



# HQIN

Health Quality Innovation Network

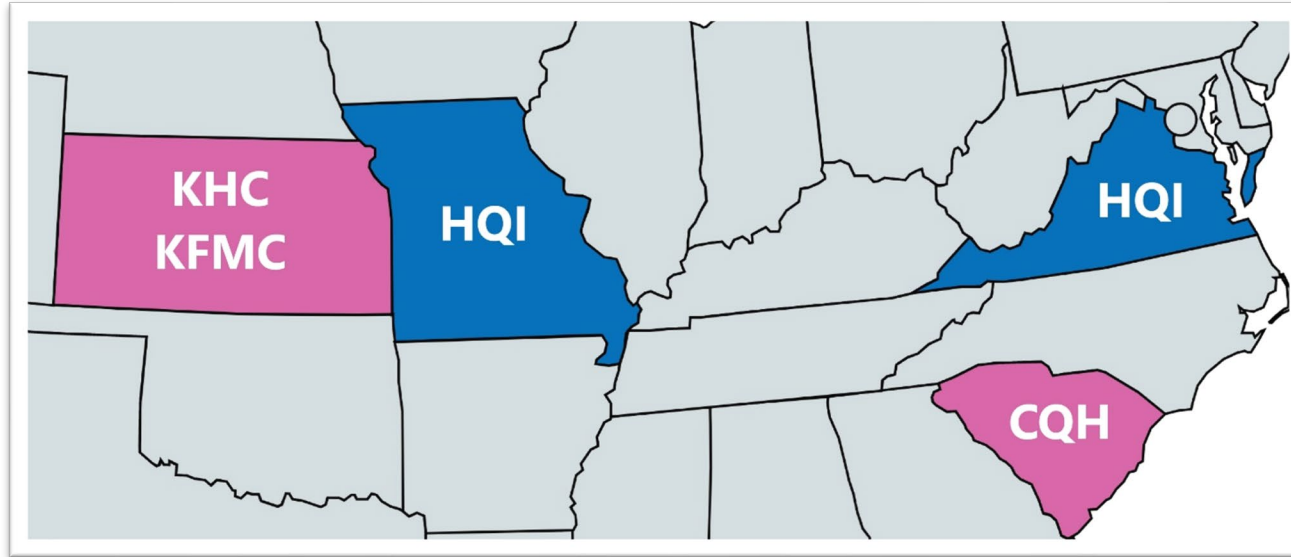


Health Quality Innovation Network

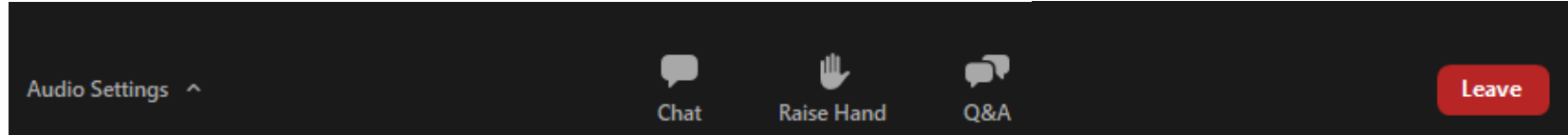
# Recognize and Respond Collaborative: INTERACT<sup>®</sup> Quality Improvement Tools

October 24, 2023

# Health Quality Innovation Network



# 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.

# Your Team



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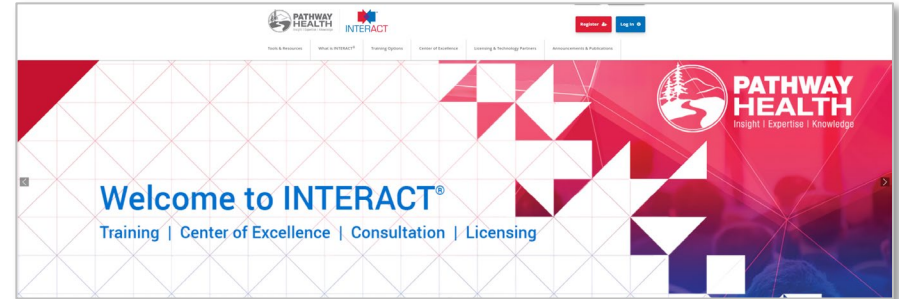
# Webinar Objectives

- Review the INTERACT® quality improvement tools
- Discuss how to use the INTERACT® QI tools for review of acute care transfers
- Implement QAPI strategies to reduce the frequency of potentially avoidable transfers



# INTERACT® Tools

- Communication tools
- Decision support tools:  
Change in condition file  
cards and care paths
- Advanced care plan tools
- **Quality improvement tools**



# Polling Question

Are you currently using, or have you used in the past, an INTERACT® QI tool to track acute care/hospitalization transfers?

