



Care Coordination Quickinar Series: Strategies to Prevent Urinary Tract Infection (UTI) and Pneumonia-Related Hospitalizations

February 7, 2023

OBJECTIVES

A close-up photograph of a hand in a dark suit jacket and 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'.

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

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



Care Coordination Quickinars

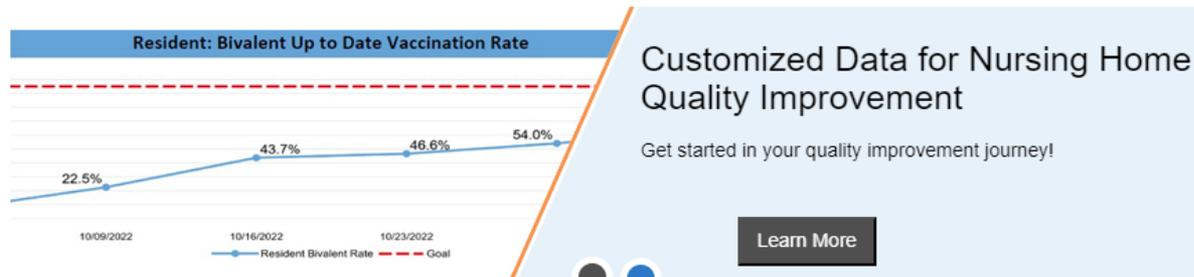
Care Coordination Resources

- 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

Do You Have Access to the QIIP?

Quality Improvement and Innovation Portal (QIIP)



Medicare Quality Improvement (QIO)

Hospitals

Nursing Homes

Physician Practices

COVID-19 Events

QIO Events

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](#)

Create an Account



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

QIIP Login



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. ¹	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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. ²	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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). ³	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Discharge Planning					
4. When patients meet high readmission-risk criteria, your facility focuses customized care coordination efforts for: ⁴	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. Social determinants of health (e.g., financial barriers, transportation, food insecurities, social isolation, housing, safety, etc.).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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). ⁵	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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. 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 BOOST (Better Outcomes to Optimize Safe Transitions from the Society of Hospital Medicine) (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. ¹	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. For high-risk medications (anticoagulants, opioids, and diabetic agents), you utilize pharmacists to educate patients, verifying patient comprehension using evidence-based methodology. ²	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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 for affordability verification). ³	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Discharge Planning					
4. When patients meet high readmission-risk criteria, your facility focuses case coordination efforts for: ⁴	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. Social determinants of health (e.g., financial barriers, transportation, food insecurities, social isolation, housing, safety, etc.).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Care Transitions
Emergency Department 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 Society of Hospital Medicine) (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 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). ¹	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Your department has a monthly dashboard that tracks: ²	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. Percentage of patients prescribed opioids per physician prescriber.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Percentage of patients prescribed naloxone with opioid prescriptions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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). ³	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Discharge Planning					
4. Your department uses electronic health record (EHR) best-practice alerts to: ⁴	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. Identify patients that are taking or are newly prescribed high-risk medications (anticoagulants, antidiabetics, and opioids).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Identify patients who are prescribed both benzodiazepines and opioids.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Notify case management of high-risk/high-need patients (e.g., homelessness, financial need, access to care, food insecurities, transportation needs, etc.). ⁵	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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). ¹	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Your facility regularly meets with acute care partners to identify and review care transition plans of: ²	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. Super-utilizers (residents with four admissions in one year—or six emergency department visits within one year).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. 30-day acute care readmissions of residents on high-risk medications (anticoagulants, opioids, antidiabetics, and antipsychotics)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Your facility monitors the timeliness of provider (medical director, SNFist, etc.) response for resident change-of-condition events. ³	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Your facility uses a risk stratification tool to identify residents who are high risk for readmission to the hospital. ⁴	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Discharge Planning					
5. Your facility provides focused case management for residents at high risk for readmissions to coordinate care addressing: ⁵	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. Ability to pay for medications.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Scheduling of physician follow-up visits.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Transportation to follow-up visits.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The Impact of the Public Health Emergency

- Increased patient acuity
- Increased length of inpatient stay
- Increased device utilization
- Staffing concerns
- Bundle compliance
- Resource availability
- Staff burnout
- *What must be done versus what should be done (drift)*



