Improving Transitions Into Skilled Nursing Facilities

Peg M. Bradke

September 29, 2015
Session Objectives

Participants will be able to:

- Identify effective tools from the INTERACT 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
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 to Home
- Post-acute Care/Sub-acute Care
- Assisted Living
Discussion in Your Cross-Continuum Team

- Describe how a patient and family would ideally experience care as they transition into a SNF setting (i.e., what they might want and need).
- Identify three things that you will need to do in order to deliver that ideal care for your patients and families.
SNF Functions as Key Transitions Out of the Acute Care Episode

- Results of hospital care are dependent on the post-acute care
- Appropriate follow-up care post-SNF matters equally
  - SNF discharges to Home Health (30%); Outpt. Rehab. (6%)
- National SNF Readmission Rate Average = 22%
- Quality, staff skill mix, and available technology differs significantly by site
- One-third of beneficiaries admitted to SNFs experience a care-related adverse event
### Timely Consults

#### Stop and Watch Early Warning Tool

If you have identified a change while caring for or observing a resident, please **circle** the change and notify a nurse. Either give the nurse a copy of this tool or review it with her/him as soon as you can.

- 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 and Progress Note

**Before Calling MD / NP / PA:**
- Evaluate the Resident: Complete relevant aspects of the SBAR form below
- Check Vital Signs: BP, pulse, and/or respiratory rate, temperature, respiratory rate, axiometry, and finger stick glucose, if indicated
- Review Records: Recent progress notes, labs, orders
- Review an INTERACT Care Path or Acute Change in Condition File Card, if indicated
- Have Relevant Information: Available when Reporting (i.e., medical record, vital signs, advance directives such as DNR and other care limiting orders, allergies, medication list)

#### Situation

- The change in condition, symptoms, or signs I am calling about is/are
- This started on _/__/____ Since this started it has gotten _ Worse _ Better _ Stayed the same
- Things that make the condition or symptom worse are
- Things that make the condition or symptom better are
- This condition, symptoms, or sign has occurred before: _ Yes _ No
- Treatment for last episode (if applicable)
- Other relevant information:

#### Background

- Resident Description: This resident is in the NH for: _ Post-Acute Care _ Long-Term Care
- Primary diagnoses:
- Other pertinent history (e.g., medical diagnosis of CHF, DM, COPD):

#### Medication Alerts

- Changes in the last week (describe below) _ Resident is on Warren’s/course/medication Result of last INR _ Date _/

#### Vital Signs

- Blood Pressure _ Pulse _ Apical HR _ RR _ Temperature _ Weight _ lbs _ (date _/

- For CHF, edema, or weight loss: last weight before this event was _ on _/

- O2 saturation _ on _ O2 (liters/minute) _

- Residents Name

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Subjects: The population of interest is a cohort of long-stay NH residents. Data are from the Nursing Home Stay file, a sample of residents in 10% of certified NHs in the United States (2006–2008).

Results: Three-fifths of hospitalizations were potentially avoidable, and the majority was for infections, injuries, and congestive heart failure.
We are in this Together

The Bottom Line

“Collaboration among hospitals and community-based providers is essential for improving transitions between care settings and keeping discharged patients out of the hospital. Fostering partnerships among providers, payers, and health plans can help identify causes of avoidable rehospitalizations and align programs and resources to address them.”

Process Changes to Achieve an Ideal Transition from Hospital (or SNF) to Home
40% of Medicare Discharges Admit to PAC

Hospital

- Continuing Care Hospital (2%) ≤ 17%
- Inpatient Rehabilitation (30%) ≤ 12%
- Skilled Nursing Facility (43%) ≤ 22%
- Home Health (37%) ≤ 28%
- Outpatient Therapies (9%) ≤ 20%

Source: RTI/Cain Brothers Analysis, "Integrating Acute and Post-Acute Care" 2012
40% of the Medicare patients utilize PAC services

Medicare per capita spending on post-acute services is growing at 5% a year

PAC shows the greatest variation in spending compared to acute and ambulatory
Looming Threats for Post-Acute Care

- Broadening readmission penalties for acute providers extending into post-acute care.
  - MedPAC recommendation: FY 2017 would mark the beginning of reduced payment for SNFs failing to meet standards for lower RR. Could cost a SNF up to 3% of Medicare reimbursement.