- A. Yes (Please enter which tool in chat)
- B. INTERACT® Acute care transfer log (paper)
- C. INTERACT® Hospitalization Rate Tracker (Excel)
- D. No
- E. Unsure





# INTERACT® QI Tool Sets



## Tracking Hospitalization Rates

- Acute Care Transfer Log-Worksheet
- Calculating Hospitalization Rates
- Hospitalization Rate Tracking Tool 2023
- Tracking Tool Instructions
- Tracking Tool Trouble Shooting



## Quality Improvement Review-Root Cause Analysis

- Quality Improvement Tool for Review of Acute Care Transfers
- Quality Improvement Summary-Worksheet

# Hospitalization Rates: Why They Matter

- Tracking, trending and benchmarking specific quality measures is fundamental to any quality improvement program
- Clearly and consistently defined measures must be used to benchmark and compare your measure to others
- The Centers for Medicare & Medicaid Services (CMS) is monitoring readmission and ED rates through various quality measure initiatives:
  - Skilled Nursing Facility Value-Based Purchasing Program
  - Five Star Nursing Home Care Compare





# The Hospitalization Rate Tracking Tool

- Excel workbook with embedded formulas that calculate and trend rates for key measures
- Allows entry of census data and information on transfers to generate a variety of summary reports



# Welcome Page

**Welcome**

**INTERACT Hospital Rate Tracking Tool v1.0**  
January 1, 2013

**Confidentiality is important.** Please do not transmit this form with resident-identifying information. Instructions for de-identifying this tool are provided in the Common Qs & As tab.

<http://www.pathway-interact.com/>

This workbook contains twenty [22] worksheets to assist in tracking and evaluating hospital transfers in your home. Each worksheet can be accessed by clicking the tabs that appear at the bottom of this workbook.

Worksheet	Description
Welcome	Table of contents
Instructions	Step-by-step guide for using this tool is provided in a separate word document. Print for easy reference.
<a href="#">Common Qs &amp; As</a>	Answers to commonly asked questions
<a href="#">DropDownLists</a>	Step 1: Create lists of your residents, residents' rooms, and nursing units
<a href="#">Census</a>	Step 2: Record your average daily census
<a href="#">AdmittedwithRecentDischarge</a>	Step 3: List admissions to your nursing home
<a href="#">TransferLog</a>	Step 4: Track each transfer to the hospital in this sheet. Record the date of transfer, hospital name, and length of stay.
<a href="#">Hospitalization/MeasuresTracking</a>	Trend charts of your monthly outcomes.
<a href="#">ItemSummaries</a>	Summaries of selected items are provided to help you identify areas for improvement.
<a href="#">CustomizedTracking</a>	Customize for a specific hospital OR health plan.
<a href="#">CustomizedItemSummaries</a>	Customize for a specific hospital OR health plan.
<a href="#">Monthly Summaries</a>	Your four outcome measures are calculated each month.

Click the hyperlinks above or the tabs at the bottom of your Excel window to move between worksheets.

start

Website address: Click to access the INTERACT website and additional tools and resources.

Confidentiality is important. Please do not transmit this form with resident-identifying information. Instructions for de-identifying this tool are provided in the Common Qs & As tab.

Common Q&As

4 Data entry worksheets

2 sheets of charts and graphs track your aggregate information

2 more sheets allow you to customize reports for a specific hospital or health plan.

Click on the named tabs to move between worksheets.

Monthly outcome summaries for website entry.

# Drop Down Lists

**INTERACT** Version 3.0.0 Tool

## DropDownLists

**Step 1**  
In the columns below, type or paste lists of:  
A Hospitals from which you receive admissions.  
B Clinicians who order transfers to hospital from your nursing home.  
C Names of residents in your nursing home.  
D Your residents' health care plans.  
These lists will create dropdown lists in subsequent sheets.  
You may add to these lists at any time.

Instructions on Copying & Pasting Names from another Excel workbook, Word or other document

Admitted from	Clinicians	Residents	Health Plans
Beginning at row a5, add the names of acute care hospitals from which you receive admissions.	In the spaces below, list the clinicians who order transfers to hospital from your nursing home.	In the spaces below, list the residents in your nursing home. This will ensure that their names appear consistently throughout this workbook.	In the spaces below, list your residents' health plans. This will ensure that their names appear consistently throughout this workbook.
a1 Home	c1	r1	p1
a2 Assisted Living	c2	r2	p2
a3 Other Nursing Home	c3	r3	p3
a4 Other	c4	r4	p4
a5		r5	p5
a6		r6	p6
a7		r7	p7
a8		r8	p8
a9		r9	p9
a10		r10	p10

**DropDown**

Enter Hospital Name  
Include only acute medical, surgical and psychiatric hospitals by name.  
Other hospitals, including acute rehab hospitals, should be listed as 'Other.'

