A Strategy to Assess Nursing Home Readmission Gaps: HSAG Care Transitions Assessment

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

HSAG HEALTH SERVICES ADVISORY GROUP

Overview

The HSAG Care Transitions Assessment helps skilled nursing facilities identify gaps and opportunities for improvement in their care transitions processes. The assessment tool contains nine evidence-based action items in three focus areas for improvement. Response options include five levels of implementation.

Care Continuum

1. Use bi-directional feedback with acute care partners.
2. Meet regularly with acute care partners to review care transition plans for super-utilizers and residents on high-risk medications.
3. Monitor timeliness of provider response.
4. Use risk stratification to identify high-risk residents.

Discharge Planning

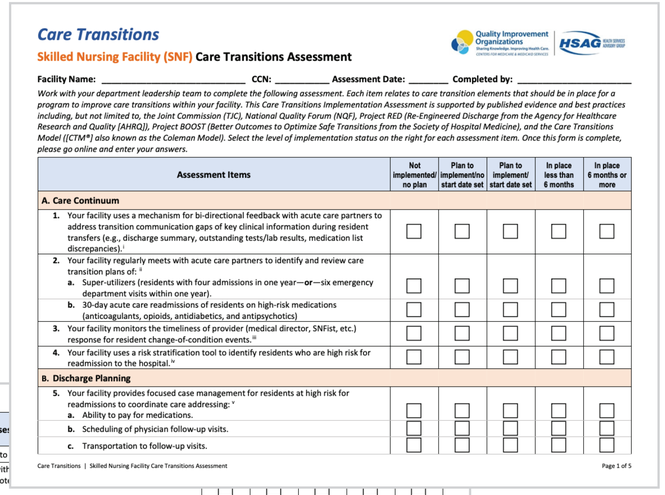
5. Provide focused case management for high-risk residents.
6. Provide medication education.
7. Validate staff proficiency in discharge instruction.
8. Perform follow-up phone calls.

Quality Improvement of Care Transitions

9. Review data.

Response Options

- Not implemented/no plan
- Plan to implement/no start date set
- Plan to implement/start date set
- In place less than six months
- In place six months or more



Care Transitions

Skilled Nursing Facility (SNF) Care Transitions Assessment

Facility Name: _____ CCN: _____ Assessment Date: _____ Completed by: _____

Work with your department leadership team to complete the following assessment. Each item relates to care transition elements that should be in place for a program to improve care transitions within your facility. This Care Transitions Implementation Assessment is supported by published evidence and best practices including, but not limited to, the Joint Commission (TJC), National Quality Forum (NQF), Project RED (Re-Engineered Discharge from the Agency for Healthcare Research and Quality [AHRQ]), Project BOOST (Better Outcomes to Optimize Safe Transitions from the Society of Hospital Medicine), and the Care Transitions Model ((CTM®) also known as the Coleman Model). Select the level of implementation status on the right for each assessment item. Once this form is complete, please go online and enter your answers.

