

# Nursing Home Readmissions Affinity Group

## Session 5: Engaging the Interdisciplinary Team



Presented by:  
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 **ALLIANT**  
HEALTH SOLUTIONS

**QIN-QIO**  
Quality Innovation Network -  
Quality Improvement Organizations  
CENTER FOR MEDICARE & MEDICAID SERVICES  
QUALITY IMPROVEMENT & INNOVATION GROUP

# Danyce Seney, RN, BSN, IP, RAC-CTA, CPHQ

## QUALITY IMPROVEMENT SPECIALIST

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

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

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# Amy Daly, MA, NHA

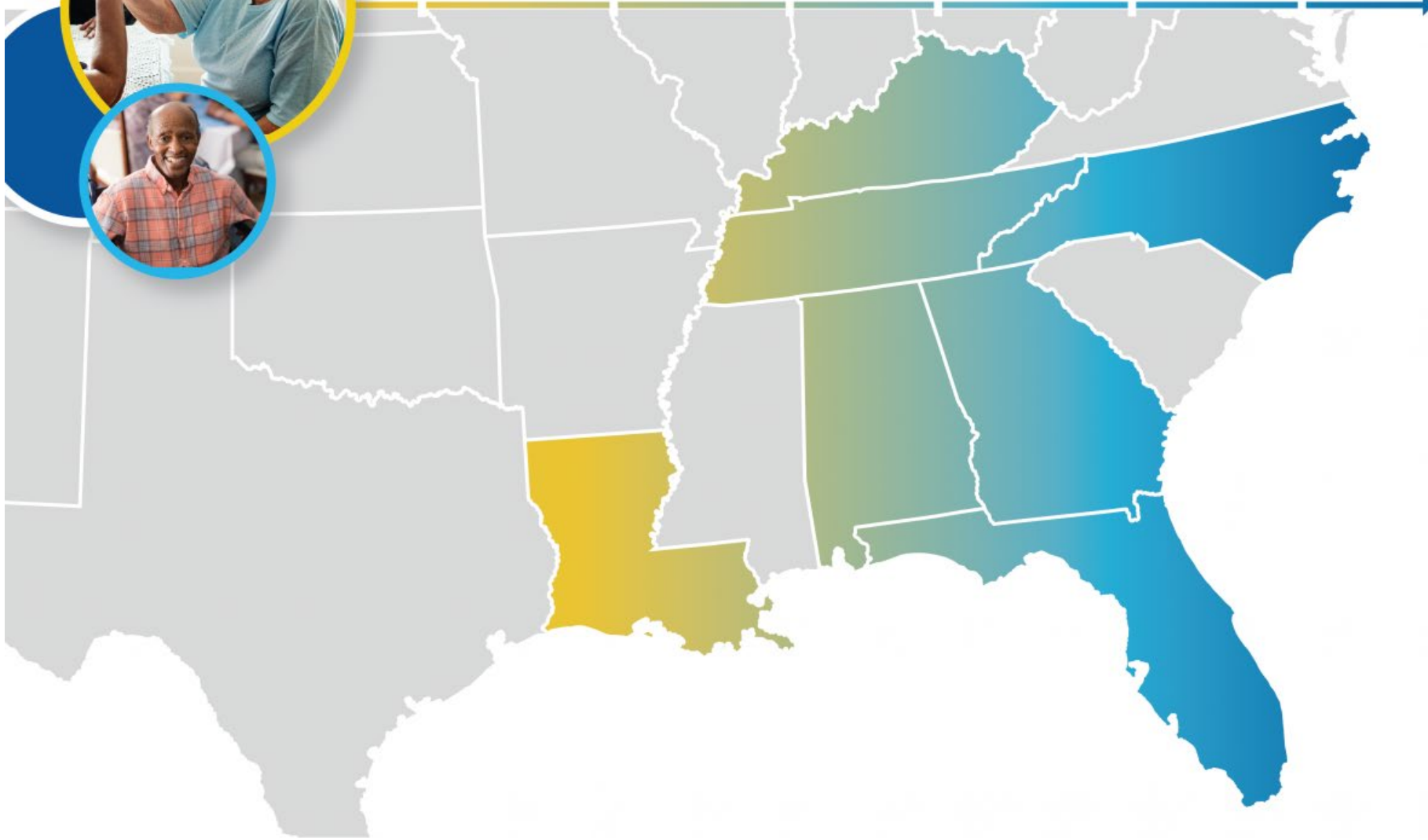
## SENIOR QUALITY IMPROVEMENT SPECIALIST

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.

