Nursing Home Readmissions Affinity Group Session 7: Communicating Across the Care Continuum

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Quality Innovation Network - Quality Improvement Organizations
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QUALITY IMPROVEMENT SPECIALIST

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

Danyce supports skilled nursing facilities in utilizing a quality improvement framework to implement evidence-based interventions and strategies to improve patient safety and 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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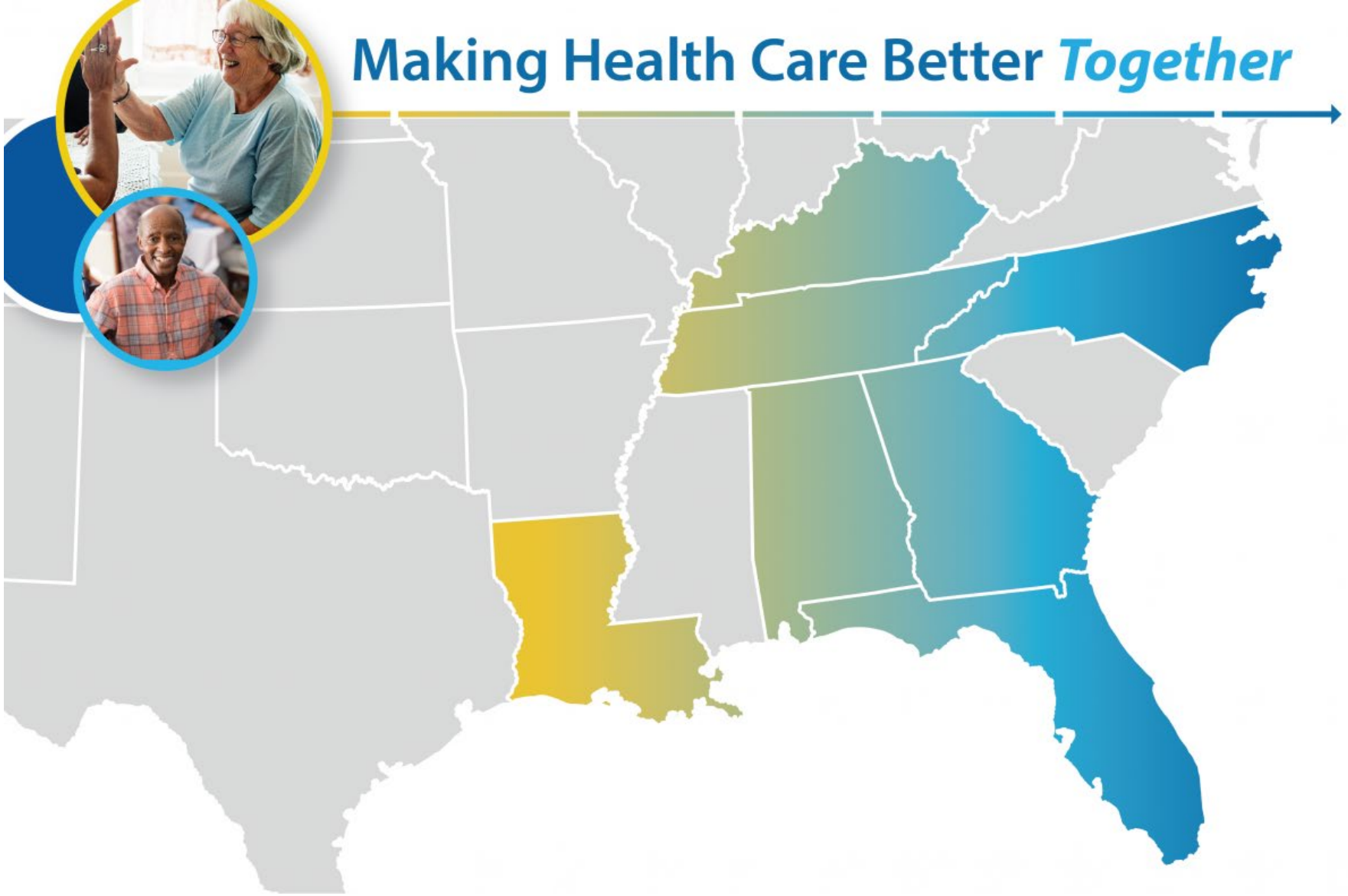

About Alliant Health Solutions

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Where We Have Been

- ✓ 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 Managing Readmission Risk
- ✓ Session 5: Engaging the Interdisciplinary Team
- ✓ Session 6: Engaging the Patient and Care Partner

Learning Objectives

Identify	Ways to use technology to support the warm hand-off across the continuum.
Explain	The importance of communication during micro-transitions.
Learn	About one facility's approach to incorporating patient education using the CHF Zone Tool across their continuum of care.

