

Stop And Watch Tool Reduces Avoidable Hospital Readmissions



Authors From TMF Health Quality Institute: **Jennifer Markley**, RN, BSN, Senior Director For Quality Improvement; **Cindy Bigbee**, RN, MSN, Quality Improvement Consultant; And **Linda Whitmire**, Communications Specialist

MRS. TERESA NAVARRO* is eighty-eight years old. Like most seniors, she has many health issues and chronic debilitating illnesses. Most problematic of these are chronic obstructive pulmonary disease (COPD), asthma, congestive heart failure (CHF), diabetes and dementia. Teresa is bedridden and dependent on her family for decisions and care. A few years ago, her family members had to rush her to the Emergency Department (ED) almost every month.

“It was hard on us, too,” said her daughter, Eloisa,* “she would be admitted right away for four, five or six days.” Margo, another of Teresa’s daughters, and her husband Raphael* said that Teresa, because of her severe dementia, does not like the hospital with its bright lights and strange noises. But whenever Teresa would have severe shortness of breath, her family did not know what else to do but hurry her to the ED.

Improving Care For Seniors

About three years ago, Teresa broke her foot. Because none of her caregivers could lift her to change or bathe her, they sought a skilled nursing facility. From its word-of-mouth reputation, they chose Valley Grande Manor. It so happens that the Weslaco, Texas facility rates five stars on the Centers for Medicare & Medicaid Services (CMS) “Nursing Home Compare,” the high-

est rating possible. Valley Grande Manor is the only facility in Hidalgo County that has achieved this ranking.

About the same time that Teresa came to them, Valley Grande Manor joined the Care Transitions Project, a CMS-funded program managed in Texas by TMF Health Quality Institute, Medicare’s Quality Improvement Organization for the state. The goal of the Care Transitions Project was to reduce avoidable 30-day rehospitalizations, and preserve Medicare funding for those hospitalizations that are unavoidable, without sacrificing quality of care.

In addition to Valley Grande Manor staff members attending the Care Transitions Project community-wide trainings and workgroups that TMF Health Quality Institute sponsored, TMF consultant Cindy Bigbee worked with staff at the facility itself. “She was here so much, she is like one of us, now,” says Luz Llasos, director of nursing (DON) at Valley Grande Manor. “We didn’t know anything about the program before she came here.”

Using Best-Practices

One of the things that TMF Health Quality Institute helped Valley Grande Manor do to keep patients out of the hospital was to use proven, evidence-based best practice methods. One of these was “Stop and Watch,” a tool made available through the

INTERACT project (Interventions to Reduce Acute Care Transfers) see **Figure 1**. Developed by the Georgia Medical Care Foundation with support from CMS and enhanced under a grant from The Commonwealth Fund, INTERACT encourages improvement in nursing home care by providing tools and resources to reduce avoidable hospital transfers.

Figure 1. Illustration Of “Stop And Watch” Tool

INTERACT^{II}
Interventions to Reduce Acute Care Transfers

EARLY WARNING TOOL
“Stop and Watch”

If you have identified an important change while caring for a resident today, please circle the change and discuss it with the charge nurse before the end of your shift.

Name of Resident _____

Seems different than usual
Talks or communicates less than usual
Overall needs more help than usual
Participated in activities less than usual

Ate less than usual (Not because of dislike of food)
N
Drunk less than usual

Weight change
Agitated or nervous more than usual
Tired, weak, confused, or drowsy
Change in skin color or condition
Help with walking, transferring, toileting more than usual

Staff _____
 Reported to _____
 Date ____ / ____ / ____ Time _____

Stop and Watch used a reminder system to prompt nursing home staff to report to the nurse in charge any changes that could be early warning signs of a problem. The emphasis was on identifying and treating disease symptoms as fast as possible to keep residents from getting so sick that they needed to be hospitalized. Aides were encouraged to carry the pocket-sized cards with them and document any changes they saw. But aides didn’t always have time to document or transfer their notes to the computer during their shift.

“Now every shift reports verbally to the charge nurse who then logs on to the computer and types a report that the assistant director of nursing reviews to make sure that we follow up with every patient exhibiting any warning signs,” says Llasos.

A monitoring tool provided by TMF Health Quality Institute

(see **Figure 2**, page 38) helped Valley Grande Manor track how often Stop and Watch was used and whether or not the resident was treated in place or hospitalized. Use of the Stop and Watch reminder cards encouraged aides to be more observant of each resident’s condition and increased the frequency with which aides reported changes to the charge nurse.

“Aides needed to know residents really well to recognize signs like confusion and lethargy, which could indicate a urinary tract infection,” says Bigbee. “Subtle signs of infection are harder to notice in residents who may have dementia or complicating issues.” According to Medicare data, infection is one of the top five reasons patients were rehospitalized in the Harlingen Hospital Referral Region from 2007-2010.

Treatment In Place

Llasos says their Medical Director works with the skilled nursing facility’s care team and supervises treatment of residents at the facility instead of automatically sending patients to the hospital. Llasos and her staff have worked with physicians in the past that routinely sent residents to the hospital at the first sign of a problem. Now, residents can receive IV antibiotics, mobile labs and even X-rays right at Valley Grande Manor. However, if residents are sick enough, Llasos emphasizes, the nursing home does not hesitate to call an ambulance and send them to the hospital. The point is to provide vigilant care so that residents won’t get that sick.

