Readmission Affinity Group Session 4: Managing Readmission Risk

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QIN-QIO
Quality Innovation Network - Quality Improvement Organizations
CENTER S FOR MEDICARE & MEDICAI D SERVICES
iQUALITY IMPROVEMENT & INNOVATION GROUP

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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.

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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.

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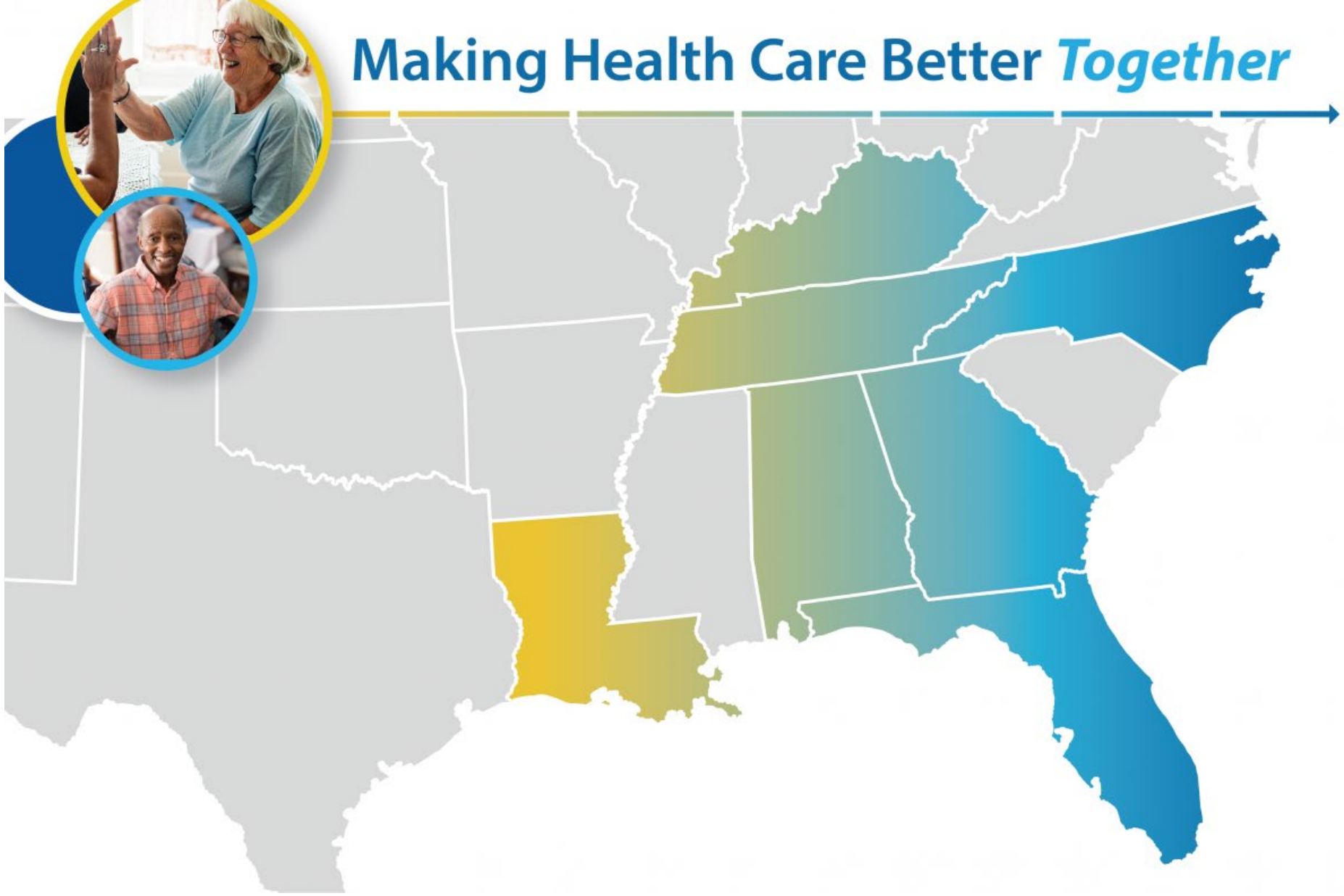