The Impact of COVID-19 on HAIs

	2020 Q1	2020 Q2	2020 Q3	2020 Q4
CLABSI	-11.8%	27.9%	46.4%	47.0%
CAUTI	-21.3%	No Change ¹	12.7%	18.8%
VAE	11.3%	33.7%	29.0%	44.8%
SSI: Colon surgery	-9.1%	No Change ¹	-6.9%	-8.3%
SSI: Abdominal hysterectomy	-16.0%	No Change ¹	No Change ¹	-13.1%
Laboratory-identified MRSA bacteremia	-7.2%	12.2%	22.5%	33.8%
Laboratory-identified CDI	-17.5%	-10.3%	-8.8%	-5.5%

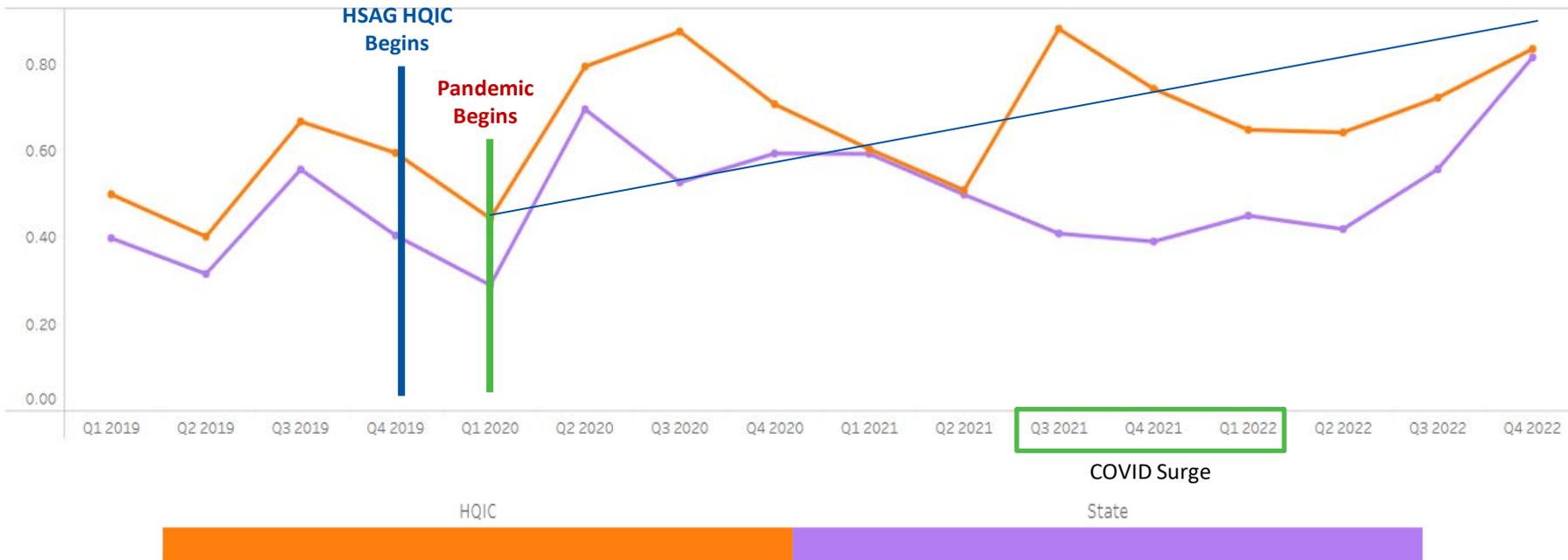
CAUTI = catheter-associated urinary tract infection
 CDI = *Clostridioides difficile* Infection
 CLABSI = central line-associated bloodstream infection

HAI = healthcare-associated infection
 SSI = surgical site infection
 VAE = ventilator-associated event

