Social Services Tips and Tricks

Quality Corner Call
February 9, 2023

HEALTHWORKS
KANSAS HOSPITAL ASSOCIATION

Kansas
Department of Health and Environment

Upcoming Webinars and Educational Offerings

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2023 Upcoming Webinars

- SHIP Informational Webinars
  - March 14
  - June 14
  - September 14
  - December 14
- Quality Corner Calls
  - May 3 – FMT Report Review and Resources

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Upcoming Offerings

Turning Data Into Improvement
- February 28 – Garden City

Care Transitions Learning Community Informational Webinar
- February 23

QAPI Networking Group
- March 1, April 5

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Kansas

Site Visits (In-person or Zoom)

MBQIP Reporting Reviews (5/quarter)

- Current requirements to continue receiving the SHIP grant
- Flex Monitoring Team reports reviewed
- Discussion of who reports what elements at your facility
- Clearing up any questions your facility may have about reporting of this data to meet the deadlines

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Kansas Healthcare Collaborative – Compass HQIC

YOU ARE INVITED!

Compass Topic-Focused Open Office Hour Series

To assist hospitals in achieving their quality improvement goals, the Compass HQIC team will be hosting topic-focused open office hour calls to review measure specifications, address frequently asked questions and provide a forum for hospitals across the HQIC network to share best practices with each other.

All calls are from 1:00 - 2:00 PM (CT)

JANUARY 31
Anticoagulation
FEBRUARY 14
Pressure Ulcer/Injury
FEBRUARY 28
Central Line-Associated Bloodstream Infection
MARCH 14
Catheter-Associated Urinary Tract Infections
MARCH 28
Sepsis
APRIL 11
Hypoglycemia
APRIL 25
Opioid
MAY 9
Clostridioides Difficile
MAY 23
Readmission
JUNE 6
Carbapenem-Resistant Enterobacteriaceae/ Methicillin-Resistant Staphylococcus Aureus

REGISTER TODAY

https://us06web.zoom.us/meeting/register/tZUscO2hqDspHNOBfgcSFtNsGtzjdVeZlwGJ (Link)

COMPASS

IHC · Kansas Healthcare · South Dakota

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Anderson County Hospital
SAINT LUKE'S HEALTH SYSTEM

Allen County Regional Hospital
SAINT LUKE'S HEALTH SYSTEM

Utilizaton Review/ Swing Bed Coordination/ Discharge Planning/ and Other Activities

Introductions

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Manager Clinical Care Coordination, Critical Access Region
Ashley Wiltse, BSN, RN—
Care Coordinator
Michelle Gast, LMSW—
Social Services, Care Coordination
Beverly Shaul, MSN, RN, NE-BC–
Director of Nursing
Allen County Regional Hospital & Anderson County Hospital

Utilization Review/Care Coordination

Staffing

- 1 Full time UR/CM nurse who splits time 50/50 between Allen County and Anderson County Hospital. This person reports to the manager who is over 4 critical access facilities. No weekend/holiday coverage.
- 1 Full time social worker who splits time between Allen and Anderson County Hospitals, plus a separate 30 bed non-skilled long term care facility. No weekend/ holiday coverage.
- Care Coordination is completed either in person or virtually.
- Inpatient RNs complete any tasks needed on the weekends.

Utilization Review/Care Coordination Related to SWB

Social Worker (not all duties included)	UR/CM Care Coordination (not all duties included)
• Leads Discharge Planning and Care Team Rounds • SS Consults • Assist with Advance Directives • Assist with Medicaid and financial aid applications • Assist with Nursing Home, Home health and hospice referrals, etc. • Assists with IMM process, along with nursing and admission staff.	• Reviews each admission using InterQual Criteria for appropriate admission. SWB are reviewed at least weekly or more based on payor needs. • Contacts insurance companies/works on initial denials • Assists with IMM process-This process involves nursing and admission staff as well. • Performs all communications and authorization duties for SWB pts. –SWB Coordinator

Swing bed Program- Referrals

Swingbed Admission & Referral Process – led by care coordinator

- Verifies insurance and skilled days available.
- Swing bed referrals are then placed on a spreadsheet with details.
- An email is sent to the team (which includes nursing, therapy, physician, dietary, pharmacy, social worker, and respiratory).
- The email includes a link to the spreadsheet and any other pertinent details.
- If the referral includes a faxed document, then it's also included in the email.
- Team members will document acceptance by their specific department and/or address any questions in the spreadsheet or by email.
- If medically accepted by the physician and the patient is ready for discharge, then contact is made with nursing to verify bed availability and coordination of the admission.
- Referring facility is then contacted to verify acceptance, bed assignment and details for nursing report and discharge orders.
- We request the discharge orders to be faxed to us (not physically sent with the patient) as soon as available, so our physician can begin entering the orders and address any questions if needed.
- We do accept Swing bed referrals afterhours/weekends/holidays, if UR has reviewed in advance- to verify insurance, skilled days and confirmed skilled need. We often accept patients on the same day as referred.
- Commercial insurances and Medicare Replacement plans accepted, if prior authorization is obtained and approved.
- If transferring from Acute to SWB status a Combined Notice Form and the DC IMM are presented to patient.

