New York State Partnership for Patients

Readmission Reduction through Partnership with Skilled Nursing Facilities
Resource Guide

WHAT IS THIS TOOL:

A resource guide to provide sample tools and guides to assist in developing and tailoring a hospital-specific strategy for reducing readmissions from skilled nursing facilities (SNF).

HOW TO USE THIS TOOL:

Select the key strategy (see column 1) that the hospital team and the SNF team would like to focus on and review the interventions in column 2; if the recommended interventions are not present at your hospital, consider reviewing the resources in column 3 and adding them to your discharge process.

Definitions

- *Key strategies* are the overarching approaches or best practices in collaborating with SNFs to increase communications, improve the patient and care partner experience across care transitions, and reduce readmissions
- *Essential elements* are specific actions that hospitals should implement to achieve the key strategy

TIPS FOR USING THIS TOOL:

Prior to selecting tools with your team, you may wish to complete the project charter to help:

- Identify and recruit the internal hospital readmissions team
- Select teams from one or two SNFs with a high volume of readmissions to your hospital
- Clarify the scope of the project and the project's goals

KEY STRATEGY 1: BUILDING AND STRENGTHENING RELATIONSHIPS ACROSS CARE SETTINGS

ESSENTIAL ELEMENT	INTERVENTIONS	RESOURCES
Develop a robust team with key stakeholders from hospital and SNF	Engage leadership support	NYSPFP Project Charter to engage leadership NYSPFP Readmission Reduction Through Partnership with Skilled Nursing Facilities Project Charter https://www.nyspfp.org/materials/snf_hospital_charter.pdf
	Team roles are identified and assigned to include agenda development, meeting facilitation, data collection, and analysis	Resource to help form an effective team *NYSPFP Unit-Based Safety and Quality Improvement Toolkit,* Section 2.1 "Selecting Your Team," page 5 https://www.nyspfp.org/materials/nyspfp_patientsafety_toolkit.pdf
Develop a project meeting structure agreed upon by team (including hospitals and SNF representatives)	Project meeting schedule is established (rotating sites between hospital and SNF is recommended)	Sample tools for effective meetings *NYSPFP Unit-Based Safety and Quality Improvement Toolkit,* Section 2.11 "Holding an Effective QI Team Meeting," page 17 https://www.nyspfp.org/materials/nyspfp_patientsafety_toolkit.pdf
Identify opportunities for improvement	Team review NYSPFP's "Improving Transitions of Care between Acute Care Hospitals and Skilled Nursing Facilities" webinar	Recorded webinar Improving Transitions of Care between Acute Care Hospitals and Skilled Nursing Facilities https://nyspfp.adobeconnect.com/p0lwi1bkajf7player
	Hospital and SNF teams complete process map or flowchart of current care transitions processes, including SNF to ED and ED to SN Hospital to SNF *Recommendation: process map is completed by a subgroup of frontline staff and a facilitator*	Guide to completing a process map NYSPFP Unit-Based Safety and Quality Improvement Toolkit, Section 2.5 "Flowchart," page 9 https://www.nyspfp.org/materials/nyspfp_patientsafety_toolkit.pdf

RESOURCE GUIDE (continued)

ESSENTIAL ELEMENT	INTERVENTIONS	RESOURCES
	Site visits to SNFs and Emergency Departments (ED) are made by hospital and SNF operational teams and physician champions (ED physician and SNF medical director) to gain a better shared understanding of capabilities	N/A
	SNF completes and shares capabilities list	Sample list of SNF capabilities Interact® Version 4.0 Nursing Home Capabilities List http://www.pathway-interact.com/wp-content/uploads/2017/04/nursing_home_capabilities_list-dec-16-2014.pdf
	Pre-meeting work documents and readmissions data are reviewed	Sample chart abstraction tool to identify opportunities for improvement NYSPFP Readmission reduction through partnership with SNF project data abstraction tool https://www.nyspfp.org/materials/snf_hospital_abstraction_tool.xlsx Potential data sources to review for opportunities for improvement NYSPFP readmissions data reports (requires NYSPFP data portal username and password) https://www.nyspfp.org/members/mydata.aspx
Develop an improvement strategy	Aim statement and measures are developed and vetted with team members	Resources to develop an effective improvement strategy IHI Model for Improvement http://www.ihi.org/resources/pages/howtoimprove/default.aspx
	Preliminary action plan developed with small tests of change (i.e., plan, do, study, act [PDSA] cycle)	Sample action planning tool and PDSA guide NYSPFP Unit-Based Safety and Quality Improvement Toolkit, Section 2.8 “Selecting Your Team,” pages 14 and 15 https://www.nyspfp.org/materials/nyspfp_patientsafety_toolkit.pdf

