CALTCM SNF 2.0®
Readmissions Webinar, Utilizing SBAR

California Association of Long Term Care Medicine (CALTCM)
and
Health Services Advisory Group (HSAG)
Wednesday, August 9, 2017
Webinar Presenters

Lindsay Holland, MHA  
Director, Care Transitions  
HSAG

Albert Lam, MD  
Chair, Department of Geriatrics  
Palo Alto Foundation Medical Group

Cheryl Reinking, MS, RN, NEA-BC  
Chief Nursing Officer  
El Camino Hospital
Objectives

• Discuss the Quality Innovation Network-Quality Improvement Organization (QIN-QIO) readmission data and metrics.

• Identify Situation Background Assessment Recommendation (SBAR) and how to effectively use it in your skilled nursing facility (SNF).

• Distinguish how SBAR is used in the hospital and the SNF.
QIN/QIO Readmission Data and Metrics

Lindsay Holland, MHA
Director, Care Transitions
HSAG
• HSAG is California’s Medicare QIN-QIO.
• QIN-QIOs in every state and territory are united in a network administered by the Centers for Medicare & Medicaid Services (CMS).
• The QIN-QIO program is the largest federal program dedicated to improving health quality at the community level.
About HSAG

Nearly 25 percent of the nation’s Medicare beneficiaries

HSAG is the Medicare QIN-QIO for California, Arizona, Florida, Ohio, and the U.S. Virgin Islands.
California Medicare Fee-for-Service (FFS) Hospital Readmission Rates

<table>
<thead>
<tr>
<th>Calendar Year (CY)</th>
<th>Readmission Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>CY 2013</td>
<td>18.5%</td>
</tr>
<tr>
<td>CY 2014</td>
<td>18.3%</td>
</tr>
<tr>
<td>CY 2015</td>
<td>18.5%</td>
</tr>
<tr>
<td>Q1 2016</td>
<td>18.4%</td>
</tr>
<tr>
<td>Q2 2016</td>
<td>18.5%</td>
</tr>
</tbody>
</table>

0% relative improvement rate

Medicare Fee-for-Service claims data representing calendar year 2013 to Q2 2016 was used for the analyses in this report. Claims data is provided to Health Services Advisory Group (HSAG) by the Centers for Medicare & Medicaid Services (CMS). The data includes Part-A claims for Fee-for-Service beneficiaries.

<table>
<thead>
<tr>
<th>Setting</th>
<th>0–7</th>
<th>8–14</th>
<th>15–21</th>
<th>22–30</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Count</td>
<td>Rate</td>
<td>Count</td>
<td>Rate</td>
</tr>
<tr>
<td>Home</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home</td>
<td>22,476</td>
<td>37.50%</td>
<td>14,869</td>
<td>24.8%</td>
</tr>
<tr>
<td>SNF*</td>
<td>12,212</td>
<td>32.80%</td>
<td>9,608</td>
<td>25.8%</td>
</tr>
<tr>
<td>HHA**</td>
<td>9,462</td>
<td>36.00%</td>
<td>6,674</td>
<td>25.4%</td>
</tr>
<tr>
<td>Hospice</td>
<td>245</td>
<td>40.20%</td>
<td>137</td>
<td>22.5%</td>
</tr>
<tr>
<td>Other</td>
<td>4,601</td>
<td>42.90%</td>
<td>2,332</td>
<td>21.7%</td>
</tr>
<tr>
<td>Total</td>
<td>48,996</td>
<td>36.40%</td>
<td>33,620</td>
<td>24.9%</td>
</tr>
</tbody>
</table>

36.4% returning within one week of discharge

* Skilled nursing facility (SNF)
** Home Health Agency (HHA)

Medicare Fee-For-Service claims data representing Q3 2015 to Q2 2016 was used for the analyses in this report. Claims data is provided to Health Services Advisory Group (HSAG) by the Centers for Medicare & Medicaid Services (CMS). The data includes Part-A claims for Fee-for-Service beneficiaries.
## California Hospital Readmission Penalties