- Due diligence in obtaining publicly available information to make decisions.
  - Only 2% of consumers use STAR ratings to make decision.

- Connectivity and engagement strategies.
Working in Cross-Continuum Teams

By understanding mutual interdependencies of the patient’s journey across the care continuum, the team can co-design processes to improve transitions in care.

Collectively, team members should explore the ideal flow of information and patient/family experiences for the individual patient and their family.
Resources Successful CCT Use to Identify Ways to Reduce Harm During Care Transitions

- INTERACT - Interventions to Reduce Acute Care Transfers
- IHI How to Guide
- Advancing Excellence (AE) – Volunteer Quality Campaign based on measurement of meaningful goals
- National Partnership to Improve Dementia Care
- Quality Assurance and Performance Improvement (QAPI)
- National Nursing Home Quality Care Collaborative
How-to Guide: Improving Transitions from the Hospital to Skilled Nursing Facilities to Reduce Avoidable Rehospitalizations.

Available at www.IHI.org.

Available at www.interact2.net.
Quality Improvement Tools

- How many transfers from your hospital or nursing home (for home health)?
- When do they occur?
- How many days since admit?
- “Ah ha” moments
- Online version
Quality Improvement Tools

Root Cause Analysis: The Rest of the Story
• Demographics
• What happened
• Contributing factors
• Attempts to manage in SNF
• Avoidable?
• Staff thoughts about this
• Opportunities for improvement
• Cross continuum review of cases

Quality Improvement Tool
For Review of Acute Care Transfers

The INTERACT QI Tool is designed to help you analyze hospital transfers and identify opportunities to reduce transfers that might be preventable. Complete this tool for each or a representative sample of hospital transfers in order to conduct a root cause analysis and identify common reasons for transfers. Examining trends in these data with the INTERACT QI Summary Tool can help you focus educational and care process improvement activities.

SECTION 1: Describe Resident Characteristics

Resident ID __________________________ Age _____________

Date of most recent admission to nursing home _______ / _______ / _______

a. Major diagnoses at admission

b. Conditions that put the resident at risk for hospital admission or readmission:

- Hospitalization within the last 6 months
- COPD
- Polypharmacy (e.g., 9 or more medications)
- Surgical complications
- Fracture
- CHF
- Cancer on active chemo or radiation therapy
- Multiple co-morbidities (e.g., CHF, COPD and DM in the same patient or multiple active diagnoses)
- Other (describe)

- Yes (list dates and reasons)

- No

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Relationship Between SNF and Hospital Information on Readmissions

- SNFs utilize the QI tool on a transfer back to hospital
- Suggest the hospital use their diagnostic tool for readmissions
- Combine the learning from the two analyses and see what can be discovered
- Interview patient/caregiver, clinicians and staff to identify problem areas from their perspective
- Similarities can be discovered, and the discussion will surface contributions on both ends
Hospital to SNF Handover Tests

- Interview or observe a handover to a post-acute or community partner
  - Did the community partner get the information they needed in a format they desired? Were there unresolved issues?
  - How could the handover be improved?
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.
Co-designing to Support the Patient

- Co-design with the hospital a standardized transfer form to ensure all critical information is reliably shared (with the preferred format)

- Establish process for warm handover for
  - Nursing
  - Case Management
  - Physician

Unintended Result: Building Relationships
Learnings

- Ensure calls are reliably received (do not get “lost”). For example, have a direct phone line for warm handovers or have a receptionist treat all warm handover calls similar to a physician call.

- Have a physician-to-physician warm handover before discharge for any questions that arise.

