



# SNF 2.0 INTERACT<sup>®</sup>

## Using Stop-and-Watch and SBAR

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SNF = skilled nursing facility


INTERACT = Interventions to Reduce Acute Care Transfers

SBAR = Situation Background Assessment Recommendation

CALTCM = California Association of Long Term Care Medicine



# OBJECTIVES

A close-up photograph of a person's hand, wearing a dark suit jacket and a white shirt cuff, pointing towards the text. The hand is positioned on the right side of the slide, with the index finger pointing towards the word 'OBJECTIVES'.

- Discuss SBAR and how to effectively use it in your facility.
- Distinguish how SBAR is used in the hospital and the SNF.
- Identify strategies for implementing Stop-and-Watch and SBAR at your facility.

# Quality Improvement Innovation Portal (QIIP): Assessments and Data Dashboard



Assessments	Reports	Hospital Dashboards	Nursing Home Dashboards	Interventions	Administration
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Quality Improvement Innovation Portal

For questions, please contact [QIIPsupport@hsag.com](mailto:QIIPsupport@hsag.com).

Assessments

Reports

Hospital Dashboards

Nursing Home Dashboards

Interventions



# Readmissions Summary Data



## Summary

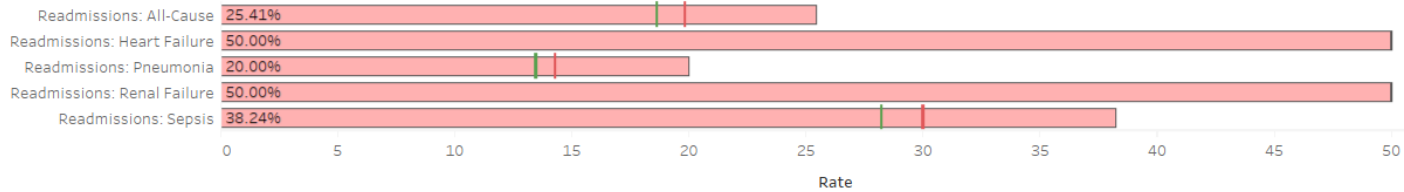


Nursing Home

Measure Category  
Readmissions

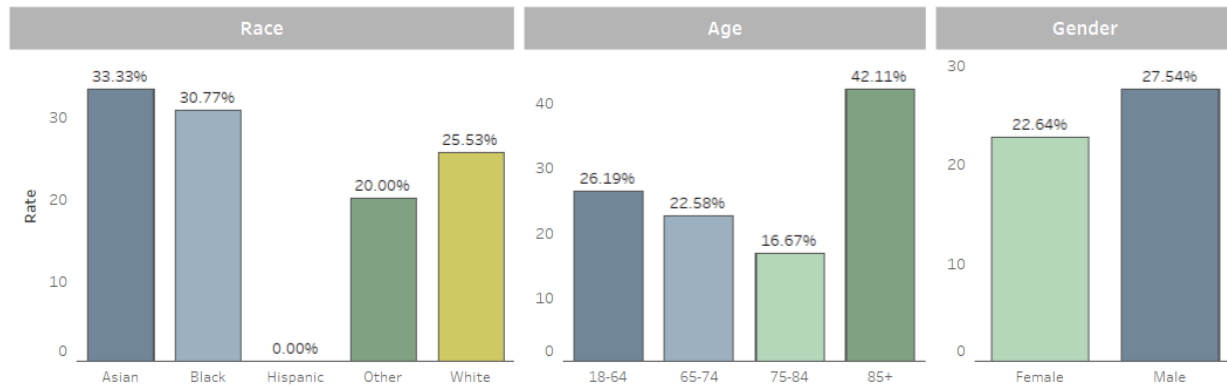
AR

### Measure Progress - CA Test Facility -111112



### Demographics

Measure  
Readmissions: All-Cause



Demographic rates shown are for the measure selected above and divided into Race, Age, and Gender demographics. If a rate is not available, no rate or bar is displayed.

# QIIP 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.

Download Assessment 

To understand the rationale and references for each question, click [here](#).

### A. Medication Management

1. Your facility has a pharmacy representative verifying the patient's pre-admission (current) medication list upon admission. <sup>i</sup>

Previous Answer as of: Not Answered

Not implemented/no plan <input type="radio"/>	Plan to implement/no start date set <input type="radio"/>	Plan to implement/start date set <input type="radio"/>	In place less than 6 months <input type="radio"/>	In place 6 months or more <input type="radio"/>
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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. <sup>ii</sup>

Previous Answer as of: Not Answered

Not implemented/no plan <input type="radio"/>	Plan to implement/no start date set <input type="radio"/>	Plan to implement/start date set <input type="radio"/>	In place less than 6 months <input type="radio"/>	In place 6 months or more <input type="radio"/>
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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). <sup>iii</sup>

Previous Answer as of: Not Answered

Not implemented/no plan <input type="radio"/>	Plan to implement/no start date set <input type="radio"/>	Plan to implement/start date set <input type="radio"/>	In place less than 6 months <input type="radio"/>	In place 6 months or more <input type="radio"/>
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### B. Discharge Planning

### C. Care Continuum



# Care Coordination Toolkit

## 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



Care Coordination Quickinars

## Care Coordination Resources

- Medication Management
- Health Equity
- Patient Engagement
- Care Coordination Collaboration
- Quality Improvement Tools
- Care Coordination Evidence-Based Models

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



# Presenter

Albert H. Lam, MD  
CALTCM Immediate Past President  
Medical Director, Geriatric Medicine  
Palo Alto Foundation Medical Group

# Our Next Care Coordination Quickinar

## Sepsis Readmission Prevention

Tuesday, September 5, 2023 | 11 a.m. PT

[bit.ly/cc-quickinars3](https://bit.ly/cc-quickinars3)





# Care Coordination Quickinar Series



Register for Phase 3: Continuation of the Care Coordination Series  
August 2023–May 2024 (Sessions 21–28).  
[bit.ly/cc-quickinars3](https://bit.ly/cc-quickinars3)

21. SNF 2.0 INTERACT, Using Stop and Watch, and SBAR



22. Sepsis Readmission Prevention



23. Preventing Pneumonia Readmissions



24. Preventing UTI Readmissions



25. Readmission Incentive and Penalty Programs, HRRP, WQIP, VBP



26. Readmissions Performance Improvement Project (PIP)



27. Readmissions and End-of-Life



28. Readmissions and Post-Discharge Follow Up



# Questions?





# Thank you!

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