9. The activity will help me engage patients and families as partners in their care	10. The teaching methods (lecture, overheads, video etc.) were effective	11. The information provided was current and accurate as reflected by the content.	12. The time (contact hours) allocated was adequate for the material presented.	13. The information presented was at an appropriate educational level.
Louisville	Mean	3.76	3.68	3.68	3.64	3.75	3.56	3.84	3.88	3.56	3.59	3.69	3.74	3.67
	N	25	25	25	25	25	25	25	25	25	25	25	25	25
	Std. Deviation	.586	.436	.388	.583	.436	.476	.476	.569	.442	.712	.374	.332	.374
Gilbertsville	Mean	3.67	3.80	3.73	3.60	3.80	3.67	3.67	3.67	3.73	3.60	3.80	3.80	3.60
	N	15	15	15	15	15	15	15	15	15	15	15	15	15
	Std. Deviation	.617	.561	.594	.737	.414	.617	.617	.816	.594	.828	.561	.414	.828

Report: Kentucky Workshop NAB Attendees

LOCATION		Obj Met	Engaging	Approp LTC	Usefulness	Instr. Knowledge	Presentators skills	Overall
Louisville	Mean	4.21	4.21	4.47	4.16	4.74	4.47	4.47
	N	19	19	19	19	19	19	19
	Std. Deviation	1.032	1.032	.772	1.068	.452	.513	.991
Gilbertsville	Mean	4.70	4.10	4.70	4.60	4.70	4.70	4.60
	N	10	10	10	10	10	10	10
	Std. Deviation	.483	.516	.483	.699	.483	.483	.516

Report: Mississippi Workshops – Nursing Attendees

Location/Date		1. This program enhanced my professional skills and/or knowledge	2. The objectives were related to the overall purpose/goal of the program	3. Provide reasons why there is concern about the occurrence of avoidable hospitalizations of nursing home residents.	4. Provide an overview of the CMS Nursing Skill Facility 30-day All Cause Readmission	5. Describe the development of the Resident and Family Decision Guide, Go to the Hospital or Stay	6. Describe effective strategies for introducing the Guide to Residents and Families.	7. Describe effective strategies for training staff on the use of the Guide	8. Presenters: the presenters were effective in conveying information	9. The activity will help me engage patients and families as partners in their care	10. The teaching methods (lecture, overheads, video etc.) were effective	11. The information provided was current and accurate as reflected by the content.	12. The time (contact hours) allocated was adequate for the material presented.	13. The information presented was at an appropriate educational level.
Jackson	Mean	3.60	3.75	3.75	3.55	3.90	3.90	3.70	3.65	3.30	3.55	3.75	3.65	3.80
	N	20	20	20	20	20	20	20	20	20	20	20	20	20
	Std. Deviation	.598	.550	.444	.605	.308	.308	.470	.489	1.455	.510	.444	.587	.410
Oxford	Mean	3.47	3.79	3.68	3.68	3.79	3.84	3.84	3.74	3.79	3.74	3.84	3.79	3.84
	N	19	19	19	19	19	19	19	19	19	19	19	19	19
	Std. Deviation	1.020	.419	.478	.582	.419	.375	.375	.452	.419	.452	.375	.419	.375
Total ALL Workshops to date	Mean	3.36	3.40	3.64	3.51	3.71	3.66	3.58	3.65	2.19	3.50	3.64	3.57	3.66
	N	212	212	212	212	212	212	212	212	212	212	212	212	212
	Std. Deviation	.874	1.037	.529	.678	.466	.524	.557	.570	1.838	.692	.562	.715	.592

Report: Mississippi Workshop NAB Attendees

LOCATION		Obj Met	Engaging	Approp LTC	Usefulness	Instr. Knowledge	Presentators skills	Overall
Jackson	Mean	4.50	4.50	4.67	4.50	4.83	4.50	4.67
	N	6	6	6	6	6	6	6
	Std. Deviation	.548	.548	.516	.548	.408	.548	.516
Oxford	Mean	4.61	4.56	4.83	4.72	4.89	4.78	4.78
	N	18	18	18	18	18	18	18
	Std. Deviation	.608	.705	.383	.461	.323	.548	.428
Total All Workshops to date	Mean	4.45	4.35	4.65	4.47	4.69	4.45	4.48
	N	154	154	154	154	154	154	154
	Std. Deviation	.616	.719	.621	.668	.489	.785	.618

