Collaborative Approach to Manage Hospital-to-Nursing Home Transitions

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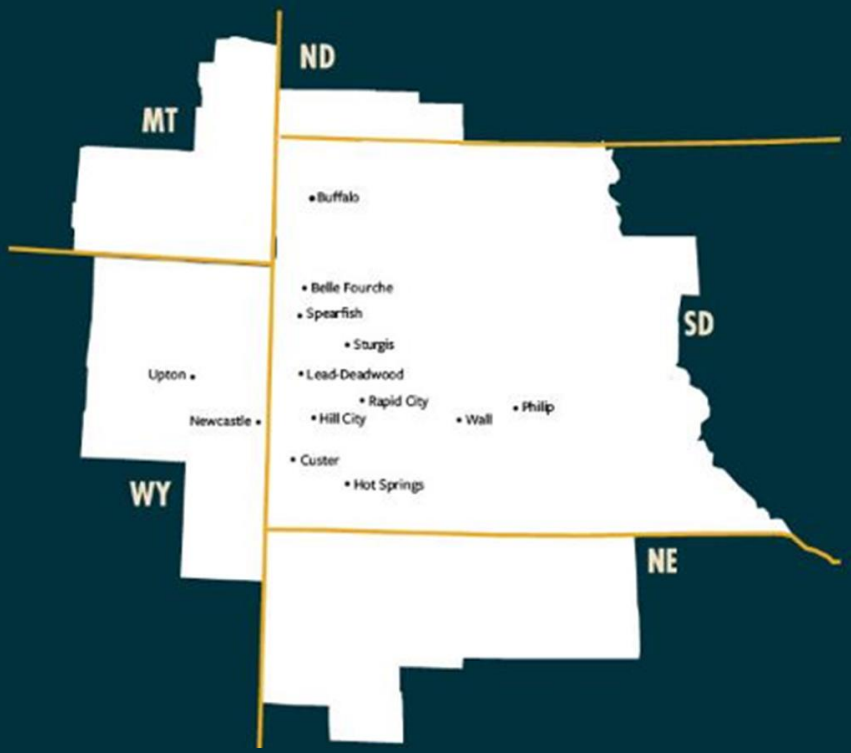
Senior Director Case Management

MONUMENT HEALTH



LARGEST HEALTH CARE SYSTEM IN WESTERN SOUTH DAKOTA

5 hospitals | 2 managed hospitals

24 clinic locations

1 assisted living facility | 2 care centers

6 urgent cares

8 specialty treatment centers:
John T. Vucurevich Cancer Care Institute,
Heart & Vascular Institute, Rehabilitation Institutes (2)
Behavioral Health Center, Dialysis Centers (2)
Surgery Center, Orthopedic and Specialty Hospital

MONUMENT HEALTH

MONUMENT HEALTH

MONUMENT HEALTH

VISION

It starts with heart.

Our vision is to be one team, to listen, to be inclusive, and to show we care.
To do the right thing. Every time.

VALUES

Trust
Respect
Compassion
Community
Excellence

PRIORITIES

Deliver high-quality care
Provide a caring experience
Be a great place to work
Impact our communities
Be here for generations to come

