Objectives

Accelerate reductions in avoidable fall-related readmissions:

- Discuss available data on fall-related readmissions
- Describe key improvements to reduce both falls and injuries and avoidable readmissions
- Analyze ways to harness resources for this work
These slides include materials that were developed in collaboration with the Institute for Healthcare Improvement (IHI) in connection with IHI’s STAAR and Reducing Falls and Related Injuries programs.”

Why work on fall-related readmissions?

- **Falls** are a major public health problem around the world.
- In hospitals falls are the top adverse event.
- Falls inflict pain and suffering for patients and families and frustrate care providers.
- Injuries from falls are “never events” associated with morbidity, mortality, and increased healthcare costs.
- Falls contribute to avoidable readmissions to hospital.

- **Avoidable Readmissions** are frequent, potentially harmful, expensive, and a significant area of waste and inefficiency in the healthcare delivery system.
- Poor coordination of care across settings contributes to avoidable readmissions.
- Reducing avoidable readmissions is one tangible step toward the dramatic improvement of health care quality and patient and family experience.
4th goal of the National Priorities Partnership (NPP) NQF report to HHS

Addressing the fourth NPP goal, the NQF report to HHS stated that in regard to care coordination:

“Healthcare should guide patients and families through their healthcare experience, while respecting patient choice, offering physical and psychological supports, and encouraging strong relationships among patients and the healthcare professionals accountable for their care....”

National Priorities Partnership (NPP)

Focus in care coordination is the link between:

**Care Transitions** ...continually strive to improve care by ... considering feedback from all patients and their families... regarding coordination of their care during transitions between healthcare systems and services, and...communities.

**Preventable Readmissions** ...work collaboratively with patients to reduce preventable 30-day readmission rates.
How Might We…….? 

...reliably coordinate care across settings and communicate vital information to the next settings of care?

What we know about data on Fall-related readmissions

- Texas medical practice review of 20,438 discharges
- Found 260 readmissions with a diagnoses indicative of a fall, and a discharge (for any diagnosis) in the year prior to the readmission.
  - 1.27% of the admissions were due to a fall.
- 212 patients make up those 260 readmissions - 48 patients had more than one admission for a fall.
  - 18.5% of patients admitted for a fall were readmitted due to another fall. This may be the most fruitful group for predictive modeling or for a quality improvement initiative.
Cohort study with 1-month follow-up after hospital discharge.

- Department of Medicine, University of Wisconsin-Madison.
  - Sample of 214 patients, aged 70 years and over
- 29 patients (13.6%) fell during the month after discharge.
- Major risk factors for falls at discharge:
  - Decline in mobility ($P = 0.005$), use of assistive device ($P = 0.002$), and cognitive impairment ($P = 0.05$),
  - After hospital discharge: self-report of confusion ($P = 0.002$).
- Functionally dependent patients who needed professional help after discharge had the highest rate of falls (20.2%).
- Only 8.4% of independent patients not requiring professional help fell ($P = 0.01$).

Incidence of Falls in older, recently hospitalized medical patients with home care (Published in 2000)

- 311 enrolled patients age 65 years and older
- Results: Rate of falls was significantly higher in the first 2 weeks after hospitalization (8.0 per 1000 person-days) compared with 3 months later (1.7 per 1000 person-days) ($P = .002$)
- Fall-related injuries accounted for 15% of all hospitalizations in the first month after discharge
- Pre-hospital risk factors significantly associated with falls: dependency in ADLs. Use of a standard walker, 2+ falls, and more hospitalizations in the prior year.


Mahoney, JE. et. al., Temporal Association Between Hospital and Rate of Falls After Discharge. Arch Intern Med. 2000;160:2788-2795
ED data through the National Electronic Injury Surveillance System - All Injury Program

- Data from January 1, 2001, to December 31, 2008
- Estimated number of fall-related hospitalizations in older adults increased 50%, from 373,128 to 559,355 cases.
- During the same time period, age-adjusted incidence rate, expressed per 100,000 population, increased from 1,046 to 1,368.
- Rates were higher in women compared with men throughout the study period.
- The age-adjusted incidence rate showed an average annual increase of 3.3% (95% CI, 1.66–4.95).


