Improving Transitions & Reducing Readmissions from Skilled Nursing Facilities

Amy E. Boutwell, MD, MPP
Collaborative Healthcare Strategies
Agenda

• Why this is so important
• What we know: a review of the data
• Getting started: best practices
• Applications for other post acute and community based providers & group discussion
Objectives

- Describe why improving transitions & reducing readmissions from SNF is an immediate priority in MD

- Describe major policy, payment or market forces that align incentives between hospitals & SNFs to reduce readmissions

- Restate the current average 30-day readmission rate from SNFs

- Identify INTERACT-3 as the gold-standard reference for improving processes to reduce avoidable hospital transfers from SNF

- Non-SNF, community based providers make links to their settings
Why this is so important …..now
Maryland has a substantially higher readmission rate than the US.

Maryland must “close the gap” over the next 5 years to meet the US average rate of readmissions.

This will require a faster pace of improvement in MD than the nation!

2014 financial pressure on hospitals to intensify efforts to reduce RA.

Attention from state-level stakeholders and associations.

125 people from 80 SNFs in MD trained in INTERACT June 2013.
CMS has data on all SNF readmissions
  – Reported quarterly for the US and state-by-state

CMS is developing a SNF 30-day all cause readmission measure

CMS is developing “readmission penalties” for SNFs (2017) projected to total $2.2 billion over 10 years

Office of the Inspector General’s November 2013 report analyzed hospitalizations from SNFs SNF by SNF
Leadership Perspectives
What we know: A Review of the Data
Department of Health and Human Services
OFFICE OF INSPECTOR GENERAL

MEDICARE NURSING HOME RESIDENT HOSPITALIZATION RATES MERIT ADDITIONAL MONITORING

Daniel R. Levinson
Inspector General
November 2013
OEI-06-11-00040
EXECUTIVE SUMMARY: MEDICARE NURSING HOME RESIDENT HOSPITALIZATION RATES MERIT ADDITIONAL MONITORING
OEI-06-11-00040

WHY WE DID THIS STUDY
Nursing homes hospitalize residents when physicians and nursing staff determine that residents require acute-level care. Such transfers to hospitals provide residents with access to needed acute-care services. However, hospitalizations are costly to Medicare, and research indicates that transfers between settings increase the risk of residents’ experiencing harm and other negative care outcomes. High rates of hospitalizations by individual nursing homes could signal quality problems within those homes.

HOW WE DID THIS STUDY
We used administrative and billing data both for nursing homes and hospitals to identify all Medicare residents in Medicare- or Medicaid-certified nursing homes who experienced hospitalizations—i.e., transfers to hospitals for inpatient stays—in fiscal year (FY) 2011. We included all Medicare nursing home residents—those in Medicare-paid skilled nursing and rehabilitative (referred to as “SNF”) stays and those in nursing home stays not paid for by Medicare, which include long-term care (LTC) stays—in our analysis. We calculated the percentage of Medicare nursing home residents that each nursing home hospitalized. We identified the diagnoses associated with these hospitalizations, calculated Medicare reimbursements for the hospital stays, and calculated the rates and costs of hospitalizations of nursing home residents. We also examined the extent to which annual rates of resident hospitalizations varied among individual nursing homes.

WHAT WE FOUND
In FY 2011, nursing homes transferred one quarter of their Medicare residents to hospitals for inpatient admissions, and Medicare spent $14.3 billion on these hospitalizations. Nursing home residents went to hospitals for a wide range of conditions, with sepsis the most common. Annual rates of Medicare resident hospitalizations varied widely across nursing homes. Nursing homes with the following characteristics had the highest annual rates of resident hospitalizations: homes located in Arkansas, Louisiana, Mississippi, or Oklahoma and homes with one, two, or three stars in the Centers for Medicare & Medicaid Services’ (CMS) Five-Star Quality Rating System.

WHAT WE RECOMMEND
In its comments on the draft report, CMS concurred with both of our recommendations to: (1) develop a quality measure that describes nursing home resident hospitalization rates and (2) instruct State survey agencies to review the proposed quality measure as part of the survey and certification process.

