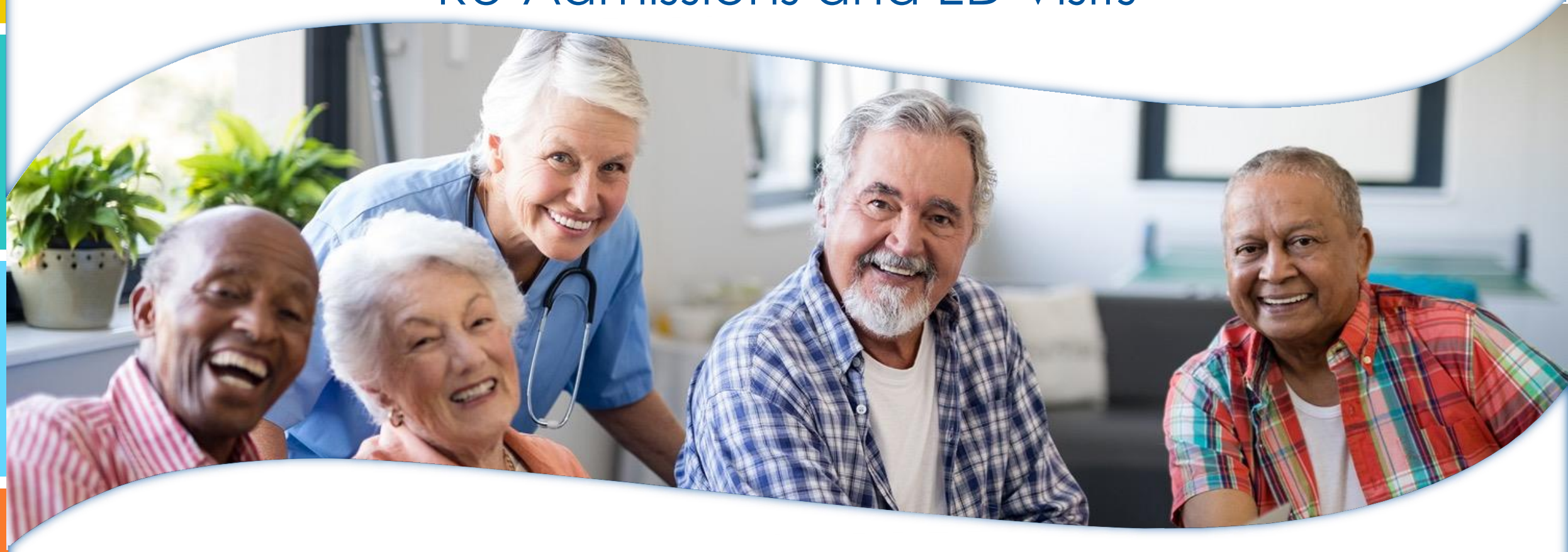
A Fresh Look at Best Practices to Reduce Readmissions:
Facility Capabilities and Impact on Admissions, Re-Admissions and ED Visits



Danyce Seney, RN, BSN, RAC-CTA

August 16, 2022

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

Welcome

- All lines are muted, so please use the Q&A box to ask any questions or the chat box to share comments.
- As we near the end of the webinar, you will have the opportunity to scan a QR code to take a poll and submit your request to receive NAB and ANCC credit for attending this session.
- Throughout the presentation, links to various resources will be shared on screen. We will share those same links with you in the chat box as they are presented.

We will now get started!

Danyce Seney, RN, BSN, RAC-CT

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.

