Readmission Affinity Group Session 4: Managing Readmission Risk
Danyce Seney, RN, BSN, IP, RAC-CTA

QUALITY IMPROVEMENT SPECIALIST

Danyce Seney is a quality improvement specialist and a registered nurse with Lean, Infection Control Preventionist and Educator for Adult Learner certifications.

Danyce supports skilled nursing facilities in utilizing a quality improvement framework to implement evidence-based interventions and strategies to improve patient safety, improve immunization rates and reduce avoidable readmissions.

Email: DSeney@ipro.org
Amy Daly, MA, NHA

SENIOR QUALITY IMPROVEMENT SPECIALIST

Amy Daly is a licensed nursing home administrator with over 20 years of leadership and long-term care management experience. In addition to her prior work as a vice president of long-term care and facility administrator, Amy has served on the boards of the Genesee Health Facilities Association (as treasurer and education committee member) and the Genesee Health Facilities Foundation. Amy serves as a New York State Department of Health Informal Dispute Resolution (IDR) panel member and has been an adjunct clinical instructor of dental hygiene at Monroe Community College. Amy has a master’s degree in health promotion and a bachelor’s degree in health sciences.

Email: adaly@ipro.org
Learning Objectives

1. Learn strategies and resources for using a readmission risk tool

2. Understand how social determinants of health can impact readmission risk

3. Identify steps to effective identification and management of acute changes in condition utilizing strategies for CHF and COPD that can be applied to other diagnoses, such as pneumonia and sepsis.
Where We Have Been and Where We Are Heading

✓ **Session 1:** Facility Capabilities and Impact on Admissions, Re Admissions and ED Visits

✓ **Session 2:** Detecting and Communicating Changes in Condition

✓ **Session 3:** Clinical Decision Support Tools and Advanced Care Planning

**Session 4:** Assessing Readmission Risk

- Using the AHS Readmission Risk tool
- PALTC framework for identifying and managing acute changes in condition

**Session 5:** CHF & COPD Engaging the Interdisciplinary Team

**Session 6:** CHF & COPD Engaging Patients and Care Partners

**Session 7:** CHF & COPD: Bridging the Gap with transition partners
Polling Question

Do you currently use a readmission risk assessment tool or process?
PALTC’s Recommendations for Managing Acute Changes of Condition

1. Recognition
2. Assessment
3. Treatment
4. Monitoring
## Table 5: Suggested Approaches to Assessing Risk for ACOCs

<table>
<thead>
<tr>
<th>Step</th>
<th>Approaches</th>
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<tbody>
<tr>
<td>Evaluate the patient’s current condition and status.</td>
<td>Determine the expected course and known complications in specific conditions (e.g., knee replacement, acute renal failure, left-sided stroke).</td>
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<tr>
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<td>Define causes and problems identified to date.</td>
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<tr>
<td>Identify all of the patient’s current problems.</td>
<td>Create a problem list that focuses on matching causes (i.e., diseases and conditions) with consequences (i.e., functional and cognitive impairments).</td>
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<tr>
<td>Identify patients at risk for poorer outcomes (e.g., death, skin breakdown, failure to regain weight).</td>
<td>Identify risk factors (e.g., functional and cognitive status, coma, number of active problems and diagnoses).</td>
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<tr>
<td>Identify interventions that may help to reduce risks and prevent complications.</td>
<td>Determine interventions (e.g., turning and positioning, medication reduction) that might reduce the incidence and severity of complications.</td>
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Recognizing and Assessing Readmission Risk

The SNF Rehospitalization Risk Assessment Tool provides a framework for interdisciplinary review, discussion, and individualized care planning for all admissions to a skilled nursing facility. The tool proactively identifies and implements mitigation strategies to reduce rehospitalization risk.

**Tips for using this tool:**
1. Utilize facility rehospitalization risk assessment documentation to identify any additional high-risk factors associated with the population served by your facility. Modify this form to include any additional clinical or social determinants of health risks.
2. Review rehospitalization risk reports generated by the facility's electronic health record (EHR). Reconcile reports with the risks identified on this assessment and ensure both tools reflect all identified risks for the facility's patient and resident population.
3. Establish facility processes for regular monitoring and interdisciplinary review of patients and residents with multiple readmission risk factors (e.g., for a number of days post admission, in daily stand-up meetings, care conferences and/or readmission risk meetings).
4. Establish a process to ensure interdisciplinary staff on all shifts are aware of risks and are closely monitoring and communicating changes in condition.
5. Consider both the readmission risk for today and for the transition to the next level of care.
6. Develop an individualized, person-centered care plan intervention for each identified risk.

**Clinical Risk Factors** (Check all that apply, both active and chronic conditions)
- Cancer, on active chemotherapy or radiation therapy
- Heart failure (HF)
- Infection with ongoing treatment
- High-Risk Medications
- Anticoagulants
- Diabetic Agent
- Opioids
- Congestive Obstructive Pulmonary Disease (COPD) or Gastroesophageal Reflux Disease (GERD)
- Dementia
- Multiple active diagnosis and/or complications (e.g., HF, COPD and Diabetes in the same patient/resident)
- Diabetes
- Fracture (hip)
- Surgical complications
- Fracture (any)
- Infection with ongoing treatment
- Heart failure (HF)
- Congestive Obstructive Pulmonary Disease (COPD) or Gastroesophageal Reflux Disease (GERD)
- Dementia
- Multiple active diagnosis and/or complications (e.g., HF, COPD and Diabetes in the same patient/resident)
- Diabetes
- Fracture (hip)
- Surgical complications

**Prior Hospitalizations or Emergency Room Visits**
- Hospitalization in the 30 days before their most recent admission to the hospital (Other than the one being reviewed in this tool)
- Hospitalization in the 30 days before their most recent admission to the hospital (Other than the one being reviewed in this tool)
- Other hospitalizations or emergency department visits in the past 12 months (Other than the one being reviewed in this tool)

**AHS SNF Rehospitalization Risk Tool**
A female patient in her early 70s weighing approximately 102 pounds. Prior to admission to our SNF for rehab, she had four previous post-hospitalization stays at other SNFs. The primary dx was COPD.