“when physicians and nursing staff determine...require acute care”
Facility-by-facility analysis – SNF and LTC; rates, diagnoses, and $$ analyzed variation across facilities
1 in 4 residents hospitalized
>$14 Billion
Range of diagnoses, sepsis #1
Wide variation across facilities
Measure NH hospitalizations; surveyors to focus on this
<table>
<thead>
<tr>
<th>State</th>
<th>Rate</th>
<th>State</th>
<th>Rate</th>
<th>State</th>
<th>Rate</th>
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<tbody>
<tr>
<td>Louisiana</td>
<td>38.3%</td>
<td>Maryland</td>
<td>25.3%</td>
<td>Nevada</td>
<td>20.9%</td>
</tr>
<tr>
<td>Mississippi</td>
<td>35.7%</td>
<td>Indiana</td>
<td>24.9%</td>
<td>New Mexico</td>
<td>19.5%</td>
</tr>
<tr>
<td>Arkansas</td>
<td>31.7%</td>
<td>Florida</td>
<td>24.9%</td>
<td>Wyoming</td>
<td>19.1%</td>
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<td>Oklahoma</td>
<td>31.6%</td>
<td>Michigan</td>
<td>24.8%</td>
<td>New Hampshire</td>
<td>19.0%</td>
</tr>
<tr>
<td>Kentucky</td>
<td>29.2%</td>
<td>Virginia</td>
<td>24.8%</td>
<td>Washington</td>
<td>18.6%</td>
</tr>
<tr>
<td>Illinois</td>
<td>29.0%</td>
<td>Connecticut</td>
<td>24.7%</td>
<td>Wisconsin</td>
<td>18.3%</td>
</tr>
<tr>
<td>Tennessee</td>
<td>28.4%</td>
<td>California</td>
<td>24.2%</td>
<td>Vermont</td>
<td>17.9%</td>
</tr>
<tr>
<td>New Jersey</td>
<td>28.2%</td>
<td>North Carolina</td>
<td>24.2%</td>
<td>Colorado</td>
<td>17.8%</td>
</tr>
<tr>
<td>Texas</td>
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<td>Delaware</td>
<td>24.2%</td>
<td>Maine</td>
<td>17.2%</td>
</tr>
<tr>
<td>Missouri</td>
<td>27.9%</td>
<td>Pennsylvania</td>
<td>23.4%</td>
<td>Montana</td>
<td>17.0%</td>
</tr>
<tr>
<td>Kansas</td>
<td>27.5%</td>
<td>South Dakota</td>
<td>23.4%</td>
<td>Alaska</td>
<td>16.9%</td>
</tr>
<tr>
<td>New York</td>
<td>27.4%</td>
<td>Ohio</td>
<td>23.0%</td>
<td>Arizona</td>
<td>16.7%</td>
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<td>Alabama</td>
<td>26.9%</td>
<td>Iowa</td>
<td>22.9%</td>
<td>Minnesota</td>
<td>16.0%</td>
</tr>
<tr>
<td>West Virginia</td>
<td>26.5%</td>
<td>Nebraska</td>
<td>22.7%</td>
<td>Idaho</td>
<td>15.9%</td>
</tr>
<tr>
<td>District Of Columbia</td>
<td>26.5%</td>
<td>Massachusetts</td>
<td>22.5%</td>
<td>Oregon</td>
<td>14.9%</td>
</tr>
<tr>
<td>Georgia</td>
<td>26.3%</td>
<td>Rhode Island</td>
<td>21.6%</td>
<td>Utah</td>
<td>14.2%</td>
</tr>
<tr>
<td>South Carolina</td>
<td>25.3%</td>
<td>North Dakota</td>
<td>21.4%</td>
<td>Hawaii</td>
<td>10.6%</td>
</tr>
</tbody>
</table>
SNF hospitalizations cost more than average

• Hospitalization of patients from SNF/LTC averages $11,255

• Average Medicare hospitalization cost is $8,447

• 33% higher
236 of 285 Diagnostic Categories Invoked

Table 1: Primary Diagnoses on Claims of All Hospitalized Medicare Nursing Home Residents in FY 2011

