Care Transitions Assessment and Toolkit

Lindsay Holland, MHA, Director, Care Coordination
Michelle Pastrano, MSG, Quality Improvement Specialist
Health Services Advisory Group (HSAG)

January 10, 2023

OBJECTIVES

- Discover how to register and access the Quality Improvement and Innovation Portal (QIIP) data application.
- Review the elements of the HSAG care transitions assessments and toolkits.
- Discuss how to use the assessment as a tool to implement and drive change at your facility.

Care Coordination Website

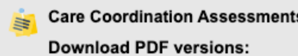
Care Coordination

Care coordination is a key priority for the Centers for Medicare & Medicaid (CMS) to improve quality and achieve safer and more effective care. However, gaps in care, such as poor communication and ineffective discharge processes, remain a challenge.To address these gaps, HSAG provides evidence-based tools, strategies, resources, and training needed to improve care coordination.

Hospital Care Coordination Toolkit

Nursing Home Care Coordination Toolkit

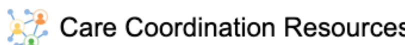
Access the QIIP



Care Coordination Assessments

Download PDF versions:

- **Acute Care Transitions Assessment**
- **ED Care Transitions Assessment**
- **SNF Care Transitions Assessment**



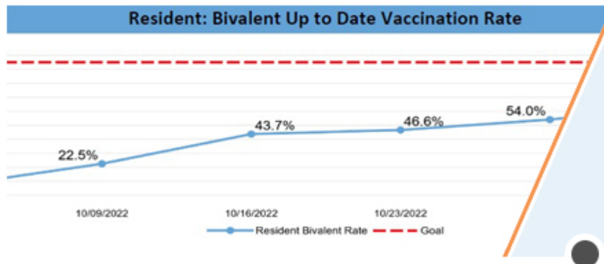
Hospitals

- **Care Coordination**
  - Hospital Care Coordination Toolkit
- Emergency Preparedness
- Infection Prevention
- Opioid Stewardship
- QIO Events

www.hsag.com/cc-resources

Do You Have Access to the QIIP?

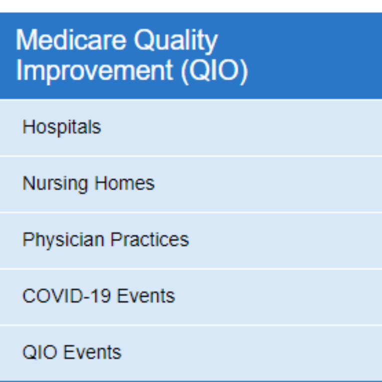
Quality Improvement and Innovation Portal (QIIP)



Customized Data for Nursing Home Quality Improvement

Get started in your quality improvement journey!

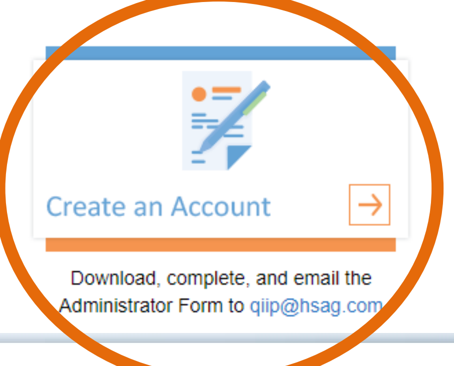
Learn More

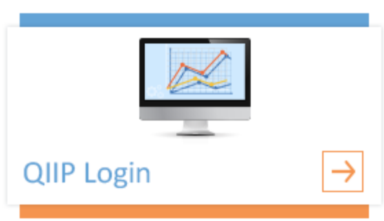


The QIIP is a data application with information to support your quality initiatives. You can complete assessments to enhance your quality improvement efforts, track interventions, view your performance dashboards, and access reports and COVID-19 data run charts.

To ensure current data on your COVID-19 Trend Reports, please join the HSAG group in NHSN. This also allows HSAG to provide real time technical assistance for any NHSN errors.

- Arizona Nursing Home Steps for Conferring Rights
- California Nursing Home Steps for Conferring Rights





Download, complete, and email the Administrator Form to qiip@hsag.com

www.hsag.com/qiip-start

Care Transitions Assessment

- Assesses the current status of care transition initiatives.
- Identifies actionable improvement opportunities.
- Measures progress.