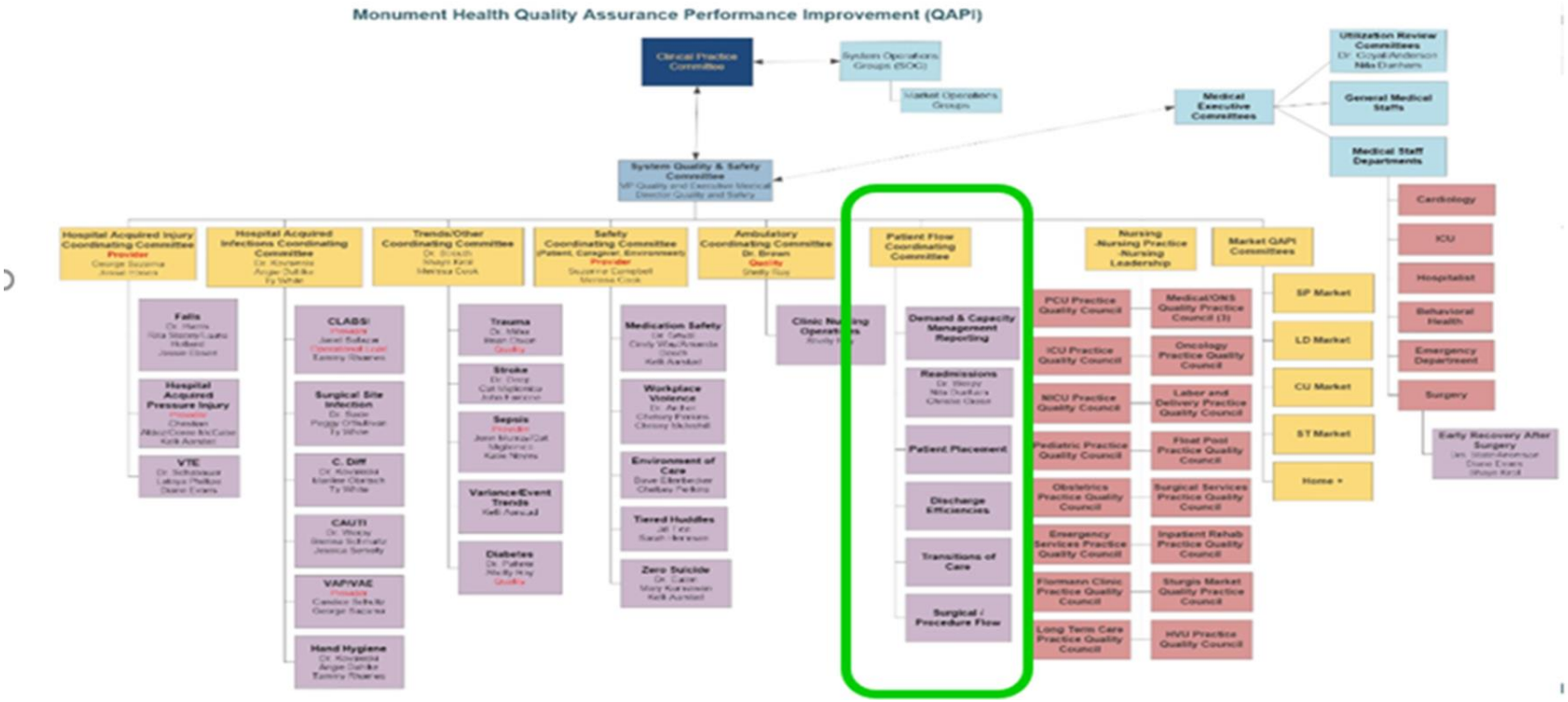
MISSION

Make a difference. Every day.

