Hospital to Skilled Nursing Facilities

Improving the transition from hospital to post-acute facility (skilled nursing, inpatient rehabilitation, and other similar facilities) is a high-leverage opportunity for improvement for the following reasons:

- Readmissions rates are generally highest between hospitals and post-acute facilities
- Warm handoffs can be implemented, with opportunities for clarification
- Clinical changes can be identified and addressed in the facility, or via treat and return from the emergency department

**Best practices to improve the transition from hospital to skilled nursing facilities include:**

- Know your data – for the hospital and each skilled nursing facility
- Jointly review readmission events between hospital and skilled nursing facility
- Form a working group with numerous providers to improve efficiency and enhance learning
- Use readmissions reviews to generate specific ways to improve handoffs and emergency department transfers
- Implement nurse to nurse warm handoffs, with the hospital nurse to call the skilled nursing facility within 24 hours to “circle back”
- Provide phone/pager number for questions and clarifications
- Send written hard copies of pain medication prescriptions at transfer
- Send a three-day supply of narcotics and other difficult-to-obtain medications to the skilled nursing facility
- Adopt the principle that the receiver defines what information it needs to assume care
- Refer to the INTERACT-3 hospital to skilled nursing facility example transfer document
- Skilled nursing facilities adopt INTERACT-3 practices
- Work with emergency department teams to use the INTERACT forms; treat and return rather than readmit
- Ensure a safe transition from the skilled nursing facility to home using similar hospital to home practices

A worksheet prompting specific action planning to improve your hospital to skilled nursing facility transitions is in the Appendix.
Hospital to Home Health

The transition from hospital to home health (nurse, therapist, medical social worker, home health aide) is a high-leverage opportunity for improvement for the following reasons:

- They typically represent the second highest rates of readmission (second to skilled nursing facilities)
- By definition, patients have "readmissions risks" (need skilled care, multiple comorbidities)
- Clinicians scheduled to provide follow-up soon after discharge are an important asset

Best practices to improve the transition from hospital to home health include:

- Know your data – for hospital and for each agency
- Jointly review cases of readmissions from home health and generate ideas for improvement
- Form a home health work group to meet with several agencies at once and share learning
- Have a home health liaison meet with the patient, caregiver, and staff prior to discharge
- Provide first contact within 24 to 48 hours; consider daily contact by phone for first 14 days
- Front-load the episode by providing intense contact by phone and in person at initiation
- Provide patients and caregivers with a symptom-specific action plan with customized info
- Provide “call me first” instructions to the patient and caregivers
- Ensure all patients have a primary care provider and follow-up within three to five days
- Ensure medications are clarified within 48 hours of episode initiation; escalate if needed
- Ensure equipment and prescriptions are received; escalate if needed
- Discuss goals of care, reason for hospitalization, home care goals, and patient goals
- Obtain orders for other disciplines, to provide “head-to-toe” treatment plan
- Create a high-risk alert system so staff on call are informed of high-risk patients
- Share readmission risk assessments conducted inpatient with post-acute providers

A worksheet prompting specific action planning to improve your hospital to home health transition is in the Appendix.
The transition from hospital to home is the most common transition type, and it is fraught with challenges for patients, caregivers, and community-based providers. Patients should not leave the hospital without:

- A follow-up appointment three to five days following discharge
- A contact number (hospital or otherwise) to call with questions post-discharge
- A clear, accurate medication list, with confirmed ability to obtain medications
- A verbalized understanding of why they were hospitalized and self-care instructions

Best practices to improve the transition from hospital to home include:

- Identify patients at high risk of readmission based on clinical, utilization, and social factors
- Identify the “learner:” do not assume the patient will retain information
- Use “teach-back” with patients/caregivers
- Ensure goals of care discussions are communicated to receiving clinicians
- Complete discharge summary at the time of discharge
- Ensure follow-up appointments are made prior to discharge
- Ensure follow up of some sort (phone, visit, office) occurs within 24 to 72 hours for high-risk patients
- Provide a direct linkage to existing community-based care managers
- Provide transitional care for high-risk patients without community-based care managers
- Use hospital-based or community pharmacists to assist with medication management
- Provide bedside delivery of medications to reduce barriers to adherence
- Know local services and support and optimize available resources

A worksheet prompting specific action planning to improve your hospital to home transitions is in the Appendix.
Reducing readmissions by focusing on the “front door”

Many readmissions reduction best practices have been developed from a body of literature that documented the failures of the discharge process and vulnerabilities of the post-discharge period. Thus, strategies to reduce admissions and readmissions from the emergency department are relatively under-described. However, some of the most successful examples of these strategies include the emergency department:

- One strategy used by Maryland’s Total Patient Revenue hospitals (those operating under a global budget) was to staff social workers in the emergency department to connect individuals to community resources
- The Massachusetts General Hospital’s CMS High Cost Beneficiary Demonstration \(^1\) notified the patient’s extended care team when registered by emergency department triage; the care team was expected to propose and coordinate ambulatory care as an alternative to an admission
- INTERACT (Interventions to Reduce Acute Care Transfers), the gold-standard resource for skilled nursing facilities to reduce readmissions and avoid unnecessary admissions, focuses heavily on providing complete, succinct information to the emergency department and facilitating evaluate-and-return when safe and appropriate

Best practices to reduce (re)admissions from the emergency department include:

- Train emergency department staff on how to use INTERACT forms from skilled nursing facilities; encourage emergency department physicians to call to clarify the nature of the complaint, especially if the patient cannot provide detailed information
- Develop an understanding with local skilled nursing facilities about the circumstances under which they can accept patients back from the emergency department
- Ask local skilled nursing facilities to fill out the INTERACT “Nursing Home Capabilities List,” and post it in key areas of the emergency department to facilitate returns for low-acuity conditions
- Staff a dedicated admission avoidance care transitions clinician in the emergency department to coordinate with families, outpatient providers, and social services for patients with low-acuity presentations who could be discharged without admission
- Create a flag in the emergency department record to make it visible to staff that the patient is a frequent user or a potential 30-day readmission
- Create individualized care plans for frequent users who present with recurrent but otherwise stable complaints