Care Transitions

Acute Care Provider 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. Medication Management					
1. Your facility has a pharmacy representative verifying the patient's pre-admission (current) medication list upon admission.[i]	☐	☐	☐	☐	☐
2. For high-risk medications (anticoagulants, opioids, and diabetic agents), your facility utilizes pharmacists to educate patients, verifying patient comprehension using an evidence-based methodology.[ii]	☐	☐	☐	☐	☐
3. Your facility has a process in place to ensure patients can both access and afford prescribed medications prior to discharge (e.g., Meds-to-Beds, home delivery of meds, for affordability verification).[iii]	☐	☐	☐	☐	☐
B. Discharge Planning					
4. When patients meet high readmission-risk criteria, your facility focuses customized care coordination efforts for:[iv] **a.** Social determinants of health (e.g., financial barriers, transportation, food insecurities, social isolation, housing, safety, etc.).	☐	☐	☐	☐	☐
b. Patient-centered care planning addressing potential transitional barriers (continual process customized for each unique patient focusing on optimal outcomes while including the patient and caregivers in decision making).[v]	☐	☐	☐	☐	☐

Who Are the Assessments For?

Assessments have been developed to align with each setting's specific needs.

Acute Care → **Emergency Department** → **Skilled Nursing**

Care Transitions
Acute Care Provider Care Transitions Assessment

Facility Name: ____________ **CCN:** ________ **Ass**

Work with your department leadership team to complete the following assessment.
program to improve care transitions within your facility. This Care Transitions Implen
including, but not limited to, the Joint Commission (TJC), National Quality Forum (NQ
Research and Quality [AHRQ]), Project BOOST (Better Outcomes to Optimize Safe Tr
Model ([CTM®] also known as the Coleman Model). Select the level of implementatio
please go online and enter your answers.

Assessment Items
A. Medication Management
1. Your facility has a pharmacy representative verifying the patient's pre-admis (current) medication list upon admission.[i]
2. For high-risk medications (anticoagulants, opioids, and diabetic agents), you utilizes pharmacists to educate patients, verifying patient comprehension us evidence-based methodology.[ii]
3. Your facility has a process in place to ensure patients can both access and af prescribed medications prior to discharge (e.g., Meds-to-Beds, home deliver for affordability verification).[iii]
B. Discharge Planning
4. When patients meet high readmission-risk criteria, your facility focuses cust care coordination efforts for:[iv] a. Social determinants of health (e.g., financial barriers, transportation, fo insecurities, social isolation, housing, safety, etc.).
b. Patient-centered care planning addressing potential transitional barrie (continual process customized for each unique patient focusing on opti outcomes while including the patient and caregivers in decision makin

Care Transitions
Emergency Department Care Transitions Assessment

Facility Name: ____________ **CCN:** ________ **Assessment Date:** ______ **Com**

Work with your department leadership team to complete the following assessment. Each item relates to care transitic
program to improve care transitions within your facility. This Care Transitions Implementation Assessment is supporte
including, but not limited to, the Joint Commission (TJC), National Quality Forum (NQF), Project RED (Re-Engineered D
Research and Quality [AHRQ]), Project BOOST (Better Outcomes to Optimize Safe Transitions from the Society of Hosp
Model ([CTM®] also known as the Coleman Model). Select the level of implementation status on the right for each ass
please go online and enter your answers.

Assessment Items	Not implemented/ no plan	Plan t impleme start dat
A. Medication Management		
1. Your emergency department (ED) conducts **audits** at least quarterly to verify the accuracy of medication histories for patients on high-risk medications (anticoagulants, opioids, and diabetic agents).[i]	☐	☐
2. Your department has a monthly dashboard that tracks:[ii] a. Percentage of patients prescribed opioids per physician prescriber.	☐	☐
b. Percentage of patients prescribed naloxone with opioid prescriptions.	☐	☐
3. Your department has a process in place to ensure patients can both access and afford **essential** prescribed medications prior to discharge (i.e., affordability verification).[iii]	☐	☐
B. Discharge Planning		
4. Your department uses electronic health record (EHR) best-practice alerts to:[iv] a. Identify patients that are taking or are newly prescribed high-risk medications (anticoagulants, antidiabetics, and opioids).	☐	☐
b. Identify patients who are prescribed both benzodiazepines and opioids.	☐	☐
c. Notify case management of high-risk/high-need patients (e.g., homelessness, financial need, access to care, food insecurities, transportation needs, etc.).[v]	☐	☐

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.	☐	☐	☐	☐	☐

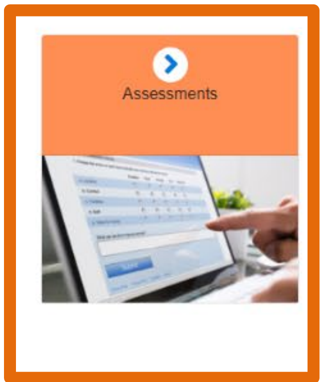
Care Transitions Assessment Access in the QIIP