- Try out innovative ideas such as sending three-day supply of meds with the patient.
Learnings

- When providing patient education information, remember to include their ability to Teach Back.
- Include “what matters to the patient” in the warm handover.
- Communicate what patient’s greatest worry is.
Handovers to Skilled Nursing Facilities

- Consider establishing SNF liaisons that are based in the hospital.
- Share patient education materials and educational processes across care settings.
- Offer education for the staff in SNF/LTC.
- Create processes for bidirectional communications for care coordination, continual learning and ongoing improvement efforts.
IHI Toolkit: Ensure SNF Staffs 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.
# Nursing Home Capabilities List

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

<table>
<thead>
<tr>
<th>Facility</th>
<th>Address</th>
<th>Tel (_______)</th>
<th>Key Contact</th>
</tr>
</thead>
</table>

Circle "Y" for yes or "N" for no to indicate the availability of each item in your facility.

<table>
<thead>
<tr>
<th>Capabilities</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Care Clinician Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>At least one physician, NP, or PA in the facility three or more days per week</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>At least one physician, NP, or PA in the facility five or more days per week</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td><strong>Diagnostic Testing</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stat lab tests with turnaround less than 8 hours</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Stat X-rays with turnaround less than 8 hours</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>EKG</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Venous Doppler</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Cardiac Echo</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Swallow Studies</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td><strong>Consultations</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatry</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Cardiology</td>
<td>Y</td>
<td>N</td>
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<tr>
<td>Pulmonary</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Wound Care</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Other Physician Specialty Consultations specify</td>
<td>Y</td>
<td>N</td>
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<tr>
<td><strong>Social and Psychology Services</strong></td>
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<td></td>
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<tr>
<td>Licensed Social Worker</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Psychological Evaluation and Counselling by a Licensed Clinical Psychologist</td>
<td>Y</td>
<td>N</td>
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<tr>
<td><strong>Therapies on Site</strong></td>
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<tr>
<td>Occupational</td>
<td>Y</td>
<td>N</td>
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<tr>
<td>Physical</td>
<td>Y</td>
<td>N</td>
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<tr>
<td>Respiratory</td>
<td>Y</td>
<td>N</td>
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<tr>
<td>Speech</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td><strong>Pharmacy Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency kit with common medications for acute conditions available</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>New medications filled within 8 hours</td>
<td>Y</td>
<td>N</td>
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<tr>
<td><strong>Interventions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IV Fluids (Initiation and maintenance)</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>IV Antibiotics</td>
<td>Y</td>
<td>N</td>
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<tr>
<td>IV Medic – Other (e.g. Furosemide)</td>
<td>Y</td>
<td>N</td>
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<tr>
<td>PICC Insertion</td>
<td>Y</td>
<td>N</td>
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<tr>
<td>PICC Management</td>
<td>Y</td>
<td>N</td>
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<tr>
<td>Total Parenteral Nutrition (TPN)</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Isolation (for MRSA, VRE, etc...)</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Surgical Drain Management</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Tracheotomy Management</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Analgesic Pumps</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Dialysis</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Advanced CPR (ACLS capability)</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Automatic Defibrillator</td>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>

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Available at www.interact2.net.
## Capabilities Summarized for Reference

<table>
<thead>
<tr>
<th>Capabilities</th>
<th>LC E/W</th>
<th>JRMC swing-22 (130 Beds)</th>
<th>Northbrook (109 BEDS)</th>
<th>Hiawatha (74 Beds)</th>
<th>Anamosa (74 Beds)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Care Clinical Services</strong></td>
<td><strong>BEDS</strong></td>
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<td>&quot;Stat&quot; lab tests with TAT less than 8 hr.</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>&quot;Stat&quot; x-rays with TAT less than 8 hr.</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td>EKG</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Bladder ultrasound</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
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<tr>
<td>Swallow studies</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>at JRMC</td>
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<td><strong>Consultations</strong></td>
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<td>Psychiatry</td>
<td>N **</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
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<td>N **</td>
<td>Y *</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
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<td>Y *</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
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<td>Wound Care</td>
<td>N **</td>
<td>Y *</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
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<td>Other physician specialty consultations (specify)</td>
<td>Y *</td>
<td></td>
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</table>
Capability List

- How often do you reassess?
- What is the distribution?
IHI Toolkit: 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
INTERACT: Acute Transfer Documentation Checklist

Encourage:
• Signatures
• Handovers
Who should use the “Stop and Watch” tool?

