Reducing Hospital Readmissions by Partnering with Skilled Nursing Facilities

SNF Program

March 30, 2023

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Objectives

- Identify what the “EQIC reducing readmissions by partnering with skilled nursing facilities” program aims are and why implementing a strategy to address this problem will benefit your facility.
- Identify principles and methodology to develop a program to reduce readmissions by partnering with skilled nursing facilities.
- Identify tools and resources for implementation and evaluation.

Agenda

- Introduction
- Aligning forces for care coordination across the continuum: The importance of collaboration for improved outcomes
- Reducing readmissions by partnering with skilled nursing facilities
- Next steps

EQIC readmissions goals and data

EQIC goal: Reduce hospital readmission by 5%

Hospitalwide All-Condition, All-Payer, Readmission Analysis Age 18+

EQIC-Wide Results

Table 5. Discharge Disposition Details	All
# of discharges to home (without home health)	394,905
# of discharges to home health	113,705
# of discharges to skilled nursing facility (SNF)	82,576
# of discharges to other	63,278
% of discharges discharged to home (without home health)	60%
% of discharges discharged with home health	17%
% of discharges discharged to SNF	13%
% of discharges discharged to other	10%
# of readmissions following discharge to home (without home health)	32,522
# of readmissions following discharge to home health	16,018
# of readmissions following discharge to skilled nursing facility (SNF)	10,931
# of readmissions following discharge to other	12,085
Readmission rate following discharge to home (without home health)	8%
Readmission rate following discharge to home health	14%
Readmission rate following discharge to skilled nursing facility (SNF)	13%
Readmission rate following discharge to other	19%

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Aligning Forces for Care Coordination Across the Continuum: The Importance of Collaboration for Improved Outcomes

"Care Transitions is a team sport, and yet too often we don't know who our teammates are, or how they can help"

Eric Coleman, MD, MPH

The Care Transitions Program
https://caretransitions.org/

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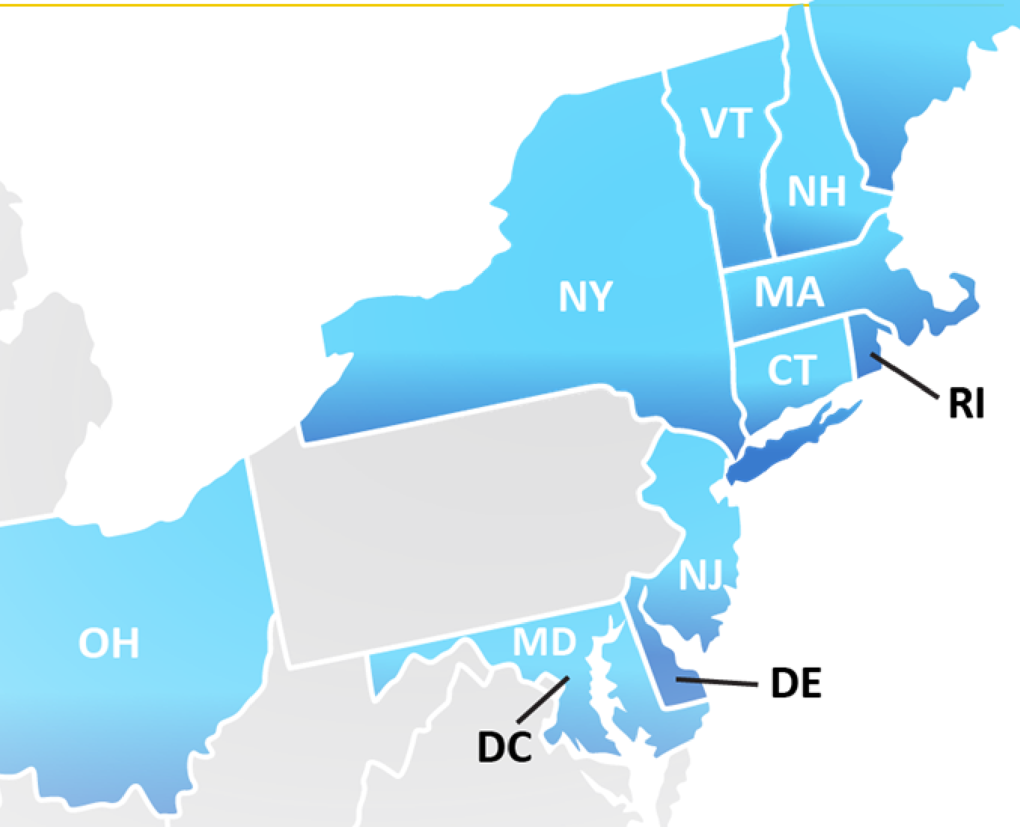
The IPRO QIN-QIO

The IPRO QIN-QIO

- A federally-funded Medicare Quality Innovation Network – Quality Improvement Organization (QIN-QIO)
- 12 regional CMS QIN-QIOs nationally



IPRO:
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Working to ensure high-quality, safe healthcare for
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CMS QIN-QIO Priority Goals

Improving Care Transitions to Reduce Unnecessary Hospitalization

Reducing Opioid-Related Adverse Events

Promoting Chronic Disease Management

Supporting Immunizations

Enhancing Patient Safety

Advancing Infection Control Strategies & Emergency Preparedness

Partnership for Community Health

Health Equity – Patient & Family Engagement – Health Information Technology

The Importance

Closer relationships can help reduce hospital readmissions and improve safety of transitions of care, which can have a detrimental impact on people living in long-term care facilities.