Contact: DSeney@ipro.org

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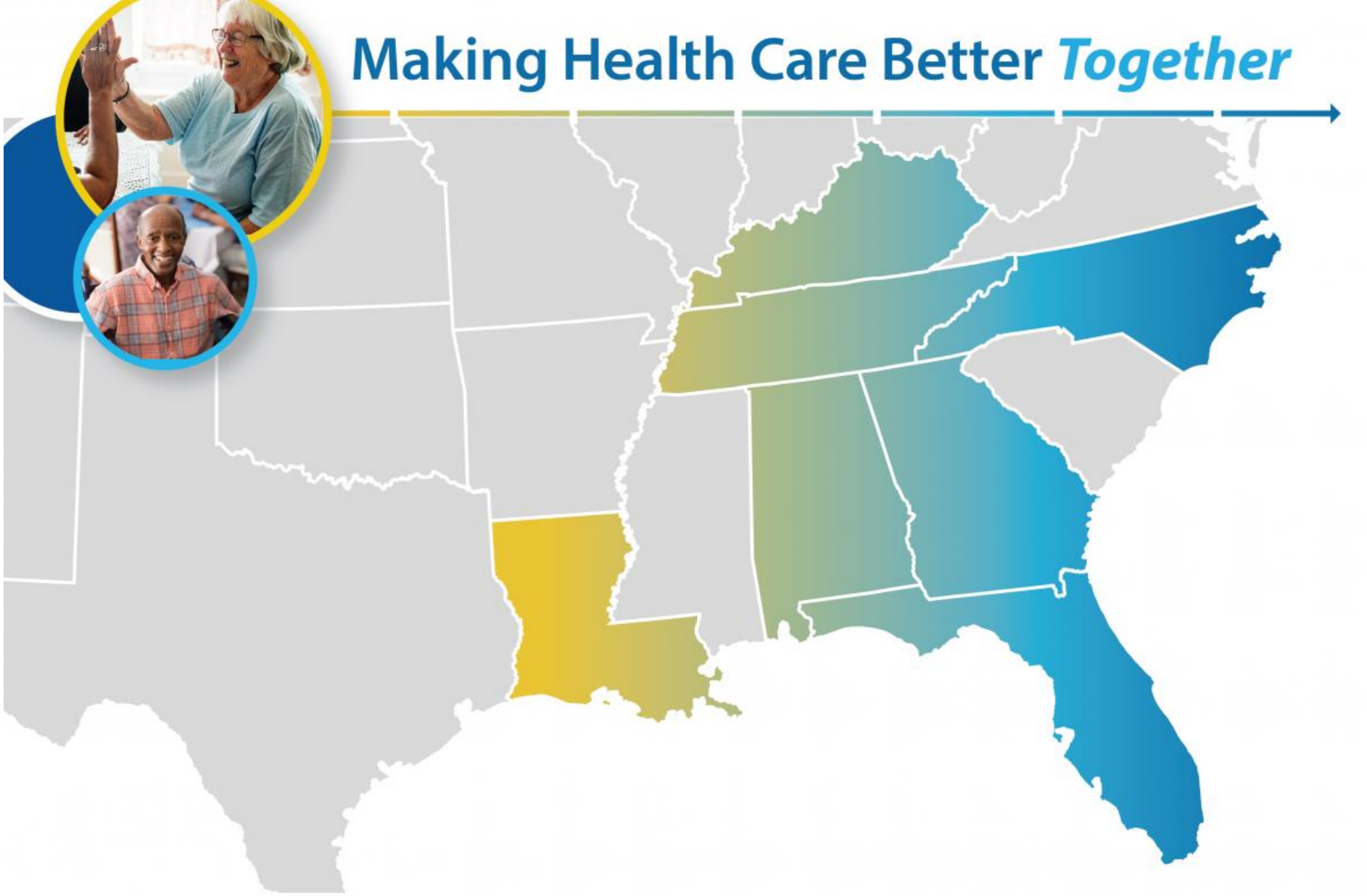

About Alliant Health Solutions

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Quality Innovation Network - Quality Improvement Organizations
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Continuing Education Information - LIVE

Learning Outcome:
Following this activity, we expect learners to share what they plan to do differently when back at work in the post-activity poll.

Nursing Professional Development: ANCC Contact Hours & Accreditation Statement
This nursing continuing professional development activity was approved by the Ohio Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation. (OBN-001-91) This activity (each event) awards 0.5 contact hours and 0 hours of pharmacology.

National Association of Long Term Care Administrator Boards
This program has been approved for Continuing Education for 1.5 total participant hours by NAB/NCERS—Approval #20230815-1.50-A86674-DL

Disclosure of Financial Relationships
No one with the ability to control content of this activity has a relevant financial relationship with an ineligible company.