<table>
<thead>
<tr>
<th>Hospital Penalty Year</th>
<th>Number of Hospitals Penalized</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>197</td>
</tr>
<tr>
<td>2014</td>
<td>165</td>
</tr>
<tr>
<td>2015</td>
<td>153</td>
</tr>
<tr>
<td>2016</td>
<td>147</td>
</tr>
<tr>
<td>2017</td>
<td>207</td>
</tr>
<tr>
<td>2018</td>
<td>221</td>
</tr>
</tbody>
</table>

Readmission penalties data, Centers for Medicare & Medicaid Services (CMS).
Doing things the same way... ...will NOT reduce readmissions.
California Care Coordination Communities

- **Cohort A**: 2014
- **Cohort B**: 2015
- **Cohort C**: 2016
The data source for the beneficiary counts within each community of the cohort is the Centers for Medicare & Medicaid Services (CMS) National Coordinating Center (NCC) Scorecard.
California Cohort B: Readmissions

The data source for the beneficiary counts within each community of the cohort is the CMS NCC Scorecard.
The data source for the beneficiary counts within each community of the cohort is the CMS NCC Scorecard.
We Can Do Better California!

Tips for improvement

• Focus on your 7-day readmission rate
  – Review case studies
  – Conduct a root-cause analysis
  – Share your findings with your hospital/SNF partners
• Implement and consistently use SBAR in your facility
• Form hospital and SNF partnerships
• Aim to reduce 10 readmissions per month to reach the 10% RIR goal
Thank you!

Health Services Advisory Group:
Lindsay Holland
Director, Care Transitions
Lholland@hsag.com
What Hospitals and SNFs Need to Know About SBARs

Albert Lam, MD
Chair, Department of Geriatrics, Co-Founder SNF 2.0®,
Co-Founder TriageTRACE digital SNF 2.0®
Background

Nursing Homes

Medical Director

Medical Group

Health Plan/Payor

Hospital

SNF 2.0®

CALTCM
California Association of Long Term Care Medicine
Plan for Success

CALTCM Premium Training + SNF 2.0®

1:1 Telephonic Coaching Sessions for 6 months

Education, Leadership Training and Patient Satisfaction

SAMPLE of 13 NHs: 10.4% Readmission Reduction after 6 months

33–66% Readmission Reduction

1:1 Mentorship Incentive Programming

Combine CALTCM Training with SNF 2.0®

Maximize Results

Improved Care Accrues to Patients

Savings are Multifaceted

Savings Accrue to Health Plans

(CALTCM)

(SNF 2.0®)
SNF 2.0®: The 5 Principles

**CALTCM SNF 2.0®** Train the Mentor Principles

**Principle 1:** See every moment as a teaching moment.

**Principle 2:** Promote Accountability in a "No shame, No blame" environment.

**Principle 3:** Never allow someone to do a first SBAR/provider call alone.

**Principle 4:** Learn to walk others through the process.

**Principle 5:** Show appreciation.

---

Copyright SNF 2.0® All rights reserved. This training material may not be modified, adapted or reproduced in part or whole without express written consent of Albert Lam, MD.
Are you using SBARs to communicate changes of condition for nurse communication?

A. Hospital—Yes, most of the time using
B. Hospital—No, most of the time not using
C. SNF—Yes, most of the time using
D. SNF—No, most of the time not using
SBAR Background

• Developed by Michael Leonard, MD; Doug Bonacum; and Suzanne Graham at Kaiser Permanente Colorado in 2002
Where Did the SBAR Come From?

