Readmissions Self-Assessment

Quality Improvement Organizations
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CENTERS FOR MEDICARE & MEDICAID SERVICES

HQIN Health Quality Innovation Network

Facility Name: _____ CCN: _____

Pre-Work Assessment Survey Date: _____ Survey Completed by: _____

Use this tool to assess your organizational systems and processes to identify areas for improvement in preventing readmissions and preventable ED visits. Each item relates to prevention elements that should be in place for a successful readmissions program. This self-assessment should be completed with your reducing readmissions PIP team or your IDT if a PIP team has not been established yet.	Yes, we have a reliable process in place.	Yes, we have a process in place, but it is not consistently performed.	We are currently working to develop and train on this process.	No process in place.	Notes
Operational Processes					
Do you have a system to track and trend resident transfers and discharges? **Rationale:** Having a reliable system in place, utilizing real time data, will help prioritize the most important indicators for a nursing home and encourage regular monitoring of the results, which is vital to the quality improvement process.					
Do you discuss unexpected resident transfers that occurred in the last 24 hours during daily stand-up meetings? **Rationale:** Daily stand-up meetings provide an opportunity to review all residents readmitted from the previous day to determine root causes for the readmission and the plan to prevent them in the future. Huddle Guide Toolkit | HQIN					
Do you conduct case reviews for residents who have unplanned rehospitalizations or ED visits? **Rationale:** Conducting case reviews on residents who return to the hospital is an important part of root cause analysis. This will provide nursing homes a comprehensive review of the resident's condition and other factors that contributed to the transfer. Quality Improvement Tool For Review of Acute Care Transfers | INTERACT					

Do you use the INTERACT chart audit tool (or other evidence-based tools) for your readmission case reviews on residents who have had unplanned rehospitalizations and ED visits? **Rationale:** Reviewing a small sample of readmitted resident charts aids in identifying patterns or trends in data and provides opportunities for improvement. When analyzing data, include key clinical information such as change in condition, vital signs at time of transfer, new or worsening symptoms, etc.					
Are you working on a Performance Improvement Project (PIP) specific to unplanned readmissions and/or ED visits? **Rationale:** A project charter clearly establishes the goals, scope, timing, milestones, and team roles and responsibilities for an improvement project. Develop a PIP charter specific to readmission prevention. Worksheet to Create a Performance Improvement Project Charter| CMS					
Are you using an evidence-based tool to assess residents who have a change in condition? **Rationale:** When all staff in all departments are trained and able to identify even subtle changes in resident condition, using a process to identify, communicate, and then evaluate the change, the nurse can then review decision-making tools and contact the clinician in an organized and concise manner. By providing the clinician with comprehensive information about the resident, they can make sound and informed decision-making for next steps for resident care. Acute Change in Condition File Cards | INTERACT					
Are you training your nurses on an assessment and communication tool? **Rationale:** Adding standardized communication tools in the annual competencies is a method to validate that staff members know how to use the communication tools. Provide training for those that are not using the tools or using them inconsistently. Consider INTERACT's Situation-Background-Assessment-Recommendation (SBAR). All INTERACT forms | INTERACT					

Do you have a readmissions committee that meets regularly and reports on readmissions, including data, to your Quality Assurance and Performance Improvement (QAPI) committee? **Rationale:** A readmission committee is a team that meets to review data, case studies, and improvements for current processes. The readmissions committee should include the administrator, director of nursing, medical director, pharmacist/consultant, case manager, and admissions coordinator. Having a dedicated review committee assists in identifying system failures, trends in data, and opportunities for improvement. As part of feedback, data systems, and monitoring for QAPI, it is important to keep the QAPI leadership in your nursing home informed of readmission-related issues and data, so they can support and provide resources to drive improvement efforts.					
Pre-Admission					
Does your primary transferring hospital know your nursing home capabilities and limitations? Who at the facility is involved in the admission decision process and determines appropriate using criteria? **Rationale:** A capabilities checklist in the ED or case management department is used by hospital staff members in the decision-making process to determine whether the resident should be admitted to the hospital or referred to the nursing home. The checklist serves as a quality improvement tool by educating hospital staff members and improving confidence in their nursing home partners. SNF/NF Capabilities List | INTERACT Engaging Hospitals in Your Program | INTERACT					
Do you obtain a standardized "hand-off" report from the hospital prior to resident transfer/admission to your facility? **Rationale:** A warm "hand-off" is a process used to communicate patient information and provide real-time provider-to-provider communication. When done properly, this process should clearly communicate all necessary information needed for the patient's care.					