Data review recommendations

Guidelines for reporting injuries issued by the Safe States Alliance, a national injury prevention organization

Key Improvements to Reduce Falls and Related Injuries

How-to Guide: Reducing Patient Injuries from Falls

Other useful resources and toolkits on falls prevention:

- ECRI Falls Prevention Resources
- VA National Patient Safety Center Falls Prevention Toolkit
- Joint Commission Resources, Preventing Patient Falls
- Minnesota Hospital Association SAFE from FALLS
- VISN 8 Patient Safety Center of Inquiry Falls Team

IHI How-to Guide: Reducing Injuries from Falls

Six Promising Changes:

1. Screen risk for falling on admission
2. Screen fall-related injury risk factors and history upon admission
3. Assess multifactorial risk of anticipated physiological falling and risk for a serious or major injury from a fall

Six Promising Changes *continued*:

4. Communicate and educate about patients’ fall and injury risks

5. Standardize interventions for patients at risk for falling

6. Customize interventions for patients at highest risk of a serious or major fall-related injury


**Designing Reliable Processes**

“5 Whys” Root Cause Analysis

WHY? was Mr. S’ bed wet?

→ WHY?

→ WHY?

→ WHY?

→ WHY?

Real solution is found here

5 Whys Root Cause Analysis

WHY? The nurse didn’t answer Mr. S’ call light

WHY? The nurse didn’t receive the call

WHY? Call light didn’t work

WHY? no call-light maintenance

No Standard Process

5 Whys Root Cause Analysis

WHY? The nurse didn’t answer Mr. S’ call light

WHY? The nurse didn’t receive the call

WHY? Call light didn’t work

WHY? no call-light maintenance

No Standard Process

Key Improvements to Reduce Avoidable Readmissions Related to Reducing Falls

1. Partner with patient & family to determine post-hospital needs
2. Provide effective teaching and facilitate learning
3. Create and activate post-hospital care follow-up
4. Provide real-time handover communications

How Might We….

“….gain a deeper understanding of the comprehensive post-hospital needs of the patient through an ongoing dialogue with the patient, family caregivers, and community providers?”
Involve Patient, Family and Community Caregivers

Involve the patient, family caregiver(s), and community provider(s) as full partners in completing a needs assessment of the patient’s home-going needs

- *“Family caregivers”* are those persons directly involved in the patient’s care at home
- *“Visitors”* are not necessarily the persons who best understand the home environment limitations/issues and the patient’s home-going needs

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Designing Reliable Handover

Standardize communication of vital fall risk/injury to the next care setting using “specified work”

- Current best, easiest and safest way to do a job
- Clarifies the value of the work or process
- Specifies:
  - who does what, when, where, why
  - handoff roles and relationships
  - methods for “how”
Ongoing Assessment of Post-Hospital Needs

Should occur throughout the hospitalization, e.g.

- Initial admission assessment
- Bedside change-of-shift report
- Ongoing conversations with patient and family caregivers
- Daily multidisciplinary rounds
- Vital information to the next settings of care


Ongoing Assessment of Patients’ Post-Hospital Needs

- Take 5 – establish a relationship and build trust
- Care team use appreciative inquiry, think like an investigative reporter
  - Ask the “5 Whys”
  - Ask patient and family caregivers - “what are you most worried about when you go home or to the next care setting?”

5 Whys Root Cause Analysis

Why wasn’t the Mr. Bell taking his meds?

Why? no $ for meds

→ Why? no insurance

→ Why? no application/Medicaid

→ Why? needs help with application

Unintended consequences of receiving Medicaid

Real solution is found here

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Always Use Teach Back

Always use Teach Back to assess the patient’s and family caregivers’ understanding of discharge instructions and ability to perform self-care.

- Include all the learners
- Assess patient’s ability to understand how to:
  - Do critical self-care activities
  - Take medications
  - Access care: next appointments, medications, etc.

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Always Use Teach Back

- Explain needed information to the patient or family caregiver
- Ask in a non-shaming way for the individual to say in his or her own words what was understood

**Example:** “I want to be sure that I did a good job of teaching you today about how to stay safe after you go home. Could you please tell me in your own words the reasons you should call the doctor?”

Using Teach Back

- Patients and family caregivers should not feel Teach Back is a test
- Close the gap in understanding or develop a new plan of care
- Use multiple opportunities to teach while patients are in the hospital
- Use Teach Back as a teaching and diagnostic tool
- Pass along to clinicians in the next site of care any patient or family caregiver struggles with Teach Back
How Might We ……..?

...use the same core content and teaching materials in all community patient care settings?