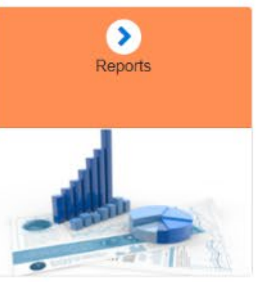
Access the QIIP here: **https://qiip.hsag.com**

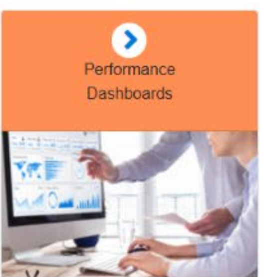
Quality Improvement Innovation Portal

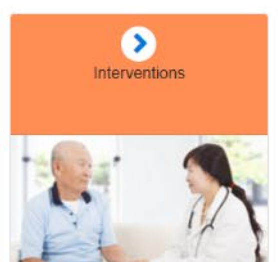
The HSAG Quality Improvement Innovation Portal (QIIP) is your centralized place to obtain and submit information in support of the quality initiatives on which you are working. The HSAG QIIP will allow you to complete assessments to enhance your quality improvement efforts, submit data, track interventions, view your performance dashboards, and access reports.

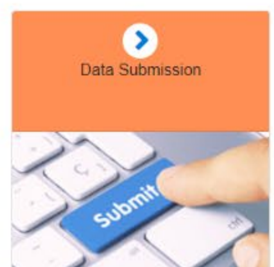
For questions, please contact QIIPSupport@hsag.com.











Completing and Submitting the Care Transitions Assessment

Acute Opioids | ED Opioids | Acute ADE | Acute Care Transitions | ED Care Transitions

Care Transitions

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.

To understand the rationale and references for each question, click here.

A. Medication Management

	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
1. Your facility has a pharmacy representative verifying the patient's pre-admission (current) medication list upon admission. [i] Previous Answer as of: Not Answered	○	○	○	○	○
2. For high-risk medications (anticoagulants, opioids, and diabetic agents), your facility utilizes pharmacists to educate patients, verifying patient comprehension using an evidence-based methodology. [ii] Previous Answer as of: Not Answered	○	○	○	○	○
3. Your facility has a process in place to ensure patients can both ac[…] medications prior to discharge (e.g., Meds-to-Beds, home delivery of[…] verification). [iii] Previous Answer as of: Not Answered			Plan to […]plement/start date set ○	In place less than 6 months ○	In place 6 months or more ○