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Learning Objectives

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

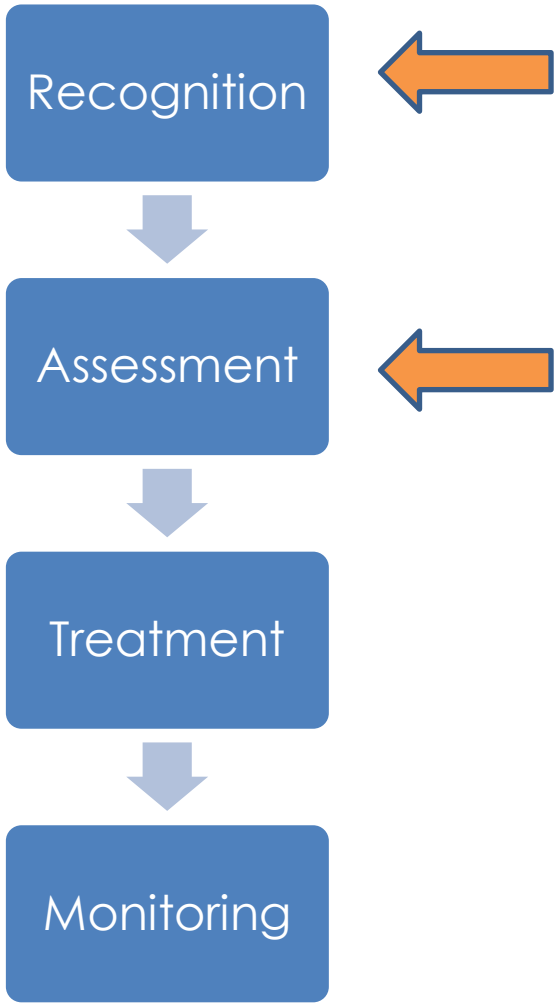
Session 6: CHF & COPD Engaging Patients and Care Partners