Report: North Carolina Workshops – Nursing Attendees

Location/Date		1. This program enhanced my professional skills and/or knowledge	2. The objectives were related to the overall purpose/goal of the program	3. Provide reasons why there is concern about the occurrence of avoidable hospitalizations of nursing home residents.	4. Provide an overview of the CMS Nursing Skill Facility 30-day All Cause Readmission	5. Describe the development of the Resident and Family Decision Guide, Go to the Hospital or Stay	6. Describe effective strategies for introducing the Guide to Residents and Families.	7. Describe effective strategies for training staff on the use of the Guide	8. Presenters: the presenters were effective in conveying information	9. The activity will help me engage patients and families as partners in their care	10. The teaching methods (lecture, overheads, video etc.) were effective	11. The information provided was current and accurate as reflected by the content.	12. The time (contact hours) allocated was adequate for the material presented.	13. The information presented was at an appropriate educational level.
Rocky Mount	Mean	3.26	3.47	3.48	3.23	3.45	3.49	3.41	3.32	3.38	2.98	3.49	3.44	3.46
	N	51	51	51	51	51	51	51	51	51	51	51	51	51
	Std. Deviation	.723	.644	.677	.889	.730	.612	.638	.794	.716	.915	.579	.760	.646
Thomasville	Mean	3.26	3.47	3.48	3.23	3.45	3.49	3.41	3.32	3.38	2.98	3.49	3.44	3.46
	N	66	66	66	66	66	66	66	66	66	66	66	66	66
	Std. Deviation	.723	.644	.677	.889	.730	.612	.638	.794	.716	.915	.579	.760	.646
Cullowhee	Mean	3.42	3.79	3.70	3.47	3.85	3.85	3.64	3.67	3.67	3.67	3.79	3.79	3.76
	N	33	33	33	33	33	33	33	33	33	33	33	33	33
	Std. Deviation	.614	.485	.529	.621	.364	.364	.699	.540	.547	.540	.600	.485	.545

Report: North Carolina Workshop NAB Attendees

LOCATION		Obj Met	Engaging	Approp LTC	Usefulness	Instr. Knowledge	Presentators skills	Overall
Rocky Mount	Mean	4.16	4.02	4.58	4.29	4.60	4.09	4.16
	N	45	45	45	45	45	45	45
	Std. Deviation	.928	1.138	.690	.920	.720	1.184	1.140
Thomasville	Mean	4.28	3.94	4.53	4.22	4.53	4.28	4.22
	N	32	32	32	32	32	32	32
	Std. Deviation	.683	1.01	.507	.751	.567	.729	.751
Cullowhee	Mean	4.30	4.40	4.80	4.70	4.70	4.50	4.70
	N	10	10	10	10	10	10	10
	Std. Deviation	.675	.843	.422	.483	.483	.707	.483

Report: South Carolina Workshops – Nursing Attendees

Location/Date		1. This program enhanced my professional skills and/or knowledge	2. The objectives were related to the overall purpose/goal of the program	3. Provide reasons why there is concern about the occurrence of avoidable hospitalizations of nursing home residents.	4. Provide an overview of the CMS Nursing Skill Facility 30-day All Cause Readmission	5. Describe the development of the Resident and Family Decision Guide, Go to the Hospital or Stay	6. Describe effective strategies for introducing the Guide to Residents and Families.	7. Describe effective strategies for training staff on the use of the Guide	8. Presenters: the presenters were effective in conveying information	9. The activity will help me engage patients and families as partners in their care	10. The teaching methods (lecture, overheads, video etc.) were effective	11. The information provided was current and accurate as reflected by the content.	12. The time (contact hours) allocated was adequate for the material presented.	13. The information presented was at an appropriate educational level.
Greenville	Mean	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00
	N	4	4	4	4	4	4	4	4	4	4	4	4	4
	Std. Deviation	.000	.000	.000	.000	.000	.000	.000	.000	.000	.000	.000	.000	.000
West Columbia	Mean	3.00	3.17	3.50	3.33	3.58	3.58	3.58	3.58	3.50	3.17	3.50	3.50	3.33
	N	12	12	12	12	12	12	12	12	12	12	12	12	12
	Std. Deviation	1.128	1.193	.522	.492	.515	.515	.515	.515	.522	.718	.522	.522	.888
Total ALL Workshops to date	Mean	3.36	3.40	3.64	3.51	3.71	3.66	3.58	3.65	2.19	3.50	3.64	3.57	3.66
	N	212	212	212	212	212	212	212	212	212	212	212	212	212
	Std. Deviation	.874	1.037	.529	.678	.466	.524	.557	.570	1.838	.692	.562	.715	.592

Report: South Carolina Workshop NAB Attendees

LOCATION		Obj Met	Engaging	Approp LTC	Usefulness	Instr. Knowledge	Presentators skills	Overall
Greenville	Mean	4.31	4.31	4.69	4.31	4.62	4.31	4.38
	N	13	13	13	13	13	13	13
	Std. Deviation	.630	.855	.480	.751	.506	.751	.650
West Columbia	Mean	4.46	4.23	4.62	4.38	4.69	4.23	4.38
	N	13	13	13	13	13	13	13
	Std. Deviation	.519	.599	.870	.650	.480	.599	.506
Total All Workshops to date	Mean	4.45	4.35	4.65	4.47	4.69	4.45	4.48
	N	154	154	154	154	154	154	154
	Std. Deviation	.616	.719	.621	.668	.489	.785	.618