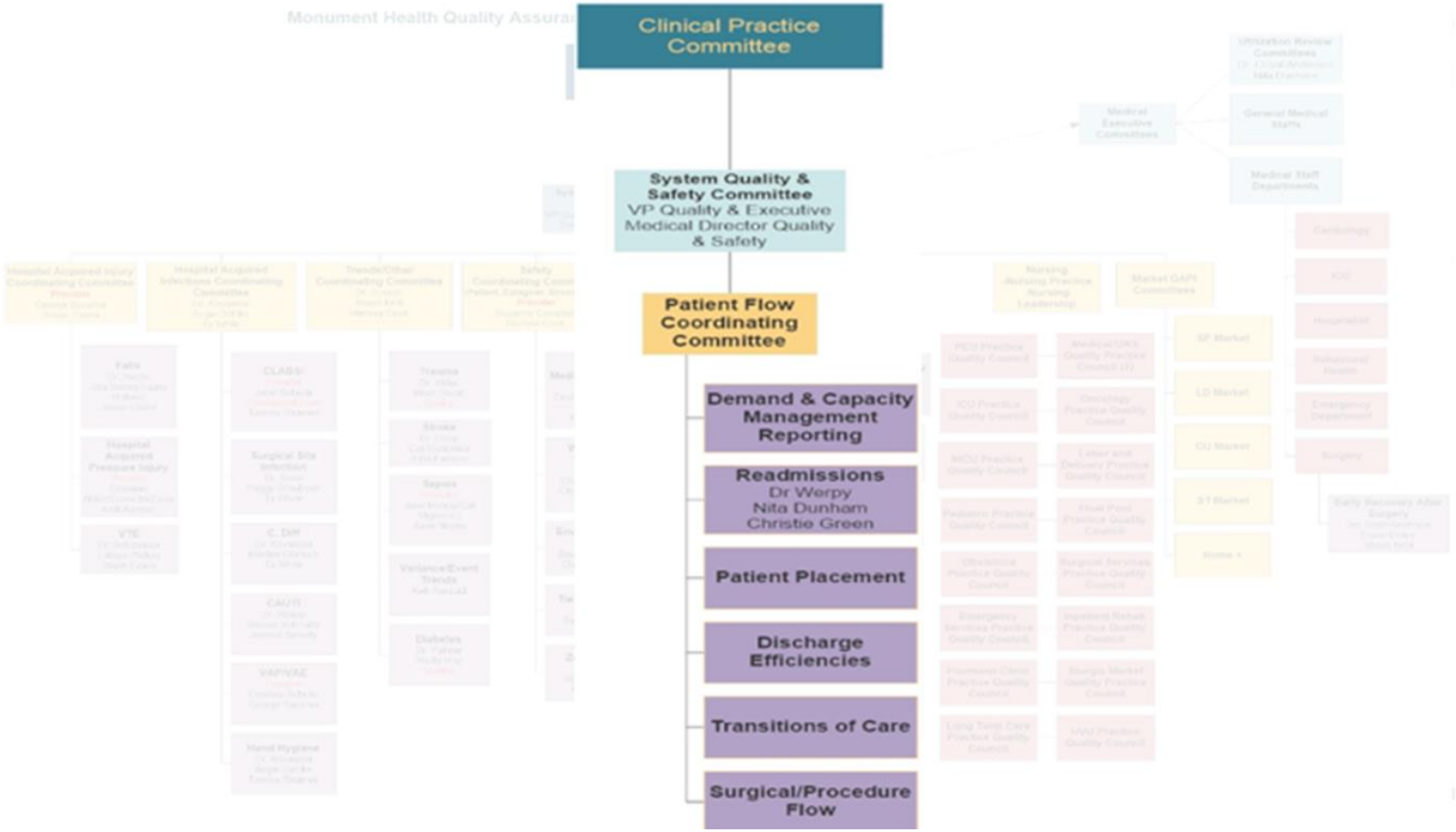
Learning Objectives

1. Review the processes for creating the Geriatric Forum Collaborative and integrating improvement strategies.
2. Discuss regulatory requirements that impact transitions in care, including formalized Nursing Home Transfer Agreement.
3. Describe standardized workflows and the sustainability plan for continued success.

Quality Assurance Performance Improvement (QAPI)



QAPI - Patient Flow Structure



Opportunities and Charter Development

Problem / Opportunity Statement:

Lack of consistent workflows, expectations and understanding of regulatory requirements between hospital and Nursing Homes, leads to inefficiencies, communication issues, safety concerns and delays in transitions in care.

Top Challenges

Multiple inefficacies that contribute to concerns about patient safety and impacts caregiver / provider satisfaction with the current process.

Black Hills Geriatric Collaborative Team

- Performance Management
- EMR colleagues
- Nursing Leadership
- Case Management
- Geriatric Nursing Home Providers
- LTC Directors of Nursing
- Hospitalist Leadership
- Ad Hoc: Pharmacy, Wound Care,
- Therapy, Medical Equipment

Committee Objectives Goals:

Areas of focus:

- Discharge Orders
- Ancillary Services
- Case Management Workflows
- Medications
- Nursing Home expectations
- Provider expectations
- Nursing contributions
- EMR functionality

Projects Identified - Orders

Standardized Admission Orders for LTC

- All Nursing Homes had different admission Orders
- Providers didn't know what to do

Optimized Discharge Orders for SNF discharges

- Created Nursing Home specific discharge order set

Community Based Projects

- **Pharmacy:**
  - Home medication
  - Diagnosis expectations

- **Nursing Home expectations:**
  - Referral/Response expectations
  - Nice to have vs Have to have

- **Geriatric provider workflows & expectations:**
  - FAQs
  - Nice to have vs Have to have
  - Hospice Orders workflows / order completion

Case Management Focused Projects

Discharge Timeout Checklist

Expectations between LTC and Case Management

Expectations around Covid

Improved Case Management Workflows

Funding for Post Acute Care

Projects Identified con't

Therapy Progression:

- Prior Level of Functioning
- Capacity for continued progress

Wound Care:

- Instructions / Recommendations for post acute care treatment

Nursing:

- Nurse to Nurse report
- Patient prepared for transportation
- Behavioral documentation
- Telemonitoring

Regulatory Compliance

- Hospital Regulatory Requirement
- Nursing Home: F843 Transfer Agreements
- Resident Rights & Protection
- Monument Health Transfer Agreement

Hospital Regulatory Requirement

§ 482.43 Condition of participation: Discharge planning

The hospital must have an effective discharge planning process that focuses on:

- Patient's goals and treatment preferences
- Includes the patient and his or her caregivers/support person(s)
- Be consistent with the patient's goals for care and
- Reduce the factors leading to preventable readmissions.

Nursing Home – F843 Transfer Agreements

Nursing homes must have in effect a written transfer agreement with one or more Medicare/Medicaid-certified hospitals in their geographic area.

The agreement has to provide:

- Reasonable assurance that the nursing home's residents will be transferred to the hospital and
- Ensured a timely admission when the attending physician has determined it is medically appropriate.

Resident Rights & Protection

Protection Against Unfair Transfer or Discharge:

Except in emergencies, nursing homes **must give** a 30-day written notice of their plan and reason to discharge or transfer.

Must also include:

- The proposed effective date
- The location of discharge (must be specific, appropriate, available and agreeable to admit)
- Appeal rights and administrative hearing option

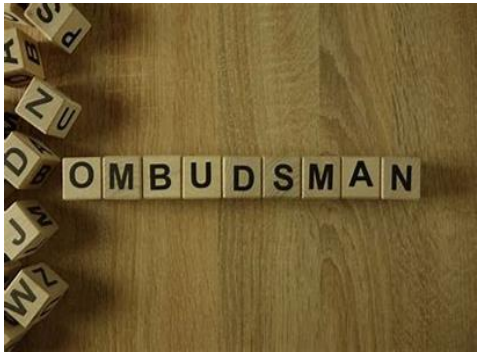
Nursing Home Discharge Rights

- **Discharges are the #1 complaint received by Long-Term Care Ombudsman Programs across the nation.**

- Individuals have the right to return to the facility following hospitalization, including the right to return to their bed or first available bed.

