



# Guide for Field Testing:

## Creating an Ideal Transition to a Skilled Nursing Facility

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### Introduction

The Institute for Healthcare Improvement (IHI), through a grant supported by The Commonwealth Fund, will soon commence a four-year, multi-state initiative to measurably reduce avoidable rehospitalizations. The primary aims for the first two years of the project will be the creation of a robust learning community and the provision of targeted technical assistance. Development of a multi-state learning community will provide an opportunity for participants to learn from content experts and peers about how to best implement front-line process improvements in transitions in care. IHI experts in improvement, change, transitions in care, and reliability will provide targeted technical assistance in select high-priority areas to address systemic barriers to reducing avoidable rehospitalizations. This guide was created to support participating individuals and organizations in their work over the course of this initiative and beyond to improve transitions in care. In contrast to an IHI How-to Guide, which includes changes that have been tested, this Guide for Field Testing includes ideas and potentially effective changes that have not yet been tested.

### The Case for Creating an Ideal Transition Home

Hospitalizations account for nearly one-third of the total \$2 trillion spent on health care in the United States.<sup>1,2</sup> In the majority of cases, hospitalization is necessary and appropriate. However, experts estimate that as many as 20 percent of US hospitalizations are rehospitalizations within 30 days of discharge.<sup>1,2</sup> These rehospitalizations are costly, potentially harmful, and often avoidable.

Poorly executed transitions in care negatively affect patients' health, well-being, and family resources, and unnecessarily increase the costs incurred by the health care system and the patients, families, and communities they serve. Maintaining continuity in patients' medical care is especially critical following discharge from the hospital, and for older patients with multiple chronic conditions, this "handoff" period takes on even greater importance. Research shows that one-quarter to one-third of these patients have to return to the hospital due to complications that could have been prevented.<sup>3</sup>

Avoidable hospitalizations typically occur due to one of 15 "ambulatory care sensitive conditions"—conditions that might have been prevented with either timely access to quality outpatient care or adoption of healthy behaviors. One aim of the hospital discharge process is to

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establish care in a new setting. Unplanned rehospitalizations may signal a failure in this process.

Evidence suggests that several specific interventions reduce the rate of avoidable rehospitalizations: improving core discharge planning and transition processes out of the hospital; improving transitions and care coordination at the interfaces between care settings; and enhancing patient coaching, education, and support for self-management. Focusing on both the “senders” and the “receivers” of patients transitioning from the acute care setting has emerged as an important priority. IHI considers the execution of an effective transition from the hospital to post-acute care settings to be a high-leverage initiative, or one likely to be associated with significant improvement in outcomes, for reducing avoidable rehospitalizations. The current initiative aims to create an ideal transition home (using the term broadly to include skilled nursing or assisted living facilities, as well as residential dwellings) as a means to reduce avoidable rehospitalizations and improve patient care.

Various terms are used to describe the care settings to which a patient is transferred after hospitalization, including:

- Nursing home;
- Skilled nursing facility;
- Long-term care facility;
- Acute rehabilitation facility; and
- Post-acute care facility.

Representatives of the organizations that participated in the developmental work that informed this Guide for Field Testing prefer “skilled nursing facility” (SNF) as an umbrella term, stating that it is the most consistent and accurate—despite the fact that these organizations offer a variety of services in addition to skilled nursing care such as short- and long-term care, palliative care, and acute rehabilitation.

In the course of the developmental work that informs this guide, IHI faculty discovered that the problems or failures that led to rehospitalization within 30 days after discharge fell into two main categories: those related to care provided within the SNF and those related to care during the transition from the hospital.

- Problems or failures leading to rehospitalizations that are related to care within the SNF:
  - Inadequate skill level of services and staff

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- Lack of laboratory and other diagnostic resources
- Lack of interventions such as intravenous catheters
- Inadequate availability and consistency of primary care providers
- Lack of prevention and early intervention of serious events (e.g., low vaccination rates of residents, inadequate infection management)
- Problems or failures leading to rehospitalizations that are related to the transition from hospital to SNF:
  - Fragility and clinical instability of the resident at transfer
  - Lack of a shared care plan that:
    - Is developed through clear communication with everyone involved, including the resident and family
    - Is inclusive of staff and departments across traditional boundaries
    - Is clear about the entire resident's situation at transition, including current status and treatments required
    - Includes medication reconciliation and availability of medications in the next care setting
    - Is clear to the resident and his or her family and includes their mutual agreement about expectations regarding outcomes of care (e.g., the resident and family may expect full recovery and return to home while care providers do not see that as a realistic plan)
    - Includes a discussion of palliative or hospice care needs as appropriate
  - Lack of an available primary provider who is familiar with the resident's condition and treatment
  - Lack of problem solving across organizational boundaries regarding the quality of transfers

Although it is helpful to consider these two distinct categories, the problem areas are related in a number of ways. Certain factors, such as preferences of the resident regarding advanced directives, influence care during the transition to the SNF and within the SNF. In addition, addressing issues in one problem area may improve care in the other setting.

