PHCA ANNUAL CONVENTION
2016 Excellence in Quality Contest

Submission Information:

- All applications should be in an electronic/typed format. (No hand-written applications will be accepted).
- The application should be no more than five pages using 12-point font.
- Attachments (charts, graphs, etc.) can be added, but should not exceed three additional pages.

Organization: Hanover Hall Nursing and Rehab Center

Company/Corporation: Wilmac Corporation

Storyboard Contact Information:

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Quality Category (Please select the one that best describes your storyboard):

Best Practice in Decreasing a PHCA Quality Measure

Evaluation Criteria: (Insert responses in each section below)

XXV. Indicate the problem that the quality project was trying to solve/impact.

Quality project was identified to reduce hospitalizations, particularly 30-day re-hospitalizations, in long term care as well as short stay residents. In addition to reduction by national benchmarks, goal of improving quality of care within the facility in regards to residents' comfort and quality of life.

XXVI. Outline the root cause analysis that occurred as part of the process.

Root cause analysis is an ongoing process with each transfer out of the facility with use of Interact and PointRight Logistic System. Any pattern or trend is identified such as Physician, after hours calls, unit, diagnosis or family preference. Nursing care and interventions prior to transfer are reviewed. Facility establishes standards based on Quality Measures and National Benchmarks. Monthly progression or regression is determined with facility reporting related to those benchmarks

XXVII. Describe the process that was implemented or adapted.

"Morning rounds" are held daily where resident condition and change in status are discussed. Any opportunity for additional in house diagnostic procedures are discussed, if not already ordered. Advanced care planning has shown to be beneficial in regards to family/resident wishes in end of life care or change in condition. Wishes are known prior to Physician notification. Nurse Navigator was implemented to assist with care within the facility and monitor while in the community after discharge.

XXVIII. Outline the monitoring plan, timeframe.

Monitoring is ongoing and monthly. Facility projection is to continue with decline in transfers out of the facility, and maintain reporting percentages below national benchmarks.

XXIX. Identify challenges/pain points that occurred throughout the process.

Family preference and resident expectation continue to be a challenge. Refusal to address code status and denial of acceptance of current prognosis often present as a barrier to in house treatment. Denial of continued stay coverage thru commercial insurance prompts premature discharge often resulting in another re-hospitalization from the community. The Nurse Navigator is instrumental in following post discharge to avoid re-hospitalizations.

XXX. Indicate any adaptations or modifications that were made throughout the process.

Meeting held with local ER to discuss goal of reduced hospitalizations and services available in facility. Evaluation of infection control practices were completed to ensure most effective practices. Staff education in IV training and maintenance provided to implement interventions as needed. Report is called to ER when transfer is made to communicate facility need for eval not just admission. RT Services utilized throughout the building at onset of symptoms and nursing support.

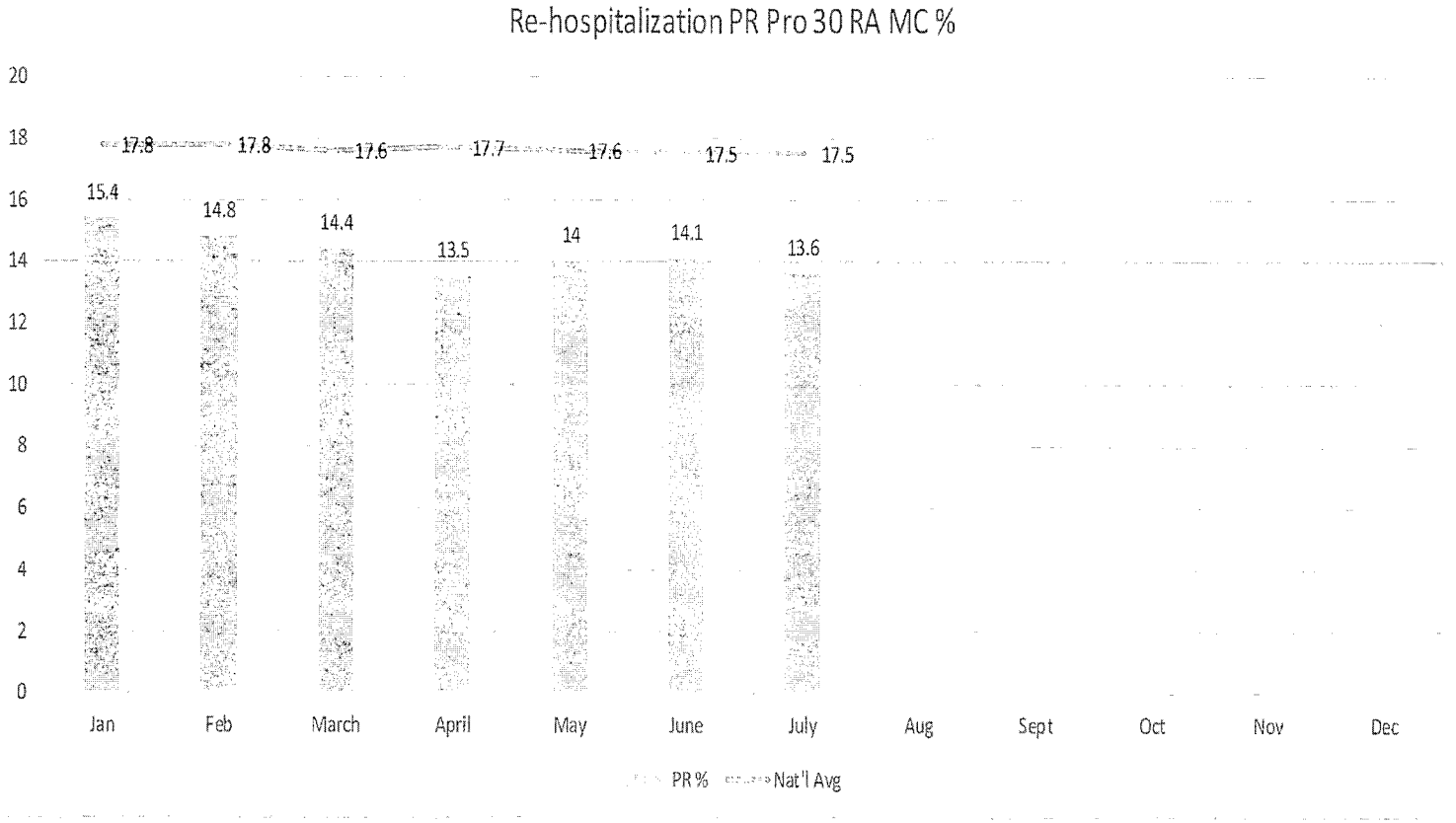
XXXI. Provide the plan for sustainability.