Health systems who have invested resources in developing relationships with nursing facilities are better able to ramp up and provide critical support during a crisis.[1]

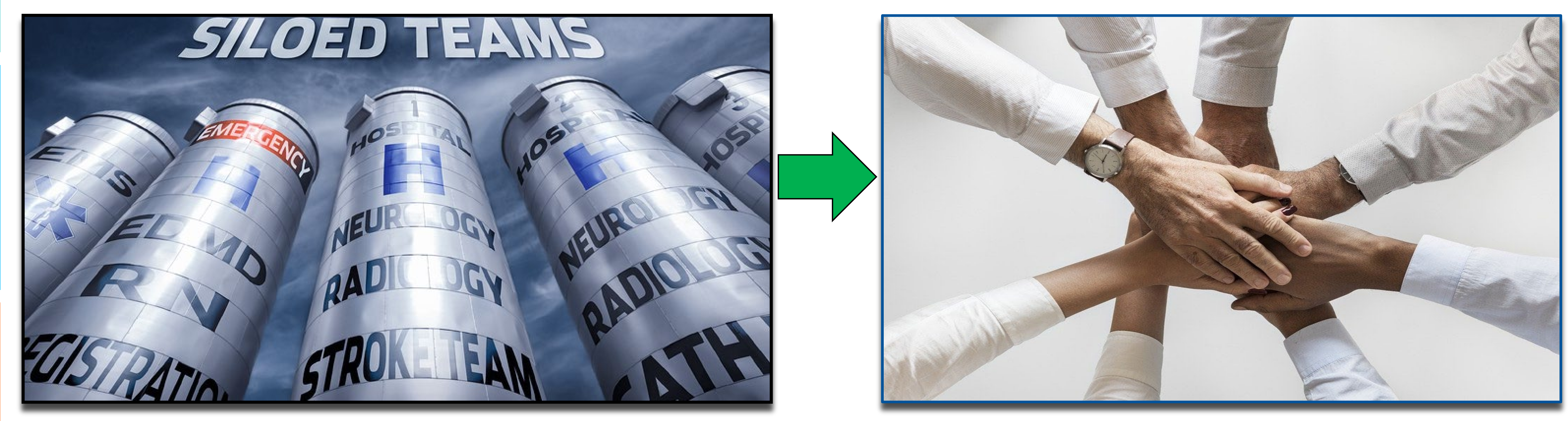
[1] Unroe, K.T & Vest, J (2020) Time to Leverage Health System Collaborations: Supporting Nursing Facilities Through the COVID-19 Pandemic. *Journal of the American Geriatrics Society.*

The Paradigm Shift: Discharge Versus Care Transition

Beyond Care Coordination to Enhanced Health

"Our Patient"

"Patient Within Our Community"



Challenges…
The Elephant in the Room

- Focus on discharge versus transition
- Ownership of transitions
- Burden of coordination is placed on patient/care partner
- Care partner may not be involved at discharge
- Absence of common medical record
- Absence of cross setting medication reconciliation
- Lack of advance directives & screening for palliative care
- No reassessment of patient and goals at each transition
- Communication gaps between healthcare settings

Readmissions in Long-Term Care

- Studies have shown that 25-67% of rehospitalizations from SNFs are potentially preventable
- 1 in 5 patients transferred from the hospital to the nursing home is re-hospitalized within 30 days
- For SNF residents who are often elderly, frail, and chronically ill, rehospitalization carries additional risks
- Loss of function, nosocomial infections and delirium are among potential complications.

Ouslander Joseph G., Lamb Gerri, Perloe Mary, Givens JoVonn H., Kluge Linda, Rutland Tracy, … Saliba Debra. (2010). Potentially Avoidable Hospitalizations of Nursing Home Residents: Frequency, Causes, and Costs. *Journal of the American Geriatrics Society*, *58*(4), 627–635.

Current State

Readmissions by Discharge Status

- New York State
- Medicare Fee-for-Service
- Not Risk-adjusted
- CMS Paid Claims Data
- 10/1/21 – 09/30/22
- All-Cause 30- Day Readmissions

New York

Readmissions by Discharge Status - Stratified by Days to Readmission

The following shows readmissions based on the discharge status code on the claim that indicates the patient's post acute care destination, stratified by the numbers of days elapsed until a patient was readmitted.

All Discharges, Oct-2021 to Sep-2022

State

	Percent
1-2 Days	10.7%
3-7 Days	24.3%
8-14 Days	25.9%
15-20 Days	17.0%
21-30 Days	22.1%

Setting Discharged To	Readmits Within 30 Days	Days to Readmission									
		1-2 Days		3-7 Days		8-14 Days		15-20 Days		21-30 Days	
		N	%	N	%	N	%	N	%	N	%
HHA	19,206	2,163	11.3%	4,719	24.6%	4,978	25.9%	3,261	17.0%	4,085	21.3%
Home	28,850	3,089	10.7%	7,125	24.7%	7,379	25.6%	4,914	17.0%	6,343	22.0%
Hospice	262	39	14.9%	76	29.0%	63	24.0%	39	14.9%	45	17.2%
Inpt. Psych.	83	30	36.1%	12	14.5%	13	15.7%	8	9.6%	20	24.1%
Inpt. Rehab.	2,396	226	9.4%	543	22.7%	631	26.3%	416	17.4%	580	24.2%
Nursing Home	18,713	1,910	10.2%	4,372	23.4%	4,925	26.3%	3,175	17.0%	4,331	23.1%
Other Hospital	414	35	8.5%	125	30.2%	112	27.1%	67	16.2%	75	18.1%
Other	170	36	21.2%	47	27.6%	34	20.0%	14	8.2%	39	22.9%
Total	70,094	7,528	10.7%	17,019	24.3%	18,135	25.9%	11,894	17.0%	15,518	22.1%

Importance of Data Sharing

We Know…

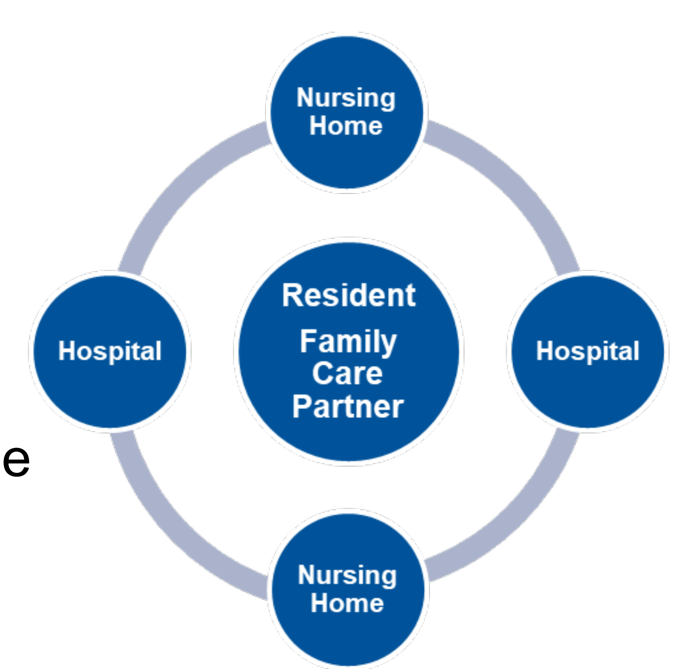
- Data drives healthcare improvement and outcomes
- Allows informed decisions to improve quality of care
- Improves performance through comparison to benchmarks
- Promotes ability to see the bigger picture