Through early assessments in field learning sites, IHI faculty identified several defects in transitions related to care within the hospital, not within the SNF, that directly contributed to rehospitalization within hours or days of the transition to the SNF. The defects stemmed from

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the lack of a holistic perspective to care across traditionally separated care boundaries. Faculty observed that caregivers within both settings strive to do their personal best for residents, but are hampered by the lack of a patient-centered system that bridges care settings.

The focus of this Guide for Field Testing is the transition of residents from the hospital to the SNF setting and the associated transfer of responsibility from the inpatient to the SNF care team. Compared with other time surrounding hospitalization, patients are most at risk for experiencing gaps in care that lead to rehospitalization during the transition from inpatient to SNF care. Based on a synthesis of the literature, interviews with experts, direct observations in SNF, and conversations with clinicians at expert field sites, the Guide for Field Testing highlights four promising changes for an ideal transition and specifies individual changes that are worthy of further testing. The guide reflects the developmental and groundbreaking work of many dedicated individuals on the quest to better understand and address the issues that increase the likelihood of rehospitalization for residents recently discharged to SNFs.

The Guide for Field Testing is designed for SNF clinical leaders: directors of nursing, admission or discharge coordinators, case managers, and medical directors; their hospital clinical leader colleagues; and clinicians in both the inpatient and SNF settings.

The Guide for FieldTesting is divided into four sections:

- [Section One](#) highlights four promising changes to create an ideal transition from hospitals to skilled nursing facilities.
- [Section Two](#) outlines a practical step-by-step sequence of activities to assist teams in testing and adapting the promising changes described in Section One.
- [Section Three](#) includes tools and resources.
- [Section Four](#) includes case studies of promising changes.

## **Section One**

This section highlights four promising changes to create an ideal transition from hospitals to skilled nursing facilities.

### **Creating an Ideal Transition to a Skilled Nursing Facility**

<p><b>I. Ensure That SNF Staff Are Ready and Capable to Care for the Resident</b></p> <ul style="list-style-type: none"><li>A. Receive and confirm understanding of resident care needs from hospital staff.</li><li>B. Resolve any questions regarding resident transition status to ensure fit between the SNF resources and capabilities and resident needs.</li><li>C. Identify an emergency provider contact for the resident.</li></ul>
<p><b>II. Reconcile the Treatment Plan and Medication List</b></p> <ul style="list-style-type: none"><li>A. Re-evaluate resident clinical status since transition.</li><li>B. Reconcile the treatment plan and medication list based on an assessment of the resident's clinical status, information from the hospital, and past knowledge of the resident (if he or she was previously a resident).</li></ul>
<p><b>III. Engage the Resident and Family Members in a Partnership to Create an Overall Plan of Care</b></p> <ul style="list-style-type: none"><li>A. Assess the resident and family members' desires and understanding of the plan of care.</li><li>B. Reconcile the care plan developed collaboratively with the resident and family.</li></ul>
<p><b>IV. Obtain a Timely Consultation When the Resident's Condition Changes</b></p> <ul style="list-style-type: none"><li>A. Use protocols to guide immediate interventions with conditions and complications that commonly occur in the SNF</li></ul>

## **I. Ensure That SNF Staff Are Ready and Capable to Care for the Resident**

Clear, consistent transfer criteria set the stage for successful transitions, because all care providers share a consistent understanding of the resident's condition. (See Section Two, [Structures for Enabling the Work of Improvement Teams in Skilled Nursing Facilities](#) for creating transfer criteria.) Prior to transfer, an accurate and insightful assessment of a resident's individualized needs based on the criteria contributes to an effective and successful transition plan. The assessment also helps the resident, family members, and SNF team to effectively plan for the resident's post-acute care needs. This consistent assessment ensures a safe transition to the SNF and reduces the likelihood of "bounce-back" rehospitalization within hours or days.

The focus of this recommended intervention is to clearly specify what SNF caregivers need to do when a resident is transitioning from hospital care to their setting. Clinicians across the health care continuum often provide care without the benefit of having complete information about the resident's condition, medical history, services provided in other settings, and medications prescribed by other clinicians.<sup>4</sup> Inadequate transfer of information (i.e., the "handoff") during care transitions plays a significant role in the problems related to care quality and safety and contributes to duplication of tests and greater use of acute care services.

Receiving caregivers at the SNF need a complete view of the resident's clinical and functional status to assume responsibility for the resident and appropriately plan his or her care.