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



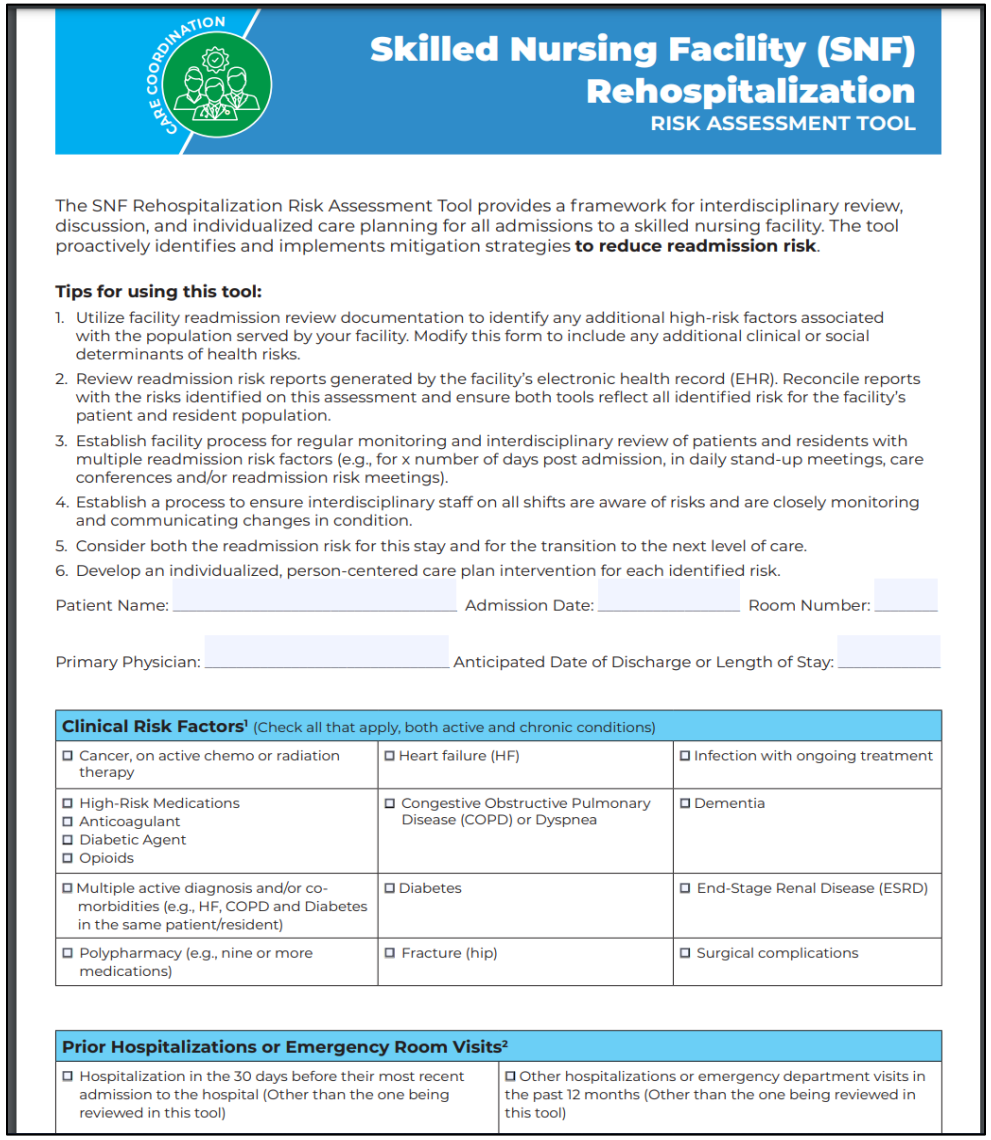
PALTC Acute Change of Condition

TABLE 5.

Suggested Approaches to Assessing Risk for ACOCs[12]

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

Recognizing and Assessing Readmission Risk



Skilled Nursing Facility (SNF) Rehospitalization

RISK ASSESSMENT TOOL

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 readmission risk**.

Tips for using this tool:

1. Utilize facility readmission review 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 readmission 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 risk for the facility's patient and resident population.
3. Establish facility process for regular monitoring and interdisciplinary review of patients and residents with multiple readmission risk factors (e.g., for x 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 this stay and for the transition to the next level of care.
6. Develop an individualized, person-centered care plan intervention for each identified risk.

Patient Name: _____ Admission Date: _____ Room Number: _____

Primary Physician: _____ Anticipated Date of Discharge or Length of Stay: _____

Clinical Risk Factors[1] (Check all that apply, both active and chronic conditions)		
☐ Cancer, on active chemo or radiation therapy	☐ Heart failure (HF)	☐ Infection with ongoing treatment
☐ High-Risk Medications ☐ Anticoagulant ☐ Diabetic Agent ☐ Opioids	☐ Congestive Obstructive Pulmonary Disease (COPD) or Dyspnea	☐ Dementia
☐ Multiple active diagnosis and/or co-morbidities (e.g., HF, COPD and Diabetes in the same patient/resident)	☐ Diabetes	☐ End-Stage Renal Disease (ESRD)
☐ Polypharmacy (e.g., nine or more medications)	☐ Fracture (hip)	☐ Surgical complications

Prior Hospitalizations or Emergency Room Visits[2]	
☐ 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)

Additional Factors That May Increase Readmission Risk		
☐ Current or previous difficulty adhering to plan of care	☐ Current or previous difficulty adhering to medication regime	☐ History of Delirium
☐ No identified or engaged care partner	☐ History of falls or fall with major injury	☐ Known home safety risk
☐ No Advance Care Planning documentation or identified goals of care	☐ Known conflict among family members around goals of care, health status or plan of care	☐ Prior declination of palliative care or hospice services
☐ Current or past complaints of poor pain control	☐ Primary language other than English	☐ Low health literacy of patient/ resident and or health care agents
☐ Introduction of a new class of medication(s)	☐ History of C. Diff, Sepsis or post-COVID syndrome	☐ No known primary care provider (PCP)