The Reality…

- All organizations within your community are measuring data to ensure quality yet everyone only has a small piece of the puzzle
- Communities of care can share their outcomes to drive improvement for the common good

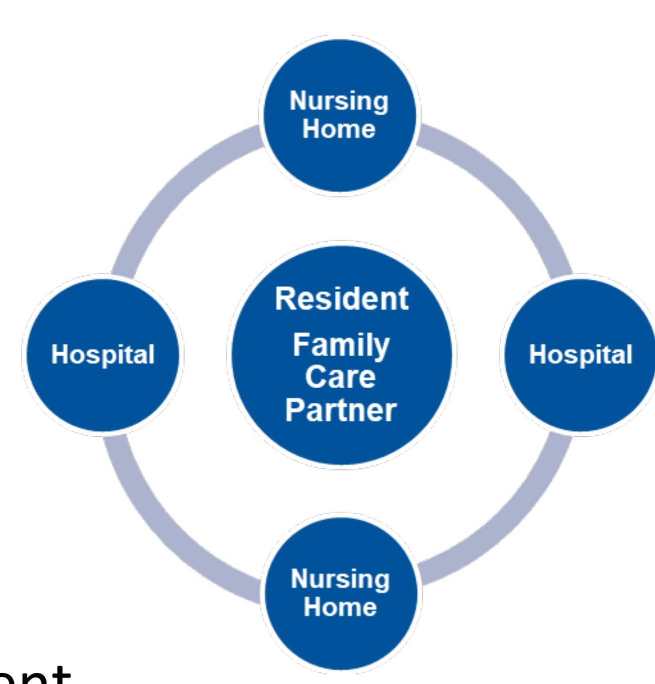
Opportunities at the Time of Transition

- Accurate assessment of resident status (risk factors, advance directives, COVID history, care partner involvement, behavior factors, communication ability)
- Bi-directional communication regarding plan of care (return to NH for treatment versus admit to hospital)
- Confirmation of NH capabilities to treat
- Information transfer
- Medication reconciliation (including purpose of medication, dose & frequency/end date)



Opportunities for Improved Outcomes

- Staff education on assessment, treatment guidelines & medications
- Cross-continuum care pathways
- Super-utilizer care management
- Streamlined transitions of care
- Capacity building
- Management of complex care
- Decrease in acute care transfers
- Shared protocols for care
- Health equity & social determinants of health assessment



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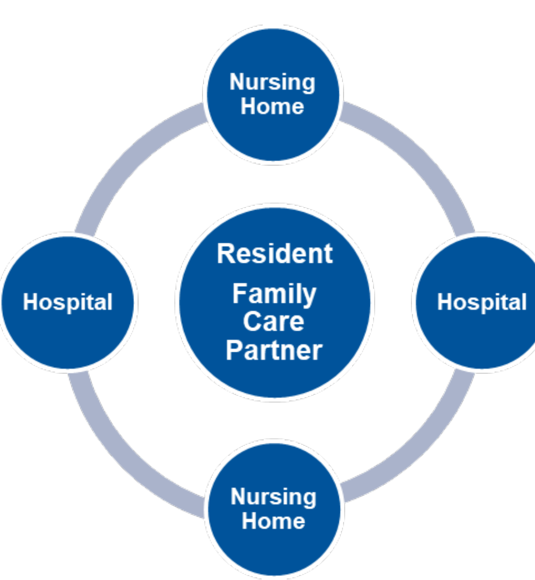
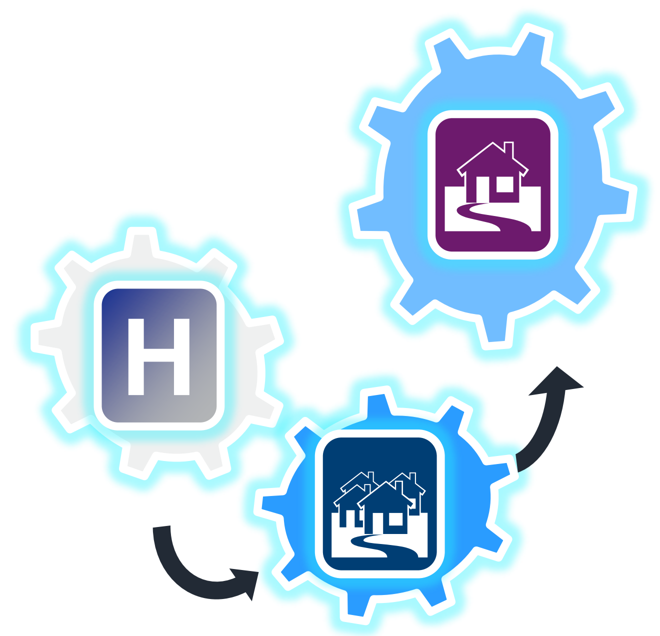
Innovative Strategies

- Improve cross setting partnerships and communication for care coordination and management
- Weekly huddles to touch base on residents in-house
- Establish point person for contact for emergent transition issues
- Create hospital & nursing home POC list for off hours & weekends
- Cross setting medication reconciliation
- Cross setting staff education
- Streamlined and standardized cross setting information transfer
- Cross setting support of resident/caregiver learning for self-management (signs/symptoms/red flags/action)



