Welcome!

We will get started promptly at 12 noon.

This material was prepared by the IPRO QIN-QIO, a Quality Innovation Network-Quality Improvement Organization, 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. 12SOW-IPRO-QIN-TA-AA-22-534

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Enhancing Transitions to the Community

Name: Kathy Calandra and Laura Benzel

Date:February 10 and 16

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Use Chat to introduce yourself & ask questions

How to use Zoom

At the bottom of your screen, you will see a black bar with icons:

Chat **Everyone** for general comments or questions

Welcome!

- Today's session is being recorded
- Although we want active participation, we ask that you please keep yourself on 'mute' during the presentation
- Please introduce yourself (name, organization & role, location) using the Chat feature

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The IPRO QIN-QIO

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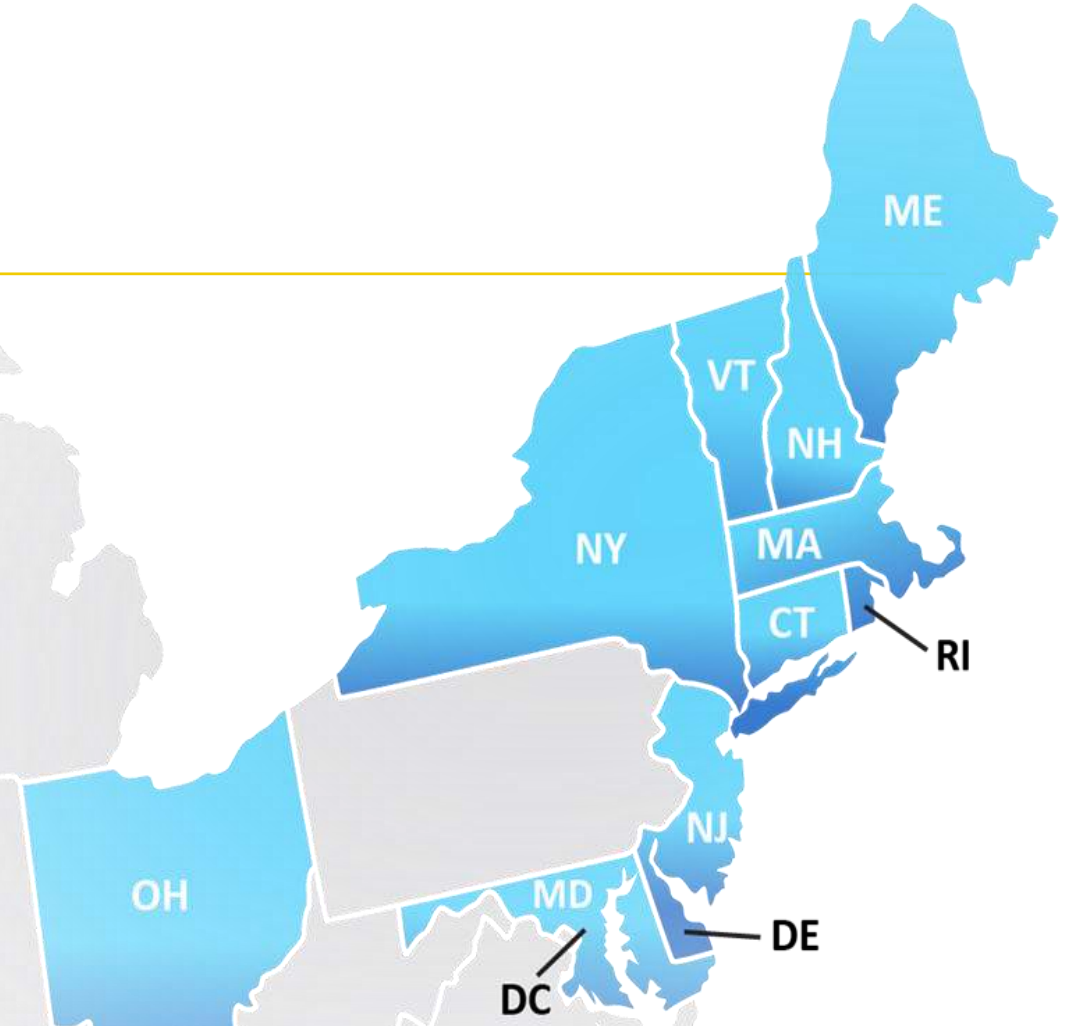
- A federally-funded Medicare Quality Innovation Network – Quality Improvement Organization (QIN-QIO) in contract with the Centers for Medicare & Medicaid Services (CMS)
- 12 regional CMS QIN-QIOs nationally