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# Making Health Care Better *Together*



About Alliant Health Solutions

# Learning Objectives

- Identify how to integrate the Interdisciplinary team into patient education beginning on admission.
- Learn how one facility integrated its interdisciplinary team into patient and care partner education utilizing the Alliant Health Solutions CHF Zone Tool.
- Understand strategies to incorporate health literacy into patient and care partner education.

# Where We Have Been

This is Session 5 of our readmission reduction series.

Previous sessions focused:

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

**Session 2:** Detecting and Communicating Change of Condition

**Session 3:** Clinical Decision Support Tools and Advance Planning: Engaging the Patient and Care Partner

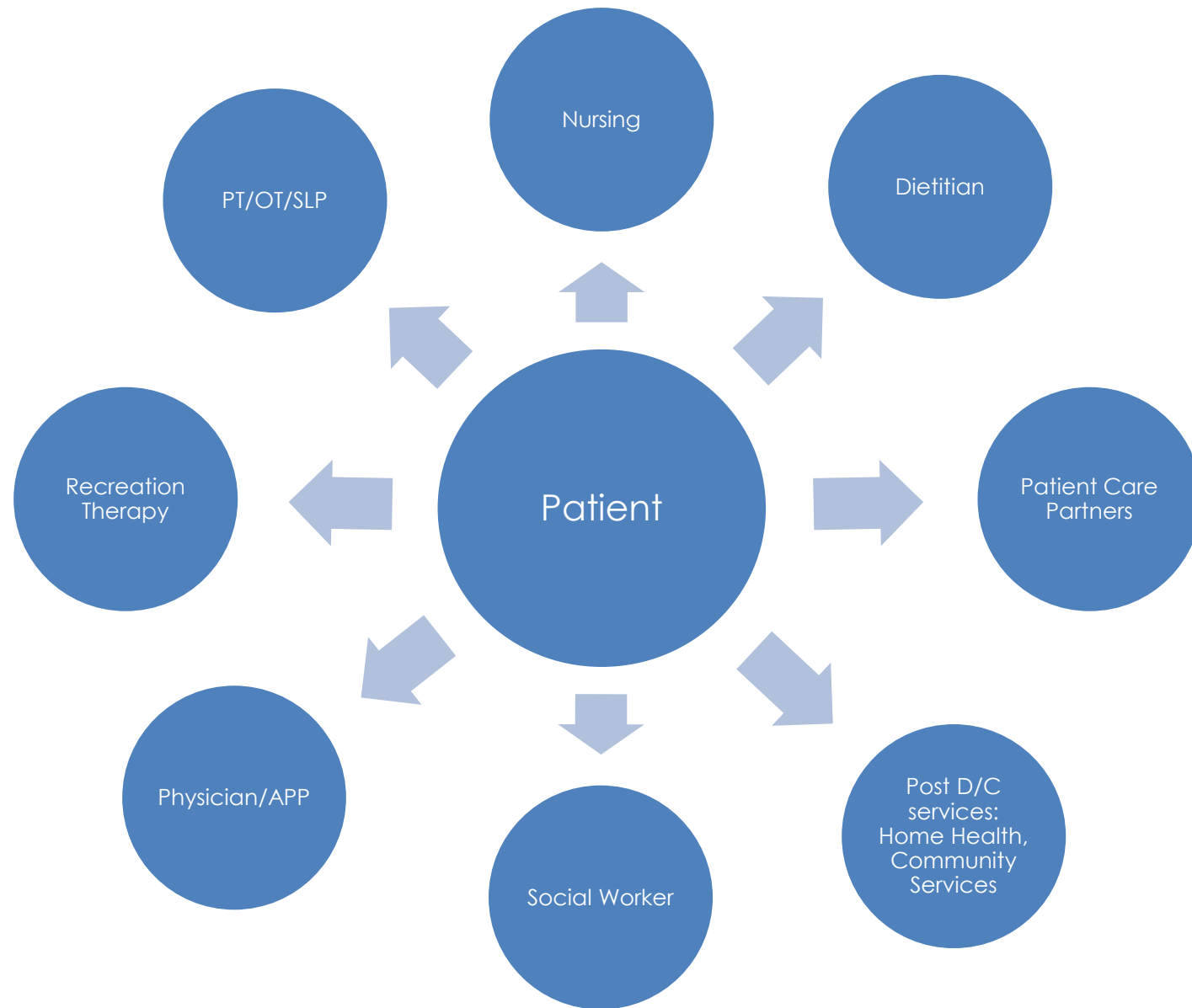
**Session 4:** [Managing Readmission Risk](#)