Use Teach Back Regularly

- In the hospital
- During home visits and follow-up phone calls
- To close understanding gaps between:
  - Caregivers and patients
  - Professional caregivers and family caregivers
- To assess the patients and family caregivers understanding of discharge instructions and their ability to do self-care and attend follow-up visits
Involve Community Providers to Assess Post-Hospital Needs

What home-going needs or contributing causes for unplanned admissions or readmissions can hospitals discover from community providers?

- Primary care providers and specialists
- Home health care nurses and staff
- Staff in skilled nursing facilities
- Rehabilitation and dialysis centers
- Pharmacies
- Palliative care or hospice programs
- Staff from community-based agencies and services


http://www.ihi.org/explore/Readmissions/Pages/default.aspx
INTERACT Quality Improvement Program

Tools to improve communication, care paths or clinical processes and advance care planning.
- Version 3.0 tools for nursing homes now available
- Coming soon tools for assisted living, home health care and accountable care organizations (ACO)

Available at: http://interact2.net/tools_v3.aspx.

Interact v.3 SBAR excerpt
Communication Form and Progress Note

2. Functional Status Changes
(compared to baseline; check all that you observe)

- N/A
- Needs more assistance with ADLs
- Decreased mobility
- Fall
- Weakness or hemiparesis
- Slurred speech
- Trouble swallowing
- Other (describe)

Describe symptoms or signs______________________________________________

Available at: http://interact2.net/tools_v3.aspx
High Risk Conditions/Treatment Information
*(check all that apply)*

- Fall Risk etc....

Precautions: ____________________________

Available at: http://interact2.net/tools_v3.aspx

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**Nursing Care**
**Physical and Sensory Function**

**Ambulation:** Independent  Not Ambulatory
- With Assistance  With Assistive Device

**Weight Bearing:** Full  Partial L / R  None L / R

**Transfer:** Self  1-Person Assist  2-Person Assist

**Sensory Function Sight:** Normal  Impaired  Blind

**Hearing:** Normal  Impaired  Deaf

**Devices:** Wheelchair  Walker  Cane  Crutches  Prosthesis  Glasses  Contacts  Dentures  Hearing Aid L / R

Available at: http://interact2.net/tools_v3.aspx
Transitional Care that Improves Patient Safety

Laura Woebbeking
Quality Improvement Manager

Grundy County Memorial Hospital

Grundy County Memorial Hospital
Transiting Inpatients to Long Term Care

On the day of patient discharge from the hospital, the Long Term Care (LTC) Coordinator arrives at the hospital before AM shift change.
The LTC Coordinator participates in care review with the night nurse.

- Is the patient at risk for falls/injury?
- Learn about patient night behaviors. Wander? Use call light?
- Up at night? Bathroom habits? Alarms? Interventions?

Grundy County Memorial Hospital

The LTC Coordinator participates in patient observation and interview.

- Welcome the patient.
- What is the patient most concerned about?
- What behaviors can be observed?

Grundy County Memorial Hospital
The LTC Coordinator participates in Inpatient shift-change report

- This builds a clear understanding of the patients needs for care.
- Enables questions to be asked/answered specific to the patients needs.

» Precautionary interventions are placed before patient’s arrival to LTC.

Grundy County Memorial Hospital

Upon arrival to LTC, the patient who is at high risk for injury/falls will...

» Be roomed near the LTC nurses station.
» Be placed on ½ hour “Quick Checks”.
» Have safety interventions put into place on arrival (alarms, low beds, etc.).
» Falls precautions will be communicated at safety huddles bringing awareness to caregivers.

Grundy County Memorial Hospital
Office Practice

How-to Guide:
Improving Transitions
from the Hospital to
the Clinical Office Practice
to Reduce Avoidable Rehospitalizations

http://www.ihi.org/explore/Readmissions/Pages/default.aspx

SETMA Standards
Patient-centered Medical Home

Annually complete five assessments for patients:

- Fall Risk Assessment and Scoring
  - Patients 50+ or with chronic conditions with fall risks
- Global Assessment of Function
- Pain Assessment
- Wellness
- Stress

Once the Fall Risk Assessment is completed, the provider should, on the basis of the score, access the “Guidelines for Fall Precaution” and prepare a plan for preventing falls.

www.setma.com/Your-Life-Your-Health/Patient-Centered-Medical-home-annual-Questionaires
SETMA Standards
Patient-centered Medical Home

