# Staying Put!

## Strategies to Reduce Avoidable Hospital Transfers from Nursing Homes

### Why is this important?

Unplanned hospital readmissions and emergency department (ED) visits from nursing homes pose a significant challenge in healthcare. Reducing 30-day unplanned readmissions to the hospital and minimizing unnecessary ED visits are key priorities for the Centers for Medicare & Medicaid Services (CMS), which is demonstrated by initiatives such as the Hospital Readmission Reduction Program (HRRP). Hospital readmissions not only serve as a key indicator for quality of care but also contribute substantially to Medicare costs, which are estimated at $52 billion annually (AHRQ, 2018). Approximately one in four residents who are discharged to a nursing home from a hospital will be readmitted to the hospital within 30 days.

Unplanned transfers frequently reveal gaps in care or signal a need for better processes and resident management. To reduce hospital transfers from nursing homes, it is essential to implement proactive care, enhance care coordination, and address the underlying health conditions that commonly result in hospitalizations.

This resource package offers an overview of the factors contributing to hospital transfers along with evidence-based, data-driven strategies for improving nursing home practices. These strategies aim to enhance the quality of care while minimizing unplanned hospital readmissions and ED visits.

**Data**

**Interventions**

**Quality Improvement**

## Data

To effectively manage hospital readmissions in the nursing home, an essential first step is to gather accurate and comprehensive data. Managing, analyzing and interpreting hospital transfer data requires a systematic and organized approach to identify patterns and take meaningful actions that lead to improved healthcare practices. Additionally, it's important to connect various pieces of information to understand a nursing home's quality baseline, goals and capabilities. A facility's Quality Assurance (QA) Plan should outline a strategy for data collection.

Setting performance benchmarks is a crucial aspect of using data effectively. Since each facility is unique, the most important benchmarks are often based on your own performance. To better understand hospital readmissions, track these key metrics (this list is not all-inclusive):

- 30-day readmission rate: The percentage of patients who are readmitted to the hospital for an impatient stay within 30 days of their admission to a skilled nursing facility.
- Primary diagnoses for readmission: Some common causes for readmission may include heart failure, infections, or complications from surgery.
- Length of stay before readmission: The average time a patient spends in the nursing home before returning to the hospital.
- Preventable readmissions: Identifying which cases could have been avoided with proper care.
- Readmission by care transition quality: Correlating readmission rates with the quality of discharge instructions and follow-up care.
- Primary physician: Which physician ordered the resident's transfer to the hospital?
- Day of the week: Which day of the week did the transfer occur?
- Shift: Which shift did the transfer occur?

Using data visualization tools is important for helping the nursing home team and stakeholders make sense of data. Visuals can help to create a narrative and highlight key information. Common visuals might include:

- Readmission trends over time: Line charts showing changes in 30-day readmission rates.
- Readmission rates by diagnosis, demographic group, day of the week, etc.: Bar charts breaking down rates by key categories.

### Resources

- Telligen's Audit Tracking Tool Workbook
- Pathway INTERACT® – Training, Tools, Licensing and Resources
  - INTERACT Hospital Rate Tracking Tool
  - INTERACT Acute Care Transfer Log