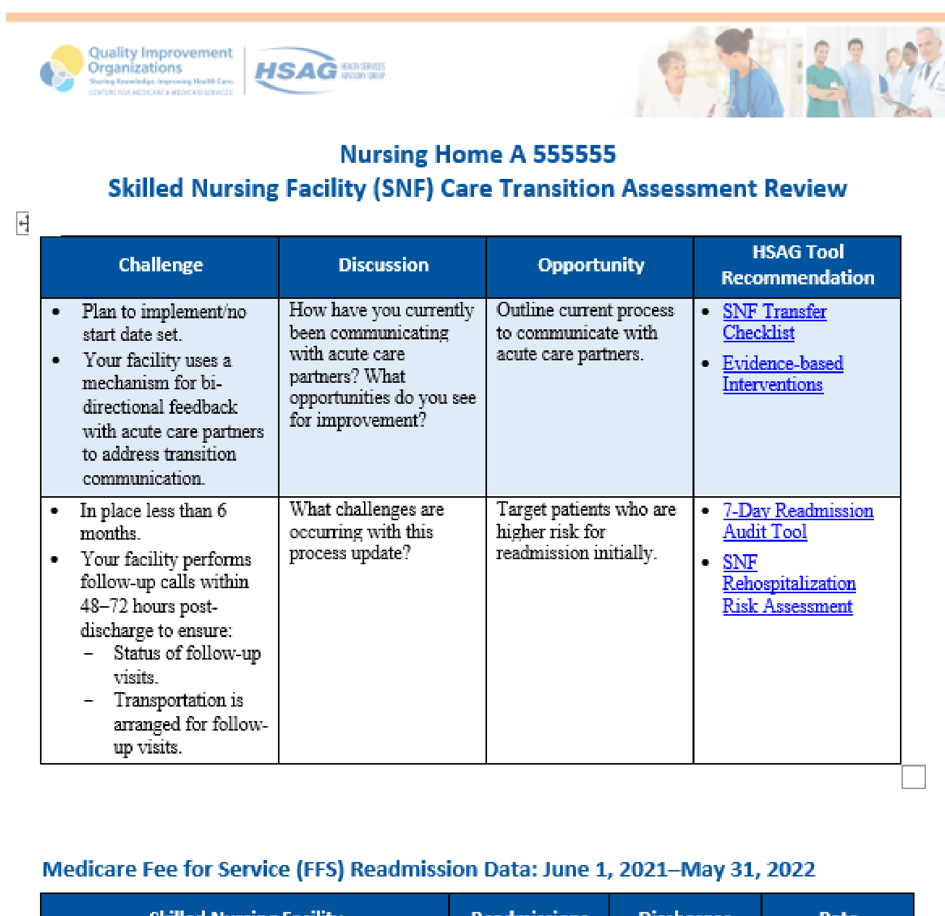
Cancel ✖ Save

B. Discharge Planning

C. Care Continuum

Care Transitions Assessment Results

HSAG will set up a 1:1 review of your assessment results and share recommended tools for implementation.



Nursing Home A 555555
Skilled Nursing Facility (SNF) Care Transition Assessment Review

Challenge	Discussion	Opportunity	HSAG Tool Recommendation
• Plan to implement/no start date set. • Your facility uses a mechanism for bi-directional feedback with acute care partners to address transition communication.	How have you currently been communicating with acute care partners? What opportunities do you see for improvement?	Outline current process to communicate with acute care partners.	• SNF Transfer Checklist • Evidence-based Interventions
• In place less than 6 months. • Your facility performs follow-up calls within 48–72 hours post-discharge to ensure: – Status of follow-up visits. – Transportation is arranged for follow-up visits.	What challenges are occurring with this process update?	Target patients who are higher risk for readmission initially.	• 7-Day Readmission Audit Tool • SNF Rehospitalization Risk Assessment

Medicare Fee for Service (FFS) Readmission Data: June 1, 2021–May 31, 2022

Skilled Nursing Facility	Readmissions	Discharges	Rate
Nursing Home A	25	99	25.2%

Hospital Care Coordination Toolkit

Hospital Care Coordination Toolkit

1 Journey to Success

2 Gap Analysis

3 Tools to Support Gap Analysis

4 Goal and Strategy Development

5 Teach-Back

6 Post-Acute Collaboratives

7 Patient Education - Zone Tools

www.hsag.com/cc-toolkit

Hospital Care Coordination Toolkit (cont.)

7-Day Readmission Chart Audit Tool

Index admission dates________through_______/Readmission dates________through_______

1. Is this readmission related to the previous admission? Y or N
2. Is this a hospital penalty related condition?
a. If yes, circle one: Acute MI / HF / PN / COPD / CABG / Elective TKA/THA*
b. If no, is readmission reason listed as a comorbid condition on the index admission? Y or N
3. What is the admission source (circle one)? Home / home health agency (HHA) / skilled nursing facility (SNF) / hospice / long-term acute care / inpatient psychiatric / inpatient rehabilitation
4. How many days between discharge and readmission (circle one)? 0–1, 2–4, or 5–7
5. How many times was the patient in the hospital in the last 6 months (circle one): 0–3, 4–7, 8–11, 12+
6. How many times was the patient in the ED in the last 6 months (circle one): 0–3, 4–7, 8–11, 12+
7. Is the patient on a high-risk medication? If yes, circle one: anticoagulant / diabetic agent / opioid
8. Discharged on seven or more medications? Y or N
9. What is the reason for readmission? Check all that apply:
   - ☐ Chronic condition/exacerbation of disease process
   - ☐ Post-operative complication (wound healing, infection, sepsis)
   - ☐ Post-discharge challenges identified (lack of transport, finances, housing, medical care) but not evaluated for or linked to available resources
   - ☐ Patient/family/caregiver did not understand discharge instructions
   - ☐ Patient/family/caregiver did not obtain medications/supplies
   - ☐ Patient/family/caregiver did not agree with higher level of care recommended at previous discharge (refused HHA or SNF)
   - ☐ Discharge services arranged/made were not followed through by service provider. If checked, add service(s) arranged here: ______________________________
   - ☐ Patient left against medical advice (AMA) from previous admission
10. Did patient have a validated primary care physician (PCP) assignment at previous discharge? Y or N
    - ☐ If yes, was a follow-up appointment made with patient's PCP or specialist at previous discharge and documented in discharge instructions? Y or N
    - ☐ Did patient keep scheduled follow up appointment? Y or N
    - ☐ If no, why (circle one)? Felt better, did not show/cancelled, no transportation, financial barrier, readmitted prior to the appointment, date, or other ____
11. Did patient comply with medication orders after discharge? Y or N
    - ☐ If no, why (circle one)? No transportation, financial barriers/lack of resources, did not want to fill, filled but not taking, had something similar at home, or other________
12. To identify if other patterns or trends exist, indicate:
    a. Discharge unit _______________
    b. Hospitalist group________________Discharging physician ________________________
    c. What day of the week was the patient discharged (circle one)?
    Sun Mon Tues Wed Thurs Fri Sat
13. Was an evaluation of discharge needs documented by case management on the index admission? Y or N
14. Were there emergency room or observation visits between the index admission and readmission? Y or N