# Risk of Readmission After Discharge From Skilled Nursing Facilities Following Heart Failure Hospitalization: A Retrospective Cohort Study

- Study published in JAMDA 2019 regarding outcomes for hospitalized patients with Heart Failure who have an SNF stay of 30 days or less was conducted for the 30 days after discharge.
- During 2012-2015, included 67,585 HF hospitalizations discharged to SNF and subsequently discharged home.
- Overall, **16,333 (24.2%)** SNF discharges to home were readmitted within 30 days of SNF discharge.

**Conclusions/implications:** The hazard rate of readmission after SNF discharge following HF hospitalization is highest during the first two days at home. This risk attenuated with longer SNF length of stay. Interventions to improve post-discharge outcomes have primarily focused on hospital discharge. This evidence suggests that interventions to reduce readmissions may be more effective if they also incorporate the SNF-to-home transition.

# Interdisciplinary Team Communication & Education



## Goals:

- To engage the interdisciplinary team in communication and education with the patient and care partner in preparation for a successful transition home.
- Ability to manage and understand health conditions without requiring avoidable emergency room visits and readmissions.



# Communication and Collaboration of Interdisciplinary Team - Research

- Study: Implementation of an interprofessional communication and collaboration intervention to improve care capacity for heart failure management in long-term care.
- Implementation of a 'heart team' made up of staff from all levels of care who were knowledgeable regarding heart failure management and communication.
- Ongoing mentoring for the staff on the 'heart team.'

## Resulted in:


- ↑ Team engagement
- ↑ Interprofessional collaboration
- ↑ Communication
- ↑ Knowledge about heart failure
- Improved clinical outcomes
- Reduced readmissions
- Reduced ED visits

# Patient Self-Management Tools

## Interdisciplinary Team Engagement

- Assess and reinforce any information the patient retained from previous education or discussions.
- Embed **What zone are you today?** in interactions with the patient and care partner.
- Entire interdisciplinary team will use Teach-Back
- Examples:
  - Therapy-safe and consistent weighing
  - SLP evaluates understanding and documentation
  - Home evaluations, social work, or discharge planning – coordinates obtaining and using a scale at home they can safely use and read
  - Dietician—fluids, choices, meals, availability
  - Customize the zone tool to include contact information for the yellow zone (home health and/or physician)

Downloadable from the Alliant website: [Alliant Zone Tools](#)  
Available in English and Spanish on a variety of topics.



### Zone Tool Heart Failure

**Every Day:**

- ✓ Weigh yourself in the morning before breakfast and write it down
- ✓ Eat low-salt/low-sodium foods
- ✓ Balance activity and rest periods
- ✓ Check for swelling in your feet, ankles, legs and stomach
- ✓ Take your medicine the way you should take it

**All Clear Zone..... This is the safety zone if you have:**

- No shortness of breath
- No weight gain more than 2 pounds (it may change 1 or 2 pounds some days.)
- No swelling of your feet, ankles, legs or stomach
- No chest pain

**Warning Zone..... Call your doctor if you have:**

- Weight gain of 3 pounds in 1 day or a weight gain of 5 pounds or more in 1 week
- More swelling of your feet, ankles, legs or stomach
- Difficulty breathing when lying down. Feeling the need to sleep up in a chair.
- Feeling uneasy; you know something is not right
- No energy or feeling more tired
- More shortness of breath
- Dry hacking cough
- Dizziness