- Fall Risk Assessment on
  - All patients over 50 and
  - Younger patients with chronic conditions who are at risk of falling
- Provider completion of assessments is publicly reported
- Falls are one of the greatest dangers to the health of our elderly and particularly our frail elderly:
  - The six-month mortality for patients over 80, who break a hip from a fall, is 50%.
  - At 30 days, the mortality rate is 10%.

www.setma.com/Your-Life-Your-Health/Patient-Centered-Medical-home-annual-Questionnaires

SETMA Fall Risk Assessment

- Level of consciousness/mental status
- Ambulation/Elimination status
- Gait/Balance
- Number of Medications
- History of falls in the past 3 months
- Vision status – with or without glasses
- Systolic Blood Pressure between lying and standing
- Predisposing diseases

www.setma.com/Your-Life-Your-Health/Patient-Centered-Medical-home-annual-Questionnaires
SETMA Fall Risk Precautions

Fall precautions are specified for inpatient/nursing home and Outpatient

- Outpatient selections include;
  - Patient cautioned about:
    - increased fall risks
    - gaining balance after standing/before walking
  - Prescribed devices if needed for mobility, toileting, bathing
  - Recommendation if walking needs to be only with assistance
  - Referral to PT if needed
  - Home health care evaluation

SETMA Fall Risk Assessments

- Assessment of fall risk and bone density of elderly patients is important in the prevention of fractures
  - Cause of high mortality is not directly the fracture but the stress related to the fracture, its treatment and other conditions
Patient-centered Medical Home

The most dramatic process modifications occurred when performance of a process measure was audited and the adherence of each team member was reported to the entire team. It was then possible to compare the outcome (reduction of falls) difference between adherent team members and those who were not.

www.setma.com

How-to Guide: Improving Transitions from the Hospital to Home Health Care to Reduce Avoidable Rehospitalizations

http://www.ihi.org/explore/Readmissions/Pages/default.aspx

Home Health Care
HHQI Process-Based Quality Improvement Manual from CMS December 2012

### Process Quality Measures Used for Public Reports.
- **Timely Care**
  - Timely Initiation of Care
- **Care Coordination**
  - Physician Notification Guidelines Established

### Assessment
- Depression Assessment Conducted
- **Multifactor Fall Risk Assessment Conducted for Patients 65 and Over**
- Pain Assessment Conducted
- Pressure Ulcer Risk Assessment Conducted

### Care Planning
- Depression Interventions in Plan of Care
- Diabetic Foot Care and Patient Education in Plan of Care
- **Falls Prevention Steps in Plan of Care**
- Pain Interventions in Plan of Care
- Pressure Ulcer Prevention in Plan of Care
- Pressure Ulcer Treatment: Moist Wound Healing in Plan of Care

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**HHQI**: [http://www.homehealthquality.org/Home.aspx](http://www.homehealthquality.org/Home.aspx)

**Home Care Fall Prevention**

**Learning Tracks:** Leadership, Nursing, Home Health Aide, Therapy, MS Worker

**Sections:** Focus on Falls, Success Stories

**Multimedia:** Falls Webinar; Podcast - Ways to communicate with physicians effectively; Video - Learn how to perform the Timed Up and Go.

**Associated Resources**
- OASIS-C and CCFP
- Tinetti article from NEJM
- Case Studies
- Post-Fall Audit Form
- Fall Prevention in the Home (English & Spanish)
- Fall Risk Assessment with Algorithm & Interventions
- Medication Simplification
- Physician Initial Order Confirmation Form – Full & 1-page versions
- Safety Starts with You Program and Procedure: Staying Steady on Your Feet
- Tips for Living

Analyze Ways to Harness Resources For This Work

Assessments

- Is the topic included in strategic aims and plans?
- Do executive leaders:
  - Demonstrate the topic is a key strategic initiative?
  - Frequently reinforce need to close the gap?
  - Provide progress reports to the Board?
  - Calendar regular attention to spread work?
  - Assess and promote leadership commitment?
  - Identify accountability and resources?
Assessments

Are Initiatives Connected?
- Reducing avoidable readmissions
- Improving patient safety
- Coordinating care across the continuum
- Managing population health and costs
- Building ACOs
- Improving patient and family experiences
- Posting data for transparency

Assessments

- Use observation to understand existing processes
- Ask staff what they have been taught about how to do a process
- Use process flow diagrams to gain consensus on how things really work
- Ask what gets in the way of reliable processes; use small tests of change to improve reliability
Assessments

- Find something that wastes staff time; Use small tests of change to eliminate the waste

- Examples:
  - Hunting for supplies used every day
  - Keep the environment safe for all
  - Screen all patients at the basic level for risk of falling and risk of serious injury
    - Intervene with additional screening and interventions on those at risk

Small sample – “Go Ask 5”

- Pick a process you want reliable that has been taught to frontline staff
- Review what was taught
- Ask 5 people who do the process to describe
  - Why the process is important
  - How they do the process
- How many of 5 got it right?
  - 4 of 5 means only 80% reliability is possible
Adoption is a SOCIAL thing!