*Stop and Watch*

Early Warning Tool

If you have identified a change while caring for or observing a resident, please **circle** the change and notify a nurse. Either give the nurse a copy of this tool or review it with her/him as soon as you can.

- 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

☐ Check here if no change noted while monitoring high risk patient

Patient/Resident

Your Name
It Takes a Team

- Patient
- Family
- Nursing Staff
- Certified Nursing Aids
- Maintenance
- Groundskeepers
- Dietary Staff

Result: Getting Engagement
Stop and Watch Tool

- Review with Patient and Family/part of admission packet
  - What to expect
  - Place the tool in a user-friendly place
- Goal to keep loved one safe and out of hospital
- Demonstrates everyone's input matters and they are the “eyes and ears”
Stop and Watch Recognition

- Early Recognition - Use as part of your QI:
  - Should intervention have occurred earlier?

- Close the Loop:
  - Follow-up: report back to individual completing within 24 hours of action taken as a result of Stop and Watch

- Recognition for Using:
  - Send Stop and Watch back to person initiating with thank-you note for filling out

- Celebrate
  - Drawing for a watch once a month
SBAR Communication Form
and Progress Note for RNs/LPN/LVNs

Before Calling the Physician / NP / PA / other Healthcare Professional:
☐ Evaluate the Resident: Complete relevant aspects of the SBAR form below
☐ Check Vital Signs: BP, pulse, and/or apical heart rate, temperature, respiratory rate, O₂ saturation and finger stick glucose for diabetics
☐ Review Record: Recent progress notes, labs, medications, other orders
☐ Review an INTERACT Care Path or Acute Change in Condition File Card, if indicated
☐ Have Relevant Information Available when Reporting
  (i.e. medical record, vital signs, advance directives such as DNR and other care limiting orders, allergies, medication list)

SITUATION

The change in condition, symptoms, or signs observed and evaluated is/are ________________________________

This started on ________ / ________ / ________ Since this started it has gotten: ☐ Worse ☐ Better ☐ Stayed the same

Things that make the condition or symptom worse are ________________________________________________

Things that make the condition or symptom better are ________________________________________________

This condition, symptom, or sign has occurred before: ☐ Yes ☐ No

Treatment for last episode (if applicable) ____________________________________________________________

Other relevant information ________________________________________________________________

BACKGROUND

Resident Description
This resident is in the facility for: ☐ Long-Term Care ☐ Post Acute Care ☐ Other: __________________________

Primary diagnoses __________________________________________________________

Other pertinent history (e.g. medical diagnosis of CHF, DM, COPD) __________________________________

Medication Alerts
☐ Changes in the last week (describe) ________________________________

☐ Resident is on (Warfarin/Coumadin) Result of last INR: ________ Date ________ / ________ / ________

☐ Resident is on other anticoagulant (direct thrombin inhibitor or platelet inhibitor)

Resident is on: ☐ Hypoglycemic medication(s) / Insulin ☐ Digoxin
Documentation

- Can the SBAR form and Stop and Watch be part of the record and be the nursing note?
- Can it be built into the electronic record?
IHI Toolkit: 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 or caregiver.
**Decision Support Tools**

**CARE PATH**

**Acute Mental Status Change**

- New Mental Status Change Noted
  - New symptoms or signs of increased confusion
  - Agitation, restlessness, disorientation
  - Decreased level of consciousness
  - Instability to perform usual activities (ie, transfers, transfers)
  - New or worsened physical or mental agitation
  - New or worsened delusions or hallucinations

- Take Vital Signs
  - Temperature
  - HR
  - RR
  - Oxygen saturation
  - Blood pressure

- Vital Signs Criteri (any met?)
  - Temperature: 101.5°F or higher, 39°C or lower
  - HR: > 100 or < 50
  - RR: 24 or more, 10 or less
  - Oxygen saturations: < 90%

- Further Nursing Evaluation
  - Mental Status
  - Functional Status
  - CDAS
  - Skin

