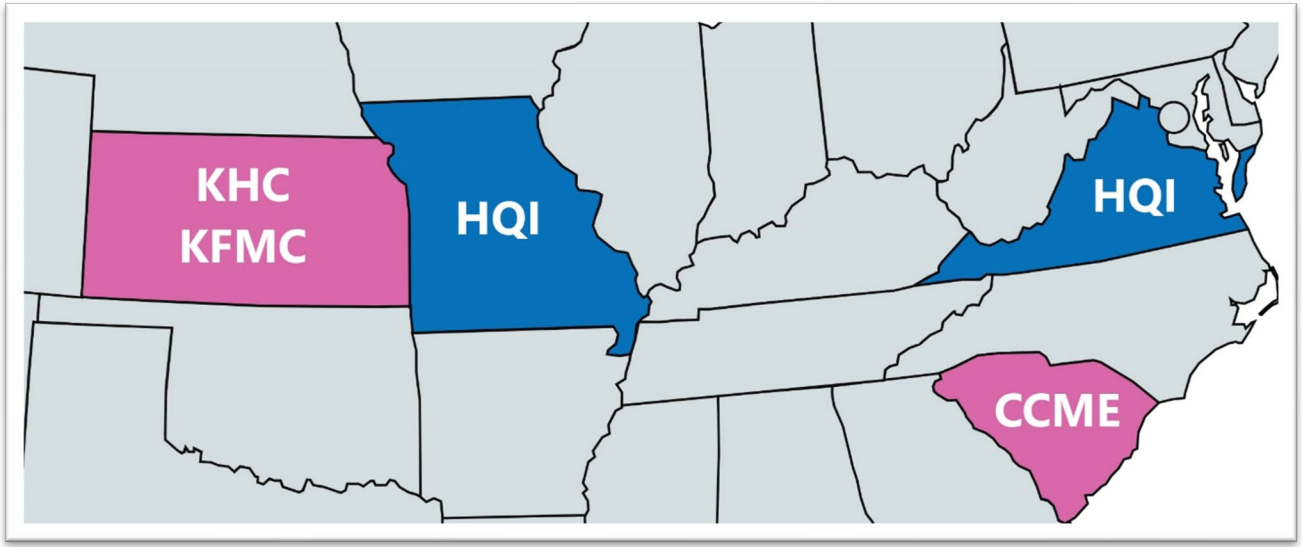
HQIN
Health Quality Innovation Network

Collaborating with Your Hospital on the Decision Guide

January 11, 2023

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

Health Quality Innovation Network



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HEALTH QUALITY INNOVATORS

The Carolinas Center for Medical Excellence

kfmc
HEALTH IMPROVEMENT PARTNERS

Kansas Healthcare
COLLABORATIVE

HQIN
Health Quality Innovation Network

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The Carolinas Center for Medical Excellence (CCME)

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Logistics – Zoom Webinar

To ask a question, click on the **Q&A** icon.

Raise your hand if you want to verbally ask a question.

Resources from today's session will be posted in **Chat**.

You may adjust your audio by clicking **Audio Settings**.

You have been automatically muted with video turned off.

What is the Guide?

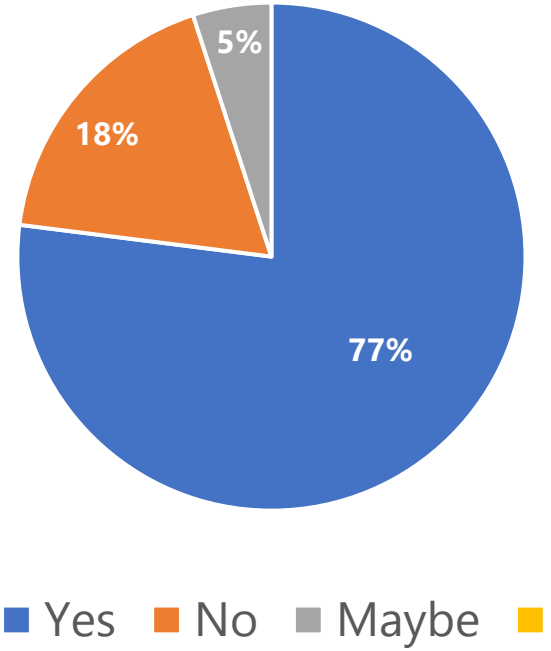
The evidenced-based tool is designed to complement individual nursing home ED transfers and readmissions.