<table>
<thead>
<tr>
<th>CCS Primary Diagnosis Category</th>
<th>Percentage of Hospitalizations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fifteen Most Frequent CCS Categories</strong></td>
<td></td>
</tr>
<tr>
<td>Septicemia</td>
<td>60.9%</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>13.4%</td>
</tr>
<tr>
<td>Congestive heart failure, nonhypertensive</td>
<td>7.0%</td>
</tr>
<tr>
<td>Urinary tract infections</td>
<td>5.8%</td>
</tr>
<tr>
<td>Aspiration pneumonitis, food/vomitus</td>
<td>5.3%</td>
</tr>
<tr>
<td>Acute renal failure</td>
<td>4.0%</td>
</tr>
<tr>
<td>Complication of device, implant, or graft</td>
<td>3.9%</td>
</tr>
<tr>
<td>Respiratory failure, insufficiency, or arrest</td>
<td>3.3%</td>
</tr>
<tr>
<td>Gastrointestinal hemorrhage</td>
<td>2.7%</td>
</tr>
<tr>
<td>Complications of surgical procedures or medical care</td>
<td>2.4%</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease (COPD) and bronchiectasis</td>
<td>2.4%</td>
</tr>
<tr>
<td>Delirium, dementia, and amnestic and other cognitive disorders</td>
<td>2.4%</td>
</tr>
<tr>
<td>Acute cerebrovascular disease</td>
<td>2.2%</td>
</tr>
<tr>
<td>Fluid and electrolyte disorders</td>
<td>2.1%</td>
</tr>
<tr>
<td>Fracture of neck of femur (hip)</td>
<td>2.0%</td>
</tr>
<tr>
<td></td>
<td>2.0%</td>
</tr>
</tbody>
</table>
## Cost of Hospitalization from SNF

<table>
<thead>
<tr>
<th>Reason for Hospitalization</th>
<th>Total Cost</th>
<th>$ / Hospitalization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sepsis</td>
<td>$3 billion</td>
<td>$17,430</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>$850 million</td>
<td>$9,500</td>
</tr>
<tr>
<td>CHF</td>
<td>$640 million</td>
<td>$8,700</td>
</tr>
<tr>
<td>Aspiration Pneumonia</td>
<td>$618 million</td>
<td>$12,200</td>
</tr>
<tr>
<td>Complications</td>
<td>$450 million</td>
<td>$14,600</td>
</tr>
</tbody>
</table>

OIG November 2013
Effect of Hospital-SNF Referral Linkages on Rehospitalization

Rahman et al, December 2013

• "Stronger hospital-SNF linkages were found to reduce readmission rates"

• “The greater the concentration of discharges a hospital sends to a single SNF, the lower the rate of readmission”

• Specifically lower rates of immediate bounce-backs (days 0-3)
SNF Readmissions in Maryland (Medicare)

59% of d/c to home
55% of all RA from home
19% RA rate
25,654 RA in from home 2012

12% of d/c to HH;
14% of all RA from HH
21% RA rate
6,262 HH RA in 2012

18% of d/c to SNF;
21% of all RA from SNF
22% RA rate
9,879 SNF RA in 2012
Planning for Success: Crunching the Numbers

- 9,879 readmissions
- 230 SNFs in Maryland
- \( \frac{9879}{230} = 43 \) readmissions on average per facility per year
- \( \frac{43 \text{ readmissions per year}}{12} = 3.5 \) readmissions per SNF per month
- Avoid 1 readmission/facility/month \( \Rightarrow 230 \times 12 = 2,760 \text{ per year!} \)
- Reduce annual SNF RA from 9879 to 7119!
Getting Started: Best Practices
“Interventions to Reduce Acute Care Transfers”
Developed by Dr Joe Ouslander & colleagues

Quality improvement approach & tools
Focused on identifying changes early & providing staff tools to act on those observations