According to Stop and Watch data, the intervention seems to be making a difference. In November 2009, roughly 25 percent of residents from Valley Grande Manor were hospitalized for warning signs noted under Stop and Watch. By September of 2010, only half as many, 12.5 percent, were.**

Behind the data are residents like Teresa Navarro who have benefited from the staff’s watchfulness. “Since we brought her here, she’s only gone to the hospital three times in three years,” said Teresa’s son-in-law Raphael.

Nebulizer breathing treatments two times a day and whenever necessary usually kept Teresa’s COPD and asthma under control. She had three hospital admissions in 2010 and was kept out of the hospital nine times due to quick reporting when staff noticed a change in her condition and facility nurses and physicians rapidly began treatment. Teresa had several infections which were treated in place, including upper respiratory and urinary tract infections as well as other problems like a wound infection and tooth abscess that required treatment with antibiotics.

An example of how Teresa was treated in place occurred last October when she had “crackles” in both the left and right lung and complained of a sore throat and trouble swallowing. She was refusing food and slept a lot during the day. A call was placed to the Medical Director, who ordered a culture and sensitivity for urinary tract infection, breathing treatments and medications to help with her condition. At 4:30 a.m., a Valley

(more on next page)

Figure 2. Monitoring Tool Tracked Use Of Stop And Watch, Treatment In Place And Hospitalizations

Skilled Nursing Facility Monitoring Log (Name of Nursing Facility)								
Patient #	Patient Name	Date of Occurrence	# of Times MD Called	# of Times CNA Report Change in Cond., STOP/WATCH	# of Times Patient Treated in Place	# of Times Patient Hospitalized	# of Times Unplanned Transfer Review Completed	# of Times Action Taken
1	A	11/1/2010	1	1	1	0	0	3
2	B	11/1/2010	1	1	1	0	0	3
3	C	11/17/2010	1	1	1	0	0	3
4	D	11/23/2010	1	1	1	0	0	3
5	E	11/27/2010	1	1	1	1	0	4
6	F	11/30/2010	1	1	1	0	0	3

Grande Manor nurse started an IV antibiotic. The Medical Director then came to see Teresa to follow up on her condition. Later the next day, Teresa was feeling better, no longer complained of pain, regained her appetite and ate all of her dinner and, most importantly, did not require a hospitalization.

Hospitals Pose Risks For Frail Elderly

“Our doctors are very much aware that sometimes residents go to the hospital and, yes, that may solve one problem, but because of the hospitalization, the patient may develop other problems,” says Alma Pena, a Valley Grande Manor team leader and the assistant DON in charge of rehab patients. She says some patients become confused and disoriented at the hospital and take a long time to return to normal. Others lose weight. Some come down with hospital-acquired infections.

Many caregivers prefer to see their family members treated at the skilled nursing facility, when possible. For example, Teresa’s family knows the staff at Valley Grande Manor and there’s a level of trust between them that comes from familiarity. “There is a lady that works at Valley Grande Manor,” said Raphael, “and she has taken care of my mother-in-law so well that I think she must be related to her.” He said that if his mother-in-law had a problem with her heart, then Valley Grande Manor called an ambulance and took her to the hospital, but if there was an infection, they would try to treat it at the nursing home first.

Affordable Care Act

In the future, hospitals are likely to partner with nursing facilities that prevent avoidable hospitalizations. Llasos knows that, under healthcare reform and the Affordable Care Act, hospitals will need to partner with skilled nursing facilities that keep hospitalization costs low by providing a high quality of care for their patients and successfully preventing avoidable readmissions. The skilled nursing facility’s work on the Care Transitions Project and Stop and Watch is positioning them well for the future.

Credit for Valley Grande Manor’s success also goes to the camaraderie and culture the care team has fostered and the teamwork they’ve reinforced with everyday communications. “The

facility’s care team did a good job of watching for changes in a resident’s condition and following through with the nurse and doctor, which is probably why the facility performed so well on Stop and Watch,” says TMF Health Quality Institute’s Bigbee.

Llasos said it takes the acceptance of those in top management to make a program successful. When asked what advice she would give to other skilled nursing facilities, Llasos said go through the quality improvement process and work one day at a time. “It’s like, when you are running, you will fall if you go too fast. But if you walk, you are more likely to reach your destination. And that’s how we work here.”

Teresa’s daughter Eloisa said, “My Mom is calmer here. At the hospital you have to be there at a certain time and only certain people can see her. And if she’s in Intensive Care, we only have ten or fifteen minutes to see her, even though she gets good treatment. Here, we can come whenever we want.”

TMF is part of a national network of Quality Improvement Organizations, one for every state and territory, under the direction of CMS. The QIO Program’s goals include improving the health of the Medicare population, improving the care that Medicare beneficiaries receive, and reducing the costs of care that Medicare purchases.

RR

**Not the beneficiary’s or family member’s real name. Medicare protects the privacy of its beneficiaries.*

***Facility self-monitoring data.*

The analyses upon which this publication is based were performed under Contract Number HHS/Mj-500-2008-TX9THC, entitled 9SOW Sub-national Theme 7.2, Care Transitions, sponsored by the Centers for Medicare & Medicaid Services (CMS), Department of Health & Human Services. The content of this publication does not necessarily reflect the views or policies of the Department of Health & Human Services, nor does mention of trade names, commercial products, or organizations imply endorsement by the U.S. Government.

The authors assume full responsibility for the accuracy and completeness of the ideas presented. This article is a direct result of the Health Care Quality Improvement Program initiated by the CMS, which has encouraged identification of quality improvement projects derived from analysis of patterns of care, and therefore required no special funding on the part of this contractor. Feedback to the corresponding author concerning the issues presented is welcomed. 9SOW-TX-CT-10-59.