Next Steps:

1. Attending physician informed of identified risks: _____ Date: _____ (signature)
2. Care plan intervention verified in place for each identified risk: _____ Date: _____ (signature)
3. Interdisciplinary team on all shifts informed of identified risks: _____ Date: _____ (signature)

Additional resources for proactively mitigating identified readmission risks:
Alliant Health Solution's My Care Transition Plan helps patients and care partners document their questions and concerns throughout their stay. Use of this tool in either brochure or portrait versions can help facility teams proactively implement mitigation strategies. **My Care Transition Plan**
Alliant Health Solution's bite-size video on the Scripps Gerontology Our Family Our Way free virtual and printable resources for family meetings and templates to help plan for care and support post-discharge. **Our Family Our Way**
Alliant Health Solution's library of zone tools can be used to initiate patient and care partner education beginning on admission and to engage patients and care partners in knowing and communicating changes in condition. **Alliant Zone Tools**
"Go To the Hospital or Stay Here" virtual and printable resources in multiple languages can help guide proactive discussions with patients and health care agents around readmission risks, goals of care, facility capabilities and the decision process when a change in condition is identified. Alliant Health Solutions has a variety of tools to guide facility implementation of these resources. **Hospital Decision Guide**
INTERACT® resources for a quality improvement program to improve identification, evaluation and communication around changes in resident status. **INTERACT**

1-2 Interact® 4.5 Quality Improvement Tool For Review of Acute Care Transfers

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[AHS SNF Rehospitalization Risk Tool]

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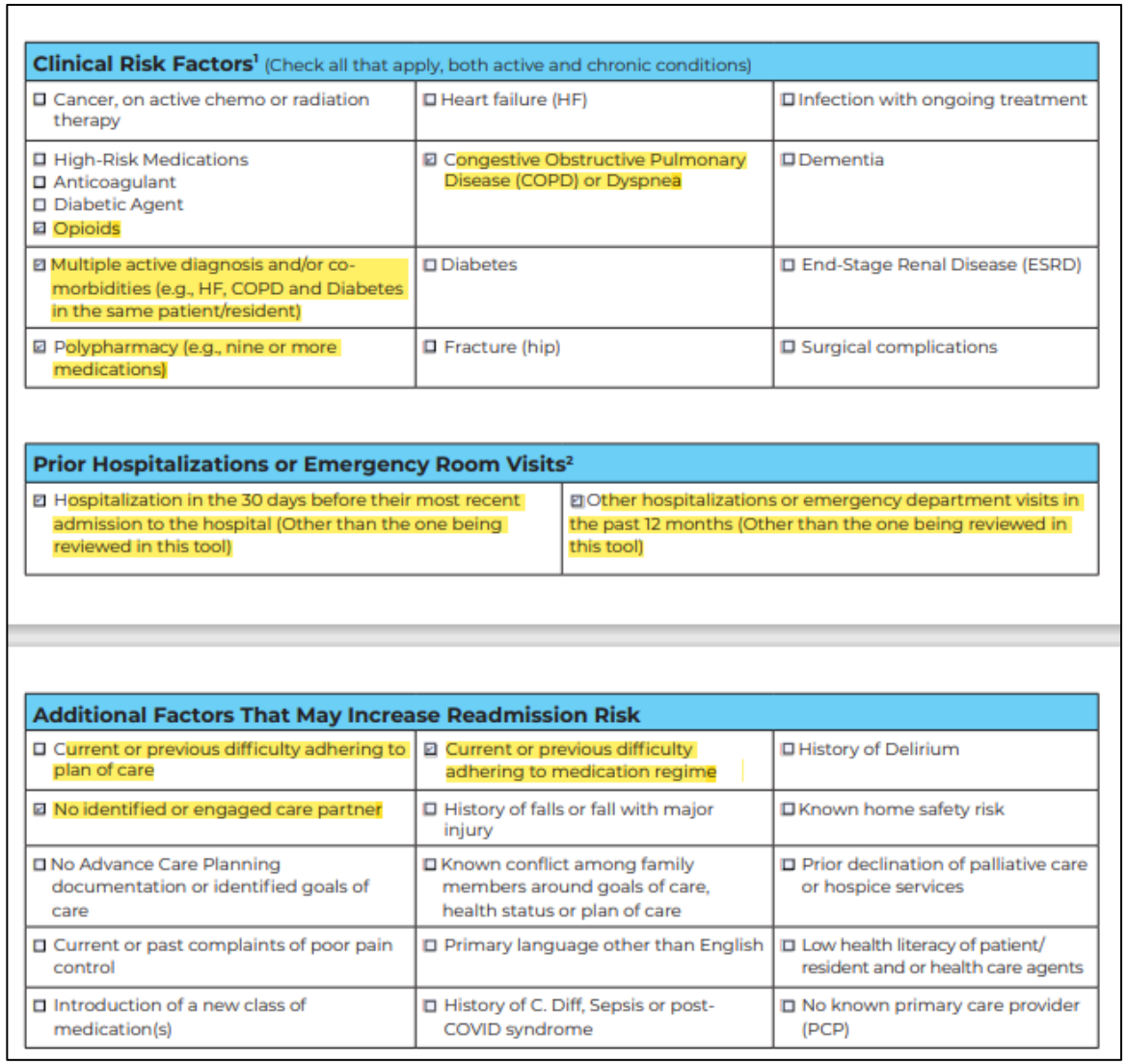
Case Study #1