Assessment Items	Not implemented/ no plan	Plan to implement/no start date set	Plan to implement/ start date set	In place less than 6 months	In place 6 months or more
A. Care Continuum					
1. Your facility uses a mechanism for bi-directional feedback with acute care partners to address transition communication gaps of key clinical information during resident transfers (e.g., discharge summary, outstanding tests/lab results, medication list discrepancies).[i]	☐	☐	☐	☐	☐
2. Your facility regularly meets with acute care partners to identify and review care transition plans of:[ii]					
a. Super-utilizers (residents with four admissions in one year—**or**—six emergency department visits within one year).	☐	☐	☐	☐	☐
b. 30-day acute care readmissions of residents on high-risk medications (anticoagulants, opioids, antidiabetics, and antipsychotics)	☐	☐	☐	☐	☐
3. Your facility monitors the timeliness of provider (medical director, SNFist, etc.) response for resident change-of-condition events.[iii]	☐	☐	☐	☐	☐
4. Your facility uses a risk stratification tool to identify residents who are high risk for readmission to the hospital.[iv]	☐	☐	☐	☐	☐
B. Discharge Planning					
5. Your facility provides focused case management for residents at high risk for readmissions to coordinate care addressing:[v]					
a. Ability to pay for medications.	☐	☐	☐	☐	☐
b. Scheduling of physician follow-up visits.	☐	☐	☐	☐	☐
c. Transportation to follow-up visits.	☐	☐	☐	☐	☐
6. Your facility provides residents with frequency, administration, and pot					
a. Anticoagulants	☐	☐	☐	☐	☐
b. Opioids	☐	☐	☐	☐	☐
c. Antidiabetics	☐	☐	☐	☐	☐
d. Antipsychotics	☐	☐	☐	☐	☐
7. Your facility has a process in place to validate staff proficiency using evidence-based education methodology (e.g., teach-back) during discharge instruction.[vi]	☐	☐	☐	☐	☐
8. Your facility performs follow-up calls within 48–72 hours post-discharge to ensure:[vii]					
a. Medications were obtained (from pharmacy or delivered).	☐	☐	☐	☐	☐
b. Status of follow-up visits.	☐	☐	☐	☐	☐
c. Transportation is arranged for follow-up visits.	☐	☐	☐	☐	☐
d. Home health services were initiated.	☐	☐	☐	☐	☐
C. Quality Improvement of Care Transitions					
9. Your facility maintains a multidisciplinary readmission team that reviews and reports data to your Quality Assurance & Performance Improvement (QAPI) committee regarding:[ix]					
a. 30-day acute care readmissions (where "day one" refers to when residents discharged from acute care and counting 30 days thereafter, regardless of the SNF discharge date).	☐	☐	☐	☐	☐
b. Gap analyses identifying trends in unmet needs leading to readmission (e.g., social determinants of health, unfilled prescriptions, undelivered durable medical equipment [DME], delay of home-based services).	☐	☐	☐	☐	☐

Care Transitions | Skilled Nursing Facility Care Transitions Assessment — Page 1 of 5

Findings

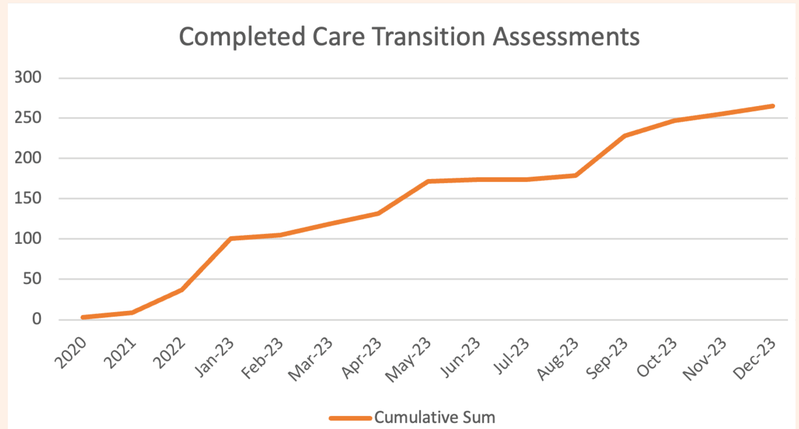
Assessment items that nursing homes most frequently identify as not implemented relate to care transition processes, including the following:

Item 2a	Your facility regularly meets with acute care partners to identify and review care transition plans of super-utilizers.	**39.11%** (106 respondents)
Item 2b	Your facility regularly meets with acute care partners to identify and review care transition plans of 30-day acute care readmissions of residents on high-risk medications.	**33.94%** (92 respondents)
Item 4	Your facility uses a risk stratification tool to identify residents who are high risk for readmission to the hospital.	**32.84%** (89 respondents)

This material was prepared by Health Services Advisory Group (HSAG), a Quality Innovation Network-Quality Improvement Organization (QIN-QIO) under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS). Views expressed in this material do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a specific product or entity herein does not constitute endorsement of that product or entity by CMS or HHS. Publication No. QN-12SOW-XC-01052024-01

Progress

67% completed assessments (271; 10/2020–12/2023)



Interventions

- One-on-one technical assistance to complete the assessment, analyze results, and provide tools and resources based on level of implementation
- Corporate outreach/presentations to present aggregate results and major findings
- Community coalition meetings
- Monthly care coordination webinars on improving care transitions
- Eblast reminders to review facility-level readmission rates and complete the Care Transitions Assessment