Provides protocols for managing common issues on-site
Supports improved communication between SNF – ED
Increase hospital awareness of SNF capabilities
Advanced care planning

….adaptations to assisted living & home health care settings
Nursing facilities who “fully engaged” in the quality improvements and tools in the INTERACT program reduced 30-day readmissions by 24%
### Implementation Guide

**Quality Improvement Tools**

**Determining Baseline Measures and Conducting Root Cause Analyses**
- In order to effectively implement any quality improvement program, you must involve all levels of staff and carry out two activities:
  - Track, trend, and benchmark well-defined measures, and;
  - Learn from root cause analyses of events (in this case hospital transfers).
- INTERACT Quality Improvement Tools are designed to assist with these activities (see description in the.
- To get started, baseline measures can be determined by:
  - Looking back at acute care transfers for the last 3-6 months using the Acute Transfer Log.
  - Reviewing records of several transfers using the INTERACT Quality Improvement Tool in order to identify factors that contribute to transfers and help identify opportunities for initial areas to focus improvement activities.

<table>
<thead>
<tr>
<th>Quality Improvement Tools</th>
<th>Use</th>
<th>Suggested For</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitalization Rate Tracking Tool</td>
<td>INTERACT champion, other facility leadership, and members of the facility quality committee, calculate hospital transfer outcomes (unplanned admissions, 30-day readmissions, emergency room visits within 30 days, and identify trends)</td>
<td>Excel template, formulas to calculate, Advancing Excel-based tool: <a href="http://www.rhquality.org">www.rhquality.org</a></td>
</tr>
<tr>
<td>Acute Care Transfer Log</td>
<td>This tool is a paper and pencil worksheet that can be used to calculate hospital transfer measures to enter into an Excel or other database.</td>
<td>8.5” x 11” pads</td>
</tr>
<tr>
<td>Quality Improvement Tool for Review of Acute Care Transfers</td>
<td>INTERACT champion, other facility leadership, and members of the facility quality committee, root cause analysis of individual transfers</td>
<td>8.5” x 11” pads</td>
</tr>
<tr>
<td>Quality Improvement Summary</td>
<td>INTERACT champion, other facility leadership, and members of the facility quality committee, summary findings and trends from individual PI Reviews, trends should guide educational and care improvement efforts</td>
<td>8.5” x 11” pads</td>
</tr>
</tbody>
</table>

### Implementation Guide

**Advance Care Planning Tools**

**Tools for Improving Resident Admission and Readmission Processes**
- At the time of or shortly after admission, the INTERACT Advance Care Planning Tools can be helpful in discussing options person-centered goals for care, and for palliative and end-of-life care if appropriate (see table below).
- Advance Care Planning should not only be done soon after admission, but should be regularly updated as the resident’s condition changes, especially when acute changes in condition occur.
- For patients admitted for post-acute care, medication reconciliation is a critical task. The INTERACT Medication Reconciliation Worksheet is designed to help nurses, primary care providers, and pharmacists develop accurate and safe medication orders on admission.

<table>
<thead>
<tr>
<th>Advance Care Planning Tools</th>
<th>Use</th>
<th>Suggested Formats</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advance Care Planning Communication Guide</td>
<td>Social workers, licensed nurses, primary care clinicians, clergy, direct care staff, educational tool on how to communicate with residents and family members for those appropriate for palliative or comfort care, or hospice care</td>
<td>Half-page laminated cards in a plastic ring binder or half-page laminated cards in a flip-chart format</td>
</tr>
<tr>
<td>Advance Care Planning Tracking Tool</td>
<td>Social workers, licensed nurses, primary care clinicians, clergy, Documents and tracking advance care planning discussions and refer to more detailed notes about the discussions</td>
<td>8.5” x 11” pads (each page can document multiple discussions) with hole punches for insertion into medical record</td>
</tr>
<tr>
<td>Comfort Order Set</td>
<td>Licensed nurses, primary care clinicians, guidance on examples of orders that may be appropriate for residents on palliative or comfort care plans who decline hospice</td>
<td>8.5” x 11” laminated cards for nurses’ stations, 4” x 6” laminated cards for primary care clinicians</td>
</tr>
<tr>
<td>Educational Information</td>
<td>Directed at residents and families, educational information designed to supplement what is available on various websites that have links on the INTERACT website, POCT, MOCPT, and POST forms illustrated with vignettes discussing DNR and No Enteral Feeding decisions</td>
<td>8.5” x 11” pads (glue adhered) for Benefits page, 8.5” x 11” laminated flip chart for vignettes</td>
</tr>
<tr>
<td>Medication Recommendation</td>
<td>All nursing home licensed nursing staff and/or primary care clinicians, structured medication reconciliation for new admissions or residents returning from the hospital</td>
<td>8.5” x 11” pads (one page, front and back)</td>
</tr>
</tbody>
</table>
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.