- Evaluate Symptoms and Signs
  - Not eating / drinking
  - New or worsened confusion
  - New delusions or hallucinations
  - New onset of confusion
  - Inability to maintain balance
  - Nuerological 
  - School or tremors
  - Blurred vision
  - Seizures
  - New daily behaviors

- Consider Orders for:
  - Blood work
  - Urine tests
  - CT / MRI scans
  - Blood pressure

- Evaluate Results
  - ABG: baseline xanthocromic of 10.6
  - Urine results indicate infection

- Manage in Facility
  - Monitor vital signs
  - Monitor medications

- Monitor Response
  - Vital signs stabilize or worsen

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**Vital Signs**

**Report why vital signs were taken**

<table>
<thead>
<tr>
<th>Vital Sign</th>
<th>Report Immediately</th>
<th>Report on Next Work Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Pressure</td>
<td>Systolic BP &gt; 200 mmHg or &lt; 90 mmHg</td>
<td>Diastolic BP &gt; 90 mmHg</td>
</tr>
<tr>
<td>Pulse</td>
<td>Diastolic BP &gt; 115 mmHg</td>
<td>New irregular pulse</td>
</tr>
<tr>
<td>Respiratory Rate</td>
<td>Resting pulse &gt; 100, &lt; 50</td>
<td>New onset of anasarca with or without weight loss</td>
</tr>
<tr>
<td>Temperature</td>
<td>Respirations &gt; 28, &gt; 10/minute</td>
<td>5% or more within 30 days</td>
</tr>
<tr>
<td>Oral temp &gt; 100.5 F</td>
<td></td>
<td>10% or more within 6 months</td>
</tr>
<tr>
<td>Oxygen saturation &lt; 90%</td>
<td>Weight Loss</td>
<td>Weight Gain</td>
</tr>
<tr>
<td></td>
<td>New onset of anasarca with or without weight loss</td>
<td>&gt; 5 lbs in one week in resident with</td>
</tr>
<tr>
<td></td>
<td>5% or more within 30 days</td>
<td>C-H</td>
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<tr>
<td></td>
<td>10% or more within 6 months</td>
<td>chronic renal failure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>other volume overload state</td>
</tr>
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**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.
Measurement

- Readmission Rate to Hospital (or ER):
  - Within 30 days post hospital d/c
  - Within 90 days post hospital d/c
  - Less than three days post hospital discharge
  - 30-day post SNF discharge

- Patient Satisfaction

- Discharge to Community

- Discharge to Home Health

- Patient scheduled to be seen within seven days from SNF discharge.
Now Available: Assisted Living and Home Health

INTERACT
Interventions to Reduce Acute Care Transfers

What is INTERACT?
INTERACT (Interventions to Reduce Acute Care Transfers) is a quality improvement program that focuses on the management of acute change in resident condition. It includes clinical and educational tools and strategies for use in everyday practice in long-term care facilities.

What is the purpose of INTERACT?

www.interact2.net
Other Test Ideas from Teams

- Timely discharge summary to SNF partner
- SNF Medical Director
- Follows patient until first PCP appointment
- Follow-up phone call to SNF 24-48 hours post transfer
- Regular meetings with SNF medical directors, emergency care physicians and/or hospitalist
Other Tests

- **Medication Reconciliation** - sending medication list to pharmacy for review/consult for reconciliation. SNF list with inpatient list and clinical evaluation of the medication list.
  - Cedar Sinai identified participating patients with drug-related issues was as high as 50%.

- **Nurse Practitioner** evaluated SNF patient within 24 hours of admission to SNF.
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.
- Consider review for 90-day readmissions.
Position for the Future

- Cross-Continuum Teams build relationships, open doors to partnering to improve transitions.
- SNF’s must tell their story to hospitals and the new ACO’s.
- INTERACT tools show your efforts
  - Some ACO’s are utilizing INTERACT as entry criteria
- In the end, what is important to the patient and family is Care Coordination, which requires relationship building.
What Is One New Thing You Learned Today That You Would Like to Test?