Does your primary transferring hospital share all necessary medical history and documents when the resident transfers to your facility? **Rationale:** Sharing patient medical history, physician orders and discharge summary among other important information is critical to receive from the acute care provider. SNF/NF to Hospital Transfer Form | INTERACT					
Admission/Transfer from Hospital					
If an admission arrives that was not accurately represented, do you have a process in place to provide feedback to the transferring hospital? Ideas that Work - Circle Back | HQIN					
Do you conduct an orientation for new residents and family members about the nursing home? **Rationale:** Preparing residents and families for their stay at the nursing home is essential to ensure they know what to expect. Readmissions may occur because residents and families get concerned about the low ratio of nurses and physicians present at the facility. A best practice is for the hospital to initiate the process by explaining to the resident what to expect at the nursing home. Once the resident arrives, conducting an orientation as soon as possible is important to alleviate concerns and instill confidence. Deciding About Going to the Hospital | INTERACT					
Do you have a process for measuring if a resident is at risk for readmission? **Rationale:** A risk-assessment tool is an evidence-based approach to stratify residents who are high-risk for readmission. Residents who are identified as high-risk should be "flagged" to receive targeted interventions throughout their care and before discharge. Skilled Nursing Facility (SNF) Re-Hospitalization Risk Assessment | HQIN					

Do you always have consistent (24/7) access to a medical provider to ensure timely responses to urgent clinical needs? **Rationale:** It is important for nursing staff members to have access to the medical director's phone number. Strengthening the role, responsibilities, and accountabilities of your medical director is essential to prevent avoidable readmissions.					
Discharge to Home					
Do you schedule labs, tests, and physician visits prior to resident discharge? **Rationale:** Connecting your resident to follow-up physician appointments within 7 days, as well as post-discharge testing, is essential to ensure continuity of care. Make sure your resident understands the reason and importance of the follow-up appointments and has a plan and transportation to get there.					
Do you ensure residents have a plan for obtaining medications post-discharge? **Rationale:** Medication errors during resident transitions are prevalent and contribute significantly to readmissions. A comprehensive medication plan in place at the time of discharge should include the discharge medication list, indication and duration of new medications, changes in medication (if any), and must be clearly communicated to and understood by the resident and family upon discharge.					
Do you use the teach-back method to validate residents' and families' understanding of their medications, medical condition, care needs and/or discharge plans? **Rationale:** Teach-back is a communication tool to confirm that a healthcare provider has explained to the patient what they need to know in a manner that the patient understands. What is Teach-Back? | IHI Teach-Back Toolkit | TeachBackTraining					

Do you conduct post-discharge follow-up phone calls to residents/ families within 24–48 hours of discharge? (Subsequent calls within 7 days is also recommended). **Rationale:** The first week following discharge is a vulnerable time for your residents. Follow-up phone calls are essential because they provide an opportunity to reinforce the discharge plan, problem solve, and resolve post-discharge issues such as challenges obtaining medications, new or worsening symptoms, and barriers to get to physician follow-up appointments. Phone calls also help maintain a positive connection with your residents to let them know that you care about them. TCM Discharge and Communications Template | HQIN					
Do you have a system in place to evaluate barriers and need for community support to facilitate a successful discharge? **Rationale:** The transition from nursing home to home can be overwhelming to many residents, especially if they have a new medical condition they are adjusting to, or medications added/ changed since their hospitalization. A home health visit can often ease that transition and, for Medicare Fee-for-Service patients, there is no co-pay. Your Discharge Planning Checklist | Medicare					

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