Completed by:____________Date:____________Follow-up action: ____________

* Myocardial infarction (MI), heart failure (HF), pneumonia (ON), chronic obstructive pulmonary disease (COPD), coronary artery bypass graft (CABG), total hip/total knee arthroplasty (THA/TKA)

Teach-Back

Teach-back has been proven to be one of the most successful teaching strategies associated with improving comprehension of discharge instructions. Teach-back is especially successful for patients with low health literacy. This section provides an overview the components of teach-back and tools to improve the quality of teaching.[1]

Overview of Resources

Form	Purpose	Rationale	Page
Practice Using Plain Language	This tool asks staff members to identify medical jargon commonly used and translate those terms into plain language.	Patients often do not comprehend common medical jargon. Translating these elements to plain language aids in comprehension and compliance of material.	5.1
Teach-Back Sentence Starters	This document is used by staff members as they become familiar with using the teach-back strategy.	Incorporating questions into plain language may be difficult for staff. Practicing this strategy will help hardwire the delivery.	5.2
Teach-back Flyers for Self-Training	To provide staff members with an overview of the importance of teach-back and connect them with teach-back resources.	Staff are often aware of teach-back but forget to implement it. These resources can help staff develop the habit of using teach-back in everyday practice.	5.3
Reminder to Use Teach-Back Posters	To provide staff with reminders to always use teach-back.	Teach-back is changing the way providers check for understanding and requires practice and reminders to foster new skill development.	5.4
Teach-Back Training Flyer Template	To promote and create awareness of teach-back training available for staff.	Using the train-the-trainer approach teaches staff to use teach-back and makes teach-back more familiar to everyone.	5.5
Teach-Back Methodology for Patient Education: Employee Competency Validation Checklist	This template may be used as a validation tool when implementing teach-back within an organization.	Ensuring each staff member preforms teach-back appropriately is essential.	5.6

Practice Experiences:
"I decided to do teach-back on five patients. With one mother and her child, I concluded the visit by saying, 'So tell me what you are going to do when you get home?' She could not tell me what instructions I had just given her. I explained the instructions again and then she was able to teach them back to me. I had no idea she did not understand—I was so wrapped up in delivering the message that I did not realize it wasn't being received."

Find more teach-back resources and information at: www.hsag.com/teach-back

Hospital Care Coordination Toolkit (cont.)

Gap/Root Cause Analysis (RCA) Sample

Before completing this form, complete the Care Transitions Assessment. Identify one of the gap assessment items where the facility's response was either: (1) not implemented/no plan, (2) plan to implement/no start date set, or (3) plan to Implement/start date set. Use this gap/RCA form to get a better understanding of what factors are contributing to the gap and what steps can be taken for improvement.

Organization:	
Team Lead:	
Team Members:	
Assessment Item/Area of Focus: (refer to Care Transitions assessment)	Facility manages super-utilizers (four admissions in one year or six emergency department visits within one year) using a customized case management approach that individualizes patient-centered care coordination plans

Component	Sample Activities Completed	Sample Key Findings
Data: What data specific to this gap area is available to help guide and measure this work? Supportive tools: • 7-Day Audit Chart Tool • 5 Whys • HSAG Data Report	Examples: • Analyzed HSAG's hospital specific readmission report. • Analyzed data in HSAG's QIIP dashboard. • Analyzed internal report of hospital readmissions and emergency room visits. • Reviewed data from medical records for super-utilizers in the last month.	• HSAG's report shows super-utilizers (SUs) account for 23% of admissions, 17% of emergency department (ED) visits, and 20% of observations stays. • 75% of SUs were identified as high-risk for readmissions. • 36% of SUs did not have a physician follow-up visit documented/scheduled before discharge. • 82% of SUs are prescribed take 13 or more medications. • 68% of SU medical records indicated they were not visited by a pharmacist while being treated at the facility. • 79% of SUs did not have a caregiver that lived with them. • 59% has no personal way to get home and needed transportation arranged for them.
Observational work: Evaluate the current processes related to patient transitions. Supportive tools: • 5 Whys	• Observed the in-patient discharge process for 10 patients identified as high-risk. • Observed the emergency-department discharge process for 10 patients.	• Patient education on diagnosis, treatment plan, new prescriptions, and signs and symptoms to watch out for was conducted in 15 or less minutes and during the last hour that the patient was hospitalized. • 40% of the 20 observations did not incorporate Teach-Back and instead said, "Do you have any questions for me?" • Only one of the 20 observed discharges did the