STOP
Seems different than usual
Talks or communicates less
Overall needs more help
Pain – new or worsening; Participated less in activities

WATCH
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 apical heart rate, temperature, respiratory rate, oximetry, and finger stick glucose, if indicated
☐ Review Record: 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 has it 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 NH for: ☐ Post-Acute Care ☐ Long-Term Care
INTERACT Clinical Decision Support

Change in Condition
When to report to the MD/NP/PA

Immediate Notification:
- Any symptom, sign or apparent discomfort that is:
  - Acute or Sudden in onset and:
  - A Marked Change (i.e., more severe) in relation to usual symptoms and signs, or
  - Unrelieved by measures already prescribed

Non-Immediate Notification:
- New or worsening symptoms that do not meet above criteria

CARE PATHS
Educational Tool and Aid for Guiding Evaluation of Specific Symptoms Than Community Care
Acute Care Transfers
INTERACT Care Planning Tools

http://interact2.net/tools.html
Keys to Engaging Your Local Hospitals

1. Transitions in care require two partners. Although there are numerous process improvements that INTERACT facilities can implement to improve care and reduce acute care transfers, safely and effectively sending patients to the hospital and receiving patients from the hospital are fundamental to improving transitional care. Hospital discharges to post-acute care (PAC) are very important and high-risk transitions in care setting. By definition, an effective transition requires the active participation of both a sending provider and a receiving provider.

2. The best ‘sending’ to the acute care setting is only meaningful if the receiver uses the information. The INTERACT III Tools include a sample NH-Hospital Transform Form, and a Transfer Document Checklist that can be printed on or taped to an envelope to help guide best-practice with complete NH-hospital transitional care information. INTERACT facilities should invest effort in ensuring that high quality information is transferred to the hospital. You will want to establish a partnership with hospital leadership to ensure that information you send is used to inform and improve care.

3. INTERACT facilities should stand ready to accept the patient back to the facility and avoid a hospitalization, if safe and appropriate. On occasion, a NH clinician will transfer a resident for tests and evaluation, but the clinician and the NH would be willing to accept the patient back following the evaluation when safe and appropriate. This represents a practice change for many hospitals and Emergency Rooms (ERs). Specific dialog about your NH capabilities will benefit your INTERACT goals. In addition, ERs should be encouraged to keep the INTERACT III NH Capabilities List readily available to consult in these situations.

4. INTERACT facilities can influence improved methods of communication and transitioning patients from hospital to NH. INTERACT facilities may note when using the INTERACT III Quality Improvement Tool for review of acute care transfers that early returns to acute care are often a result of poor hand-offs or missing information regarding the hospital clinical course. Hospital-NH partnerships to improve information and hand-off practices will benefit patients, hospitals, and post-acute care facilities. INTERACT III tools include a Hospital to Post-Acute Care Data List and Sample Form to help achieve this goal.

5. INTERACT facilities will demonstrate their value-added in an increasingly competitive post-acute care business environment. Improving care and reducing readmissions and other preventable hospital transfers will not only benefit your patients and your facility’s 30-day readmission rates, but will also provide valuable quality information to your referral base.
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.

