Session Objectives

Participants will be able to:

• Identify effective tools from the INTERACT Version 3.0 Program that are designed to prevent acute care transfers from SNFs to acute care hospitals

• Discuss specific strategies for enhancing care coordination between hospitals and skilled nursing facilities
Co-design of Handover Communications

Definition of a “Skilled Nursing Facility”

Umbrella term “Skilled Nursing Facility” refers to the following:
- Nursing Home
- Skilled Nursing Care Center
- Long-term Care
- Rehabilitation
- Post-acute Care
- Assisted Living

What community-based facilities are in your communities/regions?
Institute for Healthcare Improvement
Reducing Avoidable Readmissions Seminar

IHI’s Framework: Improving Care Transitions

Supplemental Care for High-Risk Patients

Transition from Hospital to Home or other Care Setting

Skilled Nursing Care Centers

Primary & Specialty Care

Home Health Care

Key Design Elements

Patient and Family Engagement
Cross-Continuum Team Collaboration
Health Information Exchange and Shared Care Plans

Process Changes to Achieve an Ideal Transition from Hospital (or SNF) to Home

Hospital

Skilled Nursing Care Centers

Primary & Specialty Care

Home Health Care

Home (Patient & Family Caregivers)

Supplemental Care for High-Risk Patients

The Transitional Care Model (TCM)
The Case for Improving Transitions to SNF Facilities

Nearly one-fourth of Medicare beneficiaries discharged from the hospital to SNF are readmitted to the hospital within 30 days.

Working in Cross-Continuum Teams

- Understanding mutual interdependencies at each step of the patient’s journey across the care continuum enables the team to co-design processes to improve transitions in care.

- Collectively, team members explore the ideal flow of information and patient/family experiences as the individual moves, from one setting to the next, and then home.
Table Discussion

- Small Groups:
  - Describe how a patient and/or family member would (ideally) experience care as they transition into your setting (i.e., what they might want and need?)
  - Identify three things that you have done or will need to do in order to deliver that ideal system for your patients
- Report out on your discussions

How Might We….

“….effectively communicate post-acute care plans to patients and community-based providers of care?”
In-depth Review of Residents who Were Readmitted to the Hospital

- Reviews charts of the last five readmissions, (see Diagnostic Worksheet, page 124, or INTERACT Quality Improvement Tool)

- Conduct interviews with residents recently readmitted and their family members (If possible, interview the same individuals whose charts were reviewed)

- Conduct interviews with clinicians and staff in the skilled nursing facility to identify problem areas from their perspective (see Diagnostic Worksheet part 2 page 126)
Tips for Testing

• Interview or observe a handover to a post-acute or community partner Community Partner
  - Did they get the information they needed in a format they desired?
  - Were there unresolved issues?
  - How could the handover be improved?
  - What could be tested as a result of this assignment going forward?

• Review the INTERACT Hospital to Post Acute Care INTERACT handover tool with one or two of your community partners to determine if this could be utilized as the handover tool

• Design an agenda for what should be included in the warm handover or phone call report to the post acute

Quality Improvement Tools

Available at www.interact2.net.
1. Ensure SNF Staff Are Ready and Capable to Care for the Resident

A. Confirm understanding of resident’s care needs from hospital staff
B. Resolve any questions regarding resident status to ensure fit between resident needs and SNF resources and capabilities

Learnings from STAAR

- Co-design warm handovers with hospital and SNF
- Ensure calls do not get “lost” (e.g., use a direct phone line for warm handovers or have a receptionist treat warm handover calls similar to a physician call)
- Have a physician-to-physician warm handover one day before discharge or ensure a contact number if questions arise
- Consider HHC, SNF or LTC liaisons based in the hospital (e.g., HHC liaisons help MDs determine qualifications for home health care)
Nursing Home Capabilities List

This list is for hospital emergency rooms, hospitals, and care managers and for physicians, NPs, and PAs who take off-hours calls for the facility to assist with decisions about hospital admission or return to the facility.