Report: Tennessee Workshops – Nursing Attendees

Location/Date		1. This program enhanced my professional skills and/or knowledge	2. The objectives were related to the overall purpose/goal of the program	3. Provide reasons why there is concern about the occurrence of avoidable hospitalizations of nursing home residents.	4. Provide an overview of the CMS Nursing Skill Facility 30-day All Cause Readmission	5. Describe the development of the Resident and Family Decision Guide, Go to the Hospital or Stay	6. Describe effective strategies for introducing the Guide to Residents and Families.	7. Describe effective strategies for training staff on the use of the Guide	8. Presenters: the presenters were effective in conveying information	9. The activity will help me engage patients and families as partners in their care	10. The teaching methods (lecture, overheads, video etc.) were effective	11. The information provided was current and accurate as reflected by the content.	12. The time (contact hours) allocated was adequate for the material presented.	13. The information presented was at an appropriate educational level.
Jackson	Mean	3.41	3.48	3.55	3.52	3.69	3.62	3.52	3.62	3.59	3.24	3.62	3.62	3.66
	N	29	29	29	29	29	29	29	29	29	29	29	29	29
	Std. Deviation	.780	.688	.632	.738	.471	.494	.574	.561	.568	1.023	.561	.561	.614
Nashville	Mean	3.16	3.58	3.68	3.53	3.63	3.47	3.42	3.58	3.58	3.42	3.53	3.53	3.58
	N	19	19	19	19	19	19	19	19	19	19	19	19	19
	Std. Deviation	1.015	.507	.478	.513	.496	.612	.607	.507	.507	.692	.513	.612	.607
Morristown	Mean	3.12	3.24	3.41	3.12	3.59	3.24	3.18	3.53	2.82	3.24	3.29	3.24	3.41
	N	17	17	17	17	17	17	17	17	17	17	17	17	17
	Std. Deviation	.781	.752	.507	.857	.507	.664	.728	.624	1.425	.664	.470	.664	.507
Total ALL Workshops to date	Mean	3.36	3.40	3.64	3.51	3.71	3.66	3.58	3.65	2.19	3.50	3.64	3.57	3.66
	N	212	212	212	212	212	212	212	212	212	212	212	212	212
	Std. Deviation	.874	1.037	.529	.678	.466	.524	.557	.570	1.838	.692	.562	.715	.592

Report: Tennessee Workshop NAB Attendees

LOCATION		Obj Met	Engaging	Approp LTC	Usefulness	Instr. Knowledge	Presentators skills	Overall
Jackson	Mean	4.00	3.79	4.29	4.14	4.57	3.64	4.14
	N	14	14	14	14	14	14	14
	Std. Deviation	.679	.893	.726	.663	.514	1.499	.663
Nashville	Mean	4.29	4.14	4.00	4.29	4.43	4.43	4.14
	N	7	7	7	7	7	7	7
	Std. Deviation	.488	.690	.816	.756	.535	.535	.690
Morristown	Mean	4.55	4.27	4.73	4.18	4.73	4.64	4.36
	N	11	11	11	11	11	11	11
	Std. Deviation	.688	.647	.467	.603	.467	.505	.674
Total All Workshops to date	Mean	4.45	4.35	4.65	4.47	4.69	4.45	4.48
	N	154	154	154	154	154	154	154
	Std. Deviation	.616	.719	.621	.668	.489	.785	.618

Workshop Outcomes Report

Sample Development.

Although workshop participants were asked to upload their data into the secure survey forms on the decisioneguide.org website, very few did. For increased ease of reporting, we then developed a brief survey on Survey Monkey and emailed the link to participants. The response rate was low and included duplicates from individual facilities which were combined into a single response. The third approach proved to be far more successful. Project team members placed calls to each workshop participant, omitting those who clearly were state agency staff, ombudsmen, long-term care consultants, hospital representatives, insurers, long-term care organization representatives, QIO representatives and multiple representatives from the same facility. This reduced the number of possible respondents from 1124 to 849. Of these, project team members were able to reach 293 respondents. Some provided very brief yes-no responses and ended the call, others were unable to report the results at their facilities and, despite the filters applied, till others were in the "other" category of workshop participants who were not representing a single facility (See Figure 1 CONSORT Diagram). Deletion of these additional respondents resulted in a sample for analysis of 256 respondents representing 256 individual nursing homes across the eight states of Region IV. The numbers per state are Alabama n = 42, Georgia n = 29, Florida n = 24, Kentucky n = 20, Mississippi n = 19, North Carolina n = 56, South Carolina n = 17 and Tennessee n = 49.

Facility Characteristics.

Characteristics of 243 of the 256 were retrieved for the CMS Nursing Home Compare data (see Table 1). The average overall rating was 3.33 (SD 1.36) with a range of 1 to 5. Similarly, the Health Inspection rating was 3.12 (SD 1.28), Staffing Rating was 2.96 (SD 1.07) and Quality Measure Rating was 3.35 (SD 1.27), all with a range of 1 to 5. The average number of beds was 110.51 ((SD 43.39) with a wide range of 20-388. Average resident days was 92.96 (SD 39.6), range 10.60 to 285.70. Staffing levels were as follows:

- RN minutes per resident day average 36.90, range 9 to 136
- LPN minutes per resident day average 59.37, range 18 to 160
- CNA minutes per resident day average 142.02, range 66 to 426

Facility Outcomes.