**Medical Alert Zone .... Go to the Emergency Room or call 911 if you have:**

- A hard time breathing
- Unrelieved shortness of breath while sitting still
- Chest pain
- Confusion or can't think clearly

# Scenario: DX CHF Rehab Patient

- History: A 74-year-old male presented to the Emergency Department (ED) with complaints of increased dyspnea, reduced activity tolerance, ankle swelling, and weight gain in recent days
- This was the third ED visit in four months
- Treated with medications, oxygen and change in diet in acute care
- Discharged on Day Six of this admission to Rehab
- Patient is now in the skilled nursing facility (SNF) and has not had any education on CHF, nutrition, medications, symptom management
- Plan is to discharge to home from SNF



# The Difference – Using CHF as Example

## BEFORE

-At the end of the rehab stay, the individual is set up for discharge:

- Therapy goals are met
- Discharge papers are provided, including documents on signs and symptoms of heart failure exacerbation

## ONE WEEK AFTER DISCHARGE:

- The individual is in the emergency room, short of breath, 1+ edema, and Pulse ox 87% on room air. Has been eating ham, chips, and iced tea all day, every day, etc.
- Readmitted for oxygen and diuretics.

## AFTER

-At the end of the rehab stay, the individual is set up for discharge:

- Therapy goals are met
- Discharge papers provided, with zone tool appropriate for disease

## ONE MONTH AFTER DISCHARGE:

- The individual is at the MD office for a follow-up appointment.
- The individual has a scale they can stand on and see the numbers. Has a daily morning routine and writes weight in a notebook.
- The Individual shows the physician their weight list and has a note in their notebook that they called the physician once because of a weight change.

# Implementing the Education

## Tips for reviewing handouts education or discharge instructions with patients and care partners:

- Use Teach-Back
- Personalize material by adding their name
- Emphasize importance by using during encounters throughout the day—and by incorporating all disciplines
- Obtain patient feedback on materials
- Think about how you highlight key messages
- Utilize plain language and large font for optimal patient and care partner understanding.

## Tips for implementing and embedding in staff education and facility processes:

- Train staff on patient education and Teach-Back
- Include Teach-Back in your annual competencies
- Use role play with plain language
- Video examples
  - [Inhaler Fail | House M.D. - Bing video](#)
- Peer teaching-identify facility champions; engage in peer-to-peer mentoring
- Staff training on diseases as appropriate (CHF, Diabetes, COPD)

# Summary



# Use Tomorrow

1. Talk with your team and identify one step you can take to engage your interdisciplinary team in your facility discharge education process.
2. Interview your current short-term stay patients with a chronic disease diagnosis. Ask if they have working scales at home. If they don't, think about how to collaborate with patients and families to ensure patients have scales they can safely use at home for self-management.

Can you identify a community partner that could provide scales to patients who do not have one and do not have a way to secure one upon discharge?

What other “aha” moments did this exercise with your patients and your team trigger?

# 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



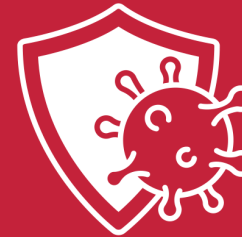
## CHRONIC DISEASE SELF-MANAGEMENT

- 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



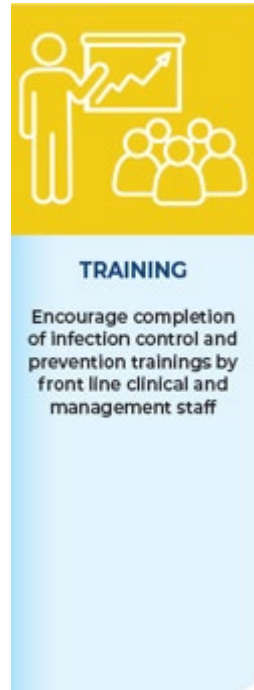
## TRAINING

- Encourage completion of infection control and prevention trainings by front line clinical and management staff

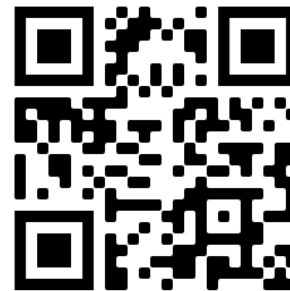
# Scan the QR codes or Click the Links to Complete the Assessments!