IPRO:
New York, New Jersey, and Ohio

Healthcentric Advisors:
Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont

Qlarant:
Maryland, Delaware, and the District of Columbia



Working to ensure high-quality, safe healthcare for
20% of the nation's Medicare FFS beneficiaries

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IPRO QIN-QIO *small Talk* series January-June 2022

Our *small Talks* are short, impactful presentations designed to meet your needs during this uniquely challenging time.

Two different topics will be presented on a monthly basis and each ***small Talk*** will:

*Consider a **challenge***

*Identify **interventions***

*Guide you to a specific **result** or outcome*

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Quick Overview

1. **CHALLENGE:** Patients who are discharged to the community without appropriate community connections are at higher risk of hospital readmissions.

2. **Intervention:** Project RED, which supports patient and family engagement and helps to make connections for social needs, has been successfully implemented in SNFs

3. **Result:** Be prepared to implement Project RED or one of the tools in order to address social determinants of health, and connect residents with community resources to decrease risk of readmission.

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Challenge – Why This Matters

- Ongoing management and evaluation needed after discharge to transition patients safely and successfully back into their home and community *doesn't always happen as planned.*
- Using the evidence based Project RED, adapted to the nursing home setting, showed a reduction in readmissions after patients were discharged

Provider and patient success story on short video. (4 minutes)

https://qi-library.ipro.org/2022/01/25/project-red-re-engineered-discharges-improve-nursing-home-discharges-and-reduce-readmissions/

Challenge – What's the Issue

- Patients returning home often do not have the information or resources needed and often end up returning to the hospital.

- Hospitals and nursing homes receive penalties for avoidable hospital readmissions

Challenge Addressed– Impact of Project RED in SNF

30% fewer hospital readmissions within 30 days of discharge

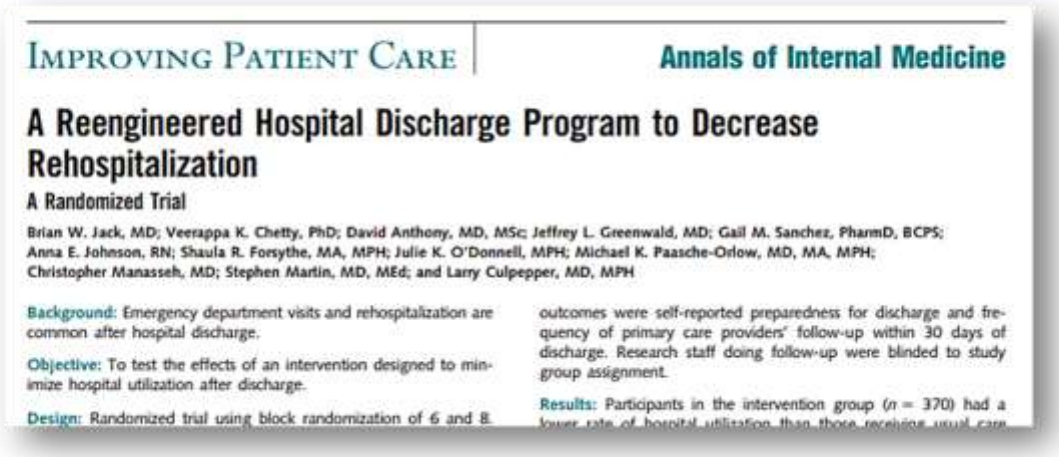
Decreased ED use from 24% to 16%

Increased PCP follow up

Improved patient "readiness for discharge"