- Being admitted to the hospital does not relieve the facility of the responsibility of following the discharge requirements.

http://theconsumervoice.org/get_help



Monument Health Transfer Agreement

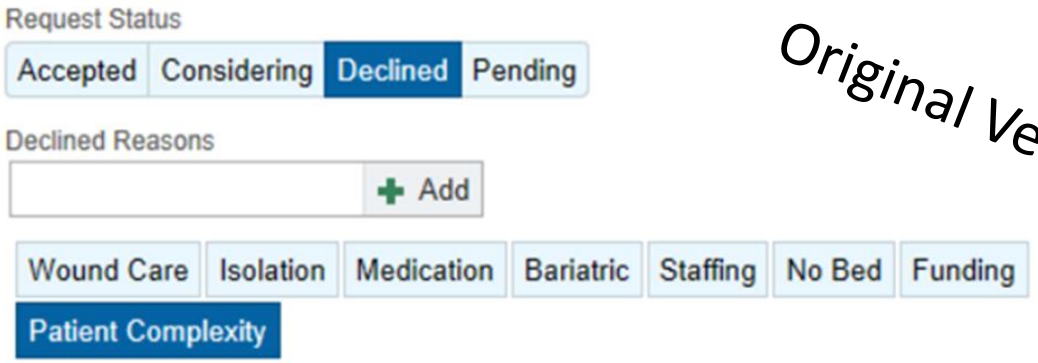
- Nursing Home agrees to accept the return admission of the patient within 24 hours if/when the hospital physician has deemed the patient no longer needs the specialized capabilities of the hospital, regardless of the status of bed hold, ability to pay and intended duration of stay.

Standardize & Sustain

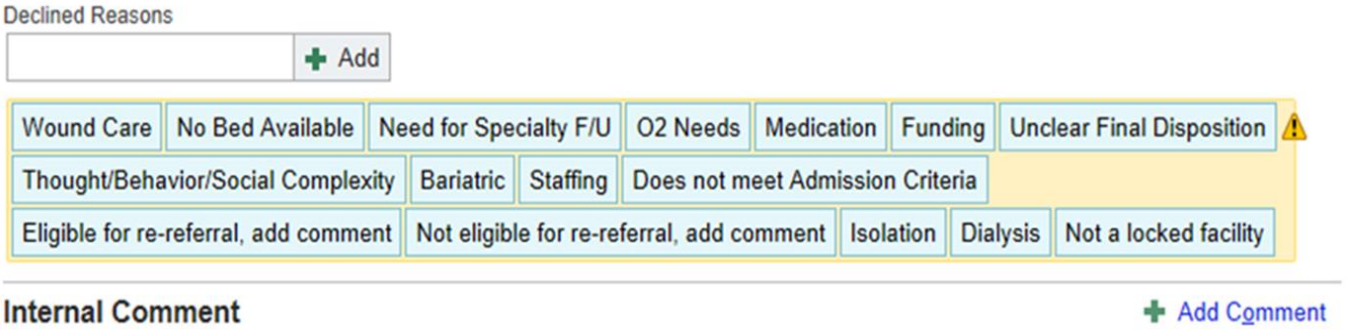
- Referral Denial Reasons
- Provider to Provider Handoff
- Discharge Timeout Checklist / Variance Tool
- Sustainability Plan