Doug Bonacum

Vice President, Quality, Safety, and Resource Management
Kaiser Permanente, Oakland, CA
June 1994–Present

Environmental, Health, and Safety Manager
Tyco, North American Printed Circuits
April 1992–June 1994

Officer
U.S. Submarine Force
June 1983–February 1991
Elements of the Original SBAR

<table>
<thead>
<tr>
<th>Situation</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am calling about &lt;patient name and location&gt;.</td>
</tr>
<tr>
<td>The patient's code status is &lt;code status&gt;.</td>
</tr>
<tr>
<td>The problem I am calling about is __________________________.</td>
</tr>
<tr>
<td>I am afraid the patient is going to arrest.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>I have just assessed the patient personally:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vital signs are: Blood pressure <strong><strong>/</strong></strong>, Pulse ____., Respiration ____ and temperature ____</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>I am concerned about the:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood pressure because it is over 200 or less than 100 or 30 mmHg below usual</td>
</tr>
<tr>
<td>Pulse because it is over 140 or less than 50</td>
</tr>
<tr>
<td>Respiration because it is less than 5 or over 40.</td>
</tr>
<tr>
<td>Temperature because it is less than 96 or over 104.</td>
</tr>
</tbody>
</table>

This SBAR tool was developed by Kaiser Permanente. Please feel free to use and reproduce these materials in the spirit of patient safety, and please retain this footer in the spirit of appropriate recognition.
Elements of the Original SBAR (cont.)

<table>
<thead>
<tr>
<th>B</th>
<th>Background</th>
</tr>
</thead>
<tbody>
<tr>
<td>The patient's mental status is:</td>
<td></td>
</tr>
<tr>
<td>Alert and oriented to person place and time.</td>
<td></td>
</tr>
<tr>
<td>Confused and cooperative or non-cooperative</td>
<td></td>
</tr>
<tr>
<td>Agitated or combative</td>
<td></td>
</tr>
<tr>
<td>Lethargic but conversant and able to swallow</td>
<td></td>
</tr>
<tr>
<td>Stuporous and not talking clearly and possibly not able to swallow</td>
<td></td>
</tr>
<tr>
<td>Comatose. Eyes closed. Not responding to stimulation.</td>
<td></td>
</tr>
</tbody>
</table>

| The skin is: |
| Warm and dry |
| Pale |
| Mottled |
| Diaphoretic |
| Extremities are cold |
| Extremities are warm |

| The patient is not or is on oxygen. |
| The patient has been on _______ (l/min) or (%) oxygen for _____ minutes (hours) |
| The oximeter is reading _______ % |
| The oximeter does not detect a good pulse and is giving erratic readings. |

This SBAR tool was developed by Kaiser Permanente. Please feel free to use and reproduce these materials in the spirit of patient safety, and please retain this footer in the spirit of appropriate recognition.
Assessment

This is what I think the problem is: __<say what you think is the problem>__
The problem seems to be cardiac infection neurologic respiratory ___
I am not sure what the problem is but the patient is deteriorating.
The patient seems to be unstable and may get worse, we need to do something.
Elements of the Original SBAR (cont.)

Recommendation

I suggest or request that you <say what you would like to see done>.
- transfer the patient to critical care
- come to see the patient at this time.
- Talk to the patient or family about code status.
- Ask the on-call family practice resident to see the patient now.
- Ask for a consultant to see the patient now.

Are any tests needed:
- Do you need any tests like CXR, ABG, EKG, CBC, or BMP?
- Others?

If a change in treatment is ordered then ask:
- How often do you want vital signs?
- How long to you expect this problem will last?
- If the patient does not get better when would you want us to call again?

This SBAR tool was developed by Kaiser Permanente. Please feel free to use and reproduce these materials in the spirit of patient safety, and please retain this footer in the spirit of appropriate recognition.
Hospital Use of SBAR

Cheryl Reinking, MS, RN, NEA-BC
Chief Nursing Officer, El Camino Hospital

Executive Sponsor for Transitions of Care Project at El Camino Hospital and Avoiding Readmissions Collaboration
Usage

• Used in some hospitals and some SNFs
• Hospitals use SBAR:
  – Structured method of gathering relevant patient information
  – Giving the nurse opportunity to organize this information before calling the physician
  – A method for clearly communicating what is needed for the patient to continue optimal care
Hospital SBAR Usage