HQIC Aggregate: Possible Ventilator-Associated Pneumonia

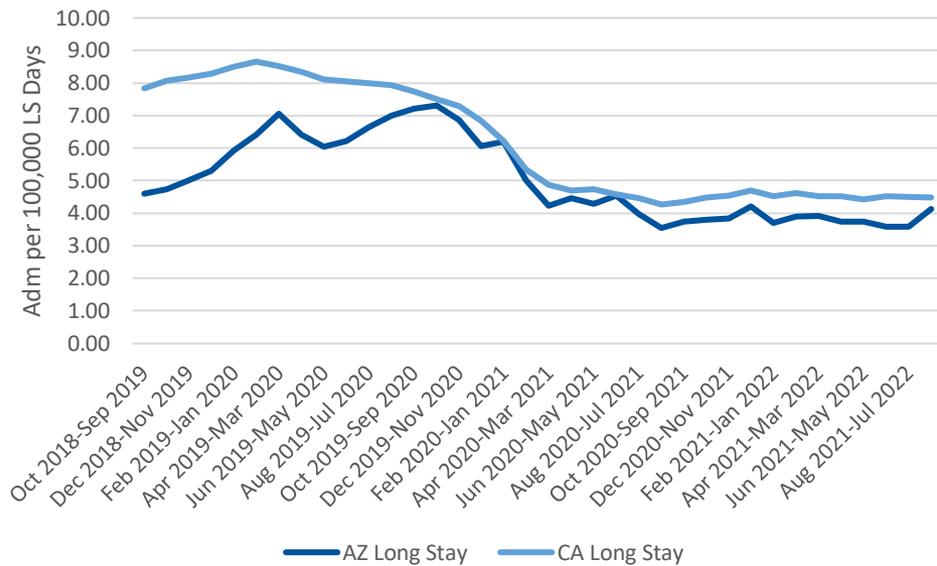
Comparisons Over Time

Measure Category:
 Measure:
 Comparisons Group:
 Time Interval:
 Affiliation Comparison:

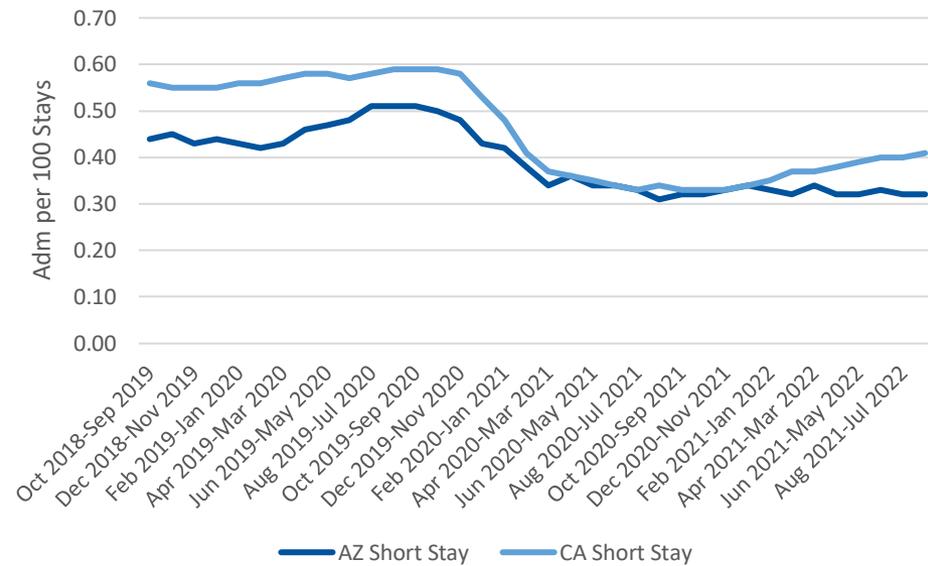


Pneumonia Admissions: Nursing Home Residents

Pneumonia Admissions from Nursing Homes for Long Stay (LS) Residents

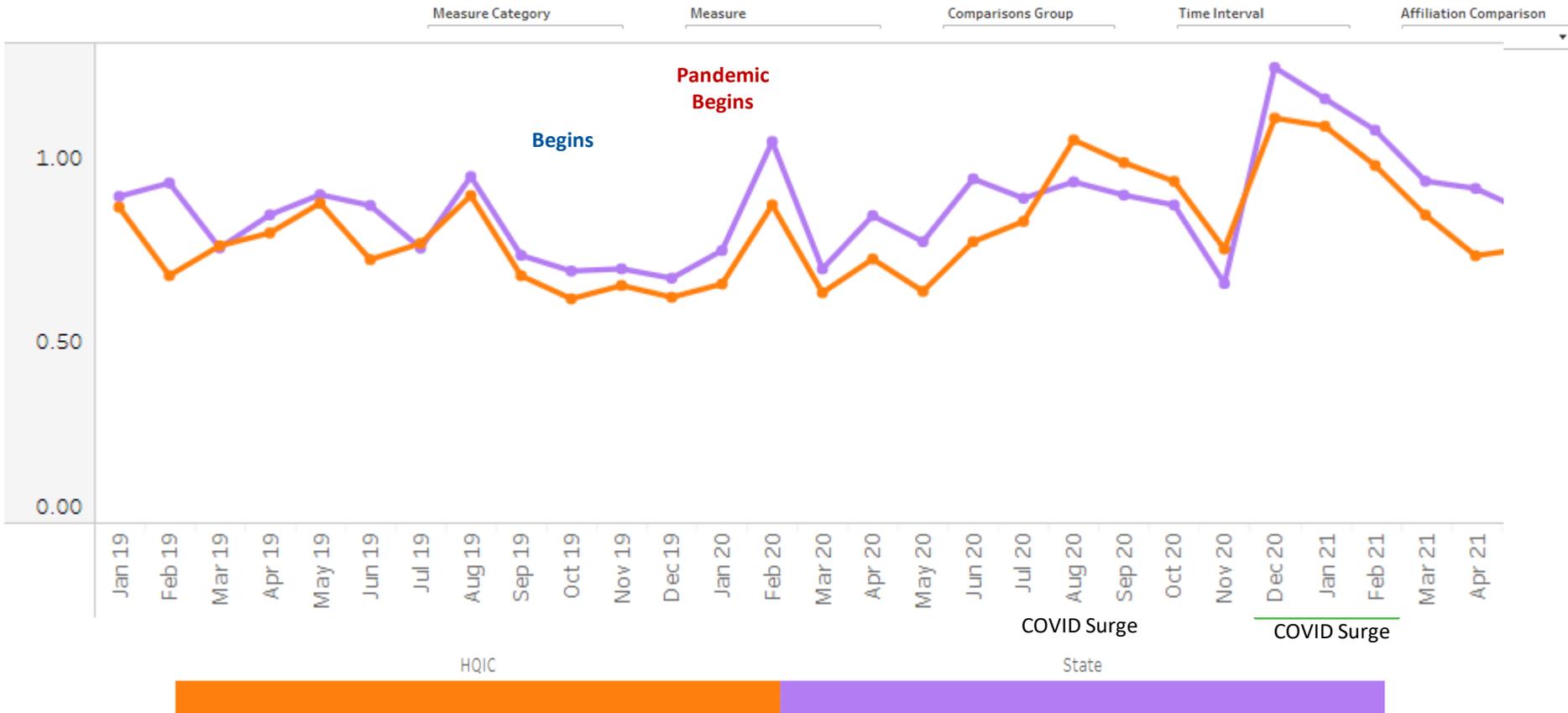


Pneumonia Admissions from Nursing Homes for Short Stay Residents



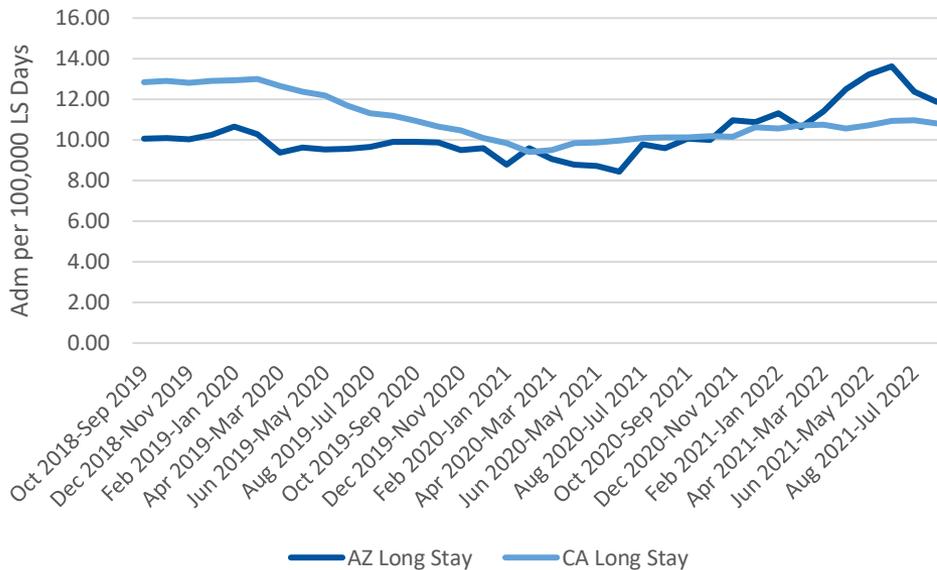
HQIC Aggregate: CAUTI Rate

Comparisons Over Time

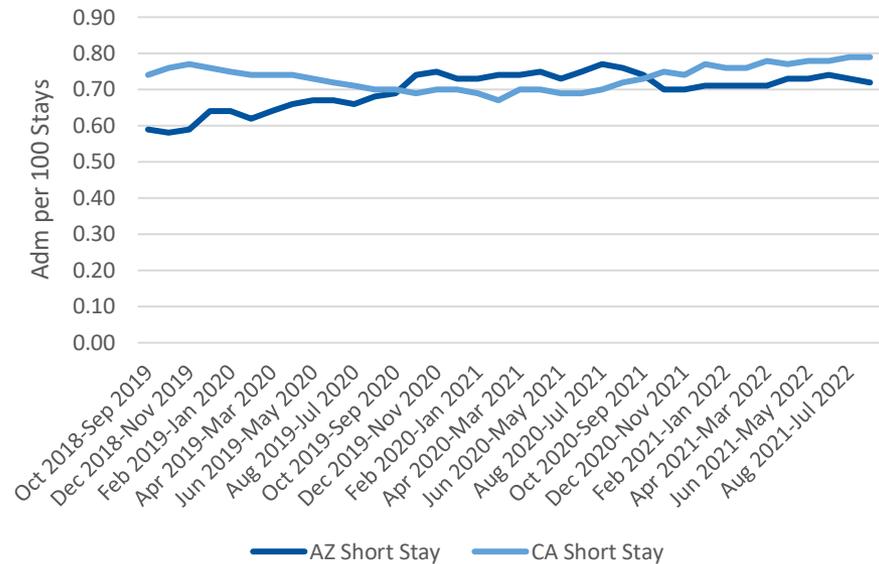


UTI Admissions: Nursing Home Residents

UTI Admissions from Nursing Homes for Long Stay (LS) Residents