<table>
<thead>
<tr>
<th>Facility Address</th>
<th>Key Contact</th>
</tr>
</thead>
</table>

- Telephone
- Facsimile
- E-mail
- Internet
- Other

- Notes

Available at www.interact2.net.
Acute Care Transfer Document Checklist

- Resident Name: ____________________________
- Facility Name: ____________________________

Copies of Documents Sent with Resident (check all that apply):
- Discharge Summary
- Discharge Instructions
- Medical History
- Medications
- Laboratory Results
- Other

Documents Recommended to Accompany Resident:
- Discharge Summary
- Medical History
- Medications
- Laboratory Results
- Other

Send These Documents (if needed):
- Recent History and Physical
- Recent Lab Results
- Recent History and Physical
- Recent Lab Results
- Recent History and Physical
- Recent Lab Results
- Recent History and Physical
- Recent Lab Results
- Recent History and Physical
- Recent Lab Results

Emergency Department:
Please ensure that these documents are forwarded to the hospital until the resident is admitted. Thank you.

[Signatures and dates]

Available at www.interact2.net.

Hospital to Post-Acute Care Transfer Form

Available at www.interact2.net.
2. Reconcile Treatment Plan and Medications

A. Re-evaluate the resident’s clinical status since transfer

B. Reconcile the treatment plan and medication list based on;
   - Assessment of the resident’s status,
   - Information from the hospital, and
   - Past knowledge of the resident (if applicable)

C. Make a plan for timely consult when the resident’s condition changes
Learnings from STAAR

- Co-design a standardized transfer form to ensure all critical information is reliably shared between care settings
- Try innovative ideas e.g., sending 3-day supply of meds with the patient
- Include “what matters to the patient” in the warm handover and communicate your understanding of that to the patient

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**Stop and Watch Early Warning Tool**

Seems different than usual
Talks or communicates less
Overall needs more help
Pain – new or worsening; Participated less in activities
Ate less
No bowel movement in 3 days; or diarrhea
Drank less
Weight change
Agitated or nervous more than usual
Tired, weak, confused, or drowsy
Change in skin color or condition
Help with walking, transferring, toileting more than usual

**SBAR Communication Form**

Available at www.interact2.net.
3. Engage the Resident and Family in a Partnership to Create an Overall Plan of Care

A. Assess the resident’s and family or caregiver’s desires and understanding of the plan of care

B. Reconcile the care plan developed collaboratively with the resident and their family caregiver
Learnings from STAAR

- Use the Teach Back method in your conversations with the resident and family (e.g., with palliative care or end-of-life care discussions)
- Share information about the resident’s health care choices across the continuum

Advance Care Planning Communication Guide
Part 1: Tips for Starting & Conducting the Conversation

Set the Stage
1. Get the facts – understand the resident’s conditions and prognosis.
2. Choose a private environment.
3. Determine an agenda for the meeting and who should be present.
4. Allow adequate time – usually these discussions take at least 30 minutes.
5. Turn cell phone or beeper to vibrate to avoid interruptions and demonstrate full attention.
6. If the resident is involved, sit at eye level with her or him.
7. Have tissues available.

Available at www.interact2.net.
Other Test Ideas from Teams

- Timely discharge summary to SNF partner
- Follow-up phone call to SNF 24-48 hrs post transfer
- Process for warm handover for:
  - Nursing
  - Case Management
  - Physicians
- Regular meetings with SNF medical directors, providers and emergency care physicians and or hospitalist

Other Test Ideas from Teams

- Weekly conference call-in for all SNFs to debrief on transfers occurring that week
- Regular meetings to review SNF readmissions with acute care team
- Education Plan to ED, primary care and the patient and family on Medicare 30-day Rule
- Include pharmacy in the transfer process
What Is One New Thing You Learned Today That You Would Like to Test?

Opportunities Discovered through Diagnostic Reviews

• Lack of a clear picture of the resident’s entire history, including the severity of the resident’s condition and complications during hospitalization (e.g., *C. difficile* infection, pressure ulcers, urinary tract infection, delirium)

• Inadequate availability and consistency of primary care providers for residents; lack of an available primary care provider who is familiar with the resident’s condition and treatment when a resident’s status changes
Opportunities Discovered through Diagnostic Reviews – continued

• Premature discharge from the hospital with unstable clinical condition
• Lack of advance directives, palliative care services, and other types of care that prevent readmission to the hospital
• Lack of understanding of patient and families’ care goals and preferences