**Typical failures** associated with SNF staff readiness and capability to care for the resident who is transitioning from the hospital setting include:

- Lack of adherence to specified transfer criteria;
- The resident is arriving in a status that is less stable than indicated by communication with the hospital staff prior to transfer;
- Lack of recognition of worsening clinical or unstable status in the hospital;
- Lack of understanding of the resident's functional health status and failure to assess the resident's physical and cognitive needs (i.e., identifying underlying depression), which may result in transfer to a SNF care venue that does not meet the resident's needs; and
- Premature discharge due to lack of hospital caregivers' knowledge of the resident's current condition, bed capacity constraints, or financial pressures.

**Promising Changes to Test**

**I. A. Receive and confirm understanding of resident care needs from hospital staff.**

Clinicians in the SNF, who are accountable for the execution of the care plan following the transfer from the hospital, should be involved when the inpatient care team formulates the transition and transportation plan. At transition, the SNF clinicians should complete the steps that follow.

**Who:** SNF staff member responsible for receiving the resident on the day of transition

**How:**

- Collaboratively plan and communicate the details of the individual resident's transition with hospital staff via phone or in person
- Review the resident's current clinical and functional status
- Ensure understanding of care needs and details required to implement immediate care needs, for example:
  - Expert heart failure clinicians from the hospital teach SNF staff care protocols to support implementation of a consistent care plan for residents with heart failure
  - SNF and hospital staff use safe transition communication techniques such as read-back-and-confirm or Teach Back to confirm mutual understanding (see an [example in Section Two](#))
- Compare the resident's current status to the transition criteria and resolve discrepancies and questions (e.g., the transition criteria require a stable oxygenation status but the resident's oxygenation levels have decreased over the past six hours)
- Revise the transition protocol as required as clinicians from both the hospital and SNF learn improved transition processes

**Tips for Testing:** Treat each transition as an opportunity to learn new ways to care for residents. After each transition, the SNF nurse should debrief with the transferring nurse from the hospital to identify the elements of the transition that worked well and those that did not. The transition team can then test changes to address problems identified during the debrief of the next transition.

**I. B. Resolve any questions regarding resident transition status to ensure fit between the SNF resources and capabilities and resident needs.**

Gaps between the anticipated resident status at transition and actual resident condition place the resident and SNF staff at risk for incomplete care. Immediate resolution of questions regarding resident status compared to transition criteria can result in improved care outcomes.

**Who:** SNF clinician accountable for the resident's transition

**How:**

- Identify and discuss with the hospital clinician any concerns regarding the resident's clinical status prior to transition to avoid care concerns that the SNF may not be equipped to address
- Identify gaps between the resident's clinical status and the transition criteria:
  - Collaboratively determine whether the resident's clinical status places that resident at risk for complications after transition
  - Resolve any concerns about the resident's status prior to transition or defer transition if a stable, safe transition cannot be ensured
  - Ensure that needed medication, treatment, and equipment (e.g., access to dialysis, wound care, or rehabilitation) are available at the SNF

**Tips for Testing:** Start small. With the next resident to be transferred, identify problems or surprises that occur with the transfer (e.g., missing information that would have fostered better care). Determine whether the problem is due to a gap in the transition criteria or a gap in the information provided by hospital caregivers. Convey information about problems or surprises to cross-organizational teams so they can study the issues and use the resulting information to redesign the transition process. Encourage the team to test changes to the transfer protocol.

**I. C. Identify an emergency provider contact for the resident.**

Residents transferred to skilled nursing care often are in fragile health with rapidly changing conditions that may require prompt modification of their plan of care. Often hospital and SNF staff struggle with the lack of timely availability of an emergency provider contact who can assist with changes in the plan of care. Some hospitals and SNFs have introduced additional providers during the transition in an attempt to address this problem. However, the addition of yet another

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transition in care sometimes exacerbates transition problems. A better approach is to reduce the number of steps in the transition, thus decreasing the opportunities for problems to develop and enhancing the reliability of the transition process.

**Who**: SNF clinician and hospital clinician

**How**: Work collaboratively to identify the name and telephone number of an emergency provider contact who will be available for the subsequent 24 to 48 hours after transition to the SNF to modify the treatment plan, if needed.

**Tips for Testing**: Identify in advance of the transition emergency primary providers or key specialists who are directly involved in the resident's care.

## II. Reconcile the Treatment Plan and Medication List

When the resident arrives at the SNF, the care team's attention should shift from needs associated with the immediate transition to updating the overall care plan, including clinical treatment as well as plans to address functional, social, and emotional needs. An essential component of updating the care plan should be reconciling previous acute care interventions with the resident's ongoing care needs. Once these needs are reconciled, the SNF staff must ensure that all members of the care team are adequately educated, enabled, and confident to carry out their part of the care plan.