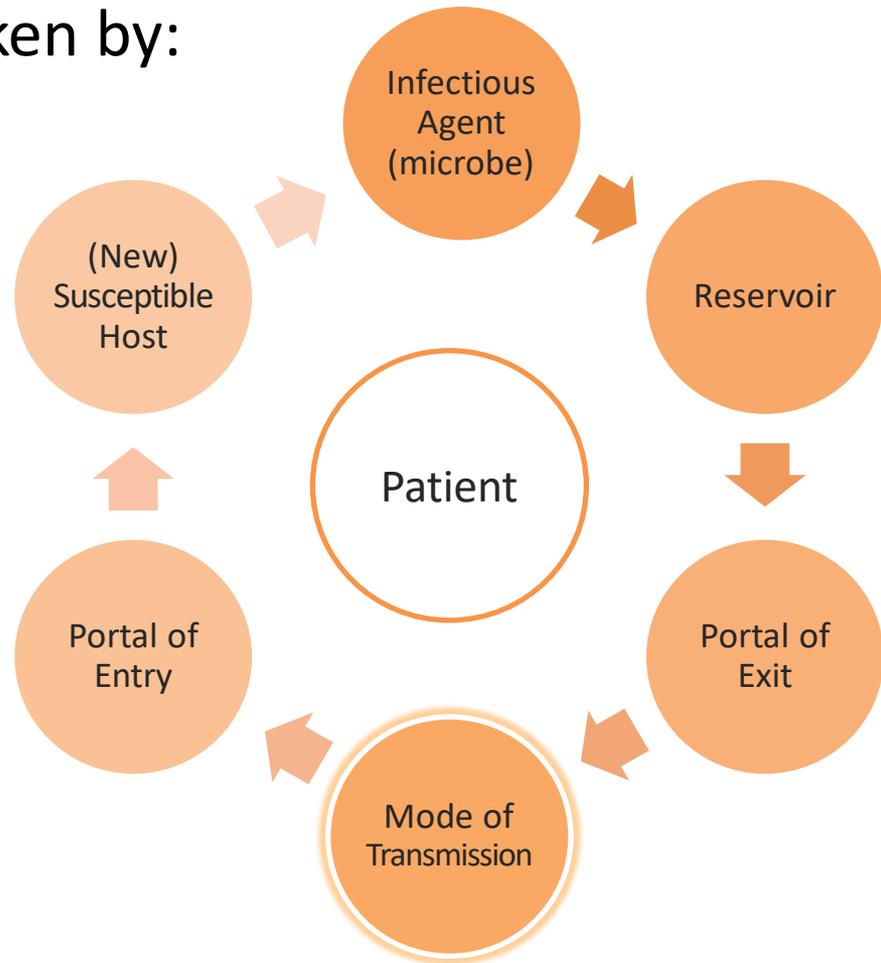
UTI Admissions from Nursing Homes for Short Stay Residents



Basics of Infection Prevention

The chain of infection can be broken by:

- Performing hand hygiene per CDC guidelines.
- Cleaning items before/after use.
- Wearing PPE, when indicated.
- Removing indwelling devices as soon as they're no longer needed.
- Monitoring for signs of infection.
- Staying up-to-date with vaccinations.
- Communicating/feedback.
- Confirming through audits.