A CMP-funded initiative, Florida Atlantic University conducted research among 250 residents, caregivers, and staff in search of valuable information that helps make decisions on whether to stay and be treated or go to the hospital.

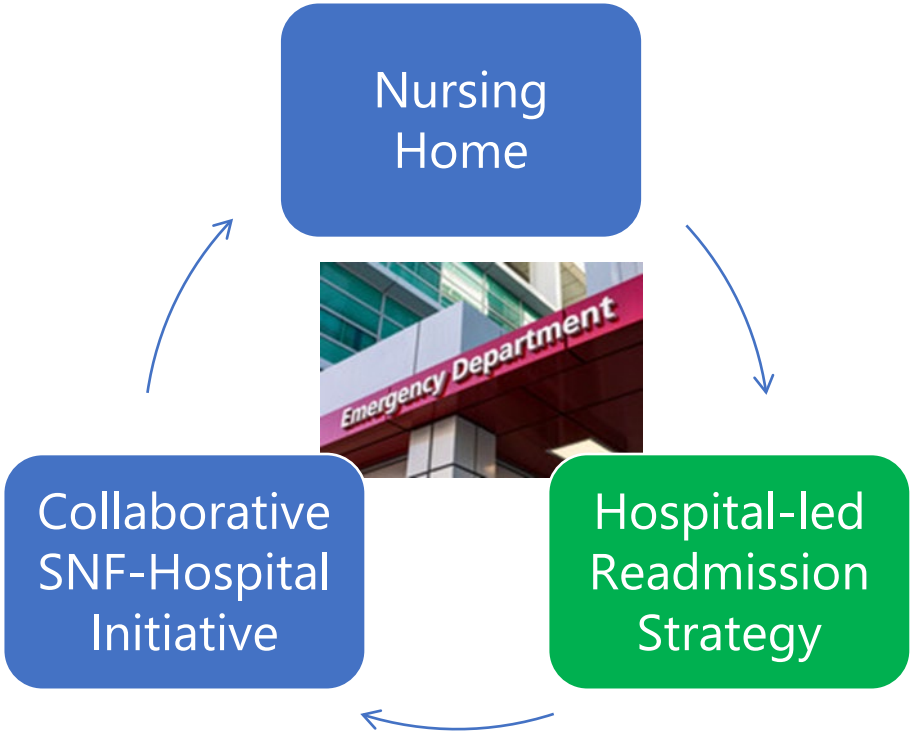
Piloted in 12 states:

- 95% of residents and families found it helpful
- 75% read it several times
- 50% shared it with friends and family

Impact on Readmissions over One Year



Who Can Implement the Guide ?