Instructions for obtaining credit
At the conclusion of the event, learners will be invited to complete an assessment. Those that complete the assessment will receive a certificate for contact hours to the email address provided. For NAB, you will receive a certificate at the conclusion of the last event this year.

Continuing Education Information - RECORDING

Learning Outcome:
Following this activity, we expect learners to share what they plan to do differently when back at work in the post-activity poll.

Nursing Professional Development: ANCC Contact Hours & Accreditation Statement
This nursing continuing professional development activity was approved by the Ohio Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation. (OBN-001-91) This activity (each event) awards 0.5 contact hours and 0 hours of pharmacology.

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Expiration Date: The credit claiming system for the recording expires 30 days after the last event.

Alliant Health Solutions Nursing Home Readmissions Affinity Group

What is an affinity group?

"A group of people having a common interest or goal or acting together for a specific purpose.[1]"

Who is participating with us?

What are the benefits of participating in an affinity group?

- Peer-to-peer sharing and support system
- Learning from each other – all teach, all learn
- Consultation and technical assistance from Alliant Health Solutions
- Learning opportunities and coaching calls
- Suggestions for implementation strategies of tools and strategies

1. https://www.merriamwebster.com/dictionary/affinity%20group

With So Many Competing Priorities, Why Keep Our Eye on Readmissions and ED Visits?

- Hospitalizations can result in complications for older adults.
  - Skin tears and skin injury
  - Falls due to an unfamiliar environment
  - Unnecessary medication
  - Fear and/or anxiety due to an unfamiliar environment and caregivers
- Readmissions are time intensive for staff (transfer out process, additional MDS time, transfer back process).
- Patient/resident and customer satisfaction improve when all care can be provided at the "home" facility.

Our performance this year impacts future years.

Measure

The SNF VBP Program's Hospital Readmission Measure

The SNF VBP Program currently awards incentive payments to SNFs based on their performance on the SNF 30-Day All-Cause Readmission Measure (SNFRM; NQF #2510). The SNFRM measures the rate of all-cause, unplanned hospital readmissions for SNF residents within 30 days of discharge from a prior hospital stay. The SNFRM is risk adjusted for stay-level factors including clinical and demographic characteristics. Each SNF receives a SNFRM result (i.e. risk-standardized readmission rate) for a baseline period and a performance period. The following table provides the baseline and performance periods for Fiscal Year (FY) 2019 through FY 2024, as finalized through the federal rulemaking process.

Program Year	Baseline Period	Performance Period
FY 2019*	CY 2015 (1/1/2015-12/31/2015)	CY 2017 (1/1/2017-12/31/2017)
FY 2020	FY 2016 (10/1/2015-9/30/2016)	FY 2018 (10/1/2017-9/30/2018)
FY 2021	FY 2017 (10/1/2016-9/30/2017)	FY 2019 (10/1/2018-9/30/2019)
FY 2022	FY 2018 (10/1/2017-9/30/2018)	4/1/2019-12/1/2019* *
FY 2023	FY 2019 (10/1/2018-9/30/2019)	FY 2021 (10/1/2020-9/30/2021)
FY 2024	FY 2019 (10/1/2018-9/30/2019)	FY 2022 (10/1/2021-9/30/2022)

CY = Calendar Year; FY = Fiscal Year.

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/SNF-VBP/Measure

Did you know there are regulatory and financial incentives for avoiding hospitalizations and Emergency Department (ED) visits?

Our Starting Place

Data: Number of transfers to hospital

- Were they admitted or ED visit and return?
- Was it a short stay or long stay patient/resident?
  - If a short stay, what day after admission was it?

Our Stretch Goal:

Our Start: Three Learning Sessions With Coaching Support

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

- Overview of Interact® as a Quality Improvement Initiative
- Quality Measures Related to Re-Admissions and Emergency Department Visits
- Facility Capabilities and Impact on Admissions, Re-Admissions and ED Visits

Session 2: Detecting and Communicating Changes in Condition

- Impact Communication Can Have on Reducing Admissions and Emergency Department Visits
- Use of Tools like Stop & Watch, SBAR, Communication Checklists and Clinical Management

Session 3: Clinical Decision Support Tools and Advanced Care Planning

- Involving the Resident/Patient Voice in Care Decisions

1

Learning Objectives:

- Introduce a quality improvement framework for readmission reduction
- Review quality measures related to readmissions and ED visits
- Evaluate the current use of a capabilities list and communication with care partners
- Identify the use of a capabilities list and how it can impact readmissions and ED Visits
- Discuss how QAPI will be part of this process
- Initiate a plan to educate and implement a process to reduce hospitalizations

Use Tomorrow:

- ✓ Review your current capabilities list – are changes needed with current staffing patterns?
- ✓ Review current processes for communicating your facility capabilities
- ✓ Identify opportunities to strengthen your processes

Interact as a Framework for a Quality Improvement Approach to Readmission Reduction

https://pathway-interact.com/ (Website Demo)

INTERACT® is an acronym for "**I**nterventions to **R**educe **A**cute **C**are **T**ransfers. Interact® 4.5 is the most current version

INTERACT® is mentioned by name in the new CMS State Operations Manual (SOM) and Interpretive Guidelines as a *program* for facilities to use to identify residents' change in conditions

Interact® is a Quality Improvement Initiative that includes a library of tools and resources such as:

- Training and Implementation Assistance,
- Case Examples,
- Care Transition Resources,
- Guidance on Infection and Possible Sepsis,
- Fall Management,
- Advance Care Planning,
- Managing Behavioral Symptoms,
- Resources on Quality Care

PATHWAY HEALTH

INTERACT

Register | Log In

Tools & Resources | What is INTERACT© | Training Options | Center of Excellence | Licensing & Technology Partners | Announcements & Publications

Resources to Support Your INTERACT™ QIP

INTERACT® Tools Library

In order to view the tools library, please REGISTER or LOG IN

Free INTERACT® Resources

Training and Implementation Assistance

INTERACT® Training and Education

Case Examples

Case Study with Hospital Transfer

Case Study without Hospital Transfer

Free to create a log in and download tools

PATHWAY HEALTH
Insight | Expertise | Knowledge

INTERACT

Log Out

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Lead With Quality

What is INTERACT®

INTERACT™ is an acronym for "Interventions to Reduce Acute Care Transfers." The interventions is a quality improvement program designed to improve the identification, evaluation, and communication about changes in resident status. INTERACT™ was first designed in a project supported by the Centers for Medicare and Medicaid Services (CMS). Now, many post-acute providers across the U.S. are using INTERACT™.

What is the purpose of the INTERACT™ Quality Improvement Program?

The overall goal of the INTERACT® program is to reduce the frequency of transfers to the acute hospital. Transfers to the hospital can be emotionally and physically difficult for residents, and result in numerous complications of hospitalization, and they are costly.

In the plans for health care reform, Medicare may financially reward facilities with lower hospitalization rates for certain conditions. By improving the identification, evaluation, and communication about changes in resident status, some, but not all acute care transfers can be avoided.

What are the INTERACT® Tools?

There are four basic types of tools:

1. Quality Improvement tools
2. Communication tools
3. Decision Support tools
4. Advance Care Planning tools

The specific tools are designed for use by selected members of the care team. However, in order for the INTERACT® team to be successful, all members of the care team should be aware of all of the tools and their uses. The INTERACT® project champion will assist your team in using the tools on a daily basis. The tools have been designed to help staff improve care, but not increase unnecessary paperwork.

To view and download, go to INTERACT™ Tools >

Contact us **to learn how INTERACT™ can assist your organization improve hospital readmission rates and improve overall efficiencies.**

Intervention List

This tool can be used by hospital emergency rooms, hospitalists, case managers for appropriate referral to Skilled Nursing Facilities.

This tool can be used within skilled Nursing Facilities to facilitate communication regarding interventions available and as part of the readmission reduction efforts.

This tool can be posted in skilled nursing facility as facility desires.

Facility _____

Address _____ **Tel** _____

Circle 'Y' for yes or 'N' for no to indicate the availability of each item in your facility.

Interventions Available	Yes	No
Primary Care Clinician Services		
At least one physician, NP, or PA in the facility two 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		
Basic Metabolic Panel *(BUN, Ca, Cl-, CRE, eGFR, GLU, K+, Na+, tCO_2)*	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		
Psychiatry	Y	N
Wound Care	Y	N
Other Physician Specialty Consultations *specify:*		
	Y	N
	Y	N
	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		
CPR	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)*		

Capability/Intervention List includes all available care and treatments that can be provided at your facility.