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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

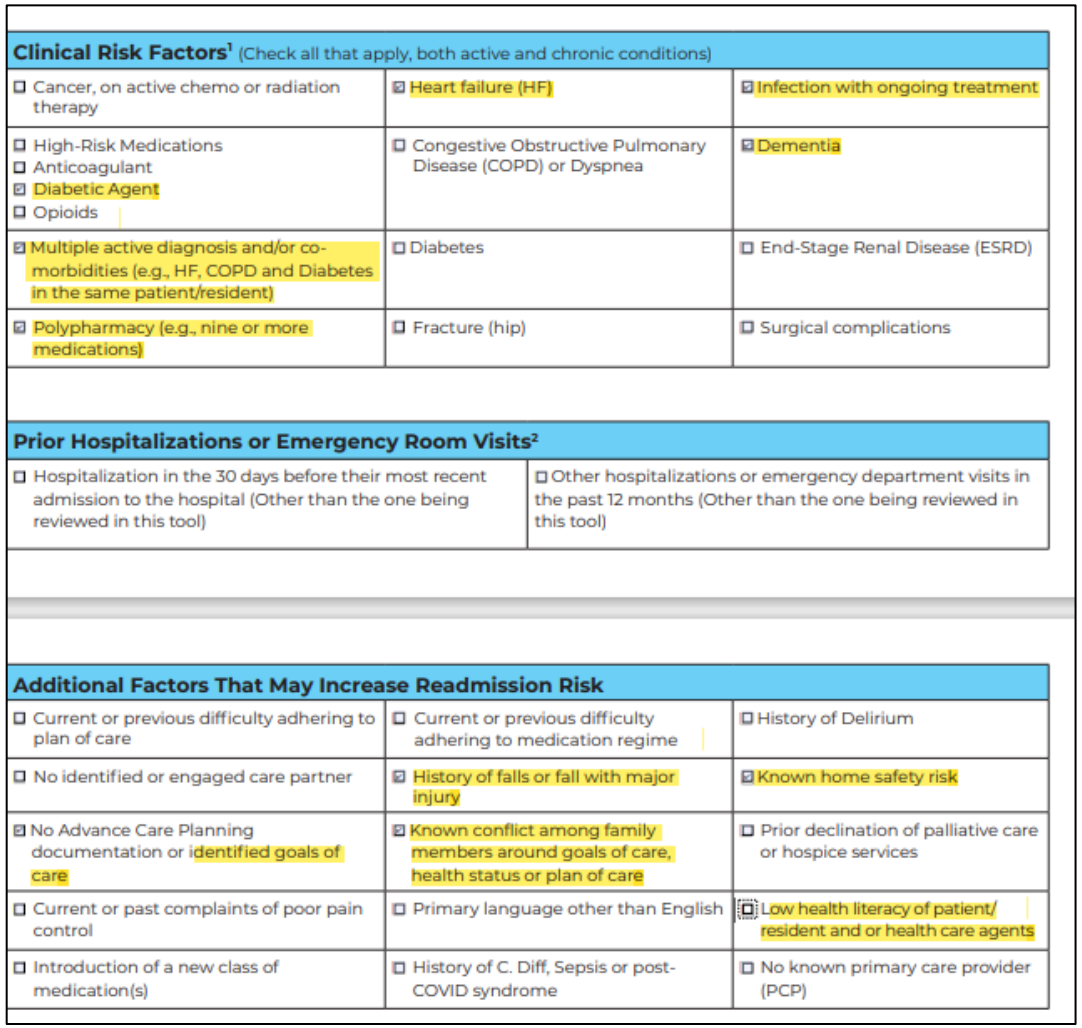
What has been tried previously, and why didn't it work?

