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CENTERS FOR MEDICARE & MEDICAID SERVICES

Great Plains Quality Innovation Network


Skilled Nursing Facility (SNF)
Shared Best Practices to Reduce Potentially Preventable Readmissions (PPRs)

Referral

- Review referrals to determine if care needs can be met in your facility by:
  - ✓ Having a clinical SNF staff member visit residents who are considered medium- to high-risk referrals to determine acuity, care and equipment needs
  - ✓ Triaging referrals into 'high-medium-low-risk' categories
- Identify residents who are at high risk for readmissions and/or have documented multiple readmissions to determine if needs can be met

Pre-Admission

- Use a consistent checklist to determine potential equipment needs or specialized service requirements, such as: fall precautions, oxygen, continuous positive airway pressure (CPAP)/ventilator, IV, wound vacuum/additional wound supplies/equipment, isolation precautions and specialized needs, such as bariatric lifts/bed; keep this consistent with your facility assessment
- Conduct a pre-admission room huddle with admission nurse and nurse aide to ensure the room is set up with necessary equipment
- Verify that required written prescriptions are complete and accurate, with indication for use, and will accompany the resident on admission
- Use a consistent process for "nurse-to-nurse" report prior to resident transfer for all admissions, readmissions and Emergency Department (ED) visits
- Verify contact information from the discharging care provider point person in the event additional clarification is needed
- Coordinate a handover clinical report from the hospitalist/physician to SNF physician for all residents

Admission Process

- Provide a facility healthcare contact and phone number for the resident, or their representative, to call with questions or concerns about care and resident change in condition
- Utilize a communication tool for care team shift change report that has consistent clinical information
- Request the resident, or their representative, bring in the resident's home medication list and all home medications
- Drug Regimen Review (DRR)-pharmacist review in 24hr; complete a DRR at admission to the SNF with timely follow-up from a physician for any medication issues identified
- Initiate a process where at least two nurses review and verify medication orders and the transfer medication sheet
- Complete a thorough head-to-toe assessment (include thorough skin assessment) and initiate a treatment plan
- Identify/clarify discrepancies, such as duplicate orders, dosages outside the recommended ranges, no indication/diagnosis and/or unnecessary medications
- Clarify lab orders for high-risk medications, such as blood thinners and diabetes medications (https://greatplainsqin.org/initiatives/medication-safety/)
- Orient the resident and their representative to the unit with an explanation of the skill level and clinical services provided by the facility
- Verify need for or appropriate diagnosis related to:
  - ✓ Foley catheter
  - ✓ Opioid medications
  - ✓ Antimicrobial medications
  - ✓ Psychotropic (anti-psychotic) medications and all other medications

During SNF Stay

- Discuss discharge goals with the resident and/or the resident's representative; include those goals in the initial Plan of Care (POC) and subsequent reviews
- Promote an interdisciplinary approach to the individualized POC and discharge plan, which includes nursing assistants, dietary staff, therapy staff and other appropriate team members
- Begin discharge education and support services within 48 hours of resident admission
- Ensure physician completes physical exam within 48 hours of resident admission
- Employ standardized documentation tools, e.g., ®Interact tools, to identify early changes in condition and best clinical practice to reduce the risk of readmissions, such as:
  - ✓ Stop and Watch: (http://www.pathway-interact.com/wp-content/uploads/2017/04/Assisted-Living-Stop-and-Watch.pdf)
  - ✓ Situation, Background, Assessment, Recommendation (SBAR): (http://www.pathway-interact.com/wp-content/uploads/2018/09/INTERACT-V4-SBAR_Communication_Form-Dec_June-2018.pdf)
  - ✓ Care Path: (http://www.pathway-interact.com/interact-tools/interact-tools-library/interact-version-4-0-tools-for-nursing-homes/)
- Discuss advance care plan with resident/family
  - ✓ Determine wishes/goals
  - ✓ Provide education regarding palliative care and hospice, as appropriate
  - ✓ Share resources, including:
    - Serious Illness Conversation Guide: (https://www.ariadnelabs.org/wp-content/uploads/sites/2/2015/08/Serious-Illness-Conversation-Guide-5.22.15.pdf)
    - Five Wishes: (https://agingwithdignity.org/five-wishes/about-five-wishes)
    - The Conversation Project: (https://theconversationproject.org/)
    - Caring Info: (http://www.caringinfo.org/)
- Ensure the resident's wishes are care-planned and communicated with staff, family or representative and resident's physician
- Promote consistent use of the warning/flags offered by Electronic Medical Record (EMR) or facility software
- Review therapy notes daily to identify those residents who have a noted decrease in therapy minutes or participation
- Assess for change in medical condition
- Engage and support development of daily huddles for residents with:
  - ✓ Changes in condition
  - ✓ Recent or abnormal lab results
  - ✓ Prescriptions for high-risk medications (anti-psychotics, opioids, blood thinners, diabetic agents)
  - ✓ High-risk diagnoses, such as sepsis, Chronic Obstructive Pulmonary Disease (COPD), and Congestive Heart Failure (CHF), pneumonia, dementia
  - ✓ Changes in therapy participation
  - ✓ Increased complaints of pain
  - ✓ Changes in behavior
- Promote the use of educational tools that assist in disease management
  - ✓ ®Project RED—Re-engineered Discharge: (http://www.bu.edu/fammed/projectred/)
  - ✓ Project BOOST: (https://www.hospitalmedicine.org/clinical-topics/care-transitions/)
- Enforce nurse accountability for the use of evidenced-based clinical practices, such as:
  - ✓ Daily weights for residents with CHF
  - ✓ Report to physician/cardiologist any weight gain of two pounds or more in one day, or five pounds or more in one week
- Ensure medical directors/ primary care providers conduct brief clinical review huddles with facility caregivers to improve critical thinking skills regarding