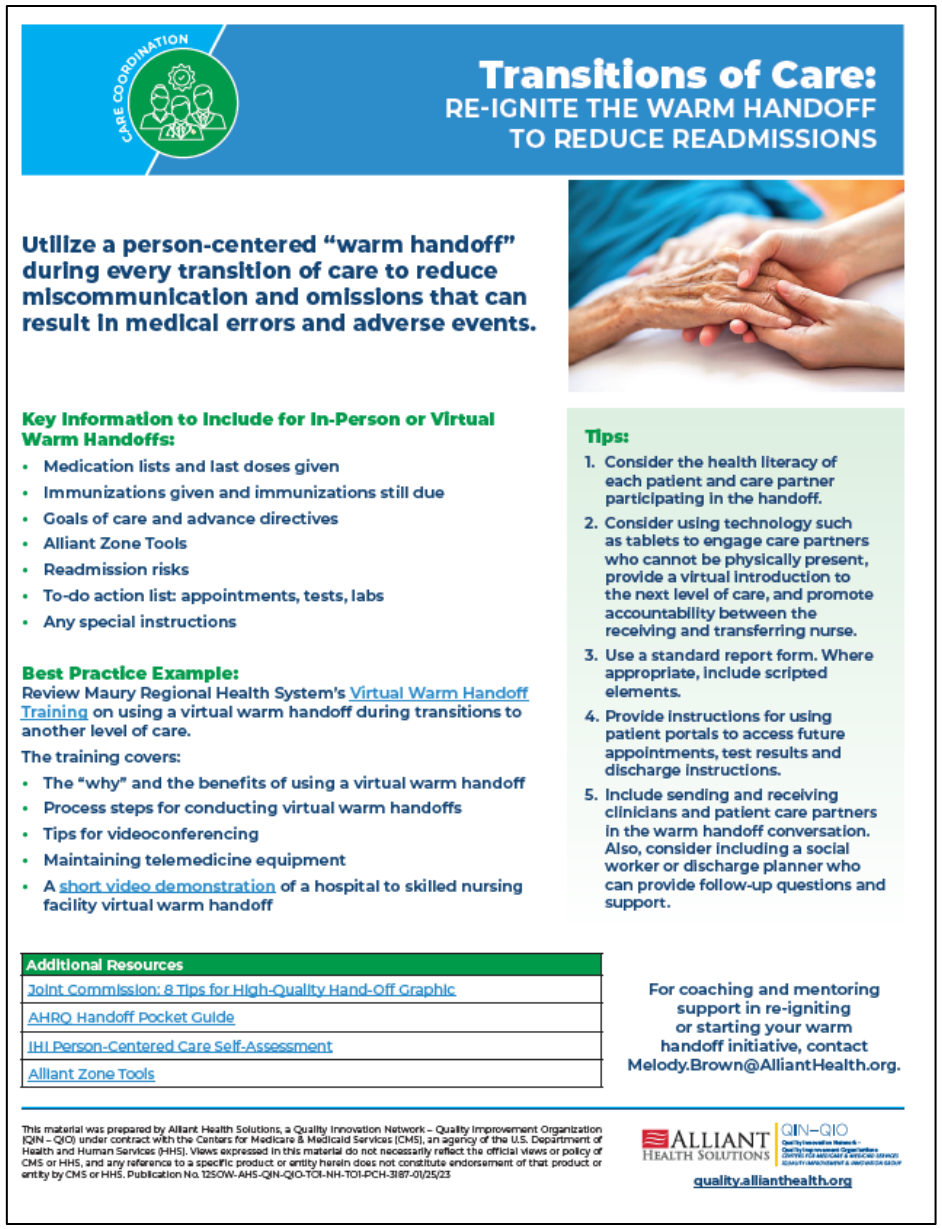
Lessons from Track and Field

"The best transition out of the hospital is only as good as the reception into the next setting of care.
Hospitals cannot improve care transitions in isolation. Consider the techniques of track and field athletes in relay races: each partner has practiced and has defined roles in either passing or receiving the baton.