**Typical failures** associated with the lack of a reconciled treatment plan and medication list include:

- Lack of a clear picture of the resident's entire history, including the severity of the resident's condition, complications during hospitalization (e.g., *C. difficile* infection, pressure ulcers, urinary tract infection, delirium), and the extent of ongoing care needs;
- Medication errors due to lack of clarity about the type, dose, and frequency of medications or failure to resume pre-hospitalization medications;
- For some SNFs, lack of timely delivery of medications, preventing appropriate administration of medications even if the medication list has been reconciled;
- Variability of insulin protocols and blood glucose trigger points for alerting physicians;
- Incomplete coumadin management and follow-up plans;

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- Lack of the right information from the right professionals (e.g., key information from social workers, nursing staff, hospitalists, and house staff);
- Lack of clear advanced directives (i.e., information beyond the basic Do Not Resuscitate [DNR] status) or inadequate use of palliative or hospice care; and
- Lack of experience of hospital staff with SNFs, and thus an inaccurate perception of the assets and limitations of a particular SNF.

### Promising Changes to Test

#### II. A. Re-evaluate resident clinical status since transition.

**Who:** SNF clinician and appropriate team members

**How:** Re-evaluate the resident's clinical status based on information from the hospital and use of a standard treatment plan.

**Tips for Testing:** Use a standard assessment process and incorporate changes in the resident's plan of care. The treatment and overall care plan should address the following:<sup>5-7</sup>

- Medication and dietary restrictions;
- Cognitive status;
- Skin and wound care;
- Psychological state;
- Cultural background;
- Access to social and financial resources;
- Recommended activity level and limitations;
- Treatment; and
- Provider follow-up with clear identification of the appropriate physicians for follow-up.

**II. B. Reconcile the treatment plan and medication list based on an assessment of the resident's clinical status, information from the hospital, and past knowledge of the resident (if he or she was previously a resident).**

**Who:** SNF clinician and team members

**How:**

- Reconcile the medications list, including medications taken prior to hospitalization but subsequently discontinued  
[Note: In a follow-up study one of every five hospitalized patients experienced adverse events due to inadequate medical care after leaving the hospital and returning home. This gap is likely to also apply to patients transferring to SNFs.]
- Reconcile any other aspects of the treatment plan, including mobility assistance, therapies, and other interventions, specifying which interventions are to be added, deleted, or modified in the SNF

**Tips for Testing:**

- Involve the resident and family caregivers when gathering information about the resident's medication and care history—eliciting their input is essential for creating an accurate and thoroughly reconciled treatment plan
- Ensure that the correct medications have been ordered and that their dose, frequency, and route are clearly specified in the care plan and are consistent with the resident's post-acute treatment needs
- Consider the use of a tool or document, such as a personalized medication list, that does not require the resident or caregiver to rely on memory
- Identify the essential aspects of care required and ensure that these are listed in the care plan, for example:
  - Daily weights and ranges triggering intervention for residents with heart failure
  - Diabetes management and glucose alert levels that signal the need for a change in medication management
  - Diet
  - Test results follow-up
  - Pressure ulcer presence, staging of ulcers, and required supplies

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- Scheduling of timely follow-up with appropriate providers and services (e.g., dialysis, physical therapy, cardiologist, and surgeon) and associated transportation

Institute for Healthcare Improvement. *Getting Started Kit: Prevent Adverse Drug Events (Medication Reconciliation) How-to Guide*. Available at: <http://www.ihl.org/NR/rdonlyres/98096387-C903-4252-8276-5BFC181C0C7F/0/ADEHowtoGuide.doc>.

### III. Engage the Resident and Family Members in a Partnership to Create an Overall Plan of Care

Rather than being passive participants, residents and family members are key partners in ensuring optimal transitions from the hospital. The experiences of care teams working to improve transitions from hospitals to home exemplify the fact that active partnerships can lead to better care and outcomes. (For more information on improving transitions to home, see Nielsen GA, Rutherford P, Taylor J. *How-to Guide: Creating an Ideal Transition Home*. Cambridge, MA: Institute for Healthcare Improvement; 2009. Available at <http://www.ihl.org>.) Experts in the SNF field affirm that a cooperative partnership with residents and families can create a trust-based relationship and improve understanding of the care goals, which can help avoid rehospitalization. Common understanding between SNF staff and residents and families regarding expected outcomes, especially those related to end-of-life care, can help avoid the situation in which SNF staff must resort to rehospitalization because of a lack of resident-determined care guidelines.

The experience of staff using best practices has shown that when SNF staff interview the resident's family members prior to transfer to clarify expectations, it helps build relationships and reduces confusion regarding care outcomes. SNF staff note that skillful conversations to ensure clarity about palliative or hospice care and the use of detailed advanced directives are key success factors. Enlisting residents and families as a consistent part of the care team, participating at the level they choose, helps to create clear care plans and support improved outcomes.