Hand Hygiene and PPE

Resident Care Unit/Dept: _____

HR = Alcohol Hand Rub HW = Hand Wash Y = Yes N = No (Mark each opportunity observed. If no opportunities observed or NA, leave blank.)

Healthcare Worker Type:

1 = Physician/Provider

3 = Physical/Occupational/Speech Therapy

5 = Dietary

7 = EVS

2 = Respiratory Therapist

4 = Nursing

6 =

8 = Other _____

# Observations	Day	Time	Health-care Worker Type	Transmission Based Precautions		COVID Specific PPE		Hand Hygiene Prior To Room Entry			Hand Hygiene Upon Room Exit			Comments
				Yes	No	Yes	No	Yes HR	Yes HW	No	Yes HR	Yes HW	No	
				See Key	See Key	See Key	See Key	See Key	See Key	See Key	See Key	See Key	See Key	
1	Month, Day, Year	Day, Evening, Night	See Key											
2														
3														
4														
5														
6														
7														
8														
9														
10														

Indwelling Device Care

Foley Catheter Observation and Quality Tool

Date: _____ Patient Census: _____ NPC= Not placed correctly
 Unit: _____ Number of Patients with Devices: _____

Complete for each Indwelling Catheter Foley in use:

COMMENTS	Foley 1	Foley 2	Foley 3
Direct observation			
ROOM #	212	214	216
1. Is a closed system being maintained?	Yes	Yes	Yes
2. Is the Foley secured to the patient's body to prevent urethral tension?	Yes	Yes	Yes
3. Is the bag below the level of the patient's bladder?	Yes	Yes	No
4. Is the tubing from the catheter to the bag free of dependent loops?	No	Yes	No
5. Is the tubing secured to the bed or chair to prevent pulling on the entire system?	No	Yes	Yes
6. Is the bag hanging free without touching the floor?	Yes	Yes	No
7. Does the patient have an individual measuring device marked with his/her name and room number?	No	Yes	Yes
Total Positive Per Patient	4	7	4
Total % Adherence Per Patient	57.1%	100.0%	57.1%
Chart Review			
8. Is there documentation indicating which department inserted the Foley and is perineal care being performed <small>*a. Note the department/unit where the Foley was inserted and when perineal care was last performed</small>	Yes	Yes	Yes
	ED	ICU	ED
9. Is there documentation available indicating Foley necessity?	No	Yes	Yes
10. Is there documentation available for completion of the insertion bundle?	No	No	Yes
11. Has there been a check for Foley catheter necessity today?	Yes	No	Yes
12. What criterion is noted?	None of the Above		Stage 3 or 4 Pressure Ulcer
13. Comments			
Total Positive Per Patient	2	2	4
Total % Adherence Per Patient	50.0%	50.0%	100.0%

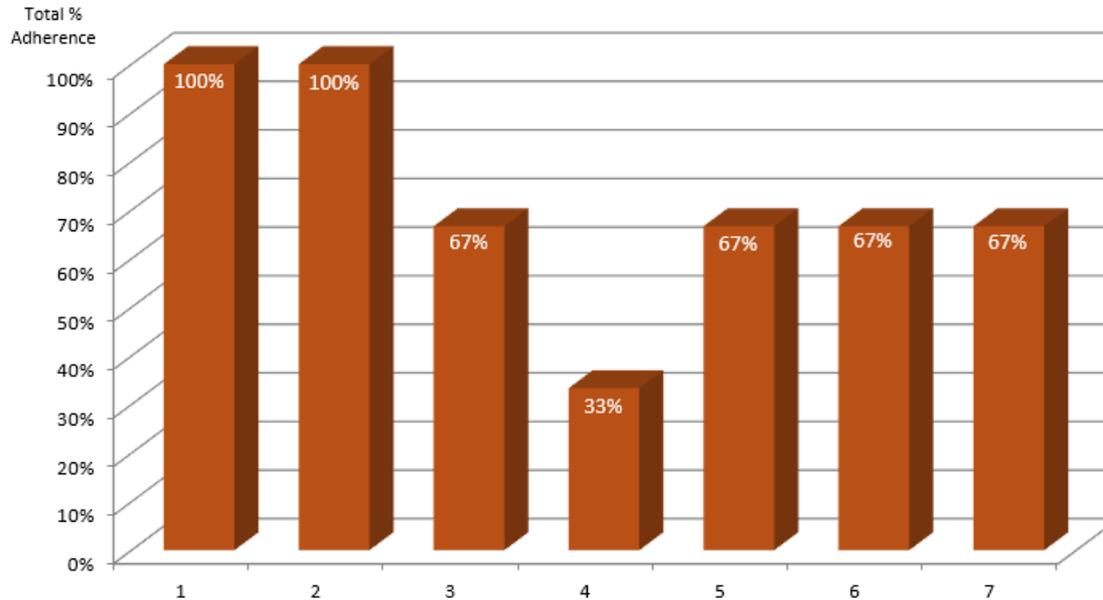
Tools and resources shared during today's webinar:

www.hsag.com/hqic-ip

Feedback Reports

Direct Observation - Foley Catheter Maintenance

0



Maintenance Indicators

- 1. Is a closed system being maintained?
- 2. Is the Foley secured to the patient's body to prevent urethral tension?
- 3. Is the bag below the level of the patient's bladder?
- 4. Is the tubing from the catheter to the bag free of dependent loops?
- 5. Is the tubing secured to the bed or chair to prevent pulling on the entire system?
- 6. Is the bag hanging free without touching the floor?
- 7. Does the patient have an individual measuring device marked with his/her name and room number?

CAUTI Exploration Tool

Catheter-Associated Urinary Tract Infection (CAUTI): Exploration Form

Complete this form for **every** CAUTI by reviewing the patient's medical record, interviewing clinicians, and observing the patient or urinary catheter (UC). As you answer the questions, remember to ask "why?" when seeking an explanation. The investigation should begin no later than three days after identifying the CAUTI to ensure that clinicians clearly remember the events that may have contributed to it.

Date(s) of investigation:		Person(s) conducting investigation:	
Patient Initials:	Age:	Medical record #:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Race: <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Not indicated in medical record		Is the patient Hispanic? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Don't know	
Admit Date:	Discharge Date:	Admitting diagnosis:	
Was the patient discharged alive? <input type="checkbox"/> Y <input type="checkbox"/> N If no, what was the cause of death?			
What co-morbidities or patient factors may have contributed to the CAUTI (e.g., concurrent infections, hyperglycemia, obesity, agitation)?			
Was there a physician order for the UC? <input type="checkbox"/> Y <input type="checkbox"/> N		Where was the patient located at the time of the UC insertion?	
Were alternatives to a UC attempted prior to insertion? <input type="checkbox"/> Y <input type="checkbox"/> N If yes, indicate the alternatives attempted:			
<input type="checkbox"/> Intermittent catheterization with use of bladder scans		<input type="checkbox"/> Specially designed absorbent underpads	<input type="checkbox"/> Condom catheter Other: _____
What was the date of the insertion or re-insertion of the UC prior to the CAUTI?			
Was there evidence-based criteria* for a UC at the time of the insertion? <input type="checkbox"/> Y <input type="checkbox"/> N If yes, describe:			
Name and credentials of the person who inserted the UC prior to the CAUTI:		When was the last time this person demonstrated that they were competent to insert a UC?	
What does the documentation of the UC insertion process state?			
Interview the person who inserted the UC. Is there additional information about the insertion process that was not included in the documentation? If yes, describe:			
Number of days the UC was in place prior to the date the positive culture was obtained:	Date urine culture was obtained:	Causative organism(s):	
Was there evidence-based criteria* for a UC when the urine culture was obtained? <input type="checkbox"/> Y <input type="checkbox"/> N If yes, describe:			
Was the UC discontinued 48 hours prior to the CAUTI? <input type="checkbox"/> Y <input type="checkbox"/> N	Did the seal between the UC and the drainage bag remain intact? <input type="checkbox"/> Y <input type="checkbox"/> N If no, explain why the seal was "broken?"		

Is there documentation that perineal care was provided per hospital protocol, or as needed, in the 72 hours prior to the infection? <input type="checkbox"/> Y <input type="checkbox"/> N If no, explain:
In the 72 hours prior to the CAUTI, is there documentation by a physician (at least once every 24 hours) of an evidence-based reason for the continued use of the UC? <input type="checkbox"/> Y <input type="checkbox"/> N
In the 72 hours prior to the CAUTI, is there documentation by a nurse (at least once every 24 hours) of an evidence-based reason for the continued use of the UC? <input type="checkbox"/> Y <input type="checkbox"/> N
How long was the UC in place prior to the CAUTI? _____ days Did the UC meet evidence-based criteria* every day? <input type="checkbox"/> Y <input type="checkbox"/> N What was the earliest date that the UC did not meet evidence-based criteria*?
On the unit where the patient was located at the time of the CAUTI, is there a process that includes observation of the UC by the charge nurse or another person? <input type="checkbox"/> Y <input type="checkbox"/> N If yes, what was the most recent date prior to the CAUTI that the UC was observed? What were the findings during the last observation? Were any actions taken as a result of these findings?
Had the unit where the patient was located when the UC was inserted received education or training about interventions to prevent CAUTIs? <input type="checkbox"/> Y <input type="checkbox"/> N If yes, when was the training date? _____ Did the training include: Evidence-based reasons for a UC? <input type="checkbox"/> Y <input type="checkbox"/> N Interventions to prevent infections? <input type="checkbox"/> Y <input type="checkbox"/> N
Were there any events occurring on the unit at the time of the insertion that may have affected the clinician's ability to insert the UC? <input type="checkbox"/> Y <input type="checkbox"/> N If yes, describe:
Were any concerns or issues related to UC equipment or supplies identified during this investigation?
What conclusions were reached as a result of this investigation?
What have you done to ensure that the next patient with a UC will be safe from acquiring an infection at your hospital?