Addresses (Cross-Cutting) Care Coordination Measures

Focuses on ED Utilization

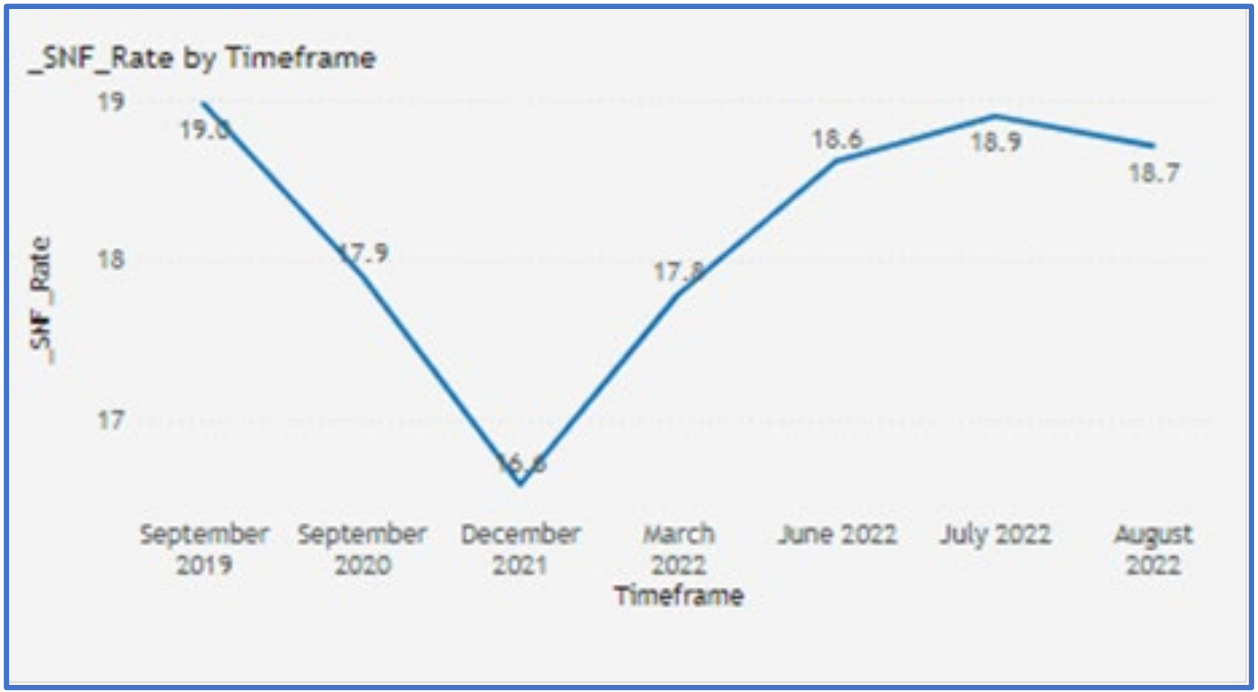
Addresses Avoidable Admissions and Readmissions

Builds a Hospital- Nursing Home Collaboration

Today's Objectives

- Use your transfer, admission, and readmission data to create a cross-continuum QI collaboration
- Discuss the Guide with your hospital partners
- Develop a strategy to reduce avoidable transfers using the Guide and INTERACT™

Number of ED Visits within 30 days of hospital discharge per 1,000 NH residents discharged from an acute care hospital. (KS, MO, SC, VA)



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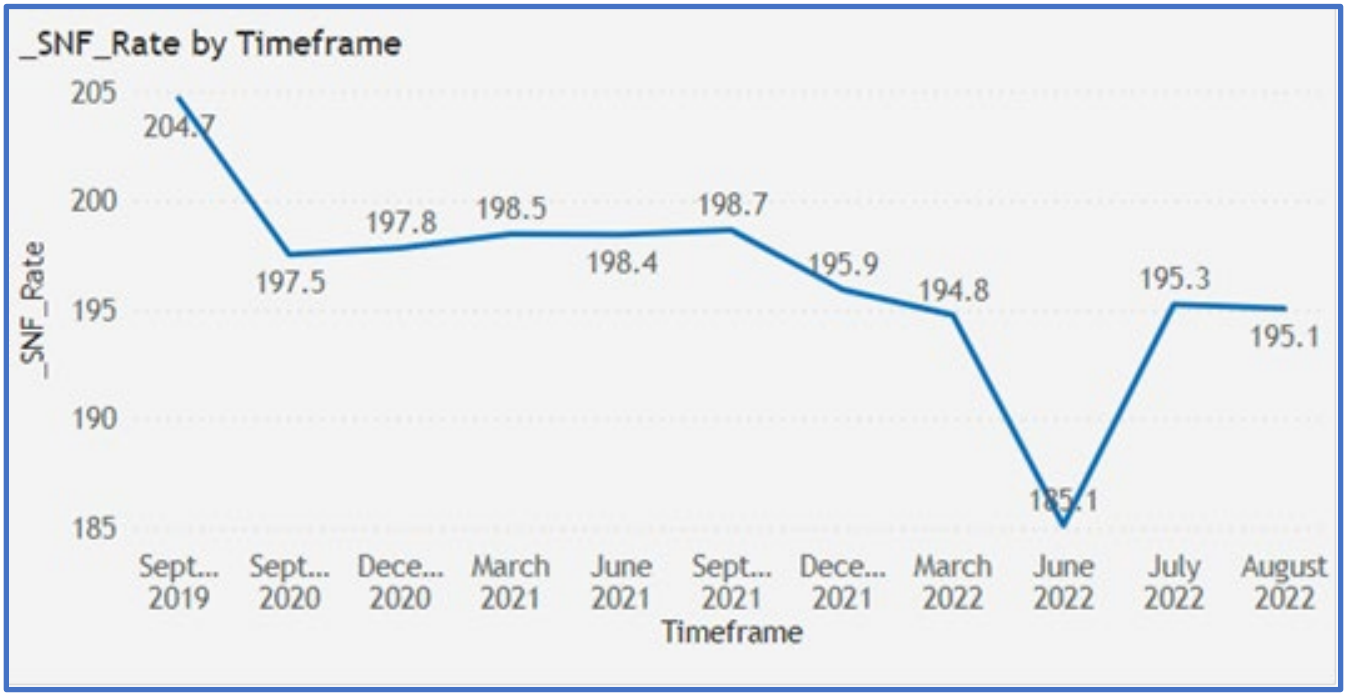