residents who are at high-risk for readmission

- Collaborate with pharmacy staff to:
  - ✓ Ensure emergency medication box (E-box) has adequate medication supply
  - ✓ Include pharmacy consultant in inter-disciplinary team meetings
  - ✓ Facilitate ongoing drug regimen review with timely follow-up from a physician for any significant medication issues identified

Preparation for Transfer/Discharge

- Use teach-back methodology with resident education (http://www.ihi.org/resources/Pages/Tools/AlwaysUseTeachBack!.aspx)
- Great Plains Quality Innovation Network teach-back training: (https://greatplainsqin.org/initiatives/coordination-care/teach-back-training/)
- Teach-back video: https://www.youtube.com/watch?v=cllXBnHBiD4
- Document resident's ability to participate in the teach-back methodology
  - ✓ Document areas of outstanding educational opportunities as well as what has already been covered
- Schedule therapy services for a home visit to evaluate home and/or make recommendations for additional safety needs, as appropriate
- Assist and provide information to the resident and/or their representative regarding available post-discharge community services based on resident goals and needs, such as:
  - ✓ Transportation services
  - ✓ Equipment needs (durable medical equipment)
  - ✓ Medication management (availability, medication cost, alternatives, and education)
  - ✓ Special dietary needs (availability, cost, alternatives, and education)
  - ✓ Chore services
- Facilitate exit meeting with the resident, and/or the resident's representative, and Inter-disciplinary Team (IDT) to discuss concerns/questions and identify any outstanding educational opportunities
  - ✓ A family member/caregiver and a representative from next level of care, such as the home health nurse or hospice nurse, should be included
- Educate resident, and/or the resident's representative, about pharmacies that provide transitional care services and packaging assistance
- Arrange and schedule follow-up appointments for residents prior to discharge
  - ✓ Assist with transportation arrangements as necessary
- Complete a discharge summary and provide copies to primary care physician and resident/resident's representative
- Develop a consistent process for nurse-to-nurse report in real time for all transfers/discharges, including physician office, assisted living, home health and dialysis facility
- Schedule follow-up calls with resident post-discharge, and when involved with care, the home health agency (on day 2, 7, 14, 28) to identify any changes in condition that require a readmission or ED visit
- Ensure the following are provided at time of transfer to ED from the SNF:
  - ✓ Nurse-to-nurse report hand-off with a standardized verbal communication tool
  - ✓ Completed transfer form, such as the ®Interact tool
    - Change in condition
    - Current medications
    - Medical management
    - Isolation precautions or MDRO status
    - Current treatment plan
    - Recommendations for ED
    - Documented readmissions within last 30 days

- Communication of SNF's level of service capabilities to ensure a smooth and safe transition back to the SNF setting
- ®Interact Version 4.0 Tools/ Capabilities List (http://www.pathway-interact.com/interact-tools/interact-tools-library/interact-version-4-0-tools-for-nursing-homes/)

Education

- Incorporate clinical education in nurse orientation and periodically assess competency for:
  - ✓ Critical thinking
  - ✓ High-risk diagnoses
  - ✓ High-risk medications
  - ✓ Advance care planning
  - ✓ Dementia care
  - ✓ CMPRP Assessment Toolkit: (https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/CMPRP-Toolkit-1-Instruction-Manual.pdf)
- Utilize expertise of contracted healthcare providers to support additional staff education, including:
  - ✓ Medical Director
  - ✓ Nurse Practitioner
  - ✓ Respiratory Therapist
  - ✓ Pharmacy Staff
  - ✓ Therapist (PT/OT)
- Provide resources and training that will support additional services, such as IV therapy and specialized units
- Set up clinical skills practice labs for nursing staff
- Train and educate key staff on all shifts to promote a peer-to-peer approach to training
- Educate and empower nursing assistants to provide best practice preventative measures, such as:
  - ✓ Ambulation programs
  - ✓ Fall prevention
  - ✓ Cough and deep breathing techniques
  - ✓ Catheter care
  - ✓ Identifying changes in resident's condition
  - ✓ Fluid intake
  - ✓ Proper body alignment and frequent position changes
  - ✓ Skin assessment and care

Resident Readmission to Hospital (within 30 Days of SNF Admission)

- All hospital readmissions within 30 days of SNF admission, necessitate that:
  - ✓ Complete an action plan based on chart audits, data, gaps, trends and drivers of readmission
  - ✓ SNF leadership meets with acute care providers to partner in improving transitions of care in reducing preventable readmissions https://www.nhqualitycampaign.org/goalDetail.aspx?g=hosp#tab2
  - ✓ If a resident is readmitted to the hospital from the SNF within 30 days, the root cause of readmission should be completed within 48 hours
    - ®Interact RCA (http://www.pathway-interact.com/wp-content/uploads/2018/09/INTERACT-QI_Tool-for-Review-Acute-Care-Transf-June-2018-02.pdf)

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