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**Typical failures** in engaging the resident and family members in a partnership for care planning include:

- Different expectations on the part of staff and the resident and his or her family members regarding the short-term and long-term outcomes for SNF care, leading to gaps in care (e.g., family members expect the resident to return home at some point but the clinical caregivers do not)
- Lack of end-of-life conversations, including the options of palliative and hospice care
- Assumption by the resident and family that a single individual is in charge of all of the resident's care and sees the big picture of his or her needs
- Failure to actively include the resident and family caregivers in identifying needs, resources, and planning for the SNF, leading to poor understanding of the resident's capacity to achieve care goals

### Promising Changes to Test

#### III. A. Assess the resident and family members' desires and understanding of the plan of care.

**Who:** SNF clinician

**How:**

- Assess the resident's and family members':
  - Expectations about short- and long-term outcomes of care at the SNF, and review options for care beyond the immediate post-acute time frame, including long-term care and return to home
  - Desires regarding detailed advanced directives beyond Do Not Resuscitate (DNR) status, including end-of-life care determination and the use of life-sustaining actions
  - Understanding of the overall care plan
- Provide the resident and family members with the name of a care team member with whom they can easily follow up if questions or concerns arise

**Tips for Testing:**

- Use effective communication techniques such as Teach Back to assess clarity and understanding during conversations with the resident and family members
- Partner with palliative care and hospice care team members for family care plan conversations
- Consider using a tool to assist with the end-of-life portion of the care plan  
[Note: Iowa Health System and SNF partners are piloting a tool to assist staff with end-of-life conversations—Physician Orders for Life-Sustaining Treatment (POLST) is a component of the care plan that follows the resident to each care setting. POLST covers a range of life-sustaining options individuals can choose, including resuscitation, types of medical interventions (i.e., comfort measures, limited interventions, full treatment), nutrition, and overall goals.]

**III. B. Reconcile the care plan developed collaboratively with the resident and family.**

**Who:** SNF clinician

**How:** Revise the overall care plan with appropriate provider(s), including providers of primary care, specialty care, palliative and hospice care, and others involved in care, based on a partnership with the resident and family members.

**Tips for Testing:**

- Communicate with the appropriate provider(s) to revise the clinical treatment plan
- If appropriate, partner with staff from palliative care and hospices services to ensure thorough reconciliation of the care plan and to complement SNF care

**IV. Obtain a Timely Consultation When the Resident's Condition Changes**

Timely access to providers who can promptly respond to changes in the resident's condition is a challenge for most SNFs. Provider scarcity in most regions of the country suggests that increasing provider availability is not a plausible near-term solution for most SNFs. Lack of access to providers often leads to reliance on resident transfer to an emergency department for immediate care, which often ultimately results in admission to the hospital. However, clinical teams have tested alternatives that contribute to better care without unnecessary transfer to the

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ED or hospitalization. These tested and emerging options show promising approaches to this dilemma.

**Typical failures** in timely consultation when the resident's condition changes include:

- Transfer to the emergency department to avoid the risk of inadequate treatment when the usual provider is unavailable
- Limited daily availability of providers, leading to a lack of timely modifications to the care plan
- Lack of an emergency plan other than transfer to the ED if providers are not available
- Lack of protocols to guide care within the SNF and provide advice to on-call providers who lack familiarity with the SNF or with the resident

### Promising Changes to Test

#### IV. A. Use protocols to guide immediate interventions with conditions and complications that commonly occur in the SNF.

**Who:** SNF clinician, director of nursing, and medical director

**How:** Develop and use clear protocols that guide changes in the care plan for all SNF clinicians and providers.

#### **Tips for Testing:**

- Identify and use protocols to guide changes in the care plan to address changes in the resident's condition that commonly occur in the SNF, such as fever, abnormal glucose levels, urinary tract infection, pneumonia, and changes related to heart failure (e.g., weight gain)
- Use protocols to ensure appropriate vaccinations for influenza and pneumococcal pneumonia
- Explore the use of alternative providers to offer timely primary care consultation for SNF residents, for example:
  - Evercare Model—This model presupposes that providing more intensive primary care will reduce the use of more expensive services such as hospitalizations. Nurse practitioners (NP) work in partnership with the

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resident's primary care provider, seeing the resident regularly and responding to concerns early in the clinical course, thus providing more preventive services. The NPs also provide training and support to SNF staff to improve care for residents. The NP's time is allocated to communication with families, primary care providers, and SNF staff; direct care; and administrative duties. One study showed the incidence of hospitalizations was twice as high among control group residents than for residents in the intervention group, which was more cost effective because NPs were used to provide additional care support.<sup>8</sup>