### Then:

1. Read Instructions.
2. Enter your hospitals.
3. Enter your clinicians.
4. Enter your residents/patients.
5. Enter residents'/patients' health plans.

**First:** Go to the DropDownLists sheet.

Notice the combination letter and number codes that appear next to each name. These codes will follow the names throughout the workbook, no matter what order the names are listed in other sheets. They may be used to de-identify this workbook for sharing. Detailed instructions are provided in Common Q&As.



# Transfer Log



## Transfer Log

Step 4: Complete the detail for each resident/patient transferred from your facility or program to hospital in the grid below.

Highlight indicates resident had an unplanned admission to the hospital within 30 days of discharge from hospital. Not all transfers result in admission.

Include ONLY transfers to acute care hospitals or critical access hospitals

\*Red asterisk indicates required field.

About this Resident			About this Transfer						
Automatic Code to de-identify your file	Resident/Patient Name* example: Jane Brown	Purpose of Nursing Home Stay* Post-acute Type Care / Chronic Long Term Care	Payment Status at Time of Transfer from Nursing Home to Hospital select from list	Date of Transfer to Hospital* example: 7/21/23	Transfer: Time of Day select from list	Clinician Ordering Transfer	Automatic Clinician Code to de-identify your file	Primary Sign/Symptom Leading to Transfer	Primary Diagnosis/Presumed Diagnosis Leading to Transfer
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									



# Census



## Census

### Step 2

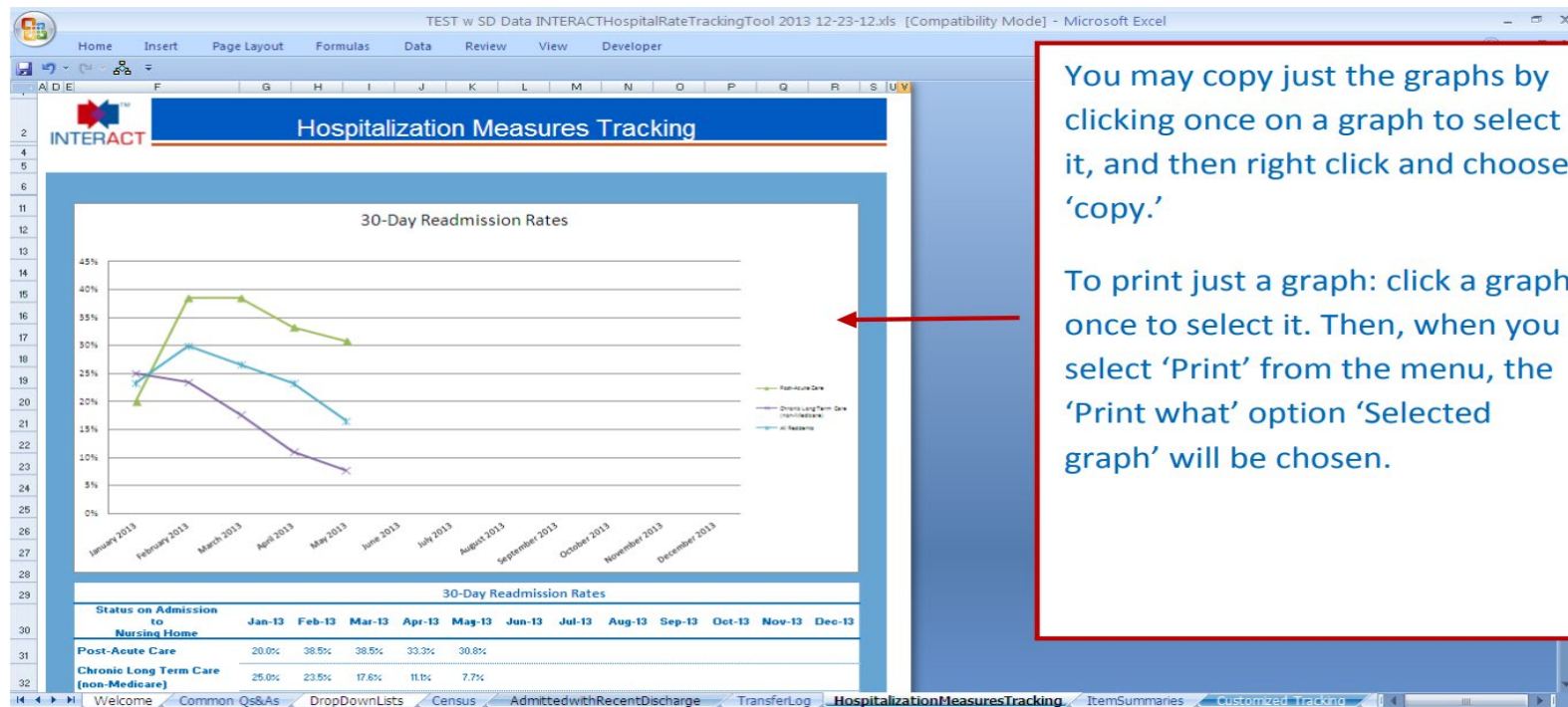
- ◆ At the **end** of each month, enter your average daily census (ADC) for the month.
- ◆ If you are tracking transfers for only part of your facility or program and/or do not have your ADC by stay type, you may use your census on the 15th day of the month.