Tools & Resources to Support Collaboration



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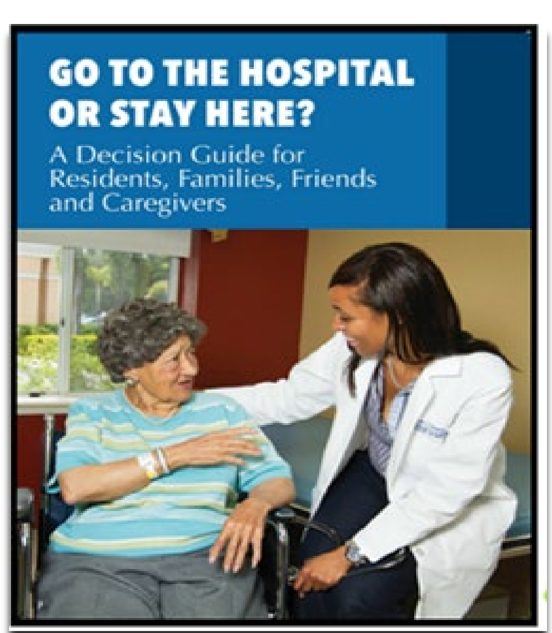
Patient/Family Education on Long-Term Care

Go to the hospital or stay here? A Decision Guide for Residents, Families, Friends and Caregivers

Explains the difference between short stay and nursing home care and what to expect when transferring to the nursing home

www.decisionguide.org



Skilled Nursing Facilities Capabilities List

SNF/NF Capabilities List

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+, tCO₂*)	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		
Occupational	Y	N
Physical	Y	N
Respiratory	Y	N
Speech	Y	N

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

Other Specialized Services *(specify)*

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INTERACT SNF Capabilities Checklist

https://pathway-interact.com/

Request referral NHs to fill out & return

Aggregate lists into 1 document for ED staff, Case Managers, Social Work, Discharge Planners & Hospitalists to reference when deciding treatment & disposition of NH residents in ED

REVISED 4/12/2016	Albany County Nursing Home 518-869-2231 780 Albany Shaker Rd. Albany, NY 12211	Baptist Health Nursing and Rehabilitation Center, Inc.	Barnwell Nursing and Rehabilitation Center 3230 Church St. Valatie, NY 12184	Bethlehem Commons 518-439-8116 125 Rockefeller Rd., Delmar, NY 12054	Centers Healthcare Out of the area facilities	Daughter's of Sarah 518-456-7801 180 Washington Ave Ext Albany, NY 12203	Diamond Hill Nursing & Rehabilitation Center 518-235-1410 100 New Turnpike Road Troy, NY 12182	Essex Center, Elizabethtown, NY	Evergreen Commons 518-479-4662 1070 Luther Road East Greenbush, NY 12061
Capabilites									
At least one Phys,NP,or PA in the facility three or more days per week	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes
At least one Phys,NP, or PA in the facility five or more days per week	Yes	Yes	Yes	Yes	**Onsite HD:**	Yes	No	Yes	Yes
Diagnostic Testing					Bronx Center				
Stat lab tests with turn around less then 8 hours	Yes	Yes	Yes	Yes	Daughters of Jacob	Yes	No	Yes	Yes
Stat X-Rays with turn around less then 8 hours	Yes	Yes	Yes	Yes	Bushwick Center	Yes	Yes	Yes	Yes
EKG	Yes		Yes-mobile	Yes	Mt Laurel Center	Yes	Yes	Yes	Yes
Bladder Ultrasound	Yes	Yes		No		Yes	Yes	No	No
Venous doppler	Yes	no	yes mobile	Yes		Yes	Yes	Yes	Yes
Cardiac Echo	Yes	no	yes mobile	No	**Vent:**	Yes	Yes	Yes, Plattsburgh	No
Swallow Studies	Yes	Yes	yes	Yes	Northern Manor	Yes	Yes	Yes, Plattsburgh	No
Other (Specify)					Daughters of Jacob	Video fluroscopy - No, FEES - Yes			
Consultations					Richmond Center				
Psychiatry	Yes	Yes	yes	Yes		Yes	Yes	Yes, Telepsych	No
Cardiology	Yes	Yes	No	No		No	No	Yes, Offsite	No
Pulmonary	Yes	Yes	No	No	**Vent Dialysis:**	Yes	No	Yes, Offsite	Yes
Wound Care	Yes	Yes	Yes Wound MD rounds weekly	Yes	Daughters of Jacob	Yes	Yes	Yes, Offsite	Yes
Other Phys. Specilaty Consultations Specify	Dental, Optometry, Podiatry, Psychology	Dental, Podiatry	Podiatry, Dental, Psychology, Optometry	Dental, cardiology, pulmonary		Derm, dental, podiatry	Dental, Optometry, Podiatry, Psychology	Optometry, Dental, Podiatry	Physistry
Social & Psychology Services									
Licensed Social Worker	Yes	Yes	Yes	Yes	**HIV/AIDS Unit:**	Yes	Yes	Yes	Yes
Psych. Eval & Counselling by Licensed Clinical Psych.	Yes	Yes	Yes	Yes	Richmond Center	Yes	Yes	No	Yes
Therapies Onsite					Hope Center - CD4 count of below 200 (at any point) is needed to be accepted				
Occupational	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes
Physical	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes
Respiratory	Yes	Yes	No	No	**TBI/Neuro Behavioral Unit:**	No	No	Yes	No
Speech	Yes	Yes	Yes	Yes	Richmond Center	Yes	Yes	Yes	Yes
Nursing Services									
Frequent Vital Signs (eg every 2 hrs)	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes
Strict intake & output (I&O) monitoring	Yes	Yes	Yes	Yes	**Methadone:**	Yes	Yes	Yes	Yes
Daily weights	Yes	Yes	Yes	Yes	Richmond Center	Yes	Yes	Yes	Yes
Accuchecks for glucose at least every shift	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes
INR	Yes	Yes	Yes-lab runs test offsite	No - Off site @ lab		No - Off site @ lab	No - off-site at lab	Yes, Venous Sticks	Yes
O2 Saturation	Yes	Yes	Yes	Yes	**Locked Dementia Unit:**	Yes	Yes	Yes	Yes
Nebulizer treaments	Yes	Yes	Yes	Yes	Washington Center	Yes	Yes	Yes	Yes
Incentive spirometry	Yes	Yes	Yes	Yes	Holliswood Center	Yes	Yes	Yes	Yes
Clinical Care					Northern Metropolitan				
IV Fluids (initiation & maintenance)	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes
IV Antibiotics	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes
IV Meds - Other (eg. Furosemide)	Case by Case	Yes	No IV Push	Yes	**Psych/Tough Cases:**	Yes	No	Yes	Yes
PICC Insertion	No	No	No	No	Far Rockaway Nursing Home	No	No	No	No
PICC Management	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes
Short term Total Parenteral Nutrition (TPN)	No	No	No	No		No	No	No	No
Isolation (for MRSA, VRE, etc...)	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes
Surgical Drain Management	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes
Tracheostomy Management	Yes	Yes	Yes	Yes		Established Trach	Yes	Yes	Yes
Analgesic Pumps	No	no	implantable only	Yes w/ notice		No	No	No	Yes
Dialysis	Outpatient	no	OutPt	Outpatient		No - Off site	Yes - off-site	Yes, HD Offsite	No
Advanced CPR (ACLS capability)	No	No	No	No		No	No	No	No
Automatic Defibrillator	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes
Pharmacy Services									
Emergency kit with common medications for acute condidtions available	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes
New medications filled within 8 hrs	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes
Other Specialized Services (Specify)	IV antibiotics, respiratory therapist on staff, trach care and teaching						Palliative Care, Wound Vac Services		Palliative Care, Wound Vac
Weekend Admission Y/N?	yes, case by case	Yes	Yes	Yes		Yes	Yes	Admissions/ Readmissions 24/7	Yes
New Patients	yes, case by case	Yes	Yes	Yes		Yes	Yes		Yes
Returns	Yes	Yes	Yes	Yes		Yes	Yes		Yes
Time to be at facility	arrive by 2 pm on weekends (new), returns are more flexible	Yes	Yes			Anytime	By 2:00 p.m.		24/7
Wheelchair Transport									
Weekdays	No		No Restricitions	Yes		No	Not currently		
Weekends	No		No Restricitions	As needed		No	No		