- Geisinger Model—The availability and cost of nurse practitioners may limit the ability of SNFs to access these providers for additional care support for residents. Geisinger Health Plan is testing an alternative model in which nurse care managers provide care for SNF residents in partnership with SNF caregivers. The care managers provide regular review of the residents' care plans, conduct medication reconciliation at transitions, and communicate with the primary providers either in person or via telephone. The model:
  - Provides a form of medical home for the SNF resident through daily assessments and focus on whole person needs in partnership with SNF care teams;
  - Aims to avoid unnecessary rehospitalizations thus saving the personal toll on the resident and family, loss of trust in the SNF care by the family, and costs;
  - Includes ongoing medication reconciliation both during transitions and across the multiple providers involved in the resident's care—especially pertinent for residents with several chronic conditions; and
  - Fosters close partnership and communication with the designated primary care provider.

## **Section Two**

This section offers seven steps to help care teams create an ideal transition to skilled nursing facilities for residents who have been hospitalized.

### **Step 1. Form a Team**

First, form an improvement team with representatives from your skilled nursing facility and others involved in the transition and care of residents. The SNF team will work collaboratively to improve transitions by ensuring that the facility is ready and capable of receiving the resident, has the necessary information to care for the resident, reconciles the care plan and medication list, engages residents and family members as partners in care, and acquires timely consultations when the resident's condition changes.

Consider choosing team members from the following:

- Residents and family members
- Nurses and staff from the SNF
- Nursing leaders
- Physician leaders (within the facility and in the community)
- Pharmacists
- Social workers
- Clergy
- Quality improvement specialists

In addition, if possible, participate on a cross-continuum care team that includes hospital staff, home care nurses, physicians, and staff in office practice, as well as residents and family members. Participation on these teams fosters better understanding of the mutual interdependencies between "sending" and "receiving" locations. The team also can identify internal customers and suppliers for every process of the resident's journey. Members of the team come to recognize the need for information to flow as the resident moves from one setting to the next and together team members learn how to improve transition handoffs.

The team should meet regularly to plan the improvement work and assess progress toward the goal of creating an ideal transition. Make sure that all staff involved in discharge and transitions understand the ways in which their work affects the overall process of care and serves their

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customers, including the residents and their family caregivers and caregivers in the next care setting.

Institute for Healthcare Improvement. *How to Improve: Forming the Team*. Available at: <http://www.ihl.org/IHI/Topics/Improvement/ImprovementMethods/HowToImprove/formingtheteam.htm>.

Institute for Family-Centered Care. Available at: <http://www.familycenteredcare.org/>.

For staff to achieve improvements in transitions, managers and leaders of their organization must provide resources and support. The following structures support and facilitate the work of improvement teams in skilled nursing facilities to develop safer, more reliable care transitions and reduce avoidable readmissions.

<b>Structures for Enabling the Work of Improvement Teams in Skilled Nursing Facilities</b>
✓ Create standard criteria with hospital colleagues to determine the required level of SNF care, readiness for transition, and transition eligibility
✓ Develop an exchange program with hospitals to allow nurses to “walk in each other’s shoes” (i.e., switch roles or shadow for half a shift)
✓ Conduct site visits to hospitals to better understand the needs of inpatient staff
✓ Provide the transferring hospital with standardized interagency transfer forms
✓ Use methods and materials for patient education that are similar to those used by referring hospitals to improve consistency of education and channels of communication across settings
✓ Revise teaching materials based on health literacy principles to facilitate resident understanding
✓ Develop a problem-solving forum that can be enacted when problems occur with transitions or when transition criteria need revision
✓ Identify hospital staff who will be signaled every time a problem occurs with a transition to focus improvement efforts

## Step 2. Identify Opportunities for Improvement

### 2a. Perform an in-depth review of the last five rehospitalizations to identify opportunities for improvement.

- Conduct chart reviews of the last five rehospitalizations within 30 days after discharge from the hospital. Transcribe key information onto the data collection sheet (see Section Three, [Worksheet A: Interviews with Residents and/or Family Members about a Recent Rehospitalization](#)).
- Conduct interviews with residents who were rehospitalized and their family members (see Section Three, [Worksheet B: Evaluate the Effectiveness of the Resident Teaching Process](#)). If possible, interview the same residents whose charts were reviewed.
- Conduct interviews with clinicians and staff who know the resident to identify problem areas (see Section Three, [Worksheet B](#)).

### 2b. Evaluate the effectiveness of the current teaching processes to check resident and family member understanding of the plan of care.

Use [Worksheet B](#) (see Section Three) with three to five current residents in your facility to observe the teaching process and identify areas for improvement. Evaluate whether the teacher assessed what the resident understood and, if so, how. Did the teacher use a yes or no question? Did he or she use repeat demonstration? Did the teacher ask the resident to share what he or she learned?