**NOTE:** Whether you use ADC or census, this number should reflect the number of residents in the specified type of care during the month. It is not the same as 'paid beds.'

	Enter Average Daily Census for PAC-type Care*	Enter Average Daily Census for Chronic LTC-type Care*	Combined Average Daily Census for the Month	Days in this Month	Resident Days this Month ADC x The Number of Days in the Month
January 2023	0.0	0.0	0.0	31	0.0
February 2023	0.0	0.0	0.0	28	0.0
March 2023	0.0	0.0	0.0	31	0.0
April 2023	0.0	0.0	0.0	30	0.0
May 2023	0.0	0.0	0.0	31	0.0
June 2023	0.0	0.0	0.0	30	0.0
July 2023	0.0	0.0	0.0	31	0.0
August 2023	0.0	0.0	0.0	31	0.0
September 2023	0.0	0.0	0.0	30	0.0
October 2023	0.0	0.0	0.0	31	0.0
November 2023	0.0	0.0	0.0	30	0.0
December 2023	0.0	0.0	0.0	31	0.0

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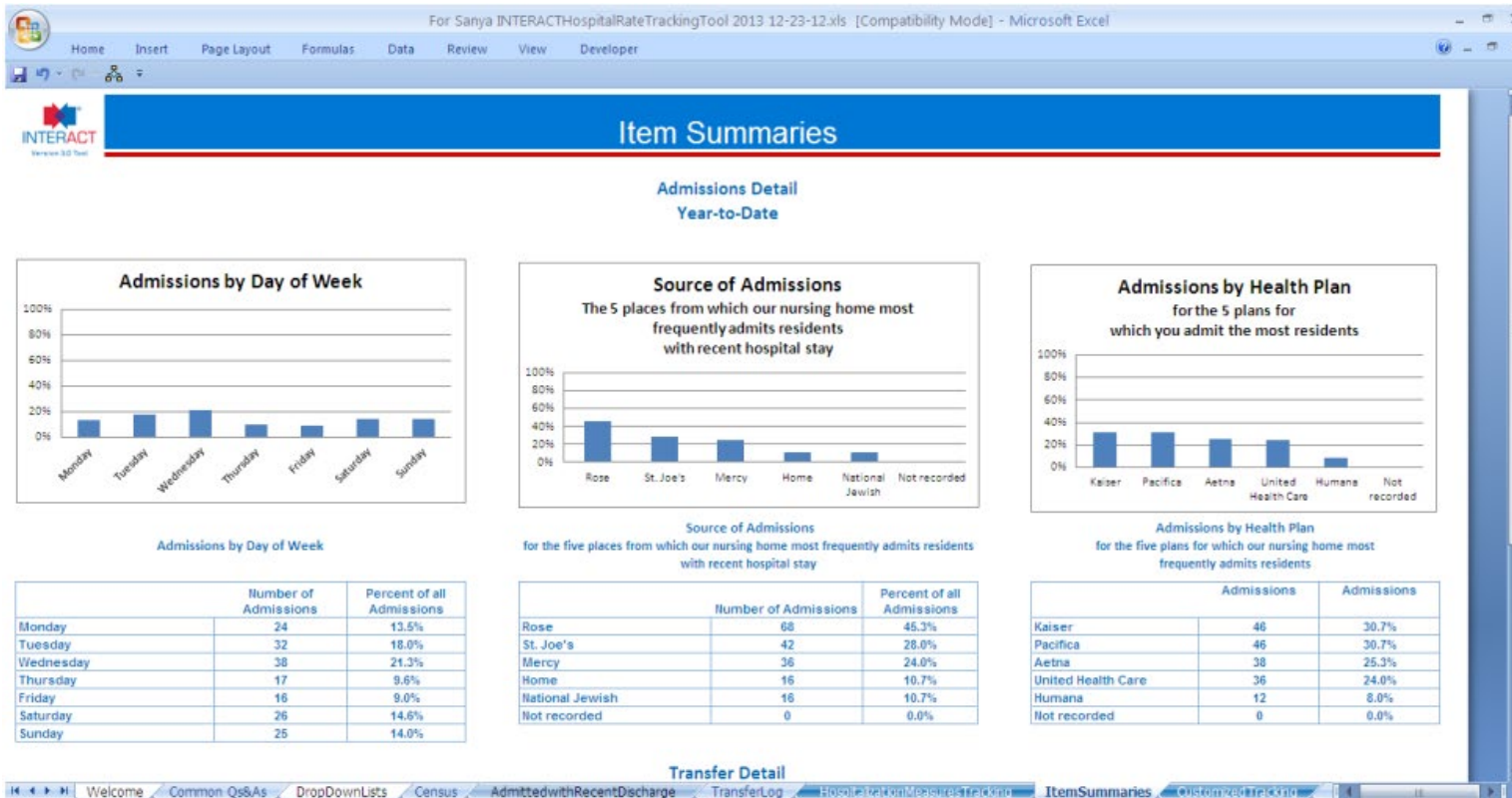
# Hospitalization Measures Tracking