Each athlete must iteratively adjust within those roles to ensure a completed handoff is successfully executed. At different times in the race, the athlete may be a sender or a receiver. Similarly, improving transitions in care involves clarifying roles, establishing norms of communication, practicing, and receiving feedback."

Dr. Amy Boutwell and Marian Bihele Johnson
STAAR Issue Brief: Reducing Barriers to Care Across the Continuum - Working Together in a Cross-Continuum Team
Amy Boutwell, MD, MPP and Marian Bihrle Johnson, MPH

Warm Hand-Off



CARE COORDINATION

Transitions of Care:
RE-IGNITE THE WARM HANDOFF TO REDUCE READMISSIONS

Utilize a person-centered "warm handoff" during every transition of care to reduce miscommunication and omissions that can result in medical errors and adverse events.

Key Information to Include for In-Person or Virtual Warm Handoffs:

- Medication lists and last doses given
- Immunizations given and immunizations still due
- Goals of care and advance directives
- Alliant Zone Tools
- Readmission risks
- To-do action list: appointments, tests, labs
- Any special instructions

Best Practice Example:
Review Maury Regional Health System's Virtual Warm Handoff Training on using a virtual warm handoff during transitions to another level of care.

The training covers:

- The "why" and the benefits of using a virtual warm handoff
- Process steps for conducting virtual warm handoffs
- Tips for videoconferencing
- Maintaining telemedicine equipment
- A short video demonstration of a hospital to skilled nursing facility virtual warm handoff

Tips:

1. Consider the health literacy of each patient and care partner participating in the handoff.
2. Consider using technology such as tablets to engage care partners who cannot be physically present, provide a virtual introduction to the next level of care, and promote accountability between the receiving and transferring nurse.
3. Use a standard report form. Where appropriate, include scripted elements.
4. Provide instructions for using patient portals to access future appointments, test results and discharge instructions.
5. Include sending and receiving clinicians and patient care partners in the warm handoff conversation. Also, consider including a social worker or discharge planner who can provide follow-up questions and support.

Additional Resources
Joint Commission: 8 Tips for High-Quality Hand-Off Graphic
AHRQ Handoff Pocket Guide
IHI Person-Centered Care Self-Assessment
Alliant Zone Tools

For coaching and mentoring support in re-igniting or starting your warm handoff initiative, contact Melody.Brown@AlliantHealth.org.

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[Warm Hand-Off Video]

- ❑ Hospital to a skilled nursing facility (SNF)
- ❑ SNF to home health
- ❑ SNF to assisted living

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Micro-Transitions

The existence of brief care transitions (usually of a few hours and definitely less than 24 hours duration) that might include a change in location within a care setting or a brief outing from the care setting. These transitions:

- Do not include hospital or ED transfers
- Can be non-medical
  - Attorney's office to sign a paper
  - Lunch outing with family
  - Hair salon

How do we prepare patients and care partners for these micro-transitions?
How do we communicate care needs?

[AMDA On-The-Go Micro-Transitions]