SWB Program

- Daily skilled need, nursing and/or therapy to qualify. (Interqual criteria provides UR with all potential skilled services.)
- Average length of stay 2 weeks, however we do have patients with longer stays if needed.
- Upon admission patients receive a copy of their Patient Rights and Responsibilities form and Swing bed Information and Agreement form and list of providers. All items are placed in a SWB Packet for them to refer to throughout their admission.
- Upon admission nursing performs a Comprehensive Admission Assessment.
- Admitting physician assesses the patient within 24 hours of admission and documents an H&P. Patients progress is then assessed weekly or more often if needed by the physician.
- Occupational Therapy performs an Activities Assessment and documents interventions in the EMR; these interventions are available for all staff to review. A monthly Activity Calendar is provided on the unit, and activities performed are documented in the EMR by therapy, nursing and social services.
- Multi-weekly Care Team Rounds performed with the patient/family and treatment team to review progress and discharge needs.

Swing bed Potential Barriers

- Bed availability – due to our beds being used also for acute patients, availability changes daily.
- Patients who need longer term services or placement – CMS discourages and monitors patients who admit to Swing bed and then go to a SNF.
- Patients with psychiatric/behavioral concerns/risk of elopement. CAHs do not have designated beds for Swing bed and/or locked units; facilities are small with sometimes limited staffing.
- Medicare Replacement plans and commercial insurances sometimes will not approve Swing bed d/t being more costly for them vs a SNF; and/or will only approve short stays.
- Sometimes specialty medications, supplies and/or equipment may require a special order and/or not readily available.
- Transportation to Swing bed – our CAHs do not provide transportation services. Our rural areas have limited transportation options.

Swing bed Program- Successes

- Creation of an email DL group for each facility where referrals are initiated and our referral spreadsheet where all departments can report acceptance or communicate concerns. (No more paper packets passed around to multiple departments for review.) Time saving and efficient!
- Expectation communicated to all team members requesting Swing bed referrals be reviewed within a few hours of being referred. Swing beds are made a top priority.
- Knowledge of all potential skilled services and not limiting ourselves to just skilled therapy admissions.
- Many options for video/remote provision of services, whether it be Care Progression staffing, physician consults or team meetings.
- Providers who are on board with Swing bed and the need of this service in our communities.

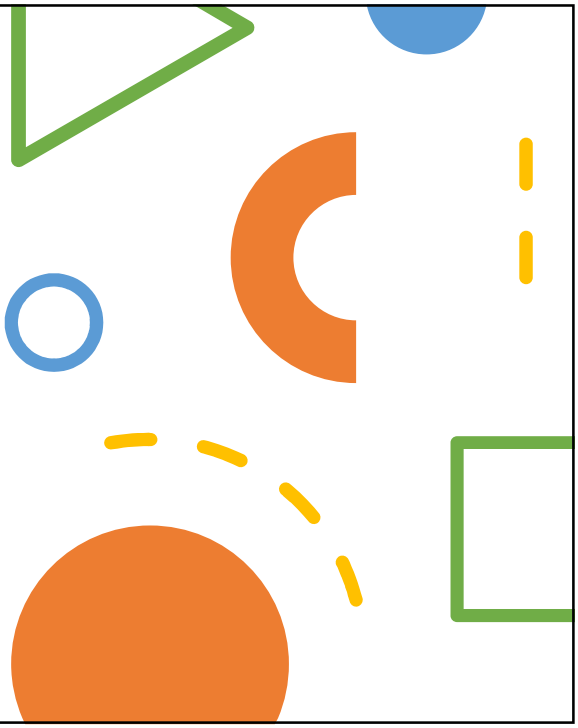
SWB Referral Template

Date of Referral	Anticipated Discharge Date	Referral ID and Access Code	COVID 19 Screening Complete?	Main diagnosis	Skilled need	Packet Reviewed by (APP name and date) and discussed with which physician?	Information still needed by hospitalist?	UR Approved? (Has 3 IP MN's? Meets SNF criteria? Medicare days checked/auth obtained?)	Nursing approve?	Dietary approved?	Therapy approved?	SW approved?	Referring SW Phone#	Pharmacy approved?	Other info?	Referral Hospital phone # (Weekend contact number) if different than referring SW phone	Hospitalist accepted?	Discharge Disposition