Several areas for usage:

- Critical/stable patient situations
- For interdepartmental transfers, post-acute transfers, and inter-shift handoff report
- Electronic health record (EHR) is built with SBAR handoff methodology, pulling relevant data from the medical record
**Nursing Differences**

**Hospital**
- 1:2 to 1:8 nurse to patient ratio
- Multidisciplinary teams including social work, pharmacists, therapists, techs, and physicians
- Frequent CEU and educational opportunities
- Top pay opportunities
- Physicians more present
- Warm handoffs standard

**Nursing Facilities**
- 1:20 to 1:40 nurse to patient ratio
- Fragmented patchwork of teams
- Infrequent educational opportunities
- Pay 1/2 to 2/3 of hospital
- Physicians minimally present
- Warm handoffs may not be standard
SNF SBARs

Key to improved assessments

Key to improved communication
SBAR in SNFs

• Key component of the INTERACT®* program developed by:
  – Joseph Ouslander, MD
  – Gerri Lamb, PhD, RN
  – Laurie Herndon, GNP
  – Ruth Tappen, EdD, RN
  – Jo Taylor, RN
  – And many others

*Interventions to Reduce Acute Care Transfers
Before Calling the Physician / NP / PA / other Healthcare Professional:

☐ Evaluate the Resident: Complete relevant aspects of the SBAR form below
☐ Check Vital Signs: BP, pulse, and/or apical heart rate, temperature, respiratory rate, O₂ saturation and finger stick glucose for diabetics
☐ Review Records: Recent progress notes, labs, medications, other orders
☐ Review an INTERACT Care Path or Acute Change in Condition File Card, if indicated
☐ Have Relevant Information Available when Reporting
  (i.e. medical record, vital signs, advance directives such as DNR and other care limiting orders, allergies, medication list)

SITUATION
The change in condition, symptoms, or signs observed and evaluated is/are:

This started on _______ / _______ / _______ Since this started it has gotten: ☐ Worse ☐ Better ☐ Stayed the same

Things that make the condition or symptom worse are ____________________________

Things that make the condition or symptom better are ____________________________

This condition, symptom, or sign has occurred before: ☐ Yes ☐ No

Treatment for last episode (if applicable) _______________________________________

Other relevant information ____________________________________________________

BACKGROUND

Resident Description
This resident is in the facility for: ☐ Long-Term Care ☐ Post-Acute Care ☐ Other: ____________________________

Primary diagnoses ___________________________________________________________

Other pertinent history (e.g., medical diagnosis of CHF, DM, COPD) ____________________________

Medication Alerts
☐ Changes in the last week (describe) _____________________________________________

☐ Resident is on (Warfarin/Coumadin) Result of last INR: ______ Date ______ / ______ / ______

☐ Resident is on other anticoagulant (direct thrombin inhibitor or platelet inhibitor)

Resident is on: ☐ Hypoglycemic medication(s) / Insulin ☐ Digoxin

Allergies ____________________________

Vital Signs
BP _______ Pulse _______ (or Apical HR _______) RR _______ Temp _______ Weight _______ lbs (date _______ / _______ / _______)

For CHF, edema, or weight loss: last weight before the current one was ______________________ on _______ / _______ / _______

Pulse Oximetry (if indicated) ______% on ☐ Room Air ☐ O₂(_______)

Blood Sugar (Diabetics) ____________________________
### Resident Evaluation

**Mental Function Behavior Resp Cards**

1. **Mental Status Evaluation (compared to baseline; check all changes that you observe)**
   - Decreased level of consciousness (sleepy, lethargic)
   - Increased confusion or disorientation
   - Memory loss (new or worsening)

   **Describe symptoms or signs**

2. **Functional Status Evaluation (compared to baseline; check all that you observe)**
   - Decreased mobility
   - Needs more assistance with ADLs
   - Falls (one or more)