Maintain competence in nursing assessment, interventions and skills pivotal in reducing hospitalizations. Early detection are key in early treatment. Improved communication with families to formulate appropriate plan of care. Interact will continue to be used routinely.

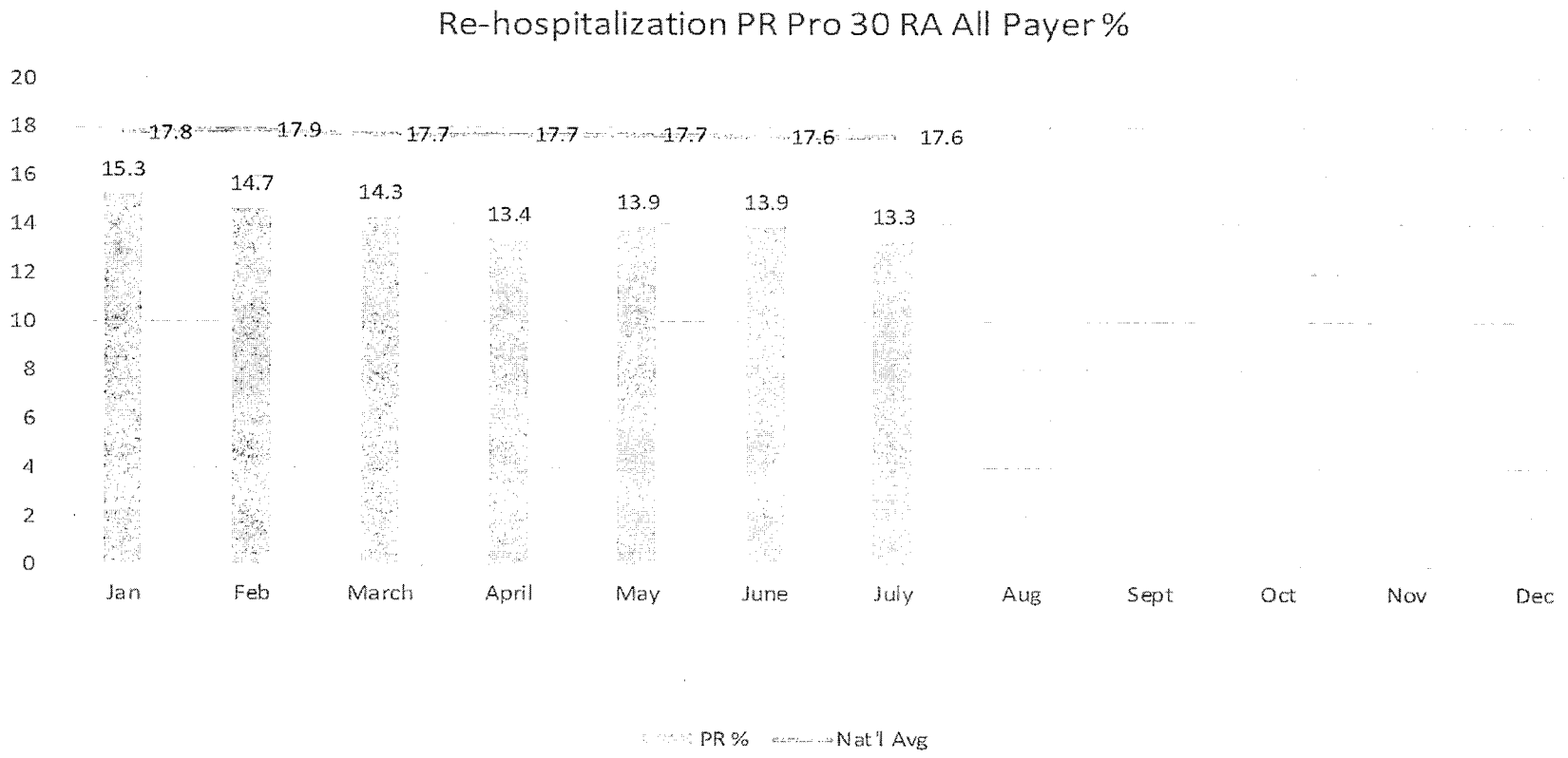
XXXII. Outline the status of the project (include progress towards goal).

Currently, our facility averages 11.2% transfers out a month, including ER visits as well as actual hospital admissions, per PCC. Since January, facility averages 2.8% resident transfer back to acute care within 30 days of their admission to our facility. Goal continues to be continuity of care with least amount of re-hospitalizations.

Re-hospitalization – PR30 Risk Adjusted Medicare Percentage



Re-hospitalization – PR 30 Risk Adjusted All Payer Percentage



Re-hospitalization – PR 30 Risk Adjusted Pneumonia Percentage