Enhanced patient satisfaction

Piloted in SNF: 10.2% had hospital readmission or ED visit vs 17.4% of control patients



IMPROVING PATIENT CARE | Annals of Internal Medicine

A Reengineered Hospital Discharge Program to Decrease Rehospitalization

A Randomized Trial

Brian W. Jack, MD; Veerappa K. Chetty, PhD; David Anthony, MD, MSc; Jeffrey L. Greenwald, MD; Gail M. Sanchez, PharmD, BCPS; Anna E. Johnson, RN; Shaula R. Forsythe, MA, MPH; Julie K. O'Donnell, MPH; Michael K. Paasche-Orlow, MD, MA, MPH; Christopher Manasseh, MD; Stephen Martin, MD, MEd; and Larry Culpepper, MD, MPH

Background: Emergency department visits and rehospitalization are common after hospital discharge.

Objective: To test the effects of an intervention designed to minimize hospital utilization after discharge.

Design: Randomized trial using block randomization of 6 and 8.

outcomes were self-reported preparedness for discharge and frequency of primary care providers' follow-up within 30 days of discharge. Research staff doing follow-up were blinded to study group assignment.

Results: Participants in the intervention group (n = 370) had a lower rate of hospital utilization than those receiving usual care

Intervention - What Can Providers Do?

Incorporate key elements into your existing discharge planning and education

1. Medication reconciliation
2. Reconcile discharge plan with National Guidelines
3. Follow-up appointments
4. Post-discharge services
5. Outstanding tests
6. Written discharge plan
7. What to do if problem arises
8. Patient education
9. Assess patient understanding
10. Discharge summary sent to PCP
11. Telephone Reinforcement