Referral Denial Responses

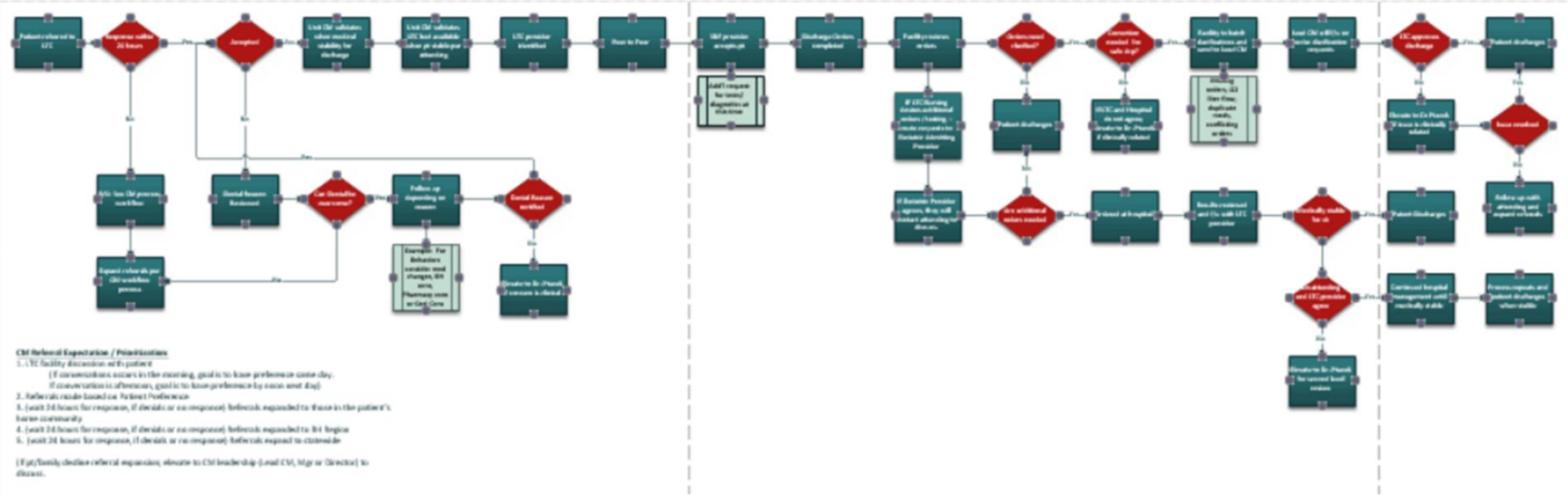
Original Version



Updated Version



Provider to Provider Handoff



Discharge Timeout & Variance

The Case Manager will arrive 15 minutes prior to discharge to initiate the timeout procedure.

Receiving facility name: _____ Phone number for report: _____
Does the facility have access to Epic? ☐ Yes ☐ No .
Transfer date: _____ Time: _____ Mode of transportation: _____
Oxygen for transport? ☐ Yes ☐ No Nurse to send oxygen with patient? ☐ Yes ☐ No
Case Manager Name PRINT: _____ Phone number: _____ Disposition code: _____

Nursing / PCC Tasks	Print Name	Notes
Verify initiate discharge order placed in Epic (PCC)		
Notify Case Manager of order (PCC)		
Follow-up appointment scheduled with specialty providers (PCC)		
Report called to facility (Nurse) - must be called prior to the patient leaving		
RED Packet-Facility Information		
Implantable device card included in red packet		(example: PICC line card)
EPIC In-Patient After Visit Summary		
Case Manager Tasks	**Print Name**	**Notes**
Covid Testing (if requested/applicable)		
Order(s) for Occupational Therapy		
Order(s) for Physical Therapy		
Order(s) for Wound Care		
Order(s) for Speech Therapy		
Order(s) for Activity		
Order(s) for Weight Bearing Status		
Order(s) for Oxygen		
Order(s) for Diet		
Discharge with Transfer Order(s) - faxed to facility		
Pre-Admission Screening and Resident Review (PASRR) completed and copy included in red packet		
Paper Rx for controlled substances for new and home medications. (applies to nursing homes only)		
Quantity / Diagnosis included in Rx		
Verification of Important Message from Medicare (IMM) completed		
Verification of Provider to Provider hand-off		

PATIENT TRANSFER VARIANCE
Fax to (605) 755-7707
Route to Nurse Manager of Care Management
(Revised 9/1//2020)

Patient Information:
Account Number: _____
Medical Record Number: _____
Date Admitted to SNF: _____

Description of issue:

- Missing orders: _____
- Follow up appt/diagnostics: _____
- Order clarification: _____
- Patient/family feedback: _____
- Pharmacy issues:
  - Medications _____
  - Prescriptions _____
- Other: _____