- 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



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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

Why do we need to be aware of it?

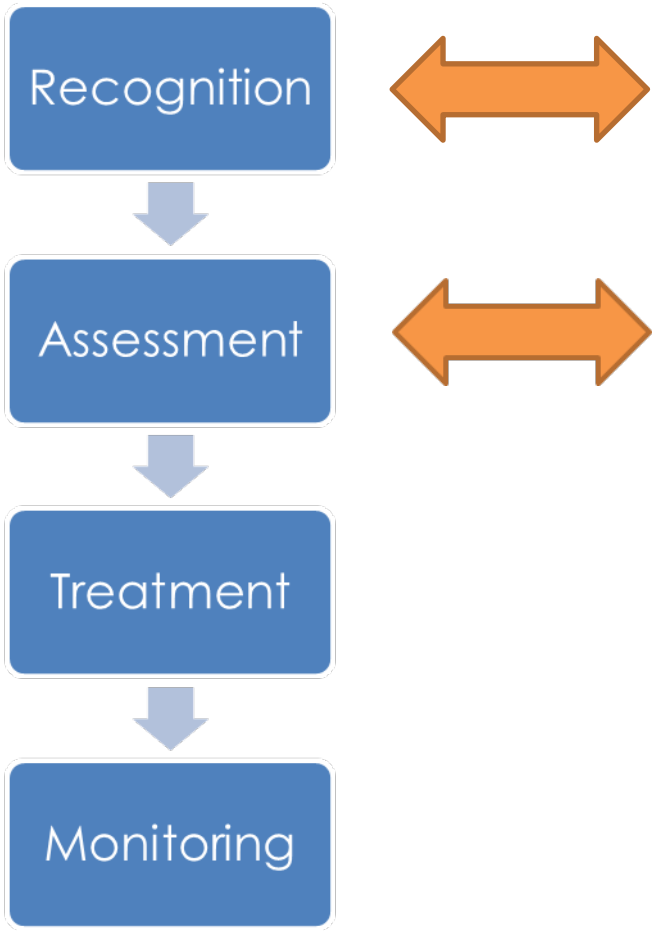
Bias in clinical decision-making results in overuse or underuse problems that can harm patients.

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



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 you incorporate a readmission risk assessment on you're 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

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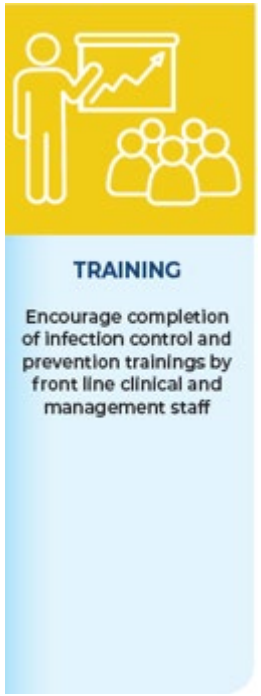
Scan the QR codes or Click the Links to Complete the Assessments!

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.