A better idea… communicated through a social network… over time


How Adopters Perceive Change is Critical

Assess what adopters perceive:
- The new process works better than the old
- Testing the change is low risk
- The change is easy to understand and adapt to current work patterns
- Improvement from the change is, or will be, easy to see

Insanity:
Doing the same thing
over and over again
and expecting different
results.
attributed to Albert Einstein

Observe the Actual Process

- Go see (don't just talk about it in meeting rooms)
- Check assumptions
- Honor existing work
- Learn what really happens compared to what is described
  - Observe and ask “why?” five times
  - Get to the root causes of current performance
- Identify what gets in the way of reliability
- Discuss changes that your team would like to test

Select Improvements to Tackle

- Pick a process to work on
- Specify the changes in the documented existing work the team would like to test
  - who, what, when, where, how
- Use iterative PDSA cycles (tests of change) to try the changes
- Use process measures to assess progress over time (aim to achieve > 90% reliability)


Agree On and Specify

Flow of Processes

Identify Patients at risk for falling and potential for injury on admission

Communicate and Educate Patients at Risk

Implement Standard & Customized Interventions

Communicate Vital Information to Next Care Setting
Designing Processes that Work

Standardized (Specified) Work
- Current best, easiest and safest way to do a job
- Clarifies value of the work
- Specifies
  - Who does what, when, why
  - Handoffs: roles and relationships
  - Methods for “how”

Specification of Work
- Allows less than perfect initial design (not a plan for every possible contingency)
  - No need to spend months coming up with the perfect design
- Assumes that when the specified process doesn’t work, further redesign will be tested
  - Requires a process for signaling more testing is needed
- Builds frontline knowledge for designing reliable processes over time with their expert input
Sequence for Testing and Improvement

- Developing a change
- Testing a change
  - Make part of routine operations
  - Test under a variety of conditions
- Implementing a change (HTG)
- Spreading a change to other locations

**Determining the Pace of Testing Changes**

<table>
<thead>
<tr>
<th>Current Situation</th>
<th>Resistant</th>
<th>Indifferent</th>
<th>Ready</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Confidence that current change idea will lead to improvement</td>
<td>Cost of failure large</td>
<td>Very Small Scale Test</td>
<td>Very Small Scale Test</td>
</tr>
<tr>
<td>High Confidence that current change idea will lead to improvement</td>
<td>Cost of failure large</td>
<td>Very Small Scale Test</td>
<td>Small Scale Test</td>
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<tr>
<td>Low Confidence that current change idea will lead to improvement</td>
<td>Cost of failure small</td>
<td>Small Scale Test</td>
<td>Large Scale Test</td>
</tr>
</tbody>
</table>
“We can’t solve problems by using the same kind of thinking we used when we created them.”

*Albert Einstein*

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**Teaching New Processes**

**OLD WAY**
- Teach & leave
- Death by slides
- During busy staff meetings
- Teach in remote conference rooms

**NEW WAY (TWI)**
- Test to reliable process
- Specify the process
- Design education
- Include help aids
- Teach test group in workplace
- Stick around to see if they can do it as taught
- If needed, redesign education, process or both
- Teach the next group; can they do it as taught?

Gail A Nielsen 2012
Reliable Use of Teach-back

Making it easier to train everyone in all settings

- Free, online, interactive training for hospitals, home care and office practices
- For individuals, their managers and coaches

www.teachbacktraining.com
Help Mid-level Managers Coach

- Honor the current work through observation
- Understand that change is hard and uncomfortable
- Resistance to change is natural; it comes from fear of change or the unknown
- Promote new skill development
- Build confidence to integrate the new habit into work patterns
- Build reliability and manage relapses

www.teachbacktraining.com

Reflections

- What processes do you already have?
- What ideas did you hear that you might apply?
- What was most exciting for you?
- What was confusing?
- Need more information about....?