Description of discrepancy: _____

Signature: _____ **Date:** _____
Director of Nursing / Facility representative

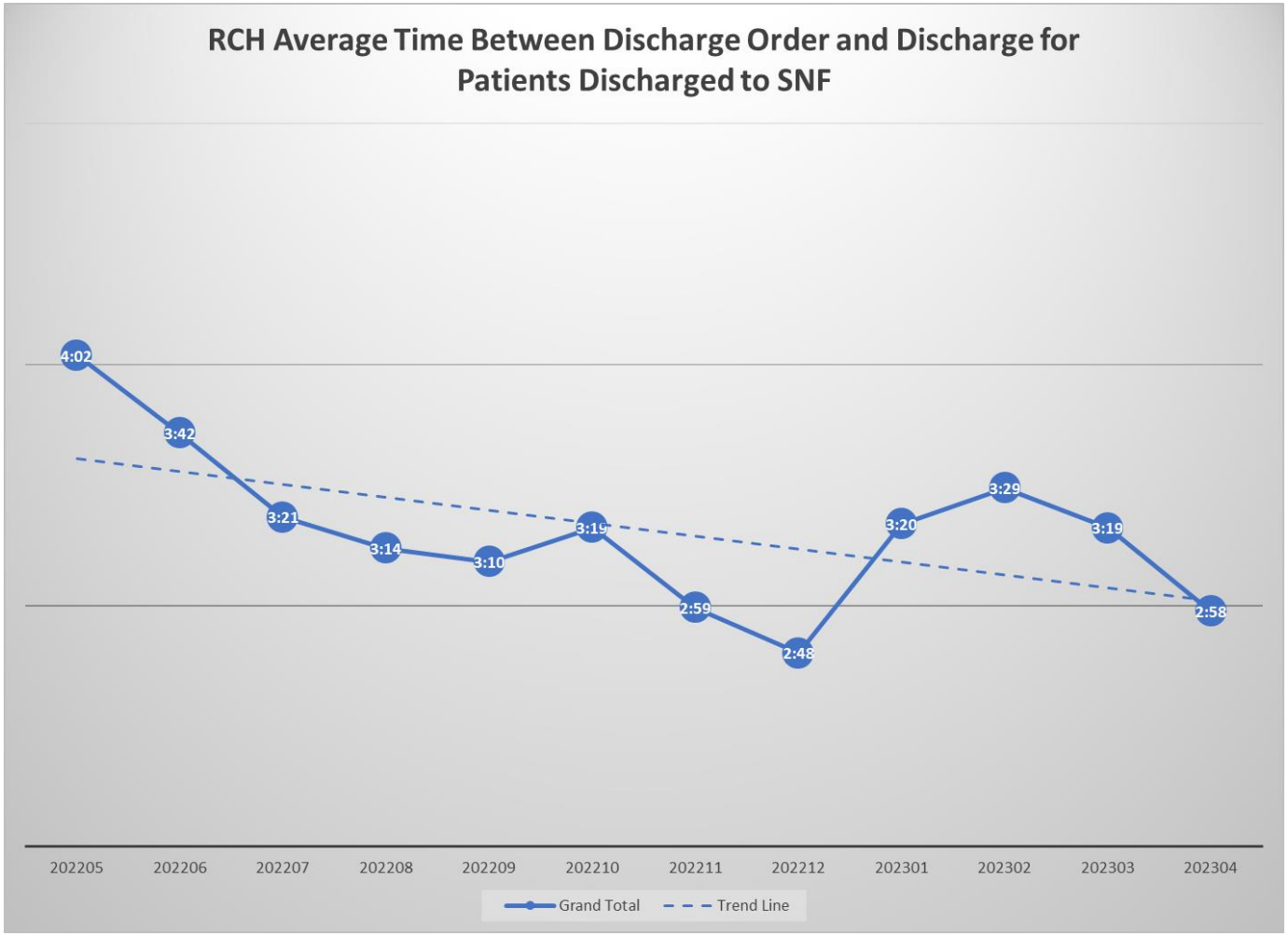
Better Together – Next Steps!

Sustainability Plan

30-60-90 Day Review

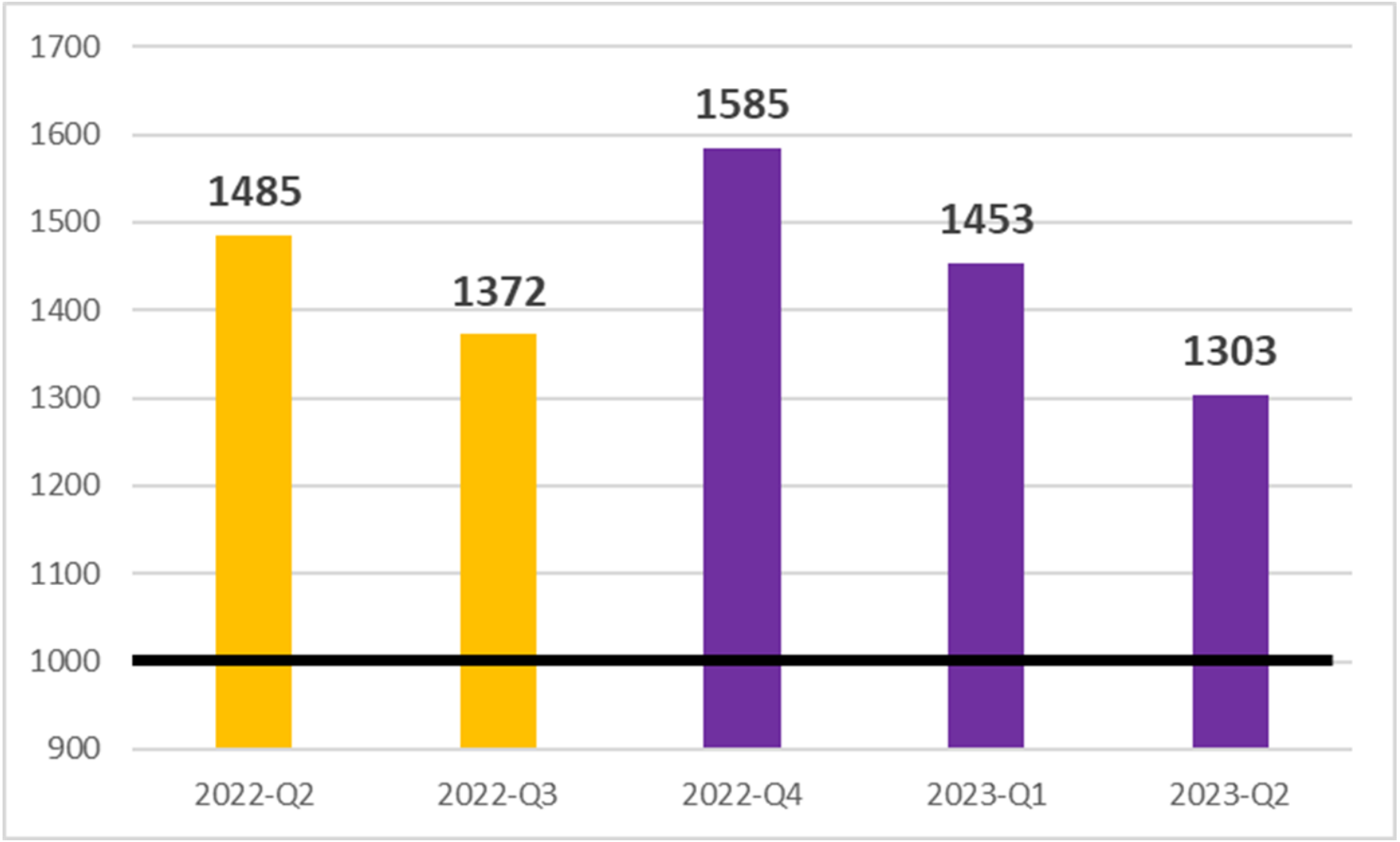
Standardized Agenda:

- Data review
- Regulatory changes
- Facility process change requests
- Variance Trends
- Open Discussion – New topics

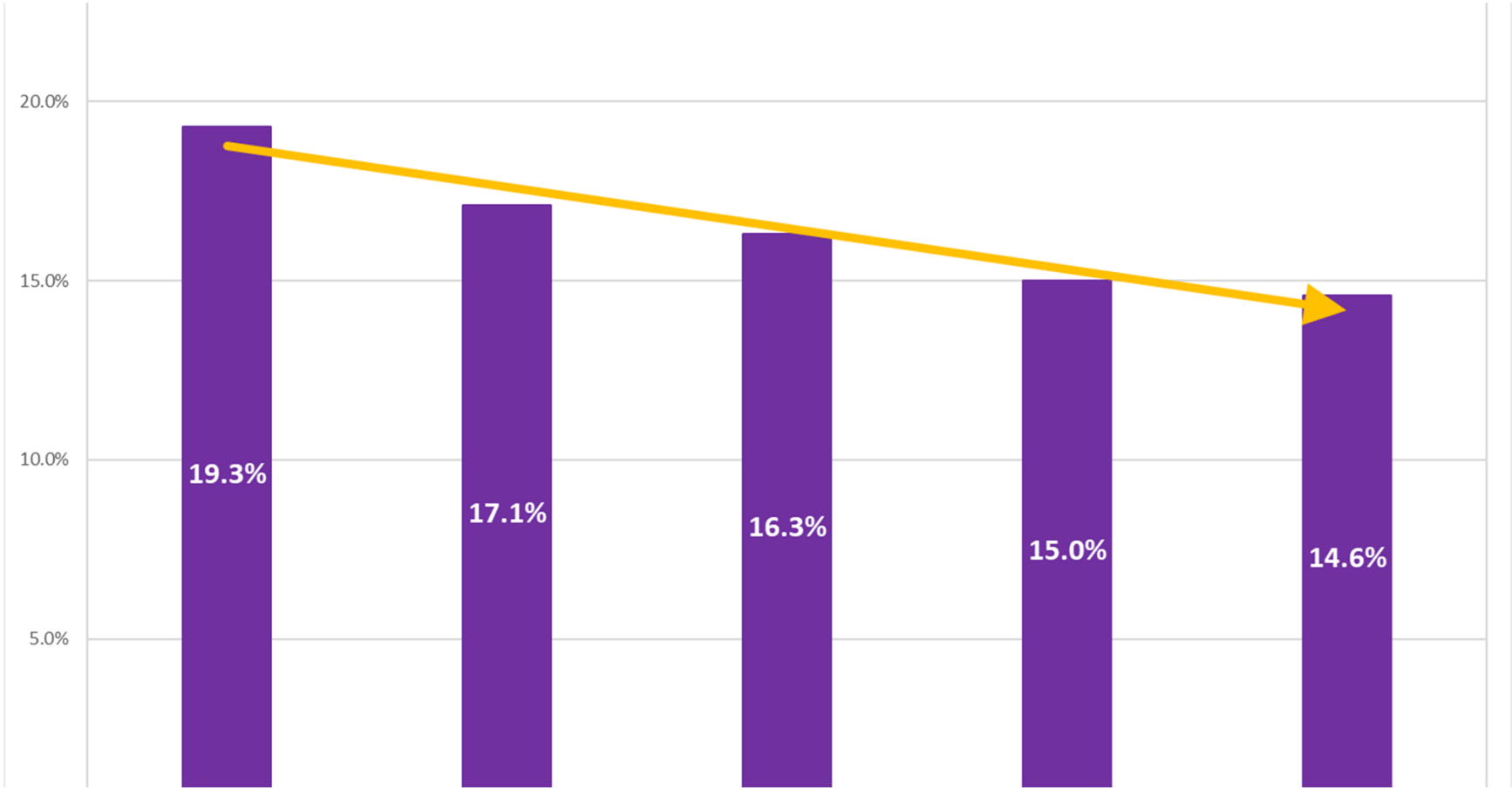

RCH Average Time Between Discharge Order and Discharge for Patients Discharged to SNF
4:02
3:42
3:21
3:14
3:10
3:19
2:59
2:48
3:20
3:29
3:19
2:58
202205
202206
202207
202208
202209
202210
202211
202212
202301
202302
202303
202304
Grand Total
Trend Line