Discharge Planning/Care Team Rounds

Multidisciplinary Approach—conducted at the patient's bedside

- Led by SW and/or Care Coordinator
- RN caring for patient
- Provider
- Patient and their person designated by them
- Try to have a nursing home representative if from a NH
- Therapy
- RT
- Pharmacy as needed
- Virtual technology is used as needed
- WMTY



Care Team Rounds

Bedside RN/House Supervisor:

This is _____and he/she was admitted on ____ for _____(diagnosis) Patient of Dr. _____. Pt support at home _____. Patient goal is _____. WMTY for patient is _____.

RN to provide any relevant information regarding pt treatment and plan of care, any areas of concerns. What services are being provided and any new consults or treatments.

Therapies-Physical, Speech, Occupational: Please send one representative for care team rounds and have that representative be able to speak to all the applicable to the pt.

PT-We are working on_____ and the pt.'s goals is to be able to _____. Recommend that following equipment for the home and the need for home health services. Discussion about an anticipated discharge date. (i.e.-anticipate pt. will need 2 weeks of therapy).

OT-Pt's ALD status prior to hospital stays. Pt goals for discharge are_____. Discharge recommendations-Home health, DME.

ST-Pt goals _____to be completed by_____. Discharge recommendations.

Respiratory Therapy-At this time the pt. is requiring_____ (amount of oxygen, CPAP, Treatments) and the goal is to _____(decrease O2, set-up with CPAP at home , sleep study.) Discuss equipment the pt. has and what the pt. needs for home and the DME providers.

Pharmacy-Medication concerns, antibiotic therapy course, etc.

Dietary-home needs (feeding tubes, TPN, dietary restrictions), diet educational needs. Any other concerns about nutritional needs at discharge.

UR/Care Manager-report concerns with insurance coverage related to stay or post hospital care that nay need a prior authorization.

Hospitalist-Discuss goals/concerns/needs if known for discharge.

Social Services-do you have any concerns or anything we can help with before you go home.

Pt/Family- Do you have any concerns or anything we can help with before you go home

Discharge date is updated on the board in the pt room.

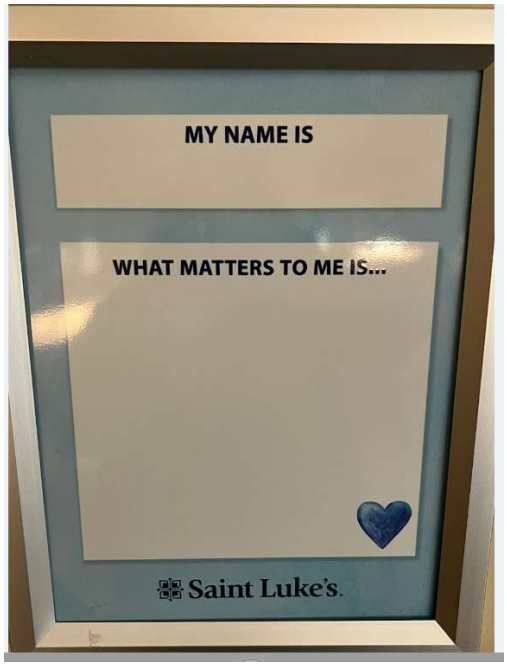
Documentation completed by social worker or nursing staff when SW not available.

Discharge Planning Tool

WMTY- What Matters To You

- Ask every patient upon admission What Matters To You and post in room
- Incorporate What Matters To You into their Goal Setting
- Everyone involved in care strives to help patient reach their What Matter's To You Goal
- Address in Bedside Shift Report and in Care Team Rounds/Discharge Planning

WMTY



SWB Activities

- Occupational Therapy performs an Activities Assessment and documents interventions in the EMR.
- The assessment and interventions are available for all staff to review.
- A monthly Activity Calendar is provided on the unit.
- Activities performed are documented in the EMR by therapy, nursing and social services.
- Prior to Covid, one of our facilities used to assign days to different ancillary departments, and they would oversee and plan the activity. This engaged others and was successful most times.


SWB Activities Space On The Unit

Round Table

- What works well for us
- What we continue to struggle with

QUESTIONS

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Funding Acknowledgement

This program is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $968,815 with 0% financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.

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