All of the 256 participants responded to our first question, "Are you using the Guide (or Trifold) in your facility?" One-hundred eighty-three (71.48%) said yes, 7 (2.73%) indicated it was partially implemented and 66 (25.78%) answered that it was not being used. They were then asked if their residents and family members found it helpful. One hundred sixty-two answered this question. Of these, 89% answered in the affirmative, another 8% answered somewhat helpful and 3% said "no". Reasons why it was found helpful (or not) can be found in

the final section of this Appendix which provides representative responses and explanations from these participants.

Participants were then asked the number of readmissions their facilities had in the three months prior to initiating use of the Guide and in the three months following introduction of the Guide. Those who were able to provide actual numbers (n = 36) reported an average of 7.76 (SD 6.9) readmissions pre-intervention compared to an average of 6.02 (SD 6.2) after implementation of the Guide. This difference is statistically significant t (df34) = 2.26 p = .03. Those who reported the change as percentages (n = 13) also reported a statistically significant change t (df 12) = 3.46 p = .0047. Average percent readmissions were 18% (SD 10.88) at pretest compared to 12.60% (SD 4.00) at posttest. (See Figure 1)

We also obtained data on increased use of the Guide and Trifold from an entirely separate and independent source, the printer (MED-PASS) who supplied the Guides and Trifolds to our Pilot Study NHs and then shipped cartons to every Medicare-certified NHs in each of the eight states. Over and above those ordered and shipped for the project, MED-PASS shipped 17,475 Trifolds and 7,050 Guides in 2019. Figures by state may be found in Table 3 attached (See Table 3).

In summary, while it was difficult to obtain reports from workshop participants, we were able to obtain sufficient information to provide valid evidence that use of the Resident/Family Guide and/or Trifold can have a significant impact on hospital readmission rates.

Table 1.

Reporting NHs' Characteristics* N = 243

	Mean	SD	Range	
			Minimum	Maximum
Number of Beds	110.51	47.89	20	388
Overall Nursing Home Compare Rating (Scale 1 to 5)	3.33	1.36	1	5
Health Inspection Ratings	3.12	1.28	1	5
Staffing Ratings	2.96	1.07	1	5
Quality Measures Ratings	3.35	1.27	1	5
Average Resident Days	92.96	39.61	10.60	285.70
RN Minutes Resident Days	36.90	18.95	9.00	136.00
LPN Minutes Resident Days	59.37	17.55	18.00	160.00
Nurse Aide Minutes Resident Days	142.02	34.91	66.00	426.00

**From Nursing Home Compare Data*

Table 2.

Workshop Participants' Facilities Outcomes: Paired Sample t Tests

Reported Numbers of Readmissions

	M	N	SD	Std Err	95% CI of the Difference		*t*	*df*	Significance
Pre Intervention*	7.76	35	6.96	.82	.18	3.53	2.26	34	.03**
Post Intervention	6.02	35	6.21						

Reported Percent Readmissions

	M	N	SD	Std Err	95% CI of the Difference		*t*	*df*	Significance
Pre Intervention	18.00%	13	10.88	2.04	2.62	11.53	3.46	12	.0047
Post Intervention	12.60%	13	4.00						

*Intervention = Introduction of the Guide

**Significant at $p \leq .05$

Table 3.