So, what’s next?
Case Study #1

What has been tried previously, and why didn’t it work?

- Scheduling her post-discharge appointments
- Arranging transportation
- Arranged for home delivery of meds (initial set)

Slowly built trust to learn more of her personal story

- Her work as a flight attendant and why she stopped doing that work
- Impact of change in the support system for her brother with disabilities (for example, the change in his daycare program schedule made it difficult for her to leave the house for doctor appointments and reduced her time for self-care and rest.)
Case Study #2

80-year-old Black female, approximately 100 lbs., with heart failure, pneumonia and diabetes, on oxygen. The patient has multiple children with poor health literacy. The daughter was a health care proxy, living with the patient and dependent on her social security.

The daughter was observed encouraging her mother to use weights outside of therapy recommendations because she needed her strong enough to go up the stairs on her hands and knees if necessary to go home.
Implementing the Risk Assessment Tool

**KEEP IT SIMPLE**

- Gather information during the pre-admission screening process
  - Admissions screener completes with what is known from screening

- Review during morning Team Huddle
  - IDT reviews new admissions
  - IDT considers triggers when doing assessments (asking patient)

- Care Planning
  - Create interventions

**TIPS**

- Use the form as the framework for interdisciplinary discussion/planning
  - Avoid thinking of the RRA tool as another document to fill out

- Think about the discharge plan from day one
  - Plan for the first two weeks at home

- Shifting our thinking away from labeling patients as “non-compliant” to identifying and care planning for the barriers that make it challenging to adhere to a plan of care
# Implicit Bias: What? Why? How?

## What is it?

Subconscious bias refers to the attitudes or stereotypes that unconsciously affect our understanding, actions and decisions.

- Favorable
- Unfavorable
- Involuntarily, without awareness or intentional control

[https://implicit.harvard.edu/implicit/takeatest.html](https://implicit.harvard.edu/implicit/takeatest.html)

## Why do we need to be aware of it?

Bias in clinical decision-making results in overuse or underuse problems that can harm patients.

## How do we overcome it?

- Perspective-taking
- Emotional regulation skills
- Partnership-building skills – person-centered care
- Paradigm shift from non-compliance to barriers to adhering to recommended plans of care
Bringing It All Together

PALTC Acute Change of Condition

- **Recognition**
- **Assessment**
- **Treatment**
- **Monitoring**

Facility Tools to apply

- Stop and Watch, Specific plain Language, define baseline-AHS Risk Assessment Tool
- SBAR, AHS Communication Checklist, Zone Tools
- Facilities Capabilities Checklist, Our Family Our Way, Decision Guide, goals of care/advanced directives planning
- Stop and Watch, timely assessment and reporting to providers using SBAR, consider PT wishes/advanced directives, involve care partner, unplanned transfer review
Use Tomorrow

☐ Set a SMART Goal- Specific, Measurable, Attainable, Realistic, and Timebound:

☑ Discuss with your Team and Medical Director how you can incorporate a readmission risk assessment on your next 3 admissions by their first care conference.

☐ Take one implicit bias test as a team and discuss key take-aways
Join Us In February

Session 5: CHF & COPD Engaging the Interdisciplinary Team

• Orienting the resident to the facility, personnel and care practices while here

• Engaging and leveraging the interdisciplinary team (IDT) in patient education and preparation for a successful return home or to a lower level of care

• Increasing facility awareness of health literacy
Questions?
Nursing Home and Partnership for Community Health: CMS 12th SOW GOALS

**OPIOID UTILIZATION AND MISUSE**
- Promote opioid best practices
- Reduce opioid adverse drug events in all settings

**PATIENT SAFETY**
- Reduce hospitalizations due to c. diff
- Reduce adverse drug events
- Reduce facility acquired infections

**CHRONIC DISEASE SELF-MANAGEMENT**
- Increase instances of adequately diagnosed and controlled hypertension
- Increase use of cardiac rehabilitation programs
- Reduce instances of uncontrolled diabetes
- Identify patients at high-risk for kidney disease and improve outcomes

**CARE COORDINATION**
- Convene community coalitions
- Reduce avoidable readmissions, admissions to hospitals and preventable emergency department visits
- Identify and promote optimal care for super utilizers

**COVID-19**
- Support nursing homes by establishing a safe visitor policy and cohort plan
- Provide virtual events to support infection control and prevention
- Support nursing homes and community coalitions with emergency preparedness plans

**IMMUNIZATION**
- Increase influenza, pneumococcal, and COVID-19 vaccination rates

**TRAINING**
- Encourage completion of infection control and prevention trainings by front line clinical and management staff
Scan the QR codes or Click the Links to Complete the Assessments!

CMS requested Alliant Health Solutions, your QIN-QIO, to work with select nursing homes to understand emerging healthcare needs in nursing homes. Alliant Health Solutions is engaging nursing home leadership in the following area to ensure plans are in place to achieve and maintain health quality and equity!

Please scan the QR codes below and complete the assessments.

Program Directors

Leighann Sauls
Leighann.Sauls@AlliantHealth.org
Georgia, Kentucky, North Carolina and Tennessee

Julie Kueker
Julie.Kueker@AlliantHealth.org
Alabama, Florida and Louisiana