**Community Connections*

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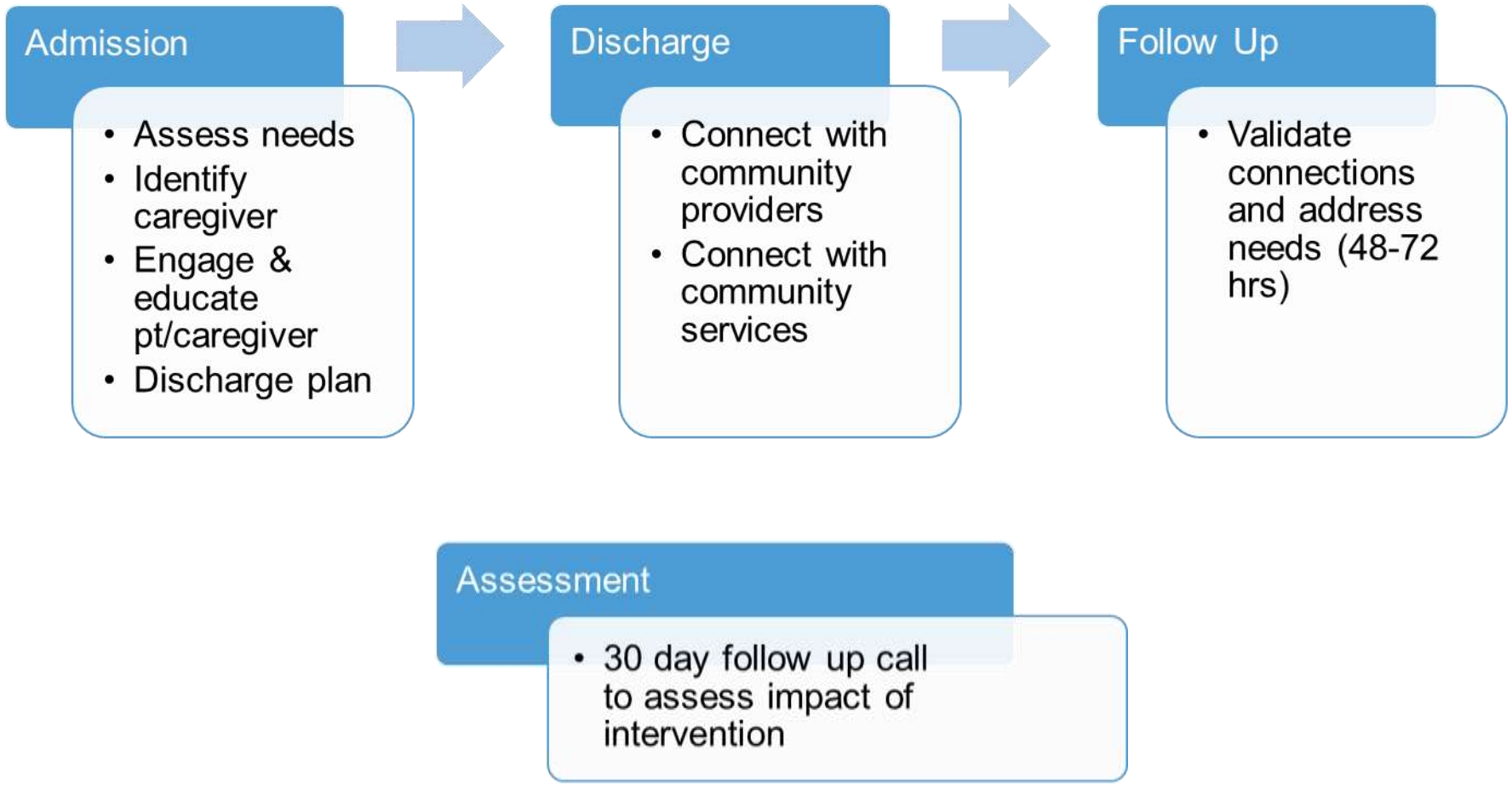
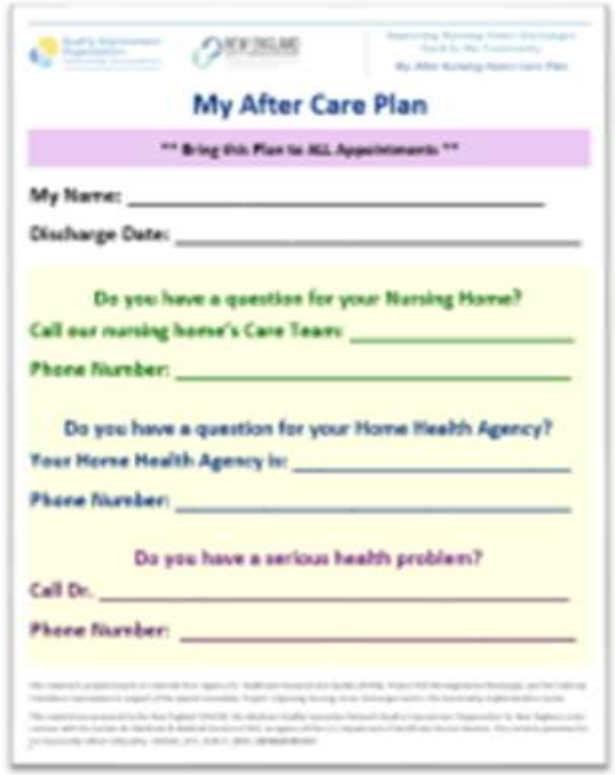
Intervention – Enhance Current Process!



Intervention - What Specific Action Needed?

- **After Care Plan 7-10 Days Prior to Discharge**
  - Introduce and engage/review with patient/caregiver
- **After Care Plan at Discharge**
  - Build upon previous engagement
- **Connecting to Community**
  - Community Physician
  - Home Health
  - Aging Service Access Point (ASAP)
- **Follow-up Call at 2 days**


My After Care Plan

My Name: _____

Discharge Date: _____

Do you have a question for your Nursing Home?