Go to the Hospital or Stay Here - Brochure and Guide
Sales by State
For 2019

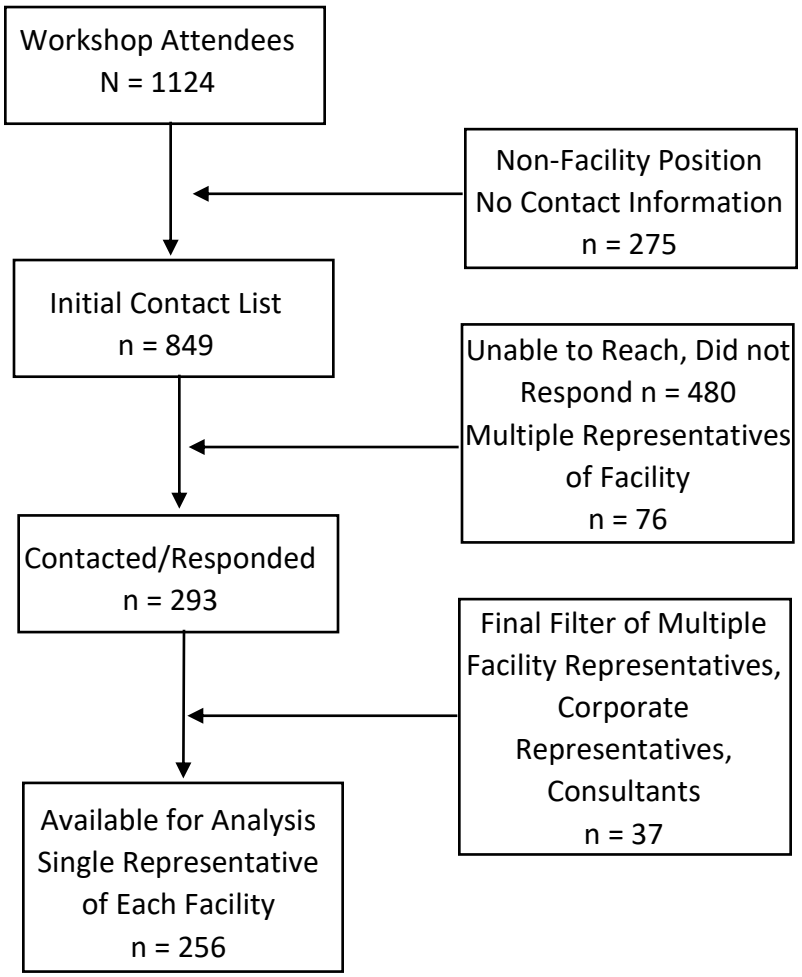
	Total Units Sold Jan 1, 2019 to June 30, 2019		Total Units Sold July 1, 2019 to Dec 31, 2019		Total Number Units Sold 2019	
State	MP57-BR	MP57-GD	MP57-BR	MP57-GD	MP57-BR	MP57-GD
AL	22	4	15	18	37	22
AR						
AZ						
CA	9				9	
CO			1	1	1	1
CT						
DE						
FL	69	42	99	52	168	94
GA	5	3	14	12	19	15
HI						
IA	4				4	
ID						
IL			1	1	1	1
IN	17	4			17	4
KS	1				1	
KY	1		4		5	
LA						
MA						
MD			12	2	12	2
ME	1	1			1	1
MI	2				2	
MO			1	1	1	1
MN	5	1			5	1
MS	20	8	4	4	24	12
MT						
NC	82	33	44	27	126	60
ND						
NE						
NH			3		3	
NJ						
NM						
NY	62		34	1	96	1
OH	21	17		12	21	29
OK						
OR		1				1
PA	5		6		11	
RI	20		10		30	
SC	28	13	6	2	34	15
TN	26	6	30	13	56	19
TX	1		2	2	3	2
VA			1	1	1	1
VT			10		10	
WI	1				1	
WY						
WV						
TOTAL	402	133	297	149	699	282

Both Brochures and Guides are sold in Packs of 25. Above numbers are the number of packs sold.

Note: Quantities do not include product sent on behalf of FAU

Figure 1.