You may copy just the graphs by clicking once on a graph to select it, and then right click and choose 'copy.'

To print just a graph: click a graph once to select it. Then, when you select 'Print' from the menu, the 'Print what' option 'Selected graph' will be chosen.

# Item Summaries



# Customized Reports

For Sanya INTERACTHospitalRateTrackingTool 2013 12-23-12.xls [Compatibility Mode] - Microsoft Excel

Home Insert Page Layout Formulas Data Review View Developer

Use this sheet to create a readmissions report for a specific hospital or health plan.

**INTERACT**  
Version 3.0 Tool

## All Hospitals and Plans

Select the hospital OR health plan you would like the report created for:

All Hospitals

OR

All Plans

- All Plans
- Aetna
- Kaiser
- United Health Care
- Pacifica
- Humana

you must set the first option to "All Hospitals."

### 30-Day Readmission Rates

Category	Point 1	Point 2	Point 3	Point 4	Point 5
Post-acute Care	20%	38%	30%	33%	30%
Chronic Lung Test (non-HIV) (all)	25%	23%	12%	11%	8%
All Residents Fee	23%	30%	20%	20%	17%

Welcome Common Q&A DropDownLists Census AdmittedwithRecentDischarge TransferLog EligibleforInpatientDischargeItemSummaries CustomizedTracking

# Monthly Summary Sheets

Home Insert Page Layout Formulas Data Review View Developer

INTERACT  
Version 3.0 Tool

## April 2013

### Monthly Summary

You may use this sheet to view your monthly transfer rates as soon as you've entered all of your information through the end of the month.

IMPORTANT: Your 30-Day Readmission Rates for April 2013 will not be final until you have completed your Transfer Log through: **Friday, May 31, 2013**

	Status at Time of Admission from Hospital	
	Post-Acute Care	Chronic Long Term Care (non-Medicare)
Number Admitted With Recent Hospital Discharge This Month	12	18
30-Day Readmission Rate percent of those readmitted to hospital within 30 days of the date of discharge from hospital	33.3%	11.1%

	Purpose of Stay at Time of Transfer to Hospital		All Residents
	Post-Acute Care	Chronic Long Term Care	
Resident Days This Month Your ADC x the number of days in the month	1200	3300	4500
Hospital Admission Rate per 1000 resident days	0.8	0.3	3.8
Rate of Transfers to Emergency Department Only per 1000 resident days	3.3	0.9	2.7
Rate of Transfers Resulting in Observation Stay	0.8	0.0	2.0

March 2013 April 2013 May 2013 June 2013 July 2013 August 2013 September 2013 October 2013 November 2013

No data entry is required on this page. The dates on this page, including the calculation for the 30-day window for readmissions, are produced automatically.

This worksheet is set to print on a single page for an easy monthly snapshot.

About the Outcomes [\[QuickLinks\]](#)

A complete and detailed discussion is provided in the last tab of your workbook: **“Calculating Hospitalization Rates.”**

**30-Day Readmission Rate:**

Residents/patients with a hospital discharge date within the calendar month form the denominator for this measure.

Among those residents/patients, any who were then ADMITTED TO THE HOSPITAL within 30 days of the date of discharge are counted as readmissions (numerator).

Only unplanned transfers that result in 'Admitted, inpatient' or 'Admitted, status uncertain' in your TransferLog are counted.