Call our nursing home's Care Team: _____

Phone Number: _____

Do you have a question for your Home Health Agency?

Your Home Health Agency is: _____

Phone Number: _____

Do you have a serious health problem?

Call Dr. _____

Phone Number: _____

https://qi-library.ipro.org/2022/01/25/my-after-nursing-home-care-plan/

Intervention – Specific Actions

Re-Engineered Discharge for Skilled Nursing Facilities Checklist

~ Please complete one copy for each patient ~

	Admission Assessment	Initials
Assess Needs: Ascertain need for and obtain language assistance	❑ Determine patient and caregivers' language proficiencies. ❑ Find out about preferred languages for oral communication, phone calls, and written materials. ❑ Arrange for language assistance as needed, including translation of written materials.	
Connect to community services and support	❑ Contact local Aging Service Access Point (ASAP) to connect patient to long term services and support. For example, list of local Massachusetts ASAP's available at https://800ageinfo.com . ❑ Contact VNA to establish any necessary short term home care services. ❑ Find out if patient already has any durable medical equipment (DME) at home. ❑ Use ASAP and VNA Referral Workflow to establish services.	

Keys to Success

- Engage Leadership
  - Train Staff
  - Develop Champions
- Track Progress
- Assess Impact

- Quarterly Learning Collaborative Meetings
- Bi-Monthly Peer Sharing Calls
- Monthly Technical Assistance

- Adherence to a process – building it in. Not redesigning a program, but building an efficiency and accountability in an existing process

- Community Collaboration
  - Get involved as soon as possible to connected patients with needed services
  - Interdisciplinary Discharge Planning Team Meeting involvement

Video of the Project RED process

- https://www.youtube.com/watch?v=JAZY7ONtJZc&feature=youtu.be

QAPI – Suggestions

- Track discharges– was checklist completed?

- Choose one element of the process, i.e. was follow up phone call completed within 48 hours?

https://qi-library.ipro.org/2022/01/25/project-red-toolkit-for-nursing-homes-table-of-contents/