### 2c. Review data on resident satisfaction regarding communications and partnerships in care and identify opportunities for improvement.

Evaluate the data over the last year from your SNF resident surveys (see Section Three, [Worksheet A](#) and [Worksheet B](#)), assessing relevant information on communication and partnership in care, or more specifically on satisfaction with transitions and support for self-care.

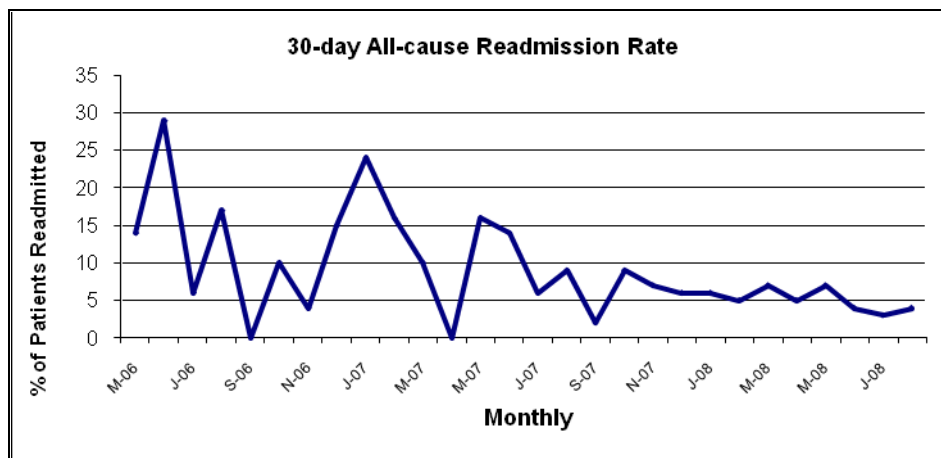
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**2d. Review data on residents who are readmitted to the hospital within 30 days of discharge to identify trends and opportunities for improvement.**

Collect historical data and display monthly rehospitalization rates over time, including at least 12 months of data, preferably more.

Measure Name	Description	Numerator	Denominator
30-Day All-Cause Readmissions	Percent of SNF admissions with readmission to hospital for any cause within 30 days	Number of readmissions to hospital for any cause within 30 days of discharge  Exclusion: Planned readmissions (e.g., chemotherapy schedule)	The number of residents admitted to SNF from the hospital in the measurement month

Sample graph of monthly 30-Day All-Cause Readmissions data tracked over time:



### Step 3. Develop a Clear Aim Statement to Create an Ideal Transition Home for Residents

#### 3a. Discuss findings from Step 2 with the entire care team in the skilled nursing facility.

Provide information from:

- Chart reviews of the last five rehospitalizations;
- Interviews with residents readmitted to the hospital within 30 days after discharge;
- Interviews with clinicians to assess teaching effectiveness and resident learning;
- Data on trends in resident satisfaction with transitions and support for self-care; and
- Data on trends in 30-Day All-Cause Readmissions.

#### 3b. Select a group of residents for initial focus based on lessons learned in Step 2.

If possible, focus improvement efforts on the residents that represent about half of the hospital readmissions from your facility. If there are few readmissions or a very small segment representing half the readmissions, simply work on reducing all readmissions and improving transitions in care when residents are discharged from the hospital.

#### 3c. Write an aim statement.

Aim statements communicate to all stakeholders the magnitude of change and the time by which the change will occur. Aim statements help teams commit to the improvement work. Develop a clear aim statement for reducing all readmissions. Aim statements include five pieces of information:

- What to improve;
- Where (specific unit in the skilled nursing facility or entire facility);
- For which residents;
- By when (a date-specific deadline); and
- Measurable goal.

Sample aim statements:

- 1) *Within the next 12 months, Tall Pines Center will improve care for discharged residents at highest risk for rehospitalization, reducing rehospitalizations by 50 percent.*

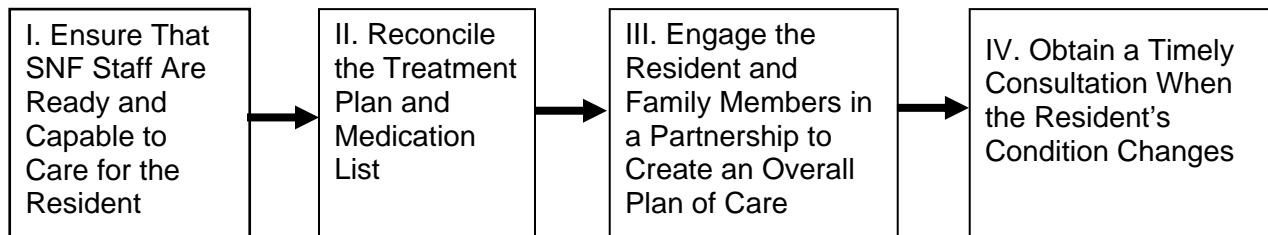
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- 2) *By December 2010, Great Valley SNF will reduce unnecessary 30-day rehospitalizations by 50 percent.*

For additional information on creating aim statements refer to *How to Improve: Setting Aims*, available at: <http://www.ihl.org/IHI/Topics/ChronicConditions/AllConditions/HowToImprove/ChronicSettingAims.htm>.