Nursing Home Infection Prevention (NHIP) Initiative Training Assessment

https://bit.ly/NHIPAssessment

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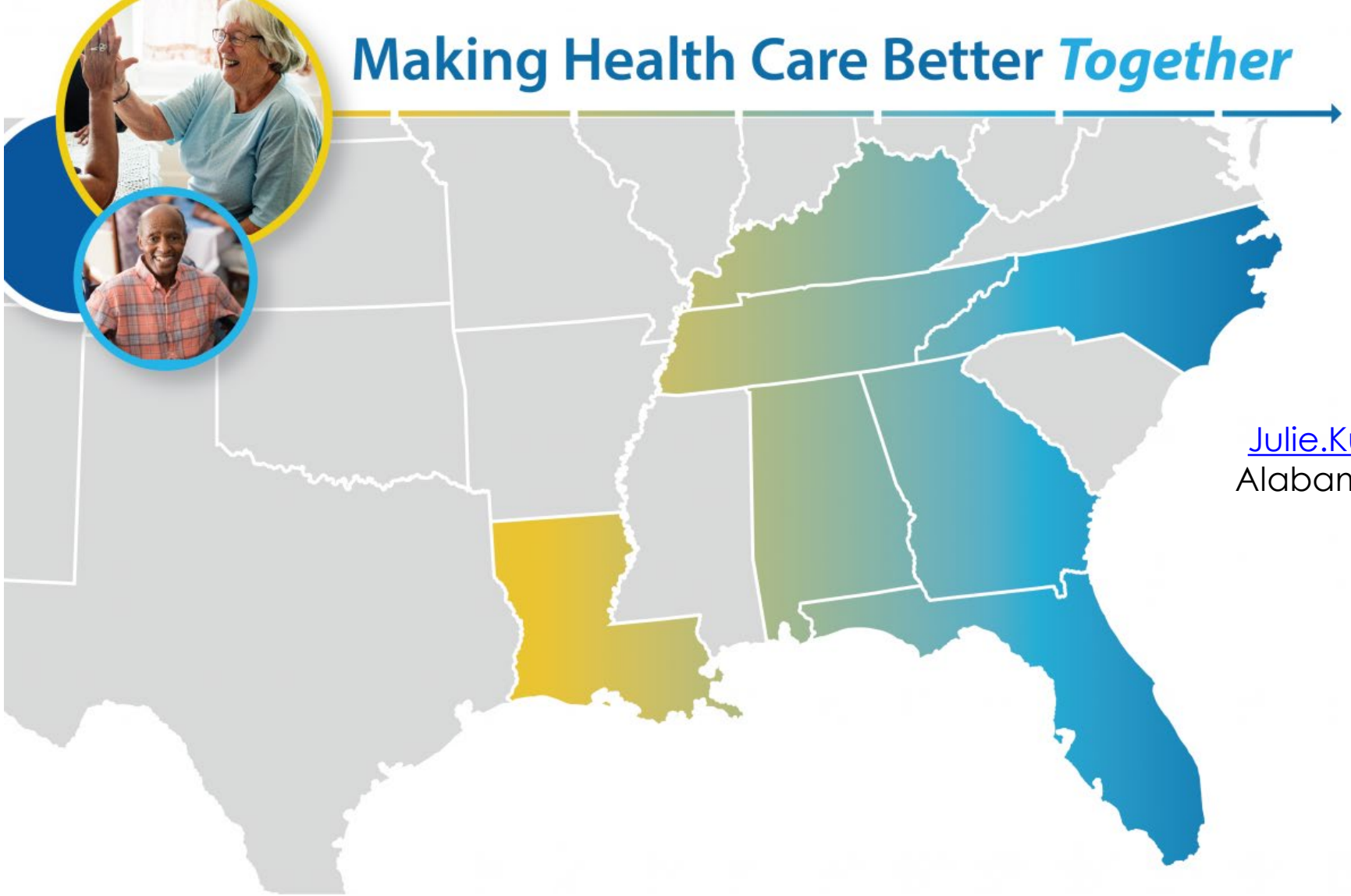

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