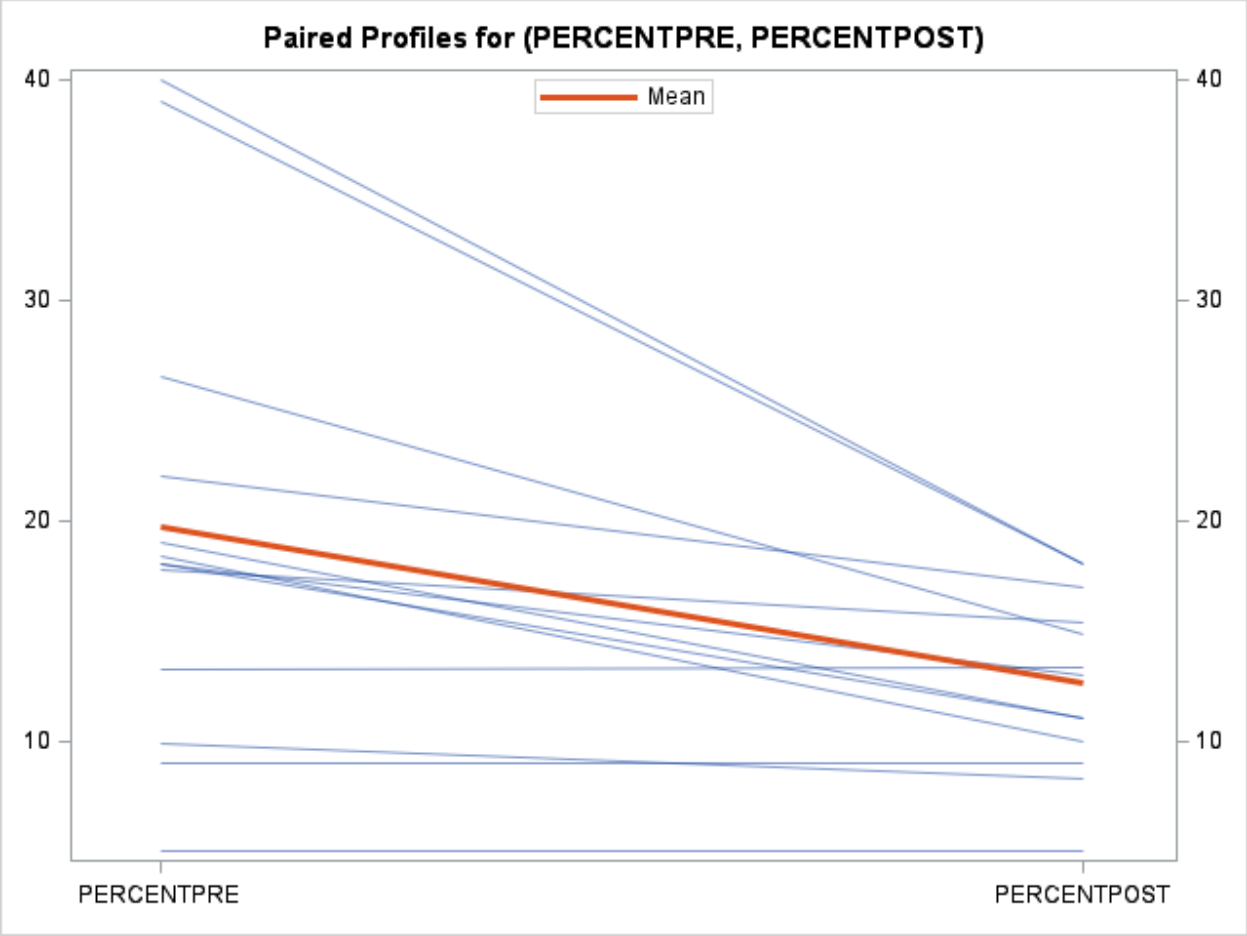
Modified CONSORT Diagram



Reference: Altman, D.G., Schulz, K.F., Moher, D., Egger, M.. Davidoff, F., Elbourne, D., Gøtzsche, P.C., & Lang, T. (2001). The revised CONSORT statement for reporting randomized trials: Explanation and elaboration. *Annals of Internal Medicine; 134*(8), 663-694.

Figure 2.

Graph of change from pre-intervention to post-intervention



Qualitative Responses from Workshop Participants Obtained During Survey Calls

1. **How and at what point in a resident's stay are you distributing the Guide/Trifold to residents? To families?**

"We are using the guide for admissions, readmissions, & quarterly care plan meetings. We have a very small amount [number of residents now] that want to go to the hospital-trusting us more. Guide is a support for what we are telling them. I check with my staff to make sure that they are using the guide. We talk about the guide and introduce it to the residents here. Guide is hardwired in the admission process & care plan process." - NC

"We have an admission folder for each resident in the Rehab to Home Unit, which has the large brochure [Guide] in it. We have the unit manager review the decision guide at 48 hours with residents/families in the short-term care unit (STC unit). In the long-term care unit (LTC unit), we review the guide at care plan meeting with residents." -KY

"Brochures are shared at admission. Unit managers and social services share the brochures and booklets. Brochures are place throughout the Center in common areas for families." - AL

"The guide is at the receptionist's desk. We give it to residents and families on admission. We talk about it during their stay. It backs up what we tell them-solidifies for them the information. If they have questions about the hospital, they have the pamphlet [Trifold]. They can ask questions. Families come in we give them the pamphlets." - NC

"It gives them (residents and families) information of what we can do at the nursinghome. We give it on admission and [have it] in our lobby for the families to pick up. It educates families that it is better to stay here. A lot of families don't know what we can do here. Anything to decrease hospital transfers-families want them to go. They think that the resident will get better-feel they can get more care at the hospital. Families can use the guide-makes them more comfortable than just hearing it from us about not to transfer and what we can do here." - NC

"I noticed that families are appreciative of the info-but old habits die hard. We have it readily available. We find that the Nurse Practitioner working with families is more effective. Guide is available at care conferences, admissions and we keep it in the binder at the patient's bedside. We find quite frequently that the guides are removed from the binders-so people are reading them. Still, feel it is best when NP & MD communicate besides [in addition to] the literature." - AL

"We have it readily available, do care conferences and on admissions and have a binder at each resident's bedside." - AL

"We use the guide when patient starts to display symptoms that could lead them to transfer to the hospital. Family will ask questions using the guide. Do not use it at admission as families are not thinking about hospital transfers at that time-too overwhelmed. Use the guide to educate families/residents about what can be done at the NH." - TN

"The guide is easy to use, simple to hand out in planning visits. It helps the nurses and residents understand the level of care we can give here in the facility. Families are better educated and even residents have an idea of when they can stay in house." - FL

2. Are follow-up discussions and/or referrals to information in the Guide/Trifold occurring during a resident stay?

"This (guide) opens the door to start a conversations and transitions to a new way of thinking. We now have something to start on that conversation-general conversations about transitions to the hospital and not going back and forth to the hospital." - MS

"We give families the guide on admission, but use it in a crisis." - AL

"They (family) take the guide with them and use it when resident is possibly going to hospital. The guide stays in the resident's room and [with] follow-up at care plan meetings. The Guide provides talking points. We really like it." - SC