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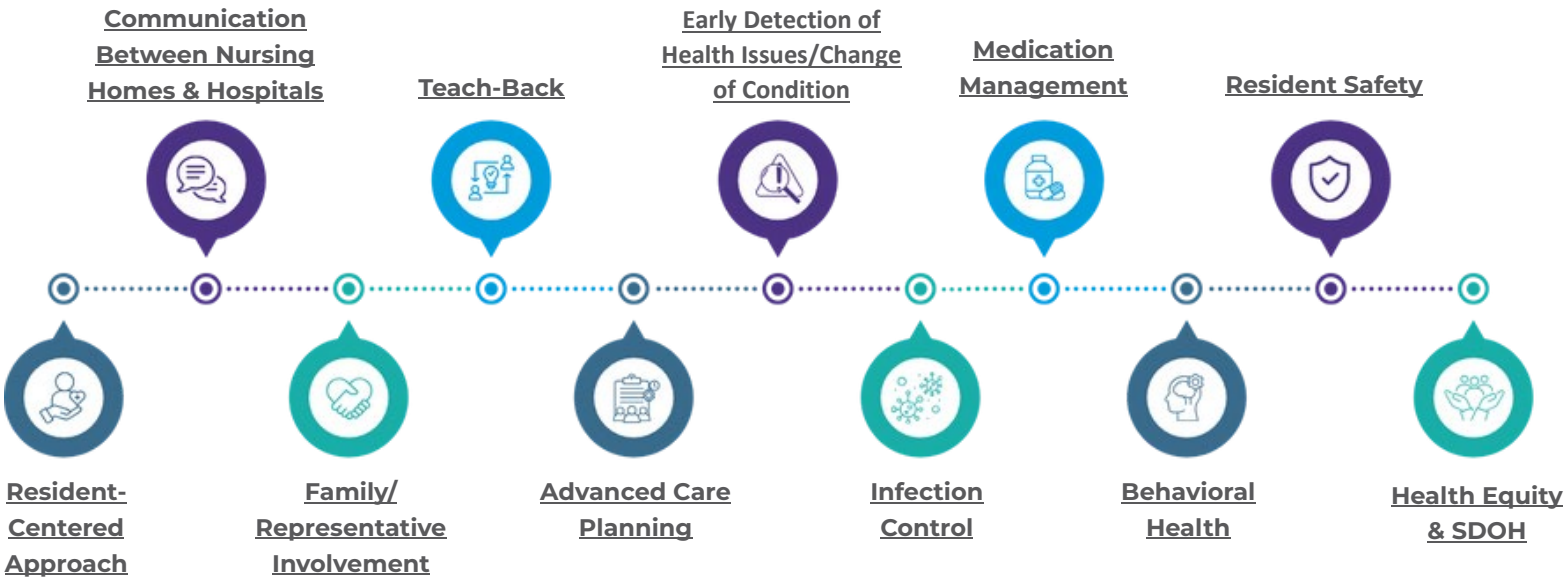
## Interventions

To effectively implement interventions to reduce or prevent hospital transfers, a resident-centered approach must prioritize clear communication between nursing homes and hospitals. Involving family members and/or representatives ensures that care aligns with the resident's wishes, while techniques such as the teach-back method enhance understanding of healthcare plans and goals. Advanced care planning plays a crucial role in reducing readmissions, allowing for proactive measures such as early detection of health issues and changes in condition. Vaccinations and comprehensive medication management further contribute to patient safety, particularly in managing behavioral health. Additionally, addressing health equity and social drivers of health (SDOH) is vital, necessitating robust staff training to foster a holistic understanding of each resident's unique needs. Together, these strategies create a supportive environment that minimizes unnecessary hospital transfers.

Facilities should have a robust onboarding and ongoing staff training program where education is offered for all interventions included in this resource packet to reduce unplanned transfers.




**Resident-Centered Approach**

- Person-Centered Care | CMS
- Vision, Mission & Values | Pioneer Network
- A Guide to Addressing Resident Goals | Moving Forward Coalition
- The Four Core Functions of Primary Care | PubMed
- Person-Centered Care in Nursing Homes and Assisted Living | Alzheimer's Association
- How and Why to Learn the Resident's Story | American Association of Post-Acute Care Nursing

**Communication Between Nursing Homes & Hospitals**

- Conduct regular meetings with referring hospitals
- Use Telligen's Unplanned Transfer Assessment
- Transitional Care Management Services | CMS Medicare Learning Network
- Facilitate a structured transition conversation from hospital to nursing home including six consistent questions: Circle Back | Health Quality Innovation Network
- Create a nursing home capability of services list
    - Pathway INTERACT® – Training, Tools, Licensing and Resources
- Foster infection control communication between providers
    - Inter-Facility Infection Control Transfer Form | CDC

**Family/Representative Involvement**

- My Care Plan: A Guide for Residents, Families and Care Partners | Alliant Health Solutions
- Decision Guide for Patients and Families – Go to the Hospital or Stay Here? | HHS
- The SHARE Approach | AHRQ