Readmission rates are calculated separately based on **Status at Time of Admission**

April 2013			
Monthly Summary			
Purpose of Stay at Time of Transfer to Hospital			
	Post-Acute Care	Chronic Long Term Care (non-Medicare)	All Residents
Number Admitted With Recent Hospital Discharge This Month	12	18	30
30-Day Readmission Rate percent of those readmitted to hospital within 30 days of the date of discharge from hospital	33.3%	11.1%	23.3%
Purpose of Stay at Time of Transfer to Hospital			
	Post-Acute Care	Chronic Long Term Care	All Residents
Resident Days This Month Your ADC x the number of days in the month	1200	3300	4500
Hospital Admission Rate per 1000 resident days	0.8	0.3	3.8
Rate of Transfers to Emergency Department Only per 1000 resident days	3.3	0.9	
Rate of Transfers Resulting in Observation Stay	0.8	0.0	

**Hospital Admission Rate:**

When you record the outcome of a transfer as being either 'Admission, inpatient,' or 'Admission, uncertain,' it will be counted in the Hospital Admission rate.

Transfer rates are calculated separately based on **Type of Care at Time of Transfer to Hospital**

# QI Reviews-Root Cause Analysis

## Quality Improvement Tool For Review of Acute Care Transfers

The INTERACT QI Tool is designed to help your team analyze **admissions** and identify opportunities to reduce transfer each or a representative sample of hospital transfers in or common reasons for transfers. Examining trends in these you focus educational and care process improvement activities.

Patient/Resident: \_\_\_\_\_  
Date of most recent admission to the facility: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Primary goal of admission:  Post-acute care  Long-stay  Other: \_\_\_\_\_

### SECTION 1: Risk Factors for Hospitalization

a. Conditions that put the resident at risk for hospital admission or readmission:

- Cancer, on active chemo or radiation therapy
- Heart Failure (HF)
- Congestive Obstructive Pulmonary Disease (COPD)
- Dementia
- Diabetes
- End-Stage Renal Disease
- Fracture (Hip)
- Infection
- High Risk
- (A)stical
- Multiple (e.g. HF, COPD)
- Polypharm
- Surgical

b. Was Patient/Resident hospitalized in the **30 days before their most recent** (Other than those being reviewed in this tool)?

c. Other hospitalizations or emergency department visits in the **past 12 mo.** (Other than those being reviewed in this tool)

### SECTION 2: Describe the Acute Change in Core Non-Clinical Factors that Contributed to the

a. Date the change in condition first noticed: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

b. Briefly describe the change in condition and other factor(s) that led to \_\_\_\_\_

### c. Vital signs at time of transfer

Temp \_\_\_\_\_ Pulse \_\_\_\_\_ (indicated) \_\_\_\_\_ on \_\_\_\_\_ Room Air \_\_\_\_\_ O<sub>2</sub> \_\_\_\_\_  
Respiratory rate \_\_\_\_\_ BP \_\_\_\_\_ Glucose (Subjective) \_\_\_\_\_

## Quality Improvement Tool For Review of Acute Care Transfers (cont'd)



### d. Check all that apply

- New or Worsening Symptoms or Signs**
- Abdominal distention
  - Hematoma
  - Abdominal Pain
  - Abnormal vital signs (low/high BP, high/low respiratory rate)
  - Altered mental status
  - Behavioral symptoms (e.g. agitation, psychosis)
  - Bleeding (other than GI)
  - Cardiac arrest
  - Chest pain
  - Constipation
  - Cough
  - Dehydration/volume depletion
  - Diarrhea
  - Disorientation
  - Edema (new or worsening)
  - Fall
  - Fever
  - Food and/or fluid intake (decreased or unable to eat and/or drink adequate amounts)
  - Function decline (worsening function and/or mobility)
  - GI bleeding, blood in stool
  - suspected bowel obstruction
  - Hypertension (uncontrolled)
  - Hypoxia - (low SpO<sub>2</sub>)
  - Loss of consciousness (syncope, other)
  - Nausea/vomiting
  - Pain (uncontrolled)
  - Respiratory arrest
  - Respiratory infection (Bronchitis, pneumonia)
  - Shortness of breath
  - Seizure
  - Skin wound or pressure ulcer/injury
  - Stroke / TIA / CVA
  - Trauma (fall related or other)
  - Unresponsive
  - Urinary incontinence
  - Weight loss
  - Other (describe)

### Abnormal L

- Blood Sugar
- COVID (P)
- ECG
- Hemoglobin
- INR (high)
- Kidney Fun
- (BUN, Cr)
- Pulse oxim
- (low oxy)
- Urinalysis
- White Blo
- X-ray
- Other (de

### Diagnosis or

- Acute renal
- Asemia (h)
- Asthma
- Cellulitis
- COPD (Ch
- Pulmonar
- COVID
- DVT (Deep
- Fracture (e
- HF (Heart
- Pneumon
- Sepsis
- UTI (Urinar
- Other (de