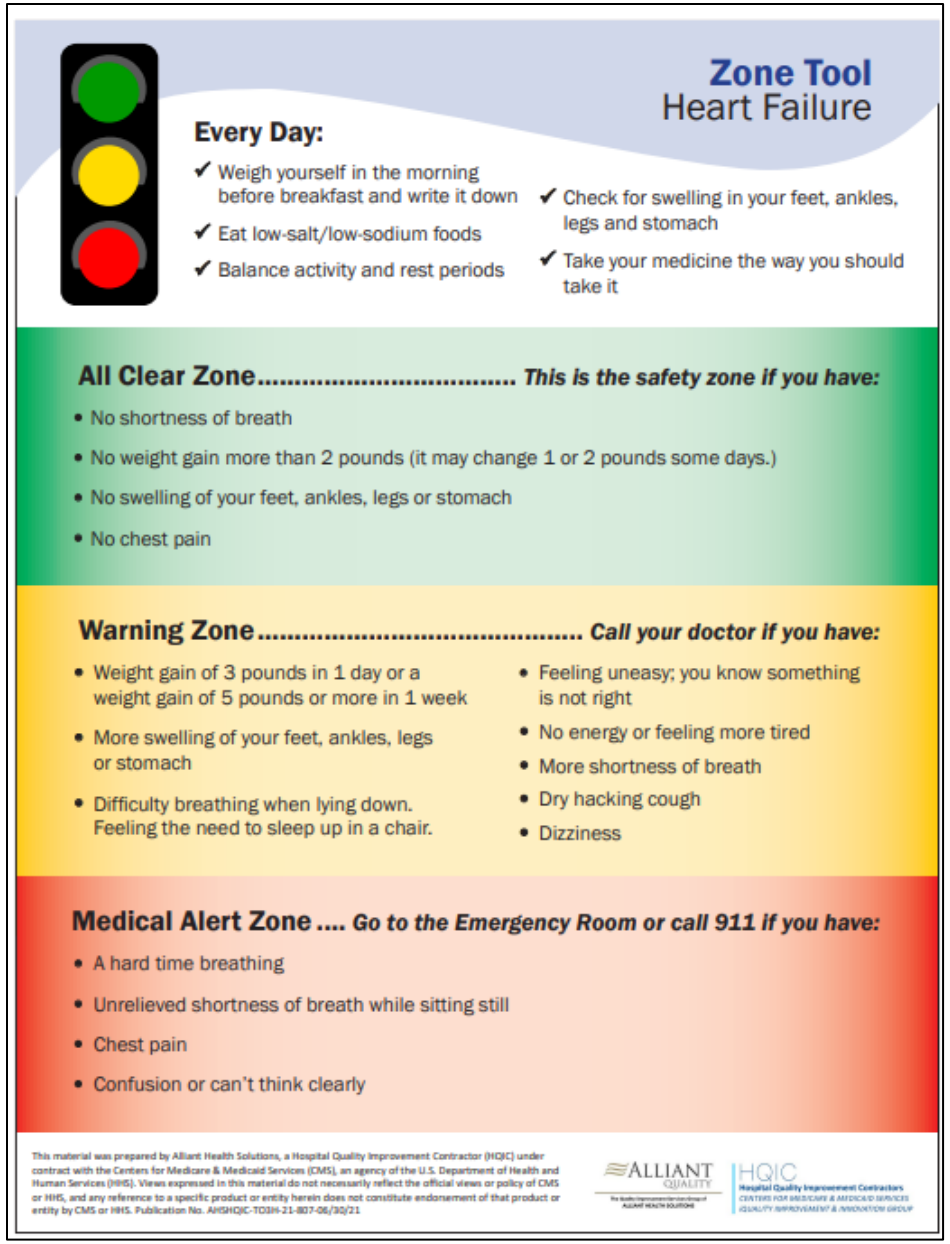
Communication to Reduce Harm

- **Education tool that can assess, educate and re-educate patients on their diseases, discharge plans and medication regimen.**

- Provide instructions on what to do if a problem arises

- Tool that can be used throughout the continuum is essential
  - Same message
  - Same verbiage
  - Same document
  - Simple
  - consistent

[Zone search - NQIIC (allianthealth.org)]



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Hand Off to Our Guests

One facility's approach to incorporating patient education using the CHF Zone Tool across their continuum of care

Use Tomorrow

Identify a partner facility to discuss a process for improved communications that engage residents/patients and care partners in transitions of care.

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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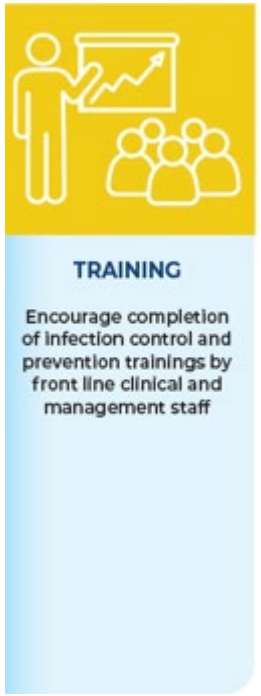
Scan the QR code or Click the Link to Complete the Assessments!