Nursing Home Care Coordination Toolkit

Nursing Home Care Coordination Toolkit

1 Journey to Success

2 Gap Analysis

3 Tools to Support Gap Analysis

4 Preparing for Change

5 Readmission Prevention

6 Teach-Back

7 Patient Education - Zone Tools

www.hsag.com/nh-cc-toolkit

Nursing Home Care Coordination Toolkit (cont.)

Worksheet to Create a Performance Improvement Project Charter

What is a project charter? A project charter clearly establishes the goals, scope, timing, milestones, and team roles and responsibilities for an Improvement Project (PIP). The charter is typically developed by the QAPI team and then given to the team that will carry out the PIP, so that the PIP team has a clear understanding of what they are being asked to do. The charter is a valuable document because it helps a team stay focused. However, the charter does not tell the team how to complete the work; rather, it tells them what they are trying to accomplish.

Use this worksheet to define key charter components.

PROJECT OVERVIEW

Name of project:
Example: Reduction in use of position change alarms

Improving the accuracy of assessed acuity at admission to reduce readmissions

Problem to be solved:
Example: Alarms going off frequently detract from a homelike environment and may give staff a false sense of security.
Nursing home staff members are discovering some residents have a higher level of acuity than expected after they are admitted from the hospital; this creates an unexpected burden on staff members, patients, caregivers, and resources when caring for the resident.

Background leading up to the need for this project:
Example: Residents and families have complained about the sound of alarms going off frequently. Staff feel pressure to do "something" when a resident falls.
[Tip: Reference specific background documents, as needed.]
The admissions coordinator, nurses, and physicians have observed that when patients are evaluated after admission, co-morbid diseases, routine medication needs, wound care, recent infections, and antibiotic use are not completely known at the time of transfer.

The goal(s) for this project:
Example: Decrease the percentage of residents with position change alarms used on XX unit by 25% by XX/XX/XX.
[Tip: See Goal Setting Worksheet]
Increase the completeness and accuracy of communication related to patients' clinical condition and care needs at transfer to ≥ 80 percent using a standardized tool (Skilled Nursing Facility [SNF] Transfer Checklist) by 12/31/22.

Scope—the boundary that tells where the project begins and ends.
The project scope **includes:**
Example: Use of position change alarms on XX unit.
The scope includes all patients transferred from one unit at Best Hospital Medical Center for skilled nursing care between 9/1, and 12/31.

PROJECT APPROACH

Recommended Project Time Table:

PROJECT PHASE	START DATE	END DATE
Initiation: Project charter developed and approved	10/2	10/4
Planning: Specific tasks and processes to achieve goals defined	10/7	10/18
Implementation: Project carried out	10/21	10/31
Monitoring: Project progress observed and results documented	10/21	10/31
Closing: Project brought to a close and summary report written	11/3	11/14

Project Team and Responsibilities:

TITLE	ROLE	PERSON ASSIGNED
Project Sponsor	Provide overall direction and oversee financing for the project	Joe Jones, NHA
Project Director	Coordinate, organize and direct all activities of the project team	Fred Kline, MD, Medical Director
Project Manager	Manage day-to-day project operations, including collecting and displaying data from the project	Sally Bailey, Admission Coordinator
Team members*	Carry out specific tasks based on action planning	Director of nursing (DON), discharge planner/case manager, nurse practitioner, staff nurse
Hospital team		Discharge team, Chief Medical Officer (CMO), case managers, nursing director of unit, care coordination staff members, unit hospitalist

*Choice of team members will likely be deferred to the project manager based on interest, involvement in the process, and availability.

Material Resources Required for the Project (e.g., equipment, software, supplies):

- Health Services Advisory Group (HSAG) SNF Transfer Checklist
- HSAG Nursing Home Readmissions Report
- Quarterly Certification and Survey Provider Enhanced Reports (CASPER) Confidential Feedback Report
- SNF 30-Day All-Cause Readmission Measure (SNF-RM) Baseline and Performance Period Rates
- Curaspan Referral Documentation Application
- Computer access and spreadsheet to track progress
- Hospital and Nursing Home Communication Log

Nursing Home Care Coordination Toolkit (cont.)