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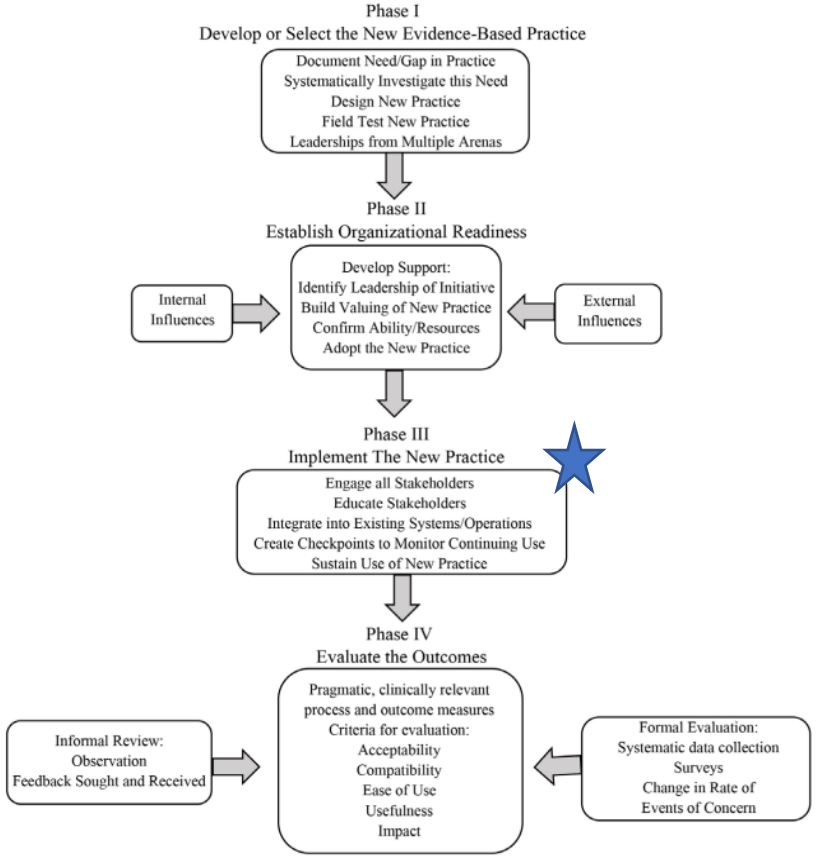
One More Tool in Preventing ED Transfers and Readmissions for Your Toolkit

The Guide provides information in an easy-to-read format about making decisions to stay and be treated at your facility.

It demonstrated a reduction in transfers and readmissions when implemented into your admission, care planning, and change in condition conversations with residents and family

Provides information about care that can be provided in the nursing home.

Phased Approach to Addressing ED Return to Hospital



Polling Question #1

Does your facility have regular meetings to work on solutions for avoidable ED transfers and readmissions?

- Yes, on a regular basis with defined actions to reduce the frequency of transfer and readmissions.
- Yes, we have meetings, and discuss the transfers and readmissions, but no formal actions taken.
- No, we are not currently meeting.
- Not sure

Polling Question #2

If you are meeting with your partners, have you seen a reduction in avoidable transfers and readmissions?

