Reducing Readmissions Preparation Program

NURSING HOME READMISSION ASSESSMENT (PRE & POST)

Facility Name: _____ CCN:* _____ ☐ Pre-Assessment Date: _____

Survey Completed By: _____ ☐ Post-Assessment Date: _____

Work with your Reducing Readmissions Committee to complete the following assessment. Each item relates to prevention elements that should be in place for a successful readmissions program in your facility. Select one of the implementation status options on the right for each assessment item.

Assessment Items	Yes, In Place With Consistent Use	Yes, In Place With Partial Use	Under Development	No, Not Doing at All
Operational Processes				
1. Do you track and trend transfers using a readmission dashboard? Rationale: "A dashboard is an ideal way to prioritize the most important indicators for a nursing home and encourage regular monitoring of the results. Nursing homes should include readmission as one of the measures in your dashboard." Source: Instructions to Develop a Dashboard, https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/InstrDevDshbddebedits.pdf.	☐	☐	☐	☐
2. Do you discuss readmissions that occurred in the last 24 hours during daily stand-up meetings? Rationale: Daily stand-up meetings provide an opportunity to review all patients readmitted from the previous day to determine the root causes for the readmission and the plan to prevent them in the future.	☐	☐	☐	☐
3. Do you conduct case reviews for residents who return to the hospital? Rationale: Conducting case reviews on patients who return to the hospital is an integral part of root cause analysis. This will provide nursing homes with a comprehensive review of the resident's condition and other factors contributing to the transfer. See the INTERACT Quality Improvement Tool for a Review of Acute Care Transfers (chart audit tool) at http://www.pathway-interact.com/.	☐	☐	☐	☐
4. Do you use the INTERACT chart audit tools (or other evidence-based tools) for your readmission case reviews on residents that return to the hospital? Rationale: Reviewing a small sample of readmitted patient charts aids in identifying patterns or trends in data and provides opportunities for improvement. Data analyzed include key clinical information, such as changes in condition, vital signs at the time of transfer, new or worsening symptoms, etc. See the INTERACT Quality Improvement Tool for Review of Acute Care Transfers (chart audit tool) at http://www.pathway-interact.com/.	☐	☐	☐	☐

**CCN is your six-digit CMS Certification Number from the Centers for Medicare & Medicaid Services.*

Assessment Items	Yes, In Place With Consistent Use	Yes, In Place With Partial Use	Under Development	No, Not Doing at All
5. Do you have more than one Performance Improvement Project (PIP) specific to readmission prevention? Rationale: A project establishes the goals, scope, timing, milestones, and team roles and responsibilities for an improvement project. Develop a PIP specific to readmission prevention. Source: Worksheet to Create a Performance Improvement Project. https://www.cms.gov/Medicare/Provider-Enrollment-and- Certification/QAPI/downloads/PIPCharterWkshtdebedits.pdf.	☐	☐	☐	☐
6. Do you have annual competencies with your nurses related to effective team communication? Rationale: Adding standardized communication tools in the annual competencies is a method to validate that staff members know how to use the communication tools. Provide training for those that are not using the tools or using them inconsistently. Consider using INTERACT Situation-Background-Assessment-Recommendation (SBAR) and the "Stop and Watch" warning tool. See the INTERACT forms at http://www.pathway-interact.com/.	☐	☐	☐	☐
7. Do you have a readmissions committee that meets monthly? Rationale: A monthly readmission committee is a team that meets to review data, case studies, and improvements for current processes. The readmissions committee should include the administrator, director of nursing, medical director, pharmacist/ consultant, case manager, and admissions coordinator. Having a dedicated review committee will assist in identifying system failures that exist, trends in data, and opportunities for improvement.	☐	☐	☐	☐
8. Do you report on readmissions, including data, to your Quality Assurance and Performance Improvement (QAPI) committee monthly? Rationale: As part of feedback, data systems, and monitoring for QAPI, it is important to keep the QAPI leadership in your nursing home informed of readmission-related issues and data so that they can support and provide resources to drive improvement efforts.	☐	☐	☐	☐
Pre-Admission				
9. Does your primary transferring hospital know your nursing home capabilities? Rationale: A capabilities checklist in the emergency department or case management department is used by hospital staff members in the decision-making process to determine whether the patient should be admitted to the hospital or referred back to the nursing home. The checklist is a quality improvement tool that educates hospital staff members and improves confidence in their nursing home partners. See the INTERACT Nursing Home Capabilities list at http://www.pathway- interact.com/.	☐	☐	☐	☐