Gap/Root Cause Analysis (RCA) Sample

Before completing this form, complete the Care Transitions Assessment. Identify one of the gap assessment items where the facility's response was either: (1) not implemented/no plan, (2) plan to implement/no start date set, or (3) plan to Implement/start date set. Use this gap/RCA form to get a better understanding of what factors are contributing to the gap and what steps can be taken for improvement.

Organization:	
Team Lead:	
Team Members:	
Assessment Item/Area of Focus: (refer to Care Transitions Assessment)	Your facility provides focused case management for residents at high risk for readmissions to coordinate care addressing: a) Ability to pay for medications b) Scheduling of physician follow-up visits c) Transportation to follow-up visits d) Availability of family/friends to assist resident at time of discharge

Component	Sample Activities Completed	Sample Key Findings
Data: What data specific to this gap area is available to help guide and measure this work? Supportive tools: • 7-Day Audit Chart Tool • 5 Whys • HSAG Data Report	Examples: • Analyzed HSAG's readmission report. • Analyzed data in HSAG's QIIP dashboard. • Analyzed internal report of readmissions. • Reviewed data from medical records for readmissions in the last month.	• HSAG's report shows 30% of readmissions were patients on high-risk medications. • 75% were identified as high-risk for readmissions. • 36% did not have a physician follow-up visit documented/scheduled before discharge. • 82% are prescribed take 13 or more medications • 68% of medical records indicated they were not asked about ability to pay for medications. • 79% did not have a caregiver that lived with them. • 59% has no personal way to get home and needed transportation arranged for them.
Observational work: Evaluate the current processes related to patient transitions. Supportive tools: • 5 Whys	• Observed the patient discharge process for 10 residents identified as high-risk.	• Resident education on diagnosis, treatment plan, new prescriptions, and signs and symptoms to watch out for was conducted in 15 or less minutes and during the last hour that the resident was in the facility. • 40% of the 10 observations did not incorporate teach-back and instead said, "Do you have any questions for me?" • Only one of the 10 observed discharges did the nurse ask if they had the money or

The 5 Whys Worksheet Sample

The 5 Whys tool aids in the identification of the root cause of a problem. Begin by identifying a specific problem and ask why this is occurring. Continue to ask "Why?" to identify causes until the underlying cause is determined. Each "Why?" should build from the previous answer. There is nothing magical about the number five; sometimes a root cause may be reached after asking "Why?" just a few times; other times deeper questioning is needed.

Steps

1. Define a problem; be specific.
2. Ask why this problem occurs and list the reasons in Box 1.
3. Select one of the reasons from Box 1 and ask, "Why does this occur?" List the reasons in Box 2.
4. Continue this process of questioning until the team agrees the problem's root cause has been identified. If there are no identifiable answers or solutions, address a different reason.

Define the problem: High volume of heart failure readmissions to acute care

Why does this occur?