How Can a Capabilities List Make a Difference?

- Clearly defined capabilities help potential and current patients, families and care partners understand the level of care you can provide.

- A complete understanding of facility capabilities allows covering physicians to provide orders for medical care, testing and treatment without requiring the patient/resident to transfer to another facility.

- A comprehensive capabilities list can be a good double-check against your orientation, annual education and competency assessment programs. Does the facility onboarding and annual competency assessment process ensure staff competency in all checked areas?

- A clearly defined and updated capabilities list can help demonstrate the basis for involuntary discharge decisions based on a facility's ability to meet the needs of the patient or resident in the facility (Federal Requirements: State Operations Manual 483.15 F621).

How and When Is the Capabilities List Shared?

Referring Hospitals

- Shared as updated?
- Shared on a regular schedule?
- Shared with multiple departments?
- Shared with each transfer to the ED (as a separate form or on the back of a one-page transfer form)?

Medical Staff and the Interdisciplinary Team

- All physician staff, including covering entities, telehealth providers, etc.,?
- Specialists such as podiatrists, wound care physicians and cardiologists?
- Facility staff, including internal staff and agency staff?
- With staff educators?

Patients, Residents, Families and Care Partners

- During the referral and intake process?
- During routine care conferences?
- During the change in condition conversations?
- When do care plan changes occur?

Use Tomorrow

- ✓ Review your current capabilities checklist.
  - Does the list reflect all of the services you are currently providing? Are there any services you have added or are temporarily unable to provide? Have changes been communicated to your physician team, referring hospitals, staff, patients/residents and care partners?

- ✓ Verify that your referring hospitals have a current capabilities checklist.
  - What departments in your referring hospitals have your current capabilities checklist easily accessible?
    - Case management
    - ED Nurses, Physicians, Discharge Planners

- ✓ Review your onboarding and annual competency processes.
  - Are competency assessments current and available for all appropriate internal and contract staff?

- ✓ Review/establish a process for review, updating and circulation of your facility capabilities checklist when changes in your capabilities occur.

- ✓ Review/establish a process for incorporating discussion of your capabilities into initial, routine and change of condition care conferences.

Next Steps on Our Journey

Your Alliant Health Solutions advisor will contact you next week to provide coaching support as you complete your Use Tomorrow reviews and, where appropriate, develop and embed new processes to enhance your readmission reduction processes. You don't have to wait for that call! If you have questions or other areas where you would benefit from coaching support, contact:

Your AHS Support	Name	Email
Alabama	Beth Greene	Beth.Greene@allianthealth.org
Florida	Julie Kueker	Julie.Kueker@allianthealth.org
Georgia	Melody Brown	Melody.Brown@allianthealth.org
Kentucky	Jeremy Bishoff	Jeremy.Bishoff@allianthealth.org
Louisiana	Latraiel Courtney	Latraiel.Courtney@allianthealth.org
North Carolina	Leighann Sauls	Leighann.Sauls@allianthealth.org
Tennessee	Julie Clark	Julie.Clark@allianthealth.org

Questions?

Complete the Post-Event Assessment to Receive Credit

https://bit.ly/NAB_ANCC_ClaimCredit

Important Assessment Coming Soon…

CMS requested Alliant Health Solutions, your QIN-QIO, to work with nursing homes to understand emerging healthcare needs in the skilled nursing facility and ensure plans addressing safe visitors and cohorting are in place to achieve and maintain health quality and equity.

Over the next several months, Alliant Health Solutions will be reaching out to your nursing homes **via phone and email** to answer two quick questions:

- Does your facility have a formal Cohorting plan?
- Does your facility have a formal Safe Visitor Policy?

We appreciate your timely response to this CMS driven directive! More to come…

What's Next?