Circle Back

- Did the patient arrive safely?
- Did you find admission packet in order?
- Were the medication orders correct?
- Does the patient's presentation reflect the information you received?
- Is patient and/or family satisfied with the transition from the hospital to your facility?
- Have we provided you everything you need to provide excellent care to the patient?

Institute for Healthcare Improvement (IHI)

www.IHI.org

How-to Guide:

Improving Transitions from the Hospital to Skilled Nursing Facilities to Reduce Avoidable Rehospitalizations

Support for the How-to Guide was provided by a grant from The Commonwealth Fund.

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How to cite this document:

Herndon L, Bones C, Bradke P, Rutherford P. *How-to Guide: Improving Transitions from the Hospital to Skilled Nursing Facilities to Reduce Avoidable Rehospitalizations*. Cambridge, MA: Institute for Healthcare Improvement; June 2013. Available at www.IHI.org.

Institute for Healthcare Improvement, 2013

Voices From the Field

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Questions

Reducing hospital readmissions by partnering with skilled nursing facilities

Implementation guide

EQIC
EASTERN US QUALITY IMPROVEMENT COLLABORATIVE

Reducing Hospital Readmissions by Partnering

Implementation Guide

What is this tool?

This guide details strategies for hospitals collaborating with skilled nursing facilities to readmissions by focusing on care transitions. This approach also improves the patient establishes a foundation for ongoing effective collaboration with post-acute care part

Who should use this tool?

The readmission team at your hospital.

How to use the tool:

1. Use this implementation guide to identify and select which strategies will opti your hospital and the SNF(s) as you collaborate to reduce readmissions.
2. Refer to the guide for implementation tools and strategies, which are organiz four key steps:

Step 1: Build relationships and collaborate with SNFs

Step 2: Establish standardized processes for information sharing between facilities to transitions

Step 3: Engage the patient and care partner in care transitions

Step 4: Understand the capabilities of the emergency department

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Reducing Hospital Readmissions by Partnering with SNFs

Process step	Interventions
Step 1: Build relationships and collaborate with	
Create an internal multidisciplinary team	Assemble a multidisciplinary team to include key stakeholders from the hospital and SNF. Consider including ED and frontline staff to help build the foundation and infrastructure of the SNF program by supporting a culture of: • patient and care partner engagement; and • SNF and hospital coordination aimed at reducing avoidable readmissions from SNF to hospital. Tool: • Unit-based safety quality improvement toolkit
Identify and invite SNFs to collaborate and partner with your team	Use data reports to identify the rehabilitation and SNF organizations most frequently referred to or where patients are received from. Identify one or two SNFs with the highest number of hospital readmissions and/or ED encounters. Consider a formal invitation in writing or contact through verbal outreach. Tools: • EQIC SNF partner contact list • EQIC Transitional care community resource list • EQIC SNF data abstraction tool • AHRQ Data analysis tool
Define program goals and measures	Establish goals and identify both process and outcome measures. Consider the following: Outcome measures: • reduce readmission rate between hospital and SNF by X %; or • reduce SNF ED visits by X %. Process measure: • HCHAPS questions 16, 20, 21 and 22
Understand the capabilities of the SNF	Hospital and SNF teams conduct site visits to SNFs and EDs to gain a better shared understanding of capabilities.

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Reducing Hospital Readmissions by Partnering with SNFs

Process step	Interventions	Notes/work plan
	Identify services provided by the SNF, including: • provider availability; • on-site diagnostic testing; • on-site social worker; • on-site therapies; • nursing capabilities; • interventions; and • pharmacy. Tool: • INTERACT Nursing home capabilities list	
Develop staff education for the SNF program to reduce readmissions	Create staff education including: • goals; • staff roles; • who to contact when a SNF patient presents or is admitted; and • an EMR notification trigger. Create workflows that include identifying SNF patients upon presentation to ED or inpatient admission.	
Step 2: Establish standardized processes for information sharing between facilities to improve care transitions		
Develop data sources for reports	Use EQIC's SNF data abstraction tool as a guide to help your team create hospital-specific reports aimed at identifying SNF patients. Work with your IT team to create data reports identifying SNF patients and make any necessary EMR modifications. Tool: • EQIC SNF data abstraction tool	

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Poll

- Do you have a readmission quality improvement team?
  - Yes
  - No

- Does your team include your community-based partners?