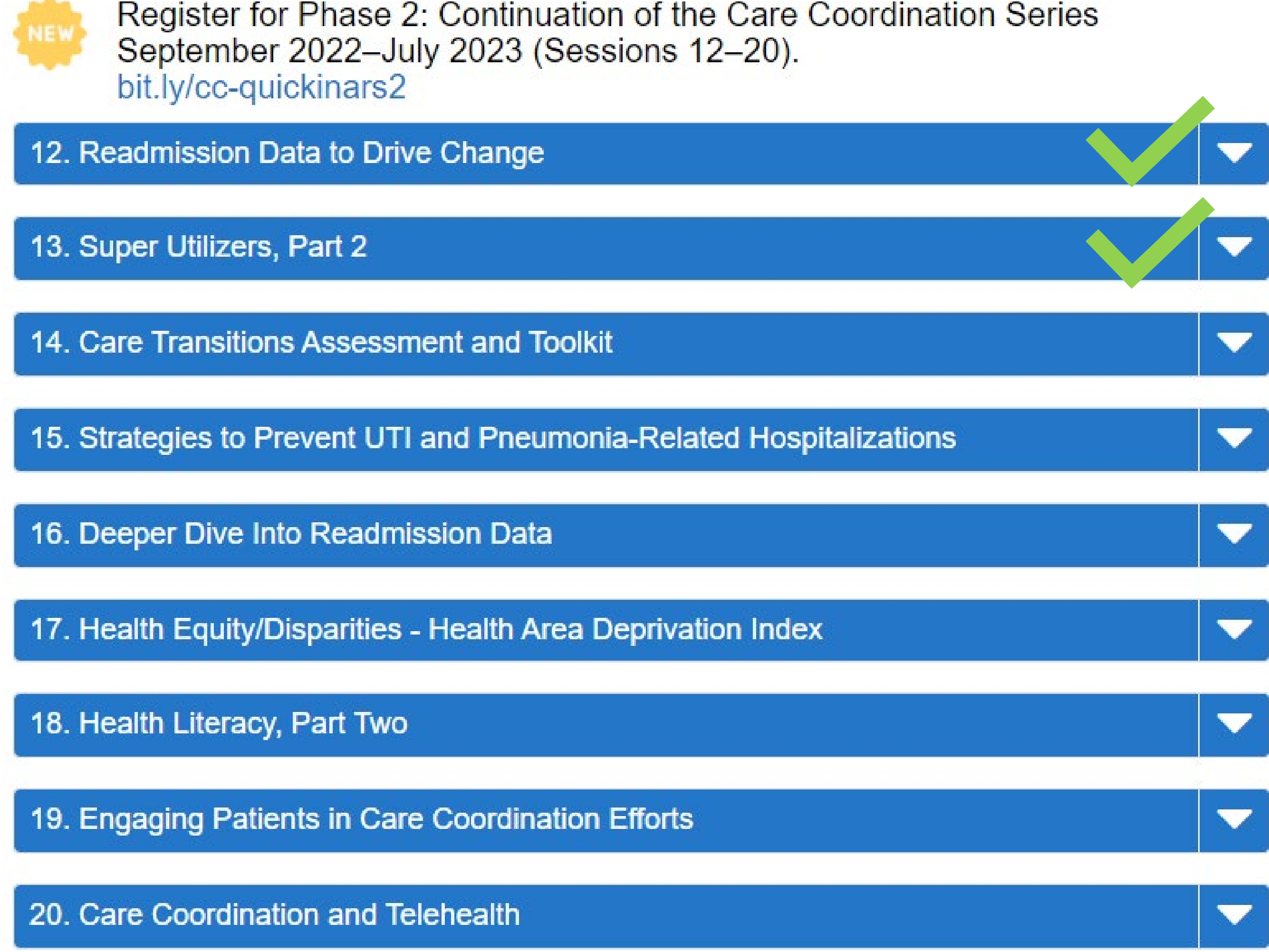
1. Residents are readmitting back to hospital within 7 days of discharge. → **Why is that?**
2. Residents with heart failure are retaining too much fluid. → **Why is that?**
3. There were delays in obtaining Lasix (furosemide) and staff were not weighing patients often enough to identify fluid retention. → **Why is that?**
4. Staff nurse is busy taking care of multiple patients and does not always have enough time to weight cardiac patients. Transferring patients to a scale is very challenging. → **Why is that?**
5. Not enough designated nursing staff available to help transfer patients to scale. → **Why is that?**

Root Causes:

1. Staff responsible for weighing residents with heart failure are being stretched too thin.
2. Medication list from acute needs to be checked for medication discrepancies to prevent delay in receiving Lasix.

To validate root causes, ask: If you removed this root cause, would this event or problem have been prevented?

Care Coordination Quickinar Series



REGISTER NOW! More info at: **www.hsag.com/cc-quickinars**

HSAG HEALTH SERVICES ADVISORY GROUP

Our Next Care Coordination Quickinar

Strategies to Prevent Urinary Tract Infection (UTI) and Pneumonia-Related Hospitalizations

Tuesday, February 7, 2023 | 11 a.m. PT

bit.ly/cc-quickinars2

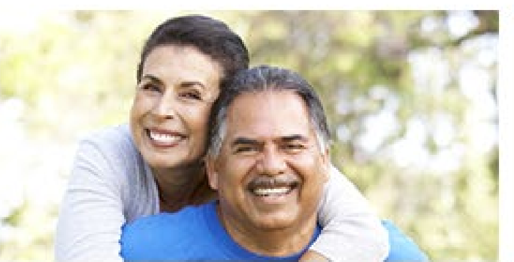
www.hsag.com/cc-quickinars

Questions?

Please Take 5 Seconds and Let Us Know

We want this call to be meaningful to you, so we need your input.

At the end of the webinar, you will be asked **one question** to determine if this call equipped your organization to begin implementing care coordination practices.



Thank you!

Lindsay Holland
818.813.2665
lholland@hsag.com

Michelle Pastrano
818.265.4648
mpastrano@hsag.com

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-01052023-01