**Facility**

**Address**

**Tel (_______)**

**Key Contact**

*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>
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<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>Bladder Ultrasound</td>
<td>Y</td>
<td>N</td>
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<tr>
<td>Venous Doppler</td>
<td>Y</td>
<td>N</td>
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<tr>
<td>Cardiac Echo</td>
<td>Y</td>
<td>N</td>
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<td>Swallow Studies</td>
<td>Y</td>
<td>N</td>
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<td><strong>Consultations</strong></td>
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<td>Psychiatry</td>
<td>Y</td>
<td>N</td>
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</table>

<table>
<thead>
<tr>
<th>Capabilities</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nursing Services</strong></td>
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<td></td>
</tr>
<tr>
<td>Frequent vital signs (e.g. every 2 hrs)</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Strict intake and output (I&amp;O) monitoring</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Daily weights</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Accucheks for glucose at least every shift</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>INR</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>O2 saturation</td>
<td>Y</td>
<td>N</td>
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<tr>
<td>Nebulizer treatments</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Incentive spirometry</td>
<td>Y</td>
<td>N</td>
</tr>
<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>
</tr>
<tr>
<td>IV Meds – Other (e.g. furosemide)</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>PICC Insertion</td>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>
Acute Care Transfer Document Checklist

Resident Name__________________________________________________________ Tel________

Facility Name: __________________________________________________________________________

Copies of Documents Sent with Resident (check all that apply)

Documents Recommended to Accompany Resident

___ Resident Transfer Form

___ Face Sheet

___ Current Medication List or Current MAR

___ SBAR and/or other Change in Condition Progress Note (if any)

___ Advance Directives (Durable Power of Attorney for Health Care)

___ Advance Care Orders (POLST, MOLST, POST, others)

Send These Documents if indicated:

___ Most Recent History and Physical

___ Recent Hospital Discharge Summary

___ Recent MD/INP/PA and Specialist Orders

___ Flow Sheets (e.g. diabetic, wound care)

___ Relevant Lab Results (from the last 1-3 months)

___ Relevant X-Rays and other Diagnostic Test Results

___ Nursing Home Capabilities Checklist (if not already at hospital)

Emergency Department:

Please ensure that these documents are forwarded to the hospital unit if this resident is admitted. Thank you.

Nursing Home to Hospital Transfer Form

Sent To (name of hospital),

Sent From (name of nursing home),

DOB / / Unit ______________________

Contact Person ______________________

Relationship/relative, guardian, or DPOA: ____________

Tel: ( )

Is this the health care proxy? [ ] No [ ] Yes

Notifies of transfer? [ ] No [ ] Yes

Aware of clinical situation? [ ] No [ ] Yes

Primary diagnosis for admission:

Code Status: [ ] DNR [ ] DNH [ ] DNI [ ] Full Code [ ] Uncertain

MD/INP/PA in Nursing Home:

[ ] MD [ ] NP [ ] PA (name): ______________________

Tel: ( )

Who to Call to Get Questions Answered about the Resident:

Name/Title: ______________________ Tel: ( )

Reason(s) for transfer:

Is the primary reason for transfer for diagnostic testing, not admission [ ] No [ ] Yes

Relevant diagnoses:

[ ] CHF [ ] COPD [ ] CIR [ ] DM [ ] Ca (active treatment) [ ] Dementia [ ] Other

Vital Signs:

BP __________ HR __________ Temp __________

Most recent pain level:

Most recent pain med:

Usual Mental Status:

[ ] Alert, oriented, follows instructions

[ ] Alert, disoriented, but can follow simple instructions

[ ] Alert, disoriented, but cannot follow simple instructions

[ ] Not Alert

Usual Functional Status:

[ ] Ambulates independently

[ ] Ambulates with assistance

[ ] Ambulates with assistive device

[ ] Not ambulatory

Additional Clinical Information:

[ ] SBAR Acute Change in Condition Note included

[ ] Other clinical notes included
Hospital to Post-Acute Care Transfer Form

A. Patient Information
- Name ________________________________
- DOB __________ Gender: __ Male or Female
- Language: __ English _ Other
- Race/Ethnicity: __ White _ Black _ Hispanic _ Other