- Yes, we are seeing a reduction in avoidable transfers and readmissions.
- No, we have not seen a reduction
- Not Sure

Using Data to Target Specific Actions

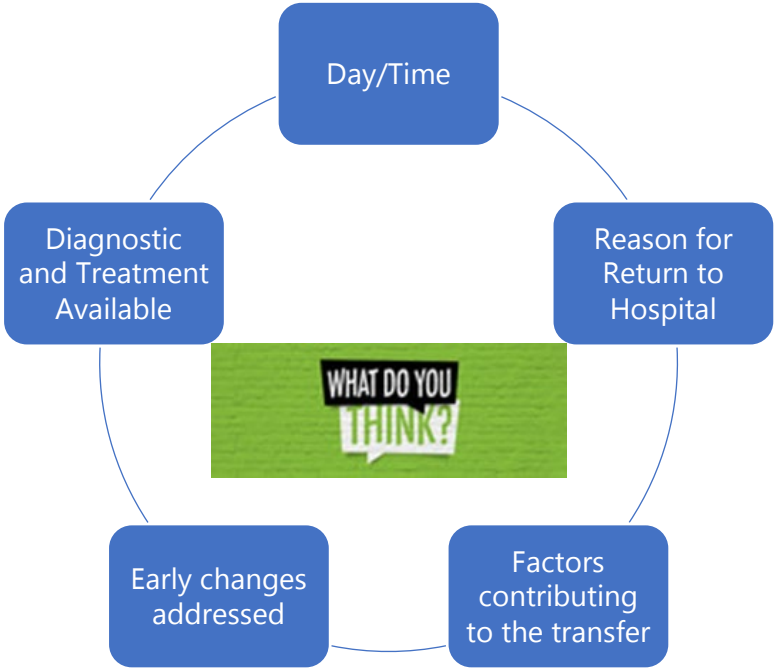
Value-based program data- Where are we compared to others?

Hospital- VBP and Pepper Reports

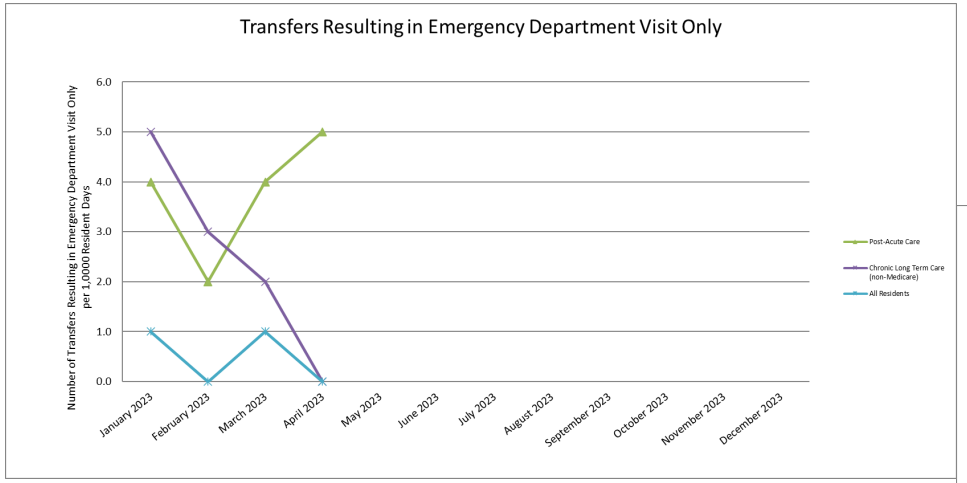
SNF – SNF Readmission Measure and Pepper Reports

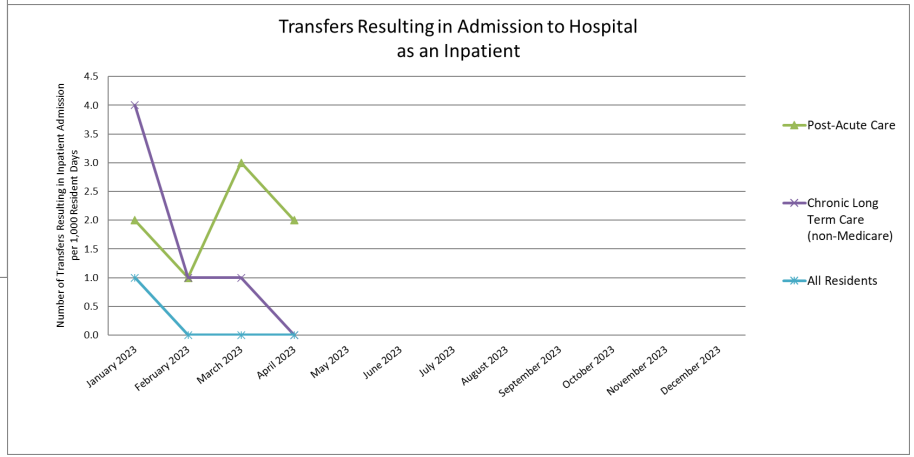
Internal Data - qualitative analysis to determine the root cause for the transfer. (Both Hospital and SNF)