   **Describe symptoms or signs**

3. **Behavioral Evaluation**
   - Danger to self or others
   - Depression (crying, hopelessness, not eating)
   - Social withdrawal (isolation, apathy)

   **Describe symptoms or signs**

4. **Respiratory Evaluation**
   - Abnormal lung sounds (rales, rhonchi, wheezing)
   - Asthma (with wheezing)
   - Cough (Non-productive □ Productive)

   **Describe symptoms or signs**

5. **Cardiovascular Evaluation**
   - Chest pain/tightness
   - Edema
   - Inability to stand without severe dizziness or lightheadedness

   **Describe symptoms or signs**

6. **Abdominal/GI Evaluation**
   - Abdominal pain
   - Constipation (date of last BM __/__/____)
   - Decreased/absent bowel sounds

   **Describe symptoms or signs**

---

**Note:** Except for Mental and Functional Status evaluations, if the item is not relevant to the change in condition check the box for “not clinically applicable to the change in condition being reported.”
### GU/Urine Evaluation
- Blood in urine
- Decreased urine output
- Lower abdominal pain or tenderness
- New or worsening incontinence
- Painful urination
- Urinating more frequently or urgency with or without other urinary symptoms
- Other (describe)
- No changes observed

Describe symptoms or signs:

- Not clinically applicable to the change in condition being reported

### Skin Evaluation
- Abrasion
- Blister
- Burn
- Contusion
- Discoloration
- Itching
- Laceration
- Pressure ulcer
- Puncture
- Rash
- Skin tear
- Splinter/silver
- Wound (describe)
- Other (describe)
- No changes observed

Describe symptoms or signs:

- Not clinically applicable to the change in condition being reported

### Pain Evaluation

1. Does the resident have pain?
   - No
   - Yes (describe below)

2. Is the pain?
   - New
   - Worsening of chronic pain

3. Description/location of pain:

4. Intensity of Pain (rate on scale of 1-10, with 10 being the worst):

5. Does the resident show non-verbal signs of pain (for residents with dementia)?
   - No
   - Yes (describe) (restless, pacing, grimacing, new change in behavior)

6. Other information about the pain:

- Not clinically applicable to the change in condition being reported

### Neurological Evaluation
- Abnormal Speech
- Decreased level of consciousness
- Dizziness or unsteadiness
- Seizure
- Weakness or hemiparesis
- Other neurological symptoms (describe)
- No changes observed

Describe symptoms or signs:

- Not clinically applicable to the change in condition being reported
• Appearance
• Notification
• Orders
• Notes
Key Differences

- Longer
- More detailed
- More documentation
- Greater emphasis on assessment

- More cumbersome
- Less focused
- More paperwork/computer work
- Less effective for MD communication
Why?

• Longer
• More detailed
• More documentation
• Greater emphasis on assessment

• 1:20 to 1:40 nurse to patient ratio
• Fragmented patchwork of teams
• Infrequent educational opportunities
• Pay 1/2 to 2/3 of hospital
• Physicians minimally present
• Warm handoffs may not be standard
What Can We Do?

Hospitals
- Publicly support and encourage accurate assessments from SNFs
- Engage physicians in promoting good SNF care
  - Avoid cutting off nursing reports
  - Ask questions
  - Encourage and express appreciation for the effort
- Own a HSAG hospital collaborative

SNFs
- Publicly support and encourage your nursing and non-nursing staff in their SBAR communication
- Be persistent
- Look for partners to reinforce the efforts
  - HSAG hospital collaboratives
  - Health plans
  - Progressive medical groups
  - CALTCM, others
Now I:

A. Understand how to use SBARs
B. Understand barriers to communication in SNFs
C. Will go out of my way to encourage SNF nurses to use SBAR communication
D. All of the above
E. None of the above
Contact Us if You Are Interested In:

• More information about how to create/join a hospital collaborative
• Nursing home mentorship with CALTCM SNF 2.0®
• Suggesting topics for future educational webinars
Thank you!