B. Family/Caregiver/Proxy Contact
- Family/Caregiver Name ______________________________________________________
- Healthcare Proxy/Guardian Name (if different) _________________________________
- Tel (______) ________________________

C. Advance Directives/Goals of Care
- _ Do Not Code _ Do Not Resuscitate
- _ Do Not Hospitalize _ Do Not Feeding
- _ Comfort Care _ Hospice Care
- _ Other (specify) ____________________________
- Were goals of care discussed during this hospitalization? _ No _ Yes (specify) ______
- Patient/decisions making capacity? _ Capable _ Requires proxy

D. Transferring Hospital Information
- Hospital _________________________________________________________________
- Unit _________________________________________________________________
- Discharge Date ____________
- Discharge MD __________
- NPI: _______________________
- Patient Admission to Hospital ___________ ___________

E. Post-Acute Care Information
- Transfer to ___________________________ ___________ ___________
- Name to Name ( pertaining) _ No _ Yes ( specify where) ______________________________________________

F. Hospital Physician Care Team Information
- Primary Care Physician (on Admission) ________________________________
- Specialist ____________________________ Specialty: ____________________________
- Specialist ____________________________ Specialty: ____________________________

G. Key Clinical Information
- Vital Signs: _ Temperature _ HR _ RR _ SBP _ DBP _ SPO2 _ Weight __________
- Mental Status: Alert __ Confused __ Oriented to Time __ Oriented to Place __
- Diagnoses: Primary Discharge Diagnosis _________________________________
- Other Medical Diagnoses _____________________________________________
- Mental Health Diagnoses _____________________________________________

H. High Risk Conditions/Treatment Information (check all that apply)
- _ Heart Failure _ New diagnosis _ Exacerbation this admission? _ Date of last echo ___________
- _ Hypertension _ Reexcess ___________ _ Low EF _ Other
- _ Diabetes ___________ _ Other
- _ On O2 ___________ _ Current Flow Rate ___________ _ Other
- _ On Antibiotics ___________ _ Other
- _ Severe Hypothyroid ___________ _ Other
- _ Diabetic patient ___________ _ Other
- _ Maintenance of blood sugar ___________ _ Other

I. Procedures & Key Findings (during this hospitalization) # Please Attach Reports #
- List Procedures (surgery, imaging)

J. Medications and Allergies
- _ New Medications Attached ___________ _ Other
- Patient Allergies: _ None known _ Yes (specify) ____________________________
- Pain meds: _ No _ Yes (specify) ____________________________
- _ DXE ___________________________________
SNF Circle Back Questions (Hospital calls back SNF 3-24h after d/c)
1. Did the patient arrive safely?
2. Did you find admission packet in order?
3. Were the medication orders correct?
4. Does the patient’s presentation reflect the information you received?
5. Is patient and/or family satisfied with the transition from the hospital to your facility?
6. Have we provided you everything you need to provide excellent care to the patient?

Insights
- Transitions are a PROCESS (forms are useful, but only a tool to achieve intent)
- Best done ITERATIVELY with COMMUNICATION

Source: Emily Skinner, Carolinas Healthcare System
Success from Meritus Medical Center

Andrea Horton, RN, BSN, ACM
ALL Skilled Nursing Facility Readmits

- Total SNF Readmits
Relevance for other PAC & Community Providers

Group Discussion
Areas of Relevance with INTERACT

- Review readmissions when they happen
- Track & monitor readmissions from your service/agency
- Improve “reception” into your care
  - Identify key information you need from hospitals & articulate that
  - Improved medication review & clarification procedures
  - Consistent discussions about care preferences
  - Consistent documentation of end of life wishes
- Monitor clients to identify changes early
  - Use tools to capture those observations
- Specify reasons to escalate issues to responding providers
  - SBAR, clinical decision aids
- Develop protocols to manage common issues without ED transfer
- Communicate your setting/agency’s capabilities to hospital
- Improve communication with hospital
- Create options for ED to evaluate & return patient to your care
Thank you!

Next Webinar: January 15 2-3pm

Topic: Reducing Readmissions from Home Health