Assessment Items	Yes, In Place With Consistent Use	Yes, In Place With Partial Use	Under Development	No, Not Doing at All
10. Do you obtain a standardized telephone "hand-off" report from the hospital prior to patient transfer/admission to your facility? Rationale: A warm "hand-off" is a process used to communicate patient information and provide real-time provider-to-provider communication. When done properly, this process should communicate all the necessary information for the patient's care. Source: https://quality.allianthealth.org/wp-content/uploads/2023/02/Transitions-of-Care-Re-ignite-the-Warm-Handoff-to-reduce-Readmissions-FINAL_508.pdf	☐	☐	☐	☐
11. Does your primary transferring hospital share all necessary medical history and documents when the patient transfers to your facility? Rationale: Sharing patient medical history, physician orders and discharge summary, among other important information, is critical to receive from the acute care provider. See the INTERACT Acute Care Transfer Document Checklist at http://www.pathway- or a Skilled Nursing Facility Transfer Checklist.	☐	☐	☐	☐
Admission/Transfer From Hospital				
12. Do you conduct an orientation about the nursing home for new residents and family members? Rationale: Preparing patients and families for their stay at the nursing home is essential to ensure they know what to expect. Readmissions may occur because patients and families are concerned about the low ratio of nurses and physicians at the facility. A best practice is for the hospital to initiate the process by explaining to the patient what to expect at the nursing home. Once the patient arrives, conducting an orientation as soon as possible is important to alleviate concerns and instill confidence. See the INTERACT tool "Deciding About Going to the Hospital" at http://www.decisionguide.org/. This tool will help patients and families understand the benefits of hospital care and the risks of unnecessary hospital readmissions.	☐	☐	☐	☐
13. Do you have a process for measuring if a resident is at risk for readmission? Rationale: A risk-assessment tool is an evidence-based approach to stratify patients who are at high risk for readmission. Patients identified as high risk should be "flagged" to receive targeted interventions throughout their care and before discharge. Source: https://quality.allianthealth.org/wp-content/uploads/2022/09/AHS-QIN-QIO-Skilled-Nursing-Facility-Rehospitalization-Risk-Assessment-Tool_508.pdf	☐	☐	☐	☐
14. Do you always have telephone access to your medical director (24/7) to ensure timely responses to urgent clinical needs? Rationale: Nursing staff members need access to the medical director's cell phone number to ensure timely responses to urgent clinical needs. Strengthening the medical director's role, responsibilities, and accountabilities is essential to prevent avoidable readmissions.	☐	☐	☐	☐

Assessment Items	Yes, In Place With Consistent Use	Yes, In Place With Partial Use	Under Development	No, Not Doing at All
Discharge to Home				
15. Do you schedule labs, tests, and physician visits prior to patient discharge (physician follow-up visits should occur within seven days of discharge)? Rationale: Connecting your resident to follow-up physician appointments within seven days and post-discharge testing is essential to ensure continuity of care. Ensure your resident understands the reason and importance of the follow-up appointments and has a plan and transportation to get there.	☐	☐	☐	☐
16. Do you ensure patients have a plan for obtaining medications post-discharge? Rationale: Medication errors during patient transitions are prevalent and contribute significantly to readmissions. A comprehensive medication plan in place at the time of discharge should include: the discharge medication list, indication and duration of new medications, and changes in medication (if any), and must be communicated to and understood by the resident and family upon discharge.	☐	☐	☐	☐
17. Do you use the teach-back method to validate residents' and families' understanding of their medications, medical condition and/or discharge plans? Rationale: Teach back is a communication tool to confirm that a healthcare provider has explained to the patient what they need to know in a manner that the patient understands. Source: https://quality.allianthealth.org/wp-content/uploads/2023/02/Transitions-of-Care-Make-Teach-back-and-Always-Event-FINAL_508.pdf	☐	☐	☐	☐
18. Do you conduct post-discharge follow-up phone calls to residents/families within 24–48 hours of discharge? (Subsequent calls within seven days are also recommended). Rationale: The first week following discharge is a vulnerable time for your residents. Follow-up phone calls are essential because they provide an opportunity to reinforce the discharge plan, problem solve, and resolve post-discharge issues such as challenges obtaining medications, new or worsening symptoms, and barriers to getting to physician follow-up appointments. Phone calls also help maintain a positive connection with your residents and let them know you care about them.	☐	☐	☐	☐
19. Do you have a process to determine if a resident meets the criteria to receive home health services? Rationale: Transitioning from a nursing home to a home can overwhelm many patients. Especially if they have had a new medical condition they are adjusting to or medications added/changed since their hospitalization. A home health visit can often ease that transition, and for Medicare Fee-for-Service patients, there is no co-pay for the patient.	☐	☐	☐	☐

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