**Teach-Back**

- Teach-Back: Intervention | AHRQ

**Advanced Care Planning**

- Pathway INTERACT® – Training, Tools, Licensing and Resources
  - Advanced Care Planning Communication Guide
  - Advanced Care Planning Tracking Tool
- What is Palliative Care and Hospice Care | National Institute of Aging
- Have You Had the Conversation? | The Conversation Project, IHI

**Early Detection of Health Issues/Change of Condition**

- Pathway INTERACT® – Training, Tools, Licensing and Resources
  - STOP AND WATCH Early Recognition tools
  - Change in Condition File Cards
  - Change in Condition Care Paths
- Review and/or customize the EMR system for reports and alerts
- Internally assess the resident for factors that place them at high-risk for hospitalization

**Infection Control**

- Implement processes for identification and management of infections that are leading causes of readmission: sepsis, urinary tract infection, COVID-19 and pneumonia
  - Pathway INTERACT® – Training, Tools, Licensing and Resources
    - Care Path: Symptoms of UTI
    - Care Path: Symptoms of Lower Respiratory Illness
    - Guidance on Possible Sepsis
    - Guidance on Possible Infection
- Outpatient Dialysis Provider Fact Sheet | CDC
- Adult Vaccine Toolkit | Telligen
- Vax Hub | Telligen

**Medication Management**

- Medications at Transitions and Clinical Handoffs (MATCH) Toolkit for Medication Reconciliation | AHRQ
- High-Risk Medication ECHO® Series | Telligen
- Anticoagulant ECHO® Series | Telligen
- Preventing Adverse Drug Events (ADEs) Related to High-Risk Medications in Long-Term Care | Telligen

**Behavioral Health**

- The Center of Excellence for Behavioral Health in Nursing Facilities
- Substance Use Disorder (SUD) Resources | American Association of Post-Acute Care Nursing
- Substance Abuse and Mental Health Services Administration (SAMHSA)
- Implementing Trauma-Informed Care: A Guidebook | Center for Health Care Strategies

**Resident Safety**

- Pathway INTERACT® – Training, Tools, Licensing and Resources
  - Fall Care Path
- Falls Tracker Tool | Telligen
- Falls Management A Quality Improvement Initiative for Nursing Facilities | AHRQ

**Health Equity & Social Drivers of Health (SDOH)**

- Health Equity | Telligen
- Guide for Reducing Disparities in Readmissions | CMS Office of Minority Health

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## Quality Improvement – Quality Assurance and Performance Improvement

Quality Assurance and Performance Improvement (QAPI) is a systematic, comprehensive, data-driven, proactive approach to performance management and improvement. It combines two complementary strategies for quality management: quality assurance (QA) and performance improvement (PI). QA focuses on meeting quality standards and ensuring that care reaches an acceptable level. It is typically a reactive, retrospective process aimed at identifying why a facility may have failed to meet specific standards. PI (also known as Quality Improvement or QI) takes a proactive and continuous approach to studying processes. The goal is to prevent or reduce the likelihood of finding issues within the facility by identifying opportunities for improvement and testing new strategies to address the root causes of persistent or systemic problems.

An effective QAPI program fosters a self-sustaining culture of improvement, enhancing both safety and quality. It encourages the active participation of all nursing home staff in practical and creative problem solving. By embedding the QAPI principles into the day-to-day operations of delivering quality care and services, facilities can achieve and sustain improvements in outcomes.

- Quality Improvement Workbook | Telligen
- Quality Improvement Process Steps and Tools | Telligen
- RCA and QA tools
  - When to Use Root Cause Analysis | Telligen
  - Five Whys Worksheet | Telligen
  - Fishbone Diagram Worksheet | Telligen
  - PDSA Worksheet | Telligen
  - PDSA Pathway Guide | Telligen
  - Additional tools can be found on Telligen's Infection Prevention and Control resource page
- QAPI at a Glance | CMS
- Storyboard Guide for PIPs | CMS
- Pathway INTERACT® – Training, Tools, Licensing and Resources
  - Hospitalization Rate Tracking Tool
  - Acute Care Transfer Log – Worksheet