### Step 4. Design and Test Standard Work for the Key Changes

The four key changes to create an ideal transition from the hospital to a skilled nursing facility (described in [Section One](#)) are depicted in the flowchart below.



The following table provides a list of process measures that can be used to evaluate the effectiveness of the implementation of each key change.

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Promising Key Changes	Process Measures
I. Ensure That SNF staff Are Ready and Capable to Care for the Resident	The number of residents admitted to the SNF for whom the hospital RN ensured understanding of care needs and details required to implement immediate care with the SNF nurse on the day of admission to the SNF. (Report monthly)
II. Reconcile the Treatment Plan and Medication List	The percentage of residents transferred back to the SNF after a hospitalization for which the treatment plan and medications were reconciled. (Report monthly)
III. Engage the Resident and Family Members in a Partnership to Create an Overall Plan of Care	<p>The percentage of residents who answer “Always” to the question, “How often were you involved as much as you wanted in decisions about your care?”</p> <p>The percentage of family members who answer “Always” to the question, “How often were you involved as much as you wanted to be in the decisions about your family member’s care?”</p>
IV. Obtain a Timely Consultation When the Resident’s Condition Changes	The percentage of resident transfers to the emergency department due to lack of availability of a provider to change the treatment plan as needed.

First, focus your improvement efforts by selecting one of the four key changes based on the interest and passion of the team, or based on the area with the most problems or failures. Each of these key changes is composed of several processes. For example, the process of Teach Back is a component of the key change, “Engage the Resident and Family Members in a Partnership to Create an Overall Plan of Care.”

Select a process such as Teach Back and precisely describe the standard work, including information regarding:

- Who does it;
- When they do it (and for which residents);
- Where they do it;
- How do they do it and each tool that is used;
- How often do they do it; and

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- Why they do it.

Ask, “What would I see if I could observe this being done?” Design the work to be flawless, each and every time, regardless of who does it. Use aids and reminders. Design tools into the system to help improve standardization and reliability. Use information technology to assist design. For example, if Teach Back is to occur immediately after taking vital signs, the information technology system could issue an automated pop-up reminder that documentation of Teach Back is required before the staff person is permitted to input complete vital sign information.

Make the desired action the default action. Take advantage of work habits and patterns. Integrating standard work with other routine care processes, such as doing Teach Back after completing the daily (or shift) assessments or vital signs, increases the likelihood the action will be completed. For example, design a system such that all residents receive their second daily Teach Back session at the end of morning medication administration. Developing reliable processes may take more than one step. The first goal is for the standard work process to be reliably performed at least 80 percent to 90 percent of the time. Later, the team can aspire to have the process work perform reliably 99 times or even 100 times out of 100.

IHI uses the Model for Improvement as a framework for selecting and testing changes and accelerating improvement. Suggestions for conducting tests of change follow.

- Use small tests of change to refine the design and learn how the standard design actually works.
- Increase reliability by testing standard work and process design.
- Make improvements and adapt the process to become more reliable.
- Whenever the process does not work as designed, ask staff who do the work to conduct small tests of change to make improvements.
- Remove each problem or failure and adapt changes to improve the reliability of the process.
- Select tests based on ideas from staff and information about process failures.
- Keep tests small and be specific.
- Learn from each test and refine changes through iterative Plan-Do-Study-Act (PDSA) cycles; refine the next test based on learning from the previous one.

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- Expand test conditions to discover whether a change will work at different times of day (e.g., day and night shifts, weekends, holidays, when the unit is adequately staffed, in times of staffing challenges), and in different locations (e.g., expand from one unit to multiple units, or from one facility to others).
- Continue the cycle of learning and testing to improve process reliability.
- Collect sufficient data to evaluate whether a test has promise, was successful, or needs adjustment.

For more information on the Model for Improvement and on selecting and testing changes, see <http://www.ihl.org/IHI/Topics/Improvement/ImprovementMethods/HowToImprove/>.

### **Examples of Small Tests of Change: Using Teach Back to Engage Residents and Family Members in Creating Overall Plans of Care**

- Test 1: One nurse, on one day, tests whether using Teach Back with one resident and one family caregiver or family member increases understanding of the plan of care and whether the resident and family can engage in co-creating the plan of care. Following Teach Back, the nurse analyzes the percentage of items taught that the resident and family can teach back and assesses whether