KEY STRATEGY 2: DEVELOP STANDARDIZED PROCESSES FOR COMMUNICATION AND INFORMATION TRANSFER BETWEEN FACILITIES

ESSENTIAL ELEMENT	INTERVENTIONS	RESOURCES
Standardize tools for readmission risk assessment and mitigation	Readmission risk factors are assessed as soon as possible on admission and communicated to all departments to develop care plan	Sample risk assessment tools • https://www.nyspfp.org/materials/readmissions_tracking_tool.pdf • https://www.nyspfp.org/materials/pilot_phase_2_tracking_tool.pdf • https://www.nyspfp.org/materials/pilot_phase_3_tracking_tool.pdf
Review hospital and SNF access to information in the electronic health record (EHR)	Review EHR access across the continuum (from hospital to SNF) to ensure clinicians at both facilities have access to all pertinent information	N/A – project team to work with hospital EHR provider
Implement circle back as a standard part of the discharge process	Ensure questions in circle back are included as standard in the EMR or in discharge documentation. Ensure that circle back is implemented as a standard part of the discharge process	Sample circle back tool NYSPFP Circle Back Interview Tool https://www.nyspfp.org/materials/readmissions_circleback_tool.pdf
Standardize transfer forms and documentation from: • Hospital to SNF • SNF to ED • ED to SNF	Review current transfer forms and modify as needed, with input from hospital, ED, and SNF teams to streamline or enhance the information shared	Sample Transfer forms Interact® 4.0 Nursing Home to Hospital Data Transfer List Interact® 4.0 Hospital to Post-Acute Data List http://www.pathway-interact.com/interact-tools/interact-tools-library/interact-version-4-0tools-for-nursing-homes/ Interact® 4.0 Hospital to Post-Acute Care Transfer Form http://www.pathway-interact.com/wp-content/uploads/2017/04/148604-hospital_to_post_acute_care_transfer_form.pdf

RESOURCE GUIDE (continued)

ESSENTIAL ELEMENT	INTERVENTIONS	RESOURCES
Standardize information in clinician to clinician handoff	Ensure that clinician to clinician verbal handoff communication utilizes a checklist, e.g., SBAR (Situation, Background, Assessment, Recommendation) or other similar tool to ensure the inclusion of key elements needed for an optimal transition	To illustrate importance of handoff *Sentinel Event Alert 58: Inadequate Handoff Communication,* Joint Commission https://www.jointcommission.org/sentinel_event_alert_58_inadequate_handoff_communications/ Sample handoff tools IHI SBAR tool http://www.ihi.org/resources/pages/tools/sbartoolkit.aspx Joint Commission Center for Transforming Healthcare https://www.centerfortransforminghealthcare.org/projects/detail.aspx?project=1 HIPAA Privacy and Security Rules and Joint Commission Standards Are NOT Barriers to Advancing Patient- and Family-Centered Care and Building Partnerships with Patients and Families http://www.ipfcc.org/bestpractices/hipaa-factsheet.pdf
Implement mechanisms to evaluate effectiveness of transfer processes	Evaluate effectiveness of medication reconciliation process *Note: effective medication reconciliation processes should include a mechanism for addressing differences in medication formularies prior to transfer and a process for addressing discrepancies identified by the SNF upon admission*	To review effectiveness of medication reconciliation processes in the hospital NYSPFP Medication Discrepancies Data Collection Tool: For Hospital to SNF Transitions https://www.nyspfp.org/materials/readmission_medrec_6_21_2018.pdf
	Evaluate effectiveness of risk assessment for readmission	To assesses effectiveness of risk factor mitigation strategy NYSPFP Mitigating Risk Factors for Readmission Patient Tracking Sheet https://www.nyspfp.org/materials/readmissions_tracking_tool.pdf