"We use the guide to explain difficult conversations-the hospital will not help. It has been crucial for my team-what to say and how to keep them in the facility. In a crisis, family members panic, staff panic. Just stop and think what we can do here. Great educational tool for staff. Gives my staff training to stop and think what we can [do]-educate the staff on what we can do." - AL

"We put it in our admissions packet and [use] during care plans. Physicians talked about it. Nurse practitioners use it as well." - GA

"It eases the process [discussion] of readmission in which families are involved. The guide is simple and well-written. It is very helpful for nursing staff & residents to understand the level of care we can give at the facility." - MS

"In June we had a family brunch to talk about the guide. We talked about Advance Directives, rolled it into thinking about healthcare and making hard decisions. What a facility can do, laying it out. We are having the conversations-guide is information on the front end. The culture of the community (small town),-they want to go to the hospital. We talk to people about the risk of infection-let us try to get a Chest x-ray here and antibiotics-you can get the Flu in the hospital Emergency Department." - NC

“We use it at a family night program on advanced directives and provide copies of the booklets/pamphlets. Use as supplemental material to inform families about advance directives (this is a CCRC). Guide is "non-threatening." We are not pushing any decision. - NC

“It helps to explain, you know, like with the elderly, how traumatic it can be transferring back and forth to the hospital. Keeping them in familiar surroundings, keeping them here, IV fluids, IV antibiotics. Easy segue into conversations about transfers and not transferring or treatments here.” - AL

“The resident and family were adamant on going to the hospital and our Nurse Navigator or liaison talked to them using the guide and then explained all the things we can do in the facility. The family was shocked that we could do all those things like a hospital can and the best part was they didn't have to put their loved one through a ride back to the hospital waiting to be evaluated; we could start treatment immediately.” - SC

“We redistribute the guide as needed. We make sure that families have a copy and remind them at care plan meetings about the guide. It gives them more understanding we have been able to explain to families that residents with co-morbidities may be more traumatic to transfer them to the hospital. The family members know our staff-family members can go home-but in the hospital where they don't know the staff, families may have to stay 24 hours because their relative gets confused.” - GA

3. Have you found the Guide/Trifold useful in reducing hospital readmissions?

“About 40 facilities in Southeast region-all are using the guide. It has helped tremendously to decrease readmissions. We encourage staff/facilities to use the tri-fold when spending time with residents. Family/residents do not understand what the NH can do and the adverse effects of hospitalizations. Corporate wants to expand the guide system-wide-across other regions in US.” - GA

“We are seeing a lot more families opting for palliative care and not opting for hospital transfers.” - AL

There are misconceptions about the hospital. We have lab turn arounds in one hour. Faster than the emergency department. We can do x-rays, bloods in the next hour. We have a lot of things that we could turn around in 3 hours. Families think the hospital can do more... Readmission rate since 1/1/19-25: June-0 readmissions and July only 1.” - AL

“Our readmission rate has dropped significantly-15 to 20%. Prior to guide, 40% range. In May, 0 readmissions.” - AL

“Guide initiated in April (Jan-March: 26 readmissions). For May-July: 16 readmissions-decrease of 10 readmissions 3 months after the guide.”

“The guide has dropped hospital readmissions from 35% in April to 17% in May.” - TN

"Our readmission rate this year (Jan-June 2019) 13%. Last year (2018)-26%. Down 13%. I feel the guide has really helped." - GA

"For patients who are going to hospital frequently, it has helped to avoid readmission for simple respiratory problems and urinary tract infections. It has reduced things like going to the emergency department for x-rays and lab work." - FL

"Residents are at end of life and we review the palliative care and they change their decisions at that time and stay in the facility for palliative or hospice care." - MS

"Sometimes residents will feel it is okay to call the physician and get orders. The residents are asking questions, so [thinking] maybe I do not need to go to the hospital. Only one readmission in May." - TN

"It eases the process [discussion] of readmission. It ensures a process in which the families are more involved. It is simple and well written, very helpful for nursing staff and residents alike." – MS

"Give it to all our new admissions and they ask lots of questions and opens the door for more questions during care plan meetings. The information really dispels the stigma about NH and gives us the opportunity to show how we can care for our residents". - NC

4. What has been the response of residents and their families to the Guide/Trifold?

"They tell me that they love the information-they just love it." - GA

"Families and residents have voiced that the guide explains their right to choose how they want their medical care, reviews/explains advance directives and goes into detail about medical services SNFs can provide." - GA

"Our families like and find it easy to read, some have lower literacy and we noticed they still understand and ask better questions now." - NC

"I feel that they have (found it helpful). The fact that they understand what our capabilities are here. It opens up conversations and helps to explain what we can do here-talking points." - AL

"They seem glad to have a guide as they make decisions." - AL

"We use it during care plan meetings and on admission to go over the care we can provide. We do get questions from many of the residents or families regarding advanced care [planning], how we can support sicker residents and also some about options for seriously ill residents." - NC