### Need for

- other pro
- titinatio
- Gastro
- blocka
- Treatm
- Other

## Quality Improvement Tool For Review of Acute Care Transfers (cont'd)



### SECTION 3: Describe Action(s) Taken to Evaluate and Manage the Change in Condition Prior to Transfer

a. Briefly describe how the changes in Section 2 were evaluated and managed and check each item that applies

### b. Check all that apply

- Tools Used**
- Steth and Watch
  - SBAR
  - Care Path(s)
  - Change in Condition File
  - Cards
  - Transfer Checklist
  - Acute Care Transfer Form (or an equivalent paper or electronic version)
  - Advance Care Planning Tools
  - Infection or Sepsis Guidance
  - Other Structured Tool or Form (describe)

### Medical Evaluation

- Telephone only
- NP or PA visit
- Physician visit
- Other (e.g. teleconsult or/while on dialysis)

### Testing

- Blood tests
- EKG
- Urinalysis and/or culture
- Venous doppler
- X-ray
- Other (describe)

### Interventions

- New or change in medication(s)
- IV or subcutaneous fluids
- Increase oral fluids
- Oxygen (flow/level)
- Other (describe)

c. Were **advance care planning** or **advance directives** considered in evaluating/managing the change? (e.g. orders for Do Not Resuscitate (DNR), Do Not Intubate (DNI), palliative/hospice care, other such as POLST, MOLST or POST)  No  Yes

If **yes**, were the relevant advance directives (check only):  No  Yes

- Modified as a result of this change in clinical condition/tranfer?
- Already in place and documented?
- New as a result of this change in clinical condition/tranfer?

Describe \_\_\_\_\_

## Quality Improvement Tool For Review of Acute Care Transfers (cont'd)



### SECTION 4: Describe the Hospital Transfer

a. Date of transfer: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Day \_\_\_\_\_ Time (am/pm) \_\_\_\_\_

b. Clinician authorizing transfer:  Primary physician  Covering physician  NP or PA  Other (specify)

c. Outcome of transfer:  ED visit only  Held for observation  Admitted to hospital as inpatient

Hospital diagnosis(es) (if available): \_\_\_\_\_

d. Resident died in ambulance or hospital:  No  Yes  Unknown

### e. Factors contributing to transfer (check all that apply and describe)

- Advance directive not in place
- Clinician insisted on transfer despite staff willing to manage in the facility
- Direct admission (from dialysis or other specialty office)
- Discharged from the hospital too soon
- Family members/representative preferred or insisted on transfer
- Planned admission (for surgery or other procedure)
- Resident preferred or insisted on transfer
- Resources to provide care in the facility were not available

### SECTION 5: Identify Opportunities for Improvement

a. In retrospect, does your team think this transfer might have been prevented?  No  Yes (describe)

If **yes**, check one or more that apply:

- The new sign, symptom, or other change might have been detected earlier
- Changes in the resident's condition might have been communicated better among facility staff, with physician/NP/PA, or other health care providers
- The condition might have been managed safely in the facility with available resources
- Resources were not available to manage the change in condition safely or effectively despite staff willing to manage in the facility (check all that apply)
- On-site primary care clinician
- Pharmacy services
- Staffing
- Lab or other diagnostic tests
- Other (describe)
- Resident and family or resident representative preferences for hospitalization might have been discussed earlier
- Advance directives and/or palliative or hospice care might have been put in place earlier
- Discharged from the hospital too soon
- Other (describe)

b. In retrospect, does your team think this resident might have been transferred sooner?  No  Yes (if, yes, describe)

c. After review of how this change in condition was evaluated and managed, has your team identified any opportunities for improvement?  No  Yes (describe changes your team can make to your care processes and related education as a result of this review)

Name of person completing form: \_\_\_\_\_ Date of completion: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

## Quality Improvement Tool for Review of Acute Care Transfers



# QI Summary Worksheet

## Quality Improvement Summary Worksheet



This Worksheet is a guide to learning from individual root cause analyses of hospital transfers. It can be used to summarize findings documented on **INTERACT Quality Improvement (QI) Tools** to determine if there are common factors involved in your hospital transfers. Identifying these common factors will help focus your education and care process changes in order to further improve care and reduce potentially preventable hospital transfers. An Excel template **QI Summary Worksheet** is also available on the INTERACT website. There are several steps involved, which are outlined below.