Common Data Elements for an RCA



Data Helps Flush Out the Priority





Interventions to Reduce Acute Care Transfers

INTERACT™

www.pathway-interact.com

Engaging Hospitals in Your Program

INTERACT
Version 4.5 Tool

Engaging Hospitals Checklist

1. **Create** a list of all hospitals your facility sends patients to or receives patients from.

2. **Identify** the 'readmissions champion' for each hospital. You can most easily discover who is leading the readmissions effort at local hospitals by reaching out to one of the leaders listed below. They will know who is the organizational lead for readmissions for example, the:
   a. Chief Quality Officer
   b. Chief Medical Officer
   c. Chief Nursing Officer
   d. Director of Case Management
   e. Director of Quality

3. **Host** or join a 'cross-continuum' or Community Care Transitions Working Group or Coalition. Start by inviting the hospitals in your area to your facility to see your capabilities first hand. Also, attend cross-continuum team meetings hosted by your local hospitals. It is optimal to meet in person to form and strengthen relationships, but start with one person and one phone call if needed.

4. **State** your facility's goals to reduce avoidable hospital transfers, admissions, and readmissions, and link that to the hospitals' goals in readmission reduction. Lead with a brief set of numbers:
   a. The average number of patients you receive from the hospital each month
   b. The current 30-day readmission rate among those patients
   c. Your facility's goal to reduce preventable and unnecessary hospital transfers

5. **Describe** the set of quality improvements underway in your facility through INTERACT and other initiatives.

6. **Ask** the hospital to be an active partner in your INTERACT improvements.
   a. Post the INTERACT IV **SNF/NF Capabilities List** in the ER and at floor case manager workstations
   b. Educate ER staff and inpatient teams about relevant INTERACT forms and tools
   c. Encourage ER physicians to review your transfer forms and consider returning the resident/patient to SNF/NF if safe and appropriate based on the **SNF/NF Capabilities Checklist**
   d. Develop a process to ensure INTERACT forms are sent from the ER to the patient care units
   e. Improve hand-off communication between hospital and SNF/NF using 'Warm Hand-Offs' (in-person communication)
   f. Engage in regular readmission reviews to identify improvement opportunities

Building Strategy Together with the Decision Guide- Getting to the RCA

Resident/Family Insistence

Lack of treatment available

Condition unstable- needs higher of care

Transfer of Care

SNF Capabilities align

Severity or care options for progressive disease

Advanced Care Planning

Interventions to Reduce Acute Care Transfers

INTERACT™

www.pathway-interact.com

SNF/NF Capabilities List

INTERACT® Version 4.5 Tool

This list is for hospital emergency rooms, hospitalists, and case managers; and for physicians, NPs, and PAs, who take off-hours call for the facility to assist with decisions about hospital admission or return to the facility.

Facility _____

Address _____

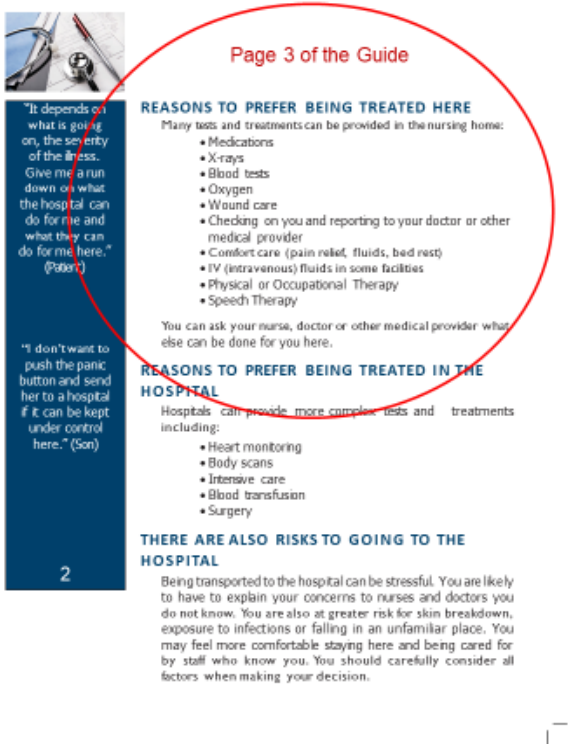
Tel _____ Key Contact _____

Circle 'Y' for yes or 'N' for no to indicate the availability of each item in your facility.