* Criteria includes accurate intake and output (ICU patients only), genito-urinary (GU) surgery, assistance with healing due to Stage III or IV perineal or sacral wounds, hospice (comfort or support), required immobilization, chronic indwelling urinary catheter, and urinary retention or obstruction. Source: Strategies to Prevent CAUTI, 2014 Update, Infection Control & Hospital Epidemiology, May 2014, Vol. 35, No. 5.

Pneumonia Prevention



Patient Label

7-Day Readmission Checklist and Audit Tool

Index admission dates _____ through _____ / Readmission dates _____ through _____

- Is this readmission related to the previous admission? Y or N
- Is this a hospital penalty related condition?
 - If yes, circle one: Acute MI / HF / PN / COPD / CABG / Elective TKA/THA*
 - If no, is readmission reason listed as a comorbid condition on the index admission? Y or N
- 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
- How many days between discharge and readmission (circle one)? 0-1, 2-4, or 5-7
- Is the patient on a high-risk medication? If yes, circle one: anticoagulant / diabetic agent / opioid
- Discharged on seven or more medications? Y or N
- Medication reconciliation completed in full on previous discharge? Y or N
- 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
- 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 _____
- 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 _____
- To identify if other patterns or trends exist, indicate:
 - Discharge unit _____
 - Hospitalist group _____ Discharging physician _____
 - What day of the week was the patient discharged (circle one)? Sun Mon Tues Wed Thurs Fri Sat
- Was an evaluation of discharge needs documented by case management on the index admission? Y or N
- 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 (PN), chronic obstructive pulmonary disease (COPD), coronary artery bypass graft (CABG), total hip/total knee arthroplasty (THA/TKA)

Pneumonia Self-Management Plan

Name _____ Date _____ Do not smoke and avoid secondhand smoke.

Green Zone: In Control

- ✓ I am breathing easily.
- ✓ I have no fever.
- ✓ I am not coughing, wheezing, or experiencing chest tightness or shortness of breath.
- ✓ I am able to maintain my normal activity level.



Green Means I Should:

- ✓ Continue to take my medicine as ordered.
- ✓ Balance activity and rest periods.
- ✓ Drink plenty of water, unless ordered otherwise.
- ✓ Take a deep breath and cough 2-3 times every hour to open up my lungs. (Coughing helps to clear my airways.)

Yellow Zone: Caution

- ✓ I have an increase or change in the color of my mucus (phlegm).
- ✓ I am coughing or wheezing more than usual.
- ✓ I become short of breath with activity.
- ✓ I have a fever of 100.5 F or greater by mouth, or 99.5 F or greater under the arm.
- ✓ Need more pillows or need to sleep sitting up.
- ✓ I have loss of appetite, low energy, or fatigue.



Yellow Means I Should:

- ✓ Contact my physician and share my symptoms.

Physician Contact:

Doctor: _____

Phone: _____

Red Zone—Medical Alert!

- ✓ I am experiencing unrelieved shortness of breath.
- ✓ I have a change in the color of my skin, nails, or lips to gray or blue.
- ✓ I have unrelieved chest pain.
- ✓ I experience an increased or irregular heartbeat.
- ✓ I feel confused or can't think clearly.



Red Means I Must:

- ✓ **Take action!**
- ✓ **You need to go to the Emergency Room or call 9-1-1 immediately!**

American Lung Association. Pneumonia. <https://www.lung.org/lung-health-diseases/lung-disease-lookup/pneumonia/symptoms-and-diagnosis>

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Our Next Care Coordination Quickinar

Deeper Dive Into Readmission Data
Tuesday, March 7, 2023 | 11 a.m. PT

bit.ly/cc-quickinars2



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!

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