Addressing Social Determinants of Health

Laura Benzel
Health Equity SME

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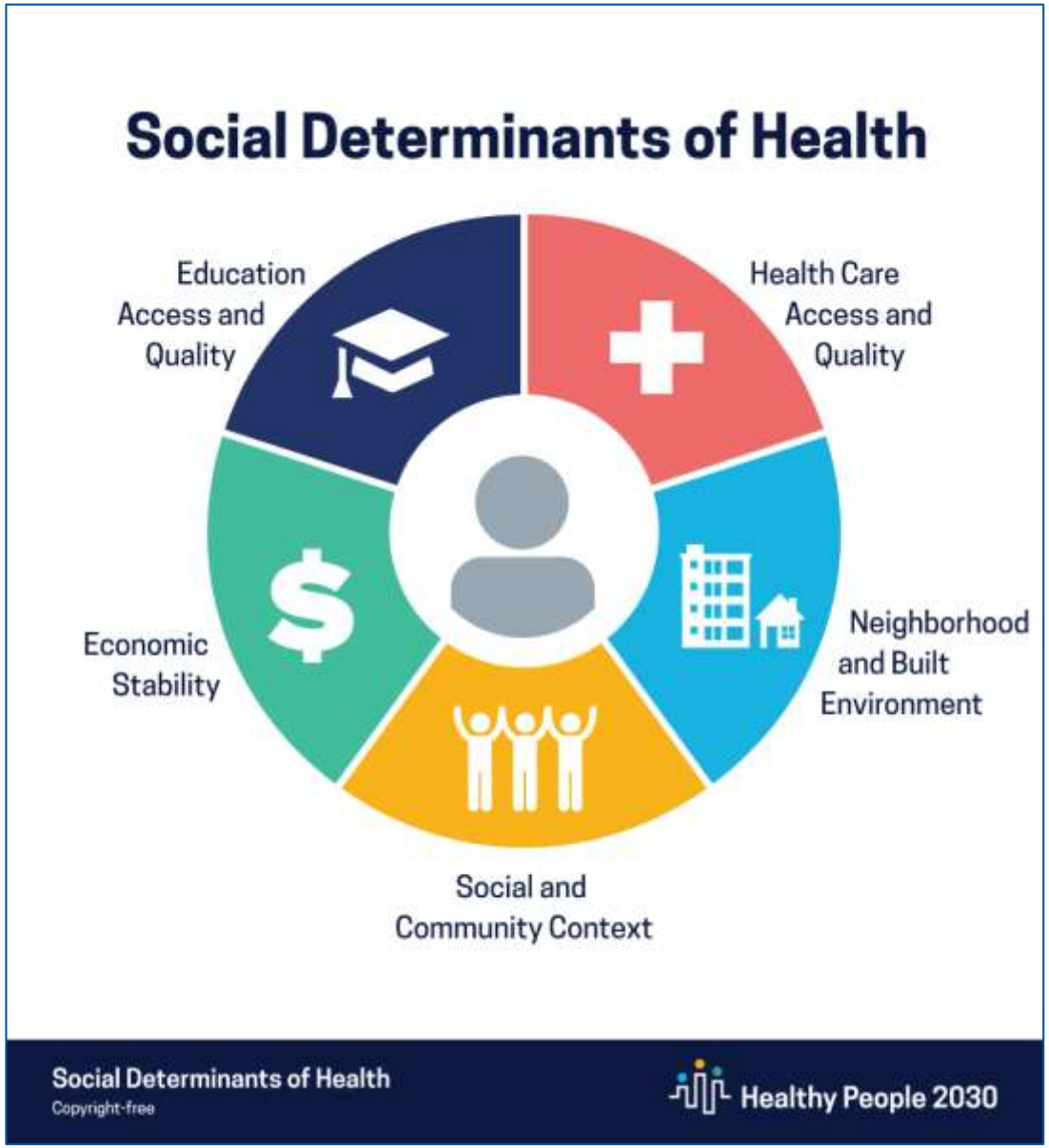

Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved January 3, 2022 from https://health.gov/healthypeople/objectives-and-data/social-determinants-health.