Capabilities	Yes	No
Primary Care Clinician Services		
At least one physician, NP, or PA in the facility three or more days per week	Y	N
At least one physician, NP, or PA in the facility five or more days per week	Y	N
Diagnostic Testing Onsite		
Basic Metabolic Panel (*BUN, Ca, Cl-, CRE, eGFR, GLU, K+, Na+, tCO_2*)	Y	N
Bladder Ultrasound	Y	N
Cardiac Echo	Y	N
Complete Blood Count (CBC)	Y	N
COVID Testing	Y	N
EKG	Y	N
INR	Y	N
Stat lab tests with turnaround less than 8 hours	Y	N
Stat X-rays with turnaround less than 8 hours	Y	N
Venous Doppler	Y	N
Consultations		
Cardiology	Y	N
Orthopedics	Y	N
Psychiatry	Y	N
Pulmonary	Y	N
Wound Care	Y	N
Other Physician Specialty Consultations *specify:*	Y	N
Social and Psychology Services		
Licensed Social Worker	Y	N
Psychological Evaluation and Counseling by a Licensed Clinical Psychologist	Y	N
Therapies On Site		

Capabilities	Yes	No
Nursing Services		
24 Hour RN Coverage	Y	N
O2 saturation	Y	N
Incentive spirometry	Y	N
Nebulizer treatments	Y	N
Interventions		
Advanced CPR *(ACLS capability)*	Y	N
Analgesic Pumps	Y	N
Automatic Defibrillator	Y	N
Blood Administration	Y	N
Hemodialysis	Y	N
Isolation *(for MRSA, VRE, etc.)*	Y	N
IV Antibiotics	Y	N
IV Fluids *(initiation and maintenance)*	Y	N
IV Meds – Other *(e.g. furosemide)*	Y	N
Peritoneal Dialysis	Y	N
PICC Insertion	Y	N
PICC Management	Y	N
Total Parenteral Nutrition (TPN)	Y	N
Tracheostomy Management	Y	N
Surgical Drain Management	Y	N
Ventilator Care	Y	N
Pharmacy Services		
Emergency kit with common medications for acute conditions available	Y	N
New medications filled within 8 hours	Y	N

Sample page



Page 3 of the Guide

"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." (Patient)

"I don't want to 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

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 medical 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 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 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.

http://www.decisionguide.org/docs/latest/BestPractices_FINAL%20(1).pdf

www.decisionguide.org

Decision Guide: Suggested Workflow

Place at bedside and review during the discussion of care options

Admission Coordinator/Nurse, DON or ADON

At every session/guide questions about care for change in condition

DON/ADON/Social Worker

As a reference during conversations

Physician/ANP, Social Worker

The Guide can facilitate your SNF/Hospital collaboration…

Review how the Decision Guide will flow across pre-admission, admission, and family meetings.- SNF

Use the ED transfer and readmission drivers to laser-focus staff education. – Hospital/SNF

Share the INTERACT Capabilities list with staff. –Hospital/SNF

Discuss opportunities to improve care coordination communication

Polling Question #3

Based on what you heard today, what do think will be most helpful in your hospital/SNF collaboration?

- Standardize our data review to determine top priorities of focus
- Utilize the SNF Capabilities List
- Implement the Guide from the hospital discharge through the SNF workflow

Integrating a New Hospital Transfer Decision Guide into Long-Term Care Practice: Application of Implementation Science Models

Authors: Tappen, Ruth; Southard, Karen; Hain, Debra; Kaye, Suzie; Adonis-Rizzo, Marie Tamara
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Publisher: Association of University Programs in Health Administration

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Join us for the final Affinity Group session:

March 15, 2023
1:00 p.m. EST
(separate session registration is required)

Sharing Implementation Best Practices and Successes

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