



OHIO NURSING HOME QUALITY IMPROVEMENT PROJECT

CPAN Readmission Reduction Project

Description

CPAN's aim is to aid facilities in improving care and reducing the frequency of potentially avoidable transfers to the acute hospital. CPAN will assist facilities in coordination of care and services of at risk residents. Our review of transfers will help to improve the identification, evaluation, and management of changes in the resident's condition. Our overall goal is to prevent avoidable transfers by identifying opportunities for improvement in reducing preventable transfers to the hospital.

CPAN Readmission Reduction program helps the facilities:

- Prioritize goals related to hospital readmissions
- Identify residents that require additional clinical support and monitoring
- Provide tools and resources about specific conditions
- Identify possible opportunities to prevent avoidable transfers
- Reduce the frequency of avoidable hospital admissions and readmissions
- Plan for continuity of care including; transition of care and transfers
- Improve resident health outcomes

CPAN has developed a program that promotes holistic case management that starts with communication prior to admission to the facility. This communication continues through the members stay at the SNF, discharge planning and transitioning to home health. CPAN analyzes each transfer to the hospital for patterns and trends. We communicate these findings back to the SNF's and their owners for follow up and education for future prevention of readmissions to hospital. We are providing each SNF owner with quarterly reports for this program for each of their facilities and for each insurance provider their facilities work with.

How to Join

Nursing homes must be members of CPAN to join. Contact Chera Osborne RN, BSN at 513-777-0280 or email cosborne@cpanohio.com

Brief Description of Required Activities

- Appoint a clinical lead for the project
- Notify CPAN of hospital admissions/ER visits within 48 hours of occurrence
- Complete CPAN transfer form or equivalent form and return to CPAN along with requested documentation within 48 hours of request

- Attend Webinars and additional training as posted by CPAN
- Maintain a book with CPAN QI reports and educational material sent to the facility
- Update/complete the CPAN Discharge Planning Worksheet and send it in with each review

Through this program, SNF's will develop plans of correction to deal with any avoidable hospital readmissions. They will write protocols for new admissions that will assist their staff in providing quality care. The SNF'S will use new approaches and policy changes to make this project a success. They will provide continuing education regarding the changing policies and practices to their staff when a change has been made. This program is designed to position the SNF with the opportunity for improved members' outcomes and strengthen the value of the SNF in their community.

Date(s) of Project

January 1, 2015 through December 31, 2017

Evidence of Participation in the Project*

**Expected evidence of participation in the project should be kept by the nursing home for use in state survey to demonstrate compliance with Sec. 3721.072 (B) which states that "Beginning July 1, 2013, each nursing home shall participate every two years in at least one of the quality improvement projects included on the list made available by the department of aging under the nursing home quality initiative established under section 173.60 of the Revised Code."*

1. The nursing home should be able to produce the CPAN QI reports sent to them on a quarterly basis.
2. The nursing home should be able to produce additional training/educational material to show participation in Webinars

Relevant links

www.cpanohio.com (for forms and educational material)

Contact

Chera Osborne RN, BSN Director of Quality Initiatives at 513-777-0280