Health Equity

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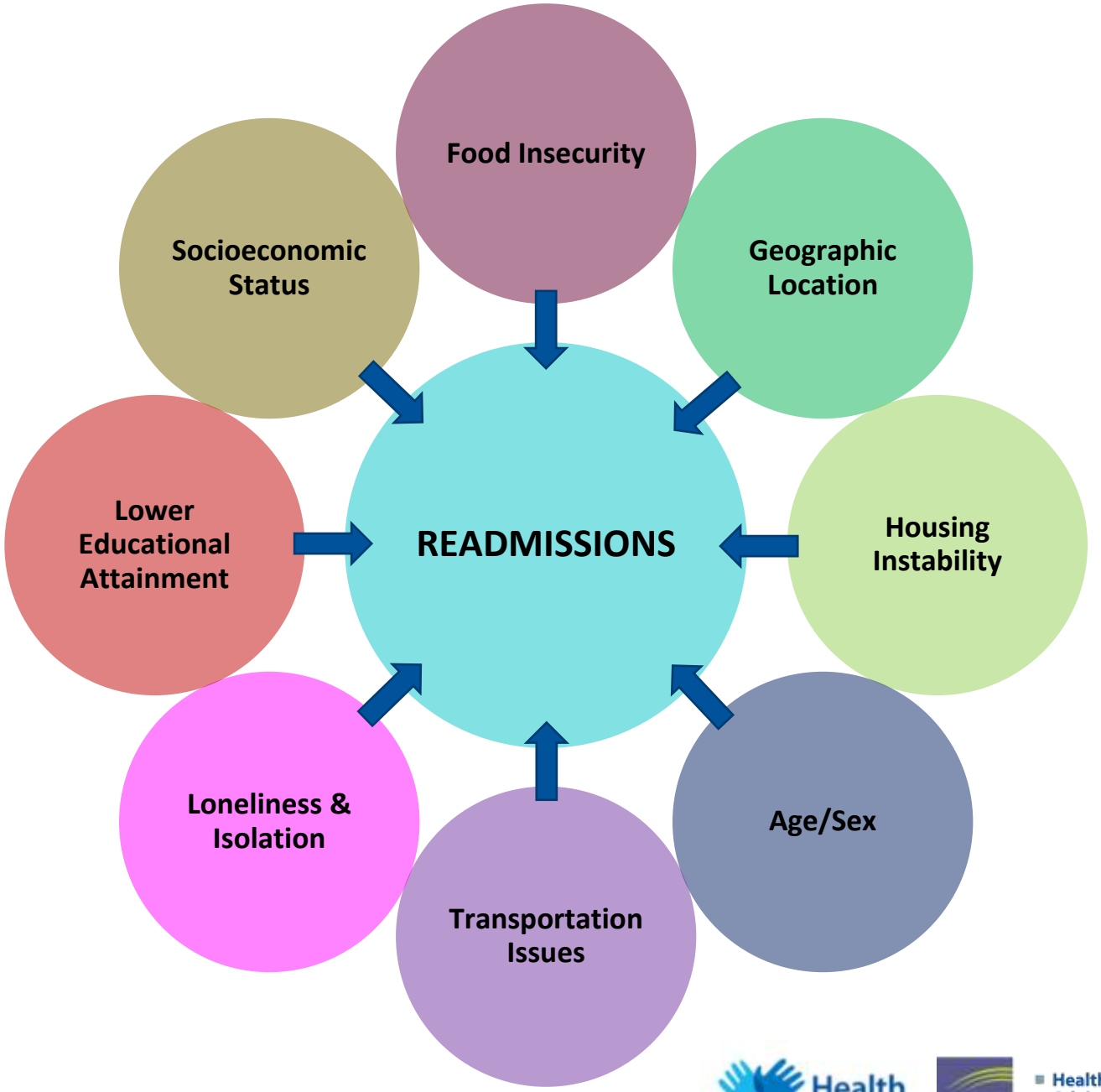

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Culturally & Linguistically Competent Care

- Ability to successfully communicate and provide care to patients with diverse beliefs, backgrounds, and values
- Provide services that are respectful of and responsive to:
  - individual cultural health beliefs and practices
  - preferred languages
  - health literacy levels
  - communication needs
  - social needs
- Employed by all members of an organization at every point of contact

Resources

The Re-Engineered Discharge Process
4 minute video
https://www.youtube.com/watch?v=JAZY7ONtJZc

Implementation Materials
https://healthcentricadvisors.org/project-red-outcomes-congress-success/

Guide to Reducing Disparities in Readmissions
CMS Office of Minority Health
https://qi-library.ipro.org/2020/10/27/guide-to-reducing-disparities-in-readmissions/

Health Leads
Social Needs Screening Toolkit
https://qi-library.ipro.org/2021/11/16/social-needs-screening-toolkit/

American Academy of Family Physicians
The EveryONE Project
Addressing Your Patients' Social Determinants of Health
https://qi-library.ipro.org/2021/11/16/social-needs-screening-tool-from-the-everyone-project/

National Association of Community Health Centers (NACHC)
PRAPARE (Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences)
https://qi-library.ipro.org/2021/11/16/prapare-tool/

American Hospital Association (AHA)
Social Determinants of Health Resources for Hospitals
https://qi-library.ipro.org/2022/01/19/go-to-the-hospital-or-stay-here-a-decision-guide-for-residents-their-families-and-caregivers/

Benefits of Boosters

Recent evidence shows that among healthcare and other frontline workers, COVID 19 vaccine effectiveness has decreased over time, especially in those 65 and older, at preventing infection or milder illness with symptoms.