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 code below and complete the assessment.



Nursing Home Infection Prevention (NHIP) Initiative Training Assessment

https://bit.ly/NHIPAssessment

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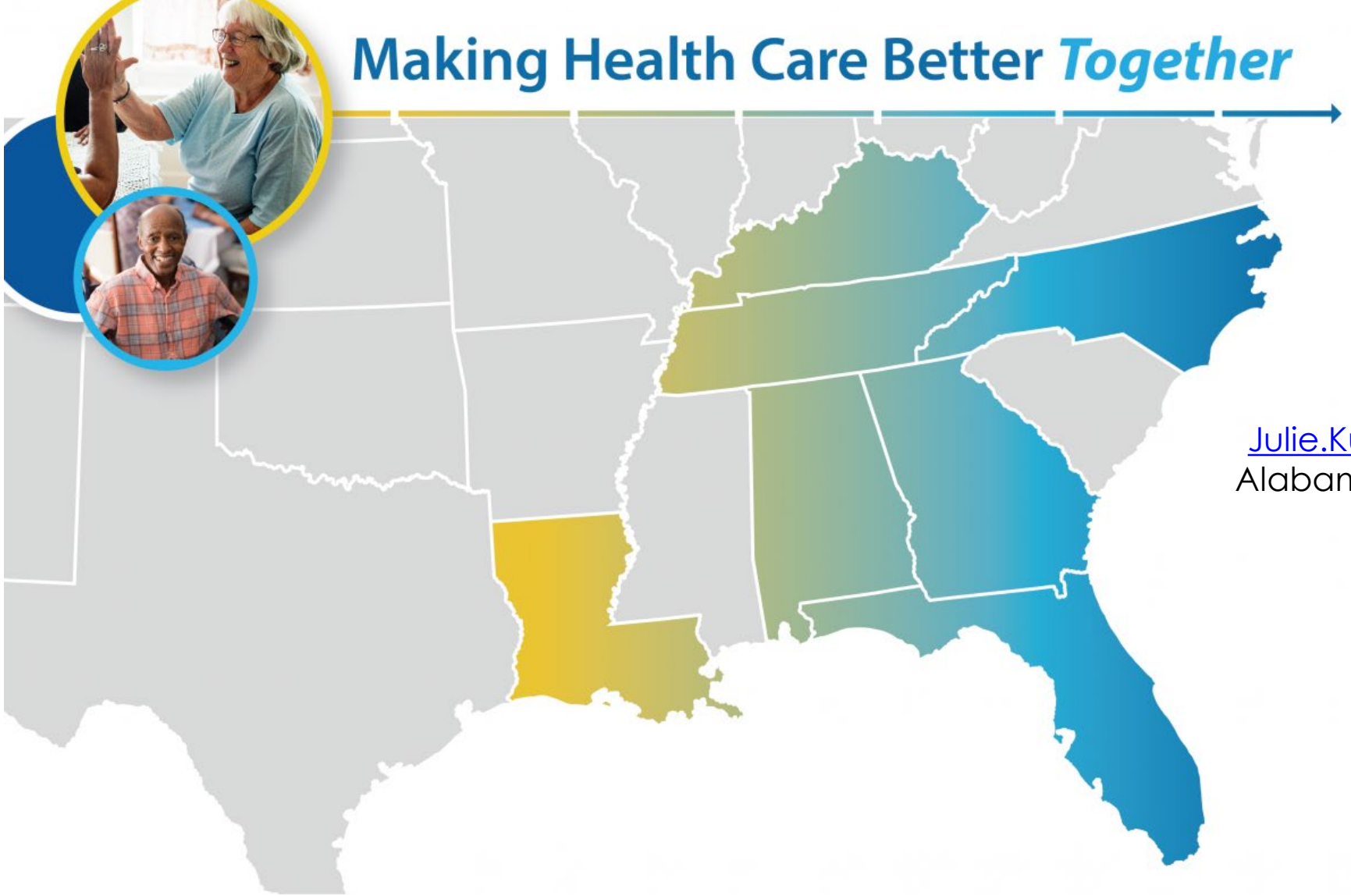

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