"[We were] slow to start the process, but we hardwire it into our admission and care plan meetings. We use both Trifold and Book form. Still have some family that no matter what they

insist on the hospital. However we have increased our ability to care for respiratory events and UTIs and it made a difference in the confidence of the families." - NC

"Families have found it helpful. Once we explain what we try to do before sending them out to the hospital, they are comfortable with that." - GA

"We had pretty good feedback on it at family council meeting. The social workers had good feedback on it as well." - GA

"From what I can tell, yes just with the decision of going to the hospital-gain trust-seem to be thinking more about what we could do at our facility. IV antibiotics. It (guide) opens up the communication." - GA

"When we give the guide to residents & family we get positive feedback. It has reduced readmissions by families that have read and understood the guide, definitely would recommend." - FL

"I sat in on a care plan meeting (LTC residents). Residents and families have found it helpful. Our social worker does care plan meeting and I noticed that the families like it. Especially to know what we could do here. One family member with a LTC resident did not realize what could be done at the facility." - KY

"The guide has provided education on the services that we can provide in the home; therefore, the residents and the families feel more comfortable with the facility providing services before sending the resident to the hospital." - MS

"They feel better about the services we provide in the facility and we agree that we will exhaust all measures in-house before we send to the hospital to ensure quality of care. Yes they have. They are reassured in the skills we can provide and that it's safer to keep their loved one out of the hospital." - NC

"We have been able to put processes in place with dementia to decrease readmissions. Residents and family-guide helpful-really like the guide. Big opportunity to have conversations with independent living residents and then provide them with services on campus." - NC

"The residents and families who use it find it helpful. Just appreciated the information, a lot of information-think of questions after the conversations having the brochures. We use the full sized booklets. Families and residents have asked questions after reading the guide. We have good relations with families. It's a great tool and answers some of the difficult questions. I wish we could use it more." - NC

"Love (families) the education that they can be treated in the facility. Like to get it in the brochure rather than staff just telling them." - SC

5. Examples of readmissions prevented by using the Guide/Trifold.

"IV fluids were given for dehydration. Family was not aware we could initiate IV fluids." - AL

"We had one individual (mother-daughter combo lives here). The other daughter lives in the community and had to make decisions about hospice for her mother. We used the guide and it helped them choose hospice through our discussions. She kept her mother at nursing home instead of the hospital and select hospice." - AL

"Patent had TIAs-at first family said-send her to the hospital and then realized that we could do the same things as the hospital." - AL

"One patient had weight loss and was not eating- we felt he was dehydrated. We ordered fluids-got them hydrated. The IV fluids increased his appetite and they stayed at the nursing home." - GA

"We had a patient this week with dementia-the son usually wants to send the patient to the hospital. We explained to the son the treatments at the NH and he agreed. We also explained the distress that hospitalization would cause to patients with dementia." - GA

"We had a specific resident has chronic pain and alert and oriented. The resident had extreme pain-but the daughter talked with the resident to stay in the facility using the guide. We controlled his pain and he was discharged home in a few days." - KY

"One family last week, the resident had a urinary tract infection. His midline catheter had infiltrated and he removed it. Family knew IV was out. Family knew that the antibiotics were completed for treatment. We have an IV team (outside agency-contract with). Family advocating to keep resident in the facility. Physician wanted to send the resident out for a PICC line but family knew we could insert an IV line in the facility. Resident stayed in the facility." - KY

"One resident whose daughter is a nurse practitioner and always wanted to send her mother to the hospital. I talked with her and let her know what we can do and we can check her more. The daughter agreed to have her mother stay in the NH. If we keep using it repeatedly it will get easier for families to accept and the risks involved in sending them (residents) out." - MS

"We used the guide the other day for a very sick resident. It helped us show the family that going back and forth to the hospital was not in the best interest of the resident. Helped them come to acceptance to this situation. Helped family and resident choose hospice and hospice was the best choice." - MS

“We had a patient with some left-sided numbness and tingling in her extremities. The patient was scared. The patient was on Vancomycin IV. She was receiving this daily. We thought that she may be experiencing symptoms of nephrotoxicity from the Vancomycin. We did the trough level 2 days earlier than it was due and it was high. Avoided patient going to the hospital for these symptoms. The patient was scared but we explained to her what we wanted to do in the NH.” - NC

“We have a couple of situations where the nurse reassured the family about not sending the resident out. A resident with respiratory issues-resident did not have instability-VS stable. The resident seemed different to the family members. The nurse talked with the family members and told them that's its flu season and she could get worse in the hospital. We did labs and IVs. The family was satisfied and kept the resident here at the NH. That resident did not eat well, had respiratory issues-the doctor ordered antibiotics, IV fluids, and labs-family satisfied. Other patient was more pain related and the nurse talked the family out of sending the resident to the hospital. The doctor changed his pain medications and the patient stayed in the facility.” - NC