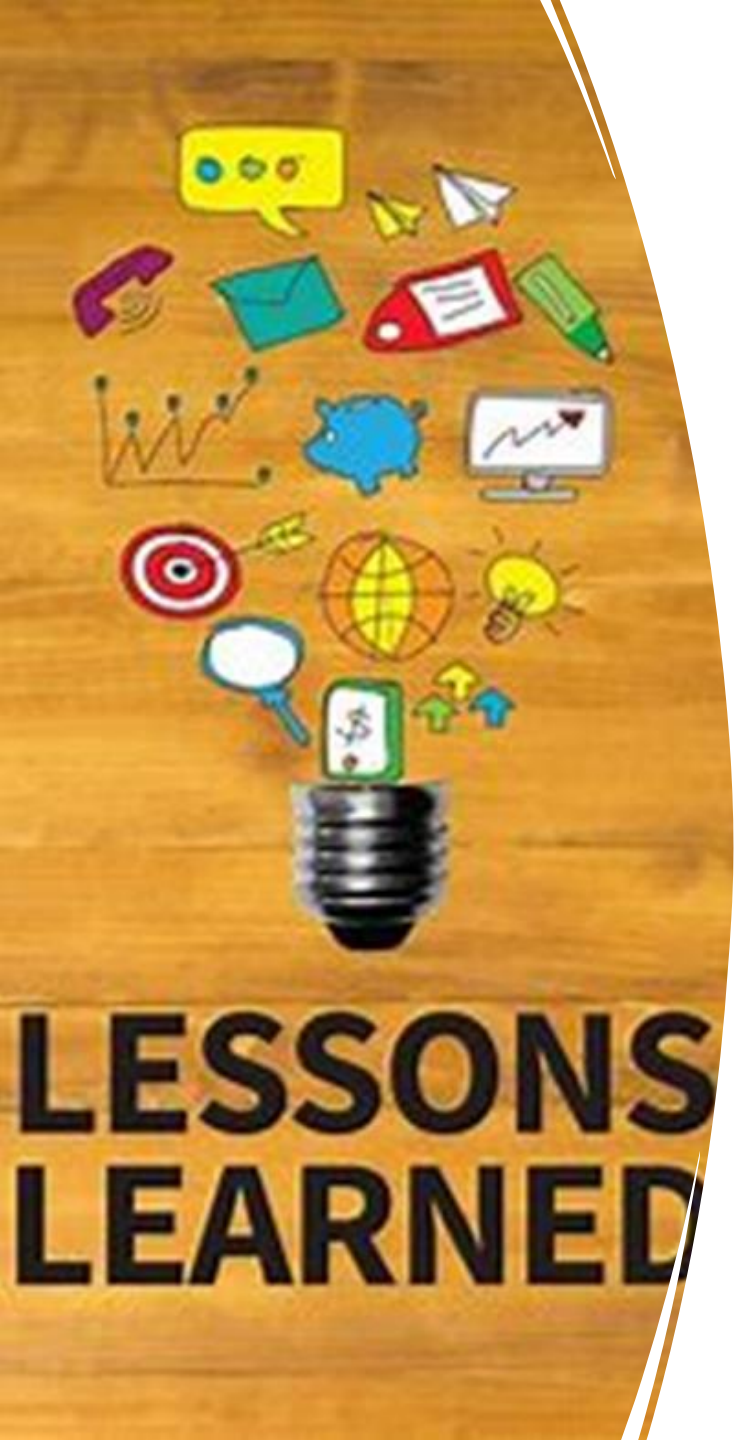
Outcomes

Excess Days in the Hospital for Nursing Home discharges



Readmission Rates 2018-2022





Consensus doesn't happen by magic... You have to drive to it.

Christine Quinn

- Seek to Understand
- Learn the regulations
- Challenged old norms
- Understand competing priorities
- Relationships are key

Possible Q&A

- Funding for Post Acute care:
  - Barriers / Opportunities
  - Partnerships
  - Impact of Medicaid Expansion

Community education

  - Community expectations
  - Community education regarding levels of care in healthcare (right service, right place, right time)

References

- https://cmscompliancegroup.com/2021/03/19/ftag-of-the-week-f843-transfer-agreement/
- 42 CFR § 482.43 - Condition of participation: Discharge planning
- § 483.10 Resident rights. https://www.cms.gov/.../residents-rights-quality-care
- https://dhs.sd.gov/ltss/ombudsman.aspx
- Effective Management of Long-Term Care Facilities Third Edition, Singh, 2016


Thank you!