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 this key 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.**

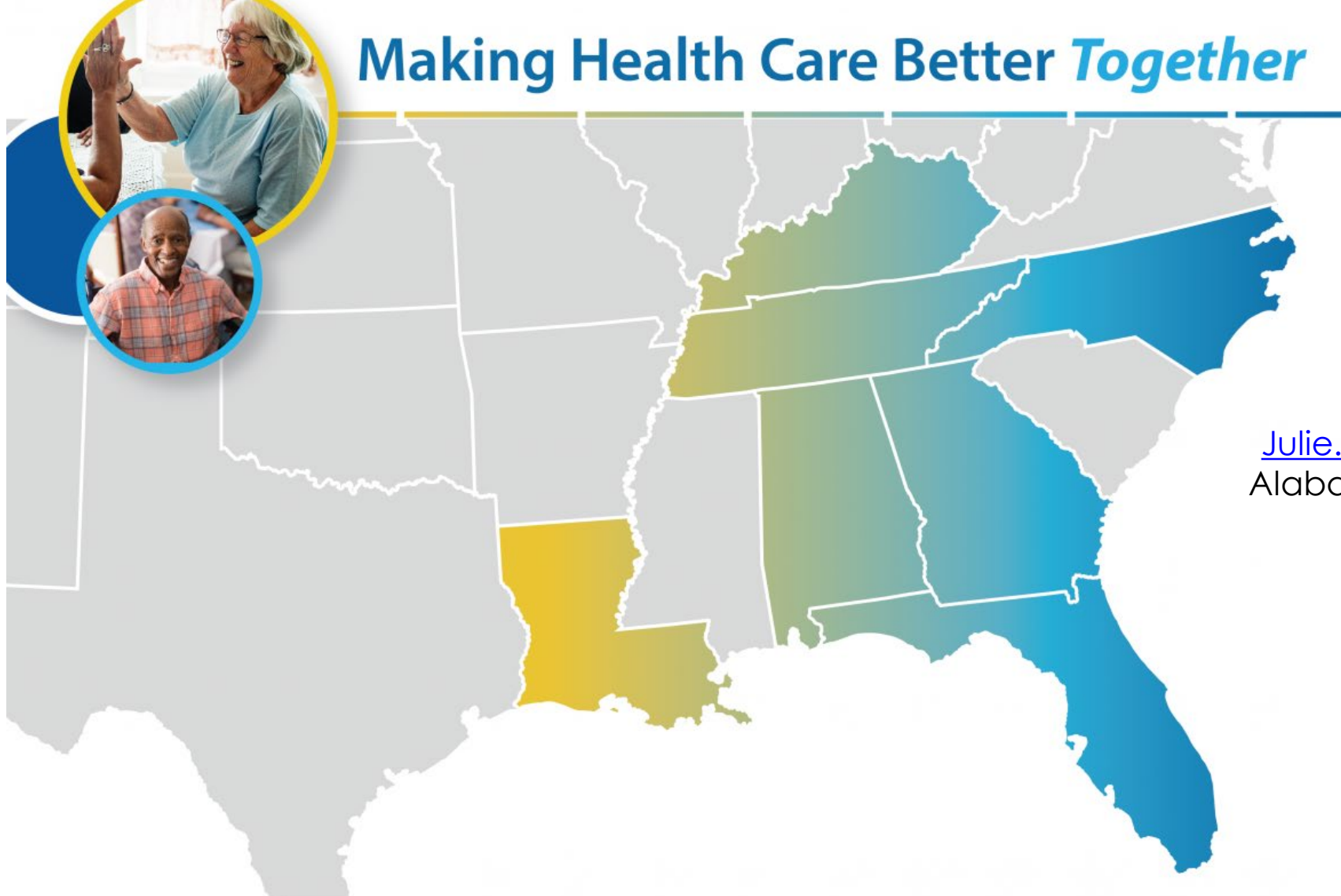


## Nursing Home Infection Prevention (NHIP) Initiative Training Assessment



<https://bit.ly/NHIPAssessment>

# Making Health Care Better *Together*



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# Making Health Care Better Together



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