Session 2: Tuesday, September 20, 2022 at 2 p.m. EST

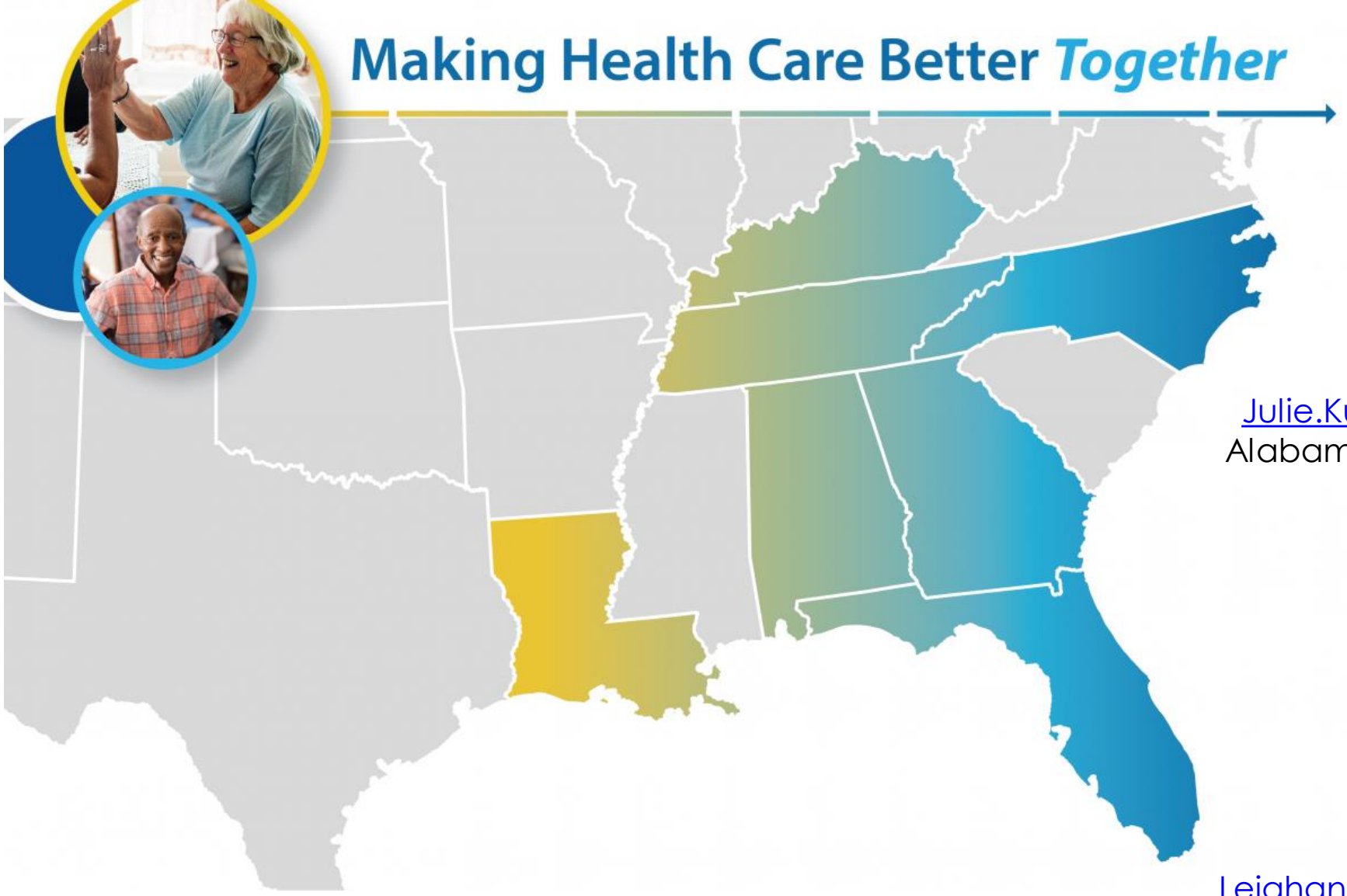
Detecting and Communicating Changes in Condition

- Impact Communication Can Have on Reducing Admissions and Emergency Department Visits
- Use of Tools like Stop & Watch, SBAR, Communication Checklists and Clinical Management

Session 3: Tuesday, October 18, 2022 at 2 p.m. EST

Clinical Decision Support Tools and Advanced Care Planning

- Involving the Resident/Patient Voice in Care Decisions



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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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