- Does your team include SNF staff?

Step 1: Build relationships and collaborate with SNFs

Step 1

- Create an internal multidisciplinary team
- Identify and invite skilled nursing facilities to collaborate with your team
- Define program goals and measures
- Understand the capabilities of the SNF
- Develop staff education for the SNF program

Create an internal multidisciplinary team

- Develop a multidisciplinary team including key stakeholders from the hospital and SNF
  - Engage leadership support
  - ED Staff
  - Frontline Staff
  - Ensuring the right people are at the table

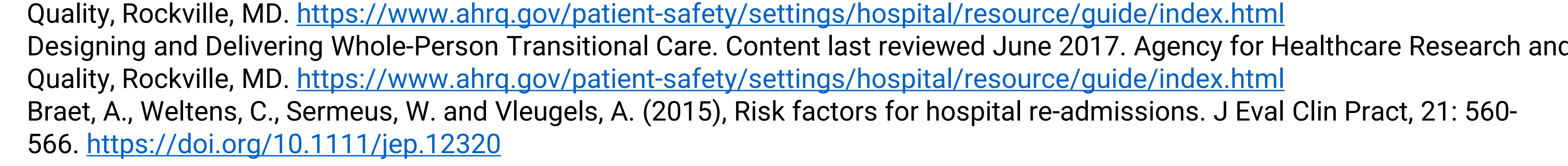
- Build a culture of:
  - patient and care partner engagement; and
  - SNF and hospital coordination aimed at reducing avoidable readmissions from SNF to hospital.

Identify and invite skilled nursing facilities to collaborate with your team

- Collect and review readmission data to identify:
  - The rehabilitation and SNF organizations most frequently referred to or received from.
  - One or two SNFs with the highest number of hospital readmissions.
- Invite SNFs to participate in collaboration through a formal invitation in writing or contact through verbal outreach.

Which patients?

- Use the AHRQ data analysis tool to identify:
  - individuals who have four or more admissions or readmissions in a 12-month period from SNFs; and
  - collaborative partners with readmissions from SNFs.


Designing and Delivering Whole-Person Transitional Care. Content last reviewed June 2017. Agency for Healthcare Research and Quality, Rockville, MD. https://www.ahrq.gov/patient-safety/settings/hospital/resource/guide/index.html
Designing and Delivering Whole-Person Transitional Care. Content last reviewed June 2017. Agency for Healthcare Research and Quality, Rockville, MD. https://www.ahrq.gov/patient-safety/settings/hospital/resource/guide/index.html
Braet, A., Weltens, C., Sermeus, W. and Vleugels, A. (2015), Risk factors for hospital re-admissions. J Eval Clin Pract, 21: 560-566. https://doi.org/10.1111/jep.12320

Define program goals and measures

Measures for consideration

Outcome

- reduce readmission rate by X %; or
- reduce SNF admissions by X %

Process

- HCAHPS questions 16, 20, 21 and 22

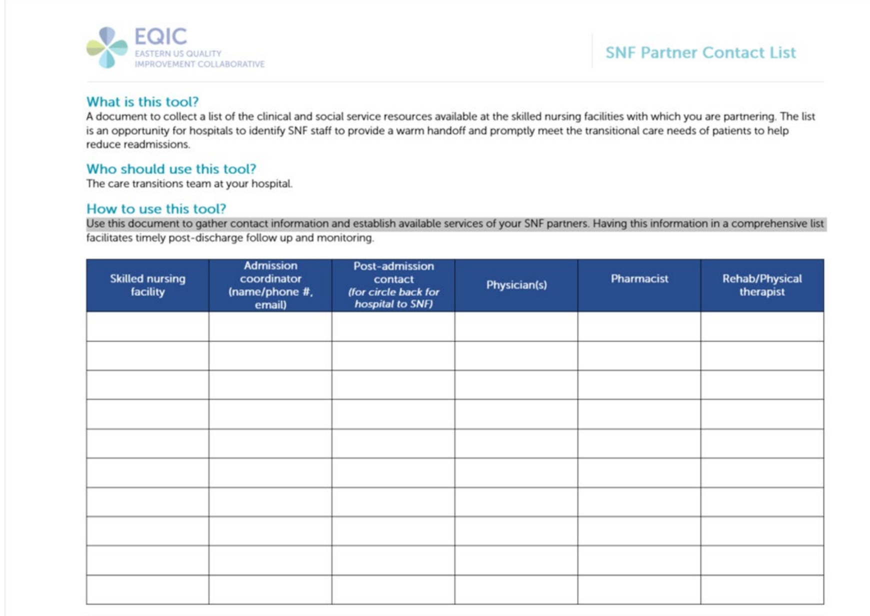
HCAHPS questions

- During this hospital stay, did doctors, nurses or other hospital staff talk with you about whether you would have the help you needed when you left the hospital?
- During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left.
- When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.
- When I left the hospital, I clearly understood the purpose for taking each of my medications.

https://hcahpsonline.org/globalassets/hcahps/quality-assurance/2022_survey-instruments_english_mail.pdf

Understand the capabilities of the SNF

EQIC SNF partner contact list



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SNF Partner Contact List

What is this tool?
A document to collect a list of the clinical and social service resources available at the skilled nursing facilities with which you are partnering. The list is an opportunity for hospitals to identify SNF staff to provide a warm handoff and promptly meet the transitional care needs of patients to help reduce readmissions.

Who should use this tool?
The care transitions team at your hospital.

How to use this tool?
Use this document to gather contact information and establish available services of your SNF partners. Having this information in a comprehensive list facilitates timely post-discharge follow up and monitoring.