### STEP 1: Document the number and timeframe of completed QI Tools included in this summary

1. Number of completed QI Review Forms included in this summary: \_\_\_\_\_
2. Time frame of completed QI Review Forms: From \_\_\_\_\_ To \_\_\_\_\_

### STEP 2: Compare the answers across each section of the QI Review Tools. Circle 'Yes' for the same or similar answers across a majority of the completed QI Tools

#### A. Resident/Patient characteristics

1. Age of residents/patients transferred to the hospital (e.g., are most over 85?) ..... Yes
2. Length of stay prior to hospital transfers? (e.g., less than 7 days) ..... Yes
3. Risk factors for hospitalizations? ..... Yes  
(note which ones) .....
4. Diagnoses associated with hospitalizations? ..... Yes  
(Note which ones) .....

#### B. Changes in condition that lead to transfer

1. Signs or symptoms that led to the transfers? ..... Yes  
(Note which ones) .....

#### C. Actions taken prior to the transfers

1. Tools that were used to manage the change in condition prior to the transfer? ..... Yes
  2. Tools that might have been used but were not? ..... Yes
  3. Type of medical evaluation conducted prior to the transfers? ..... Yes
  4. Timing of advance care planning discussions with resident and/or resident representative? ..... Yes
- Findings .....

## Quality Improvement Summary Worksheet (cont'd)



### D. Hospital transfer and contributing factors

1. Day of the week of hospital transfer? ..... Yes
2. Time of day of hospital transfer? ..... Yes
3. MD/NP/PA authorizing the transfer? ..... Yes
4. Non-clinical factors that contributed to the hospital transfer?
  - a. MD/NP/PA insisted on transfer? ..... Yes
  - b. Resident/Patient preferred or insisted on transfers? ..... Yes
  - c. Resident representative or family members preferred or insisted on transfers? ..... Yes
  - d. Resources needed to provide care in NH not available? ..... Yes
  - e. Facility policies do not support providing care in NH? ..... Yes

Findings .....

### E. Transfers rated as potentially preventable

1. Factors related to transfers rated as preventable? ..... Yes
2. Reasons provided for preventable transfers? ..... Yes

Findings .....

### STEP 3: Summarize Common Factors Across

1. What factors were most common and similar across QI Tools?
 

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. Based on this summary what areas would you target for:
  - a. Staff education: \_\_\_\_\_
  - b. Care process changes: \_\_\_\_\_
  - c. Other improvement efforts: \_\_\_\_\_

## QI Summary Worksheet



# Tips for QAPI

- Evaluate your tracking method/tools and make changes as needed
- Analyze your transfer and hospitalization data to identify areas of focus
- Identify gaps in the system and areas for improvement
- Know your hospitalization and ED visit rate and what factors are driving it



# Helpful Reminders

- Not all ED transfers and rehospitalizations should be prevented
  - Acute care may be medically necessary in many situations
  - Accurate assessment of care needs is critical
- Watch for premature hospital discharges and ensure your facility can provide the necessary care
- Know your facility's capabilities and scope of services



*"Success is not final, failure is not fatal: it is the courage to continue that counts."*

-Winston Churchill

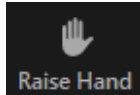


# Recognize and Respond Collaborative Learning Sessions

- Learning Session 1: September 12, 2023
  - Advance Care Planning/Resident and Family Engagement
- Learning Session 2: September 26, 2023
  - Communication Strategies
- Learning Session 3: October 10, 2023
  - INTERACT® Care Paths
- Learning Session 4: October 24, 2023
  - INTERACT® QI Tools
- **Collaborative Outcomes: November 14, 2023**
  - **Pulling it all Together and Sustainability**



# Questions? Comments? Share What is Working or What is Difficult for Your Team!



**Raise your hand** to verbally ask a question



**Type a question** by clicking the **Q&A** icon

*Don't hesitate to ask a question after the webinar is over.  
Email [LTC@hqi.solutions](mailto:LTC@hqi.solutions) or your HQIN Quality Improvement Advisor.*

# Center of Excellence for Behavioral Health In Nursing Facilities

**The Center of Excellence focuses on increasing the knowledge, competency and confidence of nursing facility staff to care for residents with behavioral health conditions.**

- Provides mental health and substance use trainings, customized technical assistance and resources at no cost
- Services are available to all CMS certified nursing facilities throughout United States
- Established by the Substance Abuse and Mental Health Services Administration (SAMHSA) in collaboration with the Centers for Medicare and Medicaid Services



**For assistance, submit a request at**  
[nursinghomebehavioralhealth.org](https://nursinghomebehavioralhealth.org)

**Contact us:**  
National Call Center: **1-844-314-1433**

**Email:** [coeinfo@allianthealth.org](mailto:coeinfo@allianthealth.org)

# Center of Excellence for Behavioral Health In Nursing Facilities

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**National Call Center: 1-844-314-1433**  
For more information or to request assistance.

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# FOR MORE INFORMATION

Call 877.731.4746 or visit [www.hqin.org](http://www.hqin.org)

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## Kansas

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