- Boosters shots increase immune response
- Boosters shots provide improved protection against becoming infected with COVID-19
- Booster shots help prevent COVID-19 with symptoms

https://www.cdc.gov/coronavirus/2019-ncov/vaccines/booster-shot.html

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Chat In

Please unmute yourself or use the chat feature to share questions, ideas, success strategies, and/or lessons learned

Improvement is a Team Support

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Leaving in Action

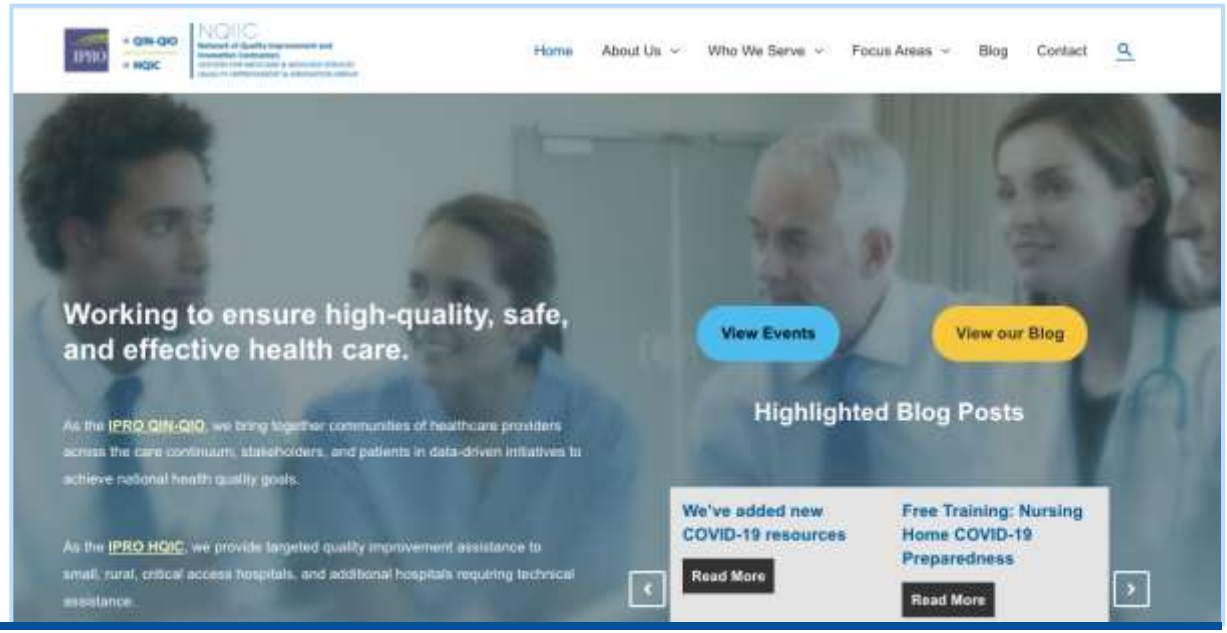
Tips for success:

- Access these tools from the IPRO QIN-QIO Resource: https://qi-library.ipro.org/

- Small steps of change: for example, start implementing the new process on one unit for two weeks, then evaluate and adjust as needed

- Reach out to our IPRO QIN-QIO team with questions or needs

Learn More & Stay Connected



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Let Us Know More…

Your feedback is critically important and will help guide us as we prepare future small Talks and other educational events.

Please take just a few minutes to complete our session evaluation (link is in chat).

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Mark your calendar for upcoming sessions

Access our calendar of events to view upcoming sessions:
https://qi.ipro.org/upcoming-events/

A Community Approach – Addressing Sepsis
Thurs - Feb 24 @ 12pm
Wed – March 2 @ 12pm

Check in with the QIO - Office Hours

- Share how it's going with your new intervention(s)
- Ask questions
- Learn from your peers

Next session: 2/17 @ 12pm

- https://healthcentricadvisors.zoom.us/j/85491530818?pwd=SUlId3QyZllvQURJTVBFdzJndnRqdz09

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Thank You

Thank you for your continued partnership and commitment to quality improvement.