KEY STRATEGY 3: ENGAGING PATIENT, FAMILIES, AND CARE PARTNERS IN CARE TRANSITIONS

ESSENTIAL ELEMENT	INTERVENTIONS	RESOURCES
Engage patient and care partner in care and discharge planning	Ensure processes are in place across the care continuum to identify patient care partners on admission	How and why it is important to identify a care partner New York State's CARE Act: A Guide for Patients and Caregivers https://www.nextstepincare.org/uploads/file/guides/nys_care_act/nys_care_act.pdf
	Ensure patient preferences and goals for care are identified on admission and reflected in multidisciplinary care plans	Sample document for engaging patient and care partner in care NYSPFP My Care Transition Plan
	Ensure SNF admission process includes education on the risks and benefits of returning to the hospital	Sample resource to help educate patients on risks and benefits of hospital readmission Interact® 4.0 "Deciding About Going to the Hospital" (available in multiple languages) http://www.pathway-interact.com/wp-content/uploads/2017/04/148604-deciding_about_going_to_hosptial-v4_0.pdf
	Ensure important health care discussions are conducted in patient's and/or care partner's preferred language	Toolkit on reducing disparities in readmissions CMS Guide to Reducing Disparities in Readmissions https://www.cms.gov/about-cms/agency-information/omh/downloads/omh_readmissions_guide.pdf
	Ensure patient and care partner cultural preferences are understood and incorporated into care plans	Toolkit on reducing disparities in readmissions CMS Guide to Reducing Disparities in Readmissions https://www.cms.gov/about-cms/agency-information/omh/downloads/omh_readmissions_guide.pdf

RESOURCE GUIDE (continued)

ESSENTIAL ELEMENT	INTERVENTIONS	RESOURCES
Engage patient and care partner in care and discharge planning (continued)	Educational materials are reviewed for health literacy and accessibility to special and vulnerable populations (e.g., elderly, cognitively impaired)	Resource to aid tailoring of educational materials for different health literacy needs US Department of Health and Human Services, Centers for Disease Control and Prevention https://www.cdc.gov/healthliteracy/pdf/olderadults-508.pdf Centers for Medicare & Medicaid Services, Guide to Reducing Disparities in Readmissions https://www.cms.gov/about-cms/agency-information/omh/downloads/omh_readmissions_guide.pdf
	SNF admission process includes review and confirmation of patient goals for care with patients, families, and care partners	Sample tools to help staff engage patients and care partners in discussing goals for care INTERACT® Version 4.0 Tools For Nursing Homes http://www.pathway-interact.com/interact-tools/interact-tools-library/interact-version-4-0tools-for-nursing-homes/
	Conduct patient and care partner interviews when readmissions occur and responses are aggregated to identify opportunities for improvement	Sample tool for hospitals to use to identify opportunities for improvement NYSPFP Patient and Care Partner Interview tool: Readmission from SNF https://www.nyspfp.org/materials/readmissions_interview_tool.pdf
	Ensure that MOLST or advance care planning documents reflect patient goals for care and accompany the patients during care transitions	Additional information on MOLST Medical Orders Life-Sustaining Treatment www.molst.org Resources for hospital staff to help guide end-of-life conversations The Conversation Project www.theconversationproject.org

KEY STRATEGY 4: UNDERSTANDING THE USE AND CAPABILITIES OF EMERGENCY DEPARTMENT AND OBSERVATION STATUS

ESSENTIAL ELEMENT	INTERVENTIONS	RESOURCES
Review the pre-admission communication	Ensure a system is in place (e.g., a dedicated phone line) for SNF clinicians to have a pre-transfer discussion with ED clinicians to discuss the reason for transfer Ensure an alert system is in place to identify SNF patients in the ED suitable for targeted interventions by designated personnel (e.g., case managers)	Resource for hospital and SNF teams on pre-admission communication NYSPFP Improving Transitions of Care between Acute Care Hospitals and Skilled Nursing Facilities, September 28, 2017 https://nyspfp.adobeconnect.com/p0lwi1bkajf7player
Ensure the ED fully leverages ED capabilities (including observation status and hospitalists)	Ensure that the ED admit decision process includes: • Determination if patient can be treated and returned to SNF • Consider use of observation status in the ED when appropriate as an alternative to admission	N/A
Explore expanded capabilities at both the hospital and the SNF	Review existing processes including use of observation status and scheduling of urgent outpatient procedures, instead of admitting patients (such as for gastric tube replacements or diuresis for SNF patients)	Resource on the role of the hospitalist in reducing readmission https://nyspfp.org/materials/nyspfp_hospitalist_readmission_report.pdf