Skilled nursing facility	Admission coordinator (name/phone #, email)	Post-admission contact *(for circle back for hospital to SNF)*	Physician(s)	Pharmacist	Rehab/Physical therapist

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INTERACT SNF capabilities list

SNF/NF Capabilities List

INTERACT Version 4.0 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+, tCO2)	Y	N
Bladder Ultrasound	Y	N
Cardiac Echo	Y	N
Complete Blood Count (CBC)	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		
Occupational	Y	N
Physical	Y	N
Respiratory	Y	N
Speech	Y	N

Capabilities	Yes	No
Nursing Services		
24 Hour RN Converage	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
Other Specialized Services (specify)		

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Develop staff education for the SNF program

- Create staff education including:
  - goals;
  - staff roles;
  - who to contact when a SNF patient presents or is admitted; and
  - EMR notification trigger.

- Create workflows that include identifying SNF patients upon presentation to ED or inpatient admission.

Step 2: Establish standardized processes for information sharing between facilities to improve care transitions

Step 2

- Develop data sources for reports
- Identify contributing factors for readmissions
- Develop communication tool for patient and care partner feedback
- Create a transitional care plan
- Create a plan for healthcare team communication
- Ensure follow-up communication with post-discharge provider(s)
- Provide post-discharge support and follow up
- Enhance discharge process

Develop data sources for reports

- Create hospital-specific reports aimed at identifying SNF patients.
- Work with your IT team to create data reports
  - identifying SNF
  - make any necessary EMR modifications
- Consider:
  - EQIC SNF data abstraction Tool
  - EQIC High-risk factors for readmission tracking tool

https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/medicaidreadmitguide/mcaidread_tool1_data_analysis_final.xlsx

Identify contributing factors for readmission

- Review the trends and volume of SNF patients to determine risk factors for readmission.
- Stratify data by patient-specific characteristics and trends to assist with the development of standardized, coordinated interventions among hospital and SNF partners.

Teams should consider:

- Disease-specific diagnosis
- Days from discharge to readmission
- Comorbidities
- Age
- Gender
- Discharge planning/inadequate transitions of care
- SNF capabilities
- ADLs/functional status
- Adverse drug events

EQIC SNF readmission data abstraction tool

A

EQIC Skilled Nursing Facility-to-Hospital Readmission Data Abstraction Tool

Description

This tool has been developed by EQIC to aid hospitals and skilled nursing facilities in tracking and performing root cause analyses on readmissions from SNF to hospital. Data on causes for readmissions entered into this tool will be automatically aggregated and displayed on the Results - Charts and Results - Tables sheets of this workbook. These results can then be used to identify opportunities to review and modify processes across care transitions to reduce readmissions.

Instructions

Information regarding each readmitted patient may be entered on the sheet titled Chart Abstraction Tool.

Prior to completing the questions on this sheet, it is recommended that you perform the following tasks:

1) On the sheet titled SNF List, enter all of the SNFs from which patients may be readmitted to your hospital.

2) On the sheet titled Diagnosis List, enter any diagnoses that you would like to track. We have included some recommended diagnoses, but you may edit these as needed.

3) On the sheet titled Language List, enter any languages that patients at your facility prefer to speak, that you would like to track. We have included some recommended languages, but you may edit these as needed.

Once the information on these three sheets has been entered, the listed items will become available as response options to related questions on the Chart Abstraction Tool.

Determining readmission criteria

It is recommended that you answer the questions on the Chart Abstraction Tool for patients that have been readmitted from a SNF to your hospital within 30 days following discharge. However, you may alter the criteria depending on the type of readmission that you would like to track.

Entering data

Each question requires that you either enter data or select a response from a dropdown box. To select a response, you must select the cell and click on the arrow that appears on the right side of the cell to view the available response options. You must then select one of the response options by clicking on the desired response. Alternatively, you may type the response into the cell. Please note that your response must match one of the response options exactly or it will not be accepted. You may choose to answer some or all of the questions depending on your hospital's needs.

Viewing results

The aggregate results of your responses to the questions will be displayed as bar charts in the sheet titled Results - Charts, and as tables in the sheet titled Results - Tables. Please note that in order for the results to be calculated correctly, a medical record number must be entered into row 5 on the Chart Abstraction Tool.

EQIC Skilled Nursing Facility-to-Hospital Readmission Data Abstraction Tool

Instructions: Provide answers to the elements included in this tool to identify current causes or trends in your readmissions from SNFs. Patients that were readmitted from a SN
The goal of using this tool is to identify opportunities to review and modify processes across care transitions to reduce readmissions. We suggest that you review readmissions

Category	Question	Patient 1	Patient 2	Patient 3
General information about patient and readmission	Enter the patient's medical record #:			
	SNF that patient was readmitted from	[Please Select]	[Please Select]	[Please Select]
	Length of stay in SNF prior to readmission to hospital	[Please Select]	[Please Select]	[Please Select]
	Patient readmitted to the hospital on a weekend (Friday 6 p.m. through Monday 8 a.m.)	[Please Select]	[Please Select]	[Please Select]
	Patient's preferred language	[Please Select]	[Please Select]	[Please Select]
	Patient's age	[Please Select]	[Please Select]	[Please Select]
	History of four or more hospitalizations in prior 12 months	[Please Select]	[Please Select]	[Please Select]
	History of four or more ED visits in prior 12 months (which did not result in hospitalization)	[Please Select]	[Please Select]	[Please Select]
Index admission and hospitalization	Primary diagnosis for index admission (defined as first admission to hospital after which there was a readmission within 30 days)	Congestive heart failure	[Please Select]	[Please Select]
	Primary diagnosis for readmission	[Please Select]	[Please Select]	[Please Select]
	Two or more chronic diseases	[Please Select]	[Please Select]	[Please Select]
	Mental health/substance abuse diagnosis	[Please Select]	[Please Select]	[Please Select]
	Cognitive limitations (this includes both temporary limitations such as delirium [any cause] and long-term limitations such as Alzheimer's, Parkinson's, stroke, etc.)	[Please Select]	[Please Select]	[Please Select]
	Patient on five or more medications at time of discharge from hospital to SNF	[Please Select]	[Please Select]	[Please Select]
	Medications changed on admission to SNF due to different formularies	[Please Select]	[Please Select]	[Please Select]
	Time of day patient transferred from hospital to SNF	[Please Select]	[Please Select]	[Please Select]
Evidence of patient and caregiver education with teachback on the following topics:	**Nutrition** (including fluid restrictions) - if on restricted diet	[Please Select]	[Please Select]	[Please Select]
	Physical therapy regarding goals for rehab at SNF	[Please Select]	[Please Select]	[Please Select]

Introduction | **Chart Abstraction Tool** | Results - Charts | Results - Tables | SNF List | Diagnosis List | Languages List

Develop communication tool for patient and care partner feedback

- Interview patient and care partner to:
  - understand their perspectives and challenges as part of readmission risk assessment at each admission; and
  - build into the routine workflow a discussion focused on patient and care partner reasons for each hospital admission.

- Optimize discharge plans to:
  - address patient concerns; and
  - identify reoccurring opportunities for improvement in the discharge process.

Create a transitional care plan

- Include the patient and care partner in the discharge plan.
- Address all risk factors identified for readmission and reasons for readmission as communicated by patient and care partner.
- Involve community-based organizations in the SNF/hospital team meetings.
- Customize patient-specific interventions post discharge at SNF team meetings.

Create a plan for healthcare team communication

- Encourage SNF program discussion among care teams, including involvement of the patient and care partner as part of the healthcare team.
- Identify SNF patients in the shift report and rounding tool and consider adding this information to the whiteboard.
- Identify best practices and interventions to hardwire into daily workflows i.e. medications:
  - Medications at transitions and clinical handoffs (MATCH) toolkit for medication reconciliation
  - Society of Hospital Medicine's MARQUIS medication collaborative

Ensure follow-up communication with post-discharge provider(s)

- Develop a feedback mechanism between hospital and SNF staff.
  - EQIC Circle back interview tool

Consider:

- data collection based on post-discharge follow-up aimed at identifying trends in opportunities for improvement.

EQIC Circle Back Interview Tool

Provide post-discharge support and follow up and enhance discharge process

- Conduct post-discharge follow-up calls to patients. Consider:
  - call to both patient and care partner;
  - review of each patient-specific intervention and support arranged through the readmissions team; and
  - using a patient and care partner interview tool or standardized risk assessment tool as a guide for these discussions.
- Call the SNF admission coordinator or charge nurse
  - Handoff communication tool
- Determine a feasible and appropriate post-discharge timeframe for follow up.

Step 3: Engage the patient and care partner in care transitions

Step 3

- Identify contributing factors for readmissions
- Gather information from patient and care partner feedback
- Regularly review risk data to identify and mitigate risk trends
- Identify and address any health equity and social determinants of health concerns for the patient

Gather information from patient and care partner

- Interview patient and care partner as part of readmission risk assessment at each admission.
- Build into the routine workflow a discussion focused on patient and care partner reasons for each hospital admission and readmission.

Regularly review risk data to identify and mitigate risk trends

- Collect, stratify and review available data to identify trends and/or high-leverage opportunities revealed in the data.
- Review:
  - the readmission risk assessment and;
  - patient and care partner interviews

Identify and address any health equity and social determinants of health concerns for the patient

- Use readmission risk assessment tool findings and additional screening tools to identify health equity and social determinants of health opportunities.
- Address these opportunities in coordination with CBOs that support these needs.

Tools:

- EQIC health equity tools and resources
- AHC Health-related social needs screening tool and PRAPARE
- AHRQ Hospital guide to reducing Medicaid readmissions *(See Tool 10, pg. 24 Whole-Person Assessment)*
- IFDHE Community partnerships: Strategies to accelerate health equity

Step 4: Understand the capabilities of the emergency department

Step 4

- Create an individualized plan for each patient
- Engage ED staff in the SNF program
- Leverage observation status

Create an individualized plan for each patient

- Create a patient-centered individualized transition plan for each SNF patient.
- SNF and ED work to understand healthcare capabilities of each facility to assist with development of transition plan.

AHRQ ED Care Plan
Interact Nursing Home Capabilities List

Engage ED staff in the SNF program

- Use SNF program notifications/flags created by IT.
- Share patient-specific SNF program discharge plans, including information on all involved CBOs. Consider modifying ED EMR to include SNF discharge instructions/plans.
- Create workflows including notification/consult of SNF program contact upon presentation.
- Provide the ED team with a completed EQIC Transitional care community resource list and SNF partner contact list.
- Continue communication between the SNF program team regarding patient-specific support and continued or additional patient needs.

EQIC Transitional care community resource list

What is this tool?
A document to collect a list of the behavioral, clinical and social service resources available in the community. The list is an opportunity for hospitals to identify local services to promptly meet the transitional care needs of patients to help reduce readmissions.

Who should use this tool?
The MAP program team at your hospital.

How to use this tool?
Use this document to gather contact information and establish available services of local community-based organizations. Having this information in a comprehensive list facilitates timely post-discharge follow up and monitoring.

Type of resource	Provider or agency name/phone number	Care services provided *Description of service, capacity and geographic area*	Service area (towns or ZIP codes)	Agency contact person *Name/number/fax/email*
Clinical services				
Behavioral health providers				
Behavioral health clinics				
Primary care providers				
Mental health providers				
Psychiatric centers				
Home health agencies				
Community health centers/Federally qualified health centers				
Health homes				
Hospice homes				
Palliative care providers				

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Leverage observation status

- Educate ED staff and providers on alternatives to inpatient admission where medically appropriate:
  - holding patient pending communication with SNF, case management; or
  - utilize observation status where appropriate.

EQIC SNF collaborative program tools and resources

https://qualityimprovementcollaborative.org/focus_areas/readmissions/

- EQIC Implementation guide
- EQIC Patient and care partner interview tool
- EQIC Circle back interview tool
- EQIC SNF partner contact list
- EQIC SNF data abstraction tool
- EQIC High-risk factors for readmission patient tracking tool
- EQIC Transitional care community resource list
- AHRQ Data analysis tool
- AHRQ IDEAL discharge process
- AHRQ ED care plan
- Interact Nursing home capabilities list

Questions

Next steps

- Work with your EQIC project manager to implement a program to reduce hospital readmissions by partnering with SNFs.
- Attend readmissions workgroup meetings.
  - Email Maria Sacco (msacco@hanys.org) to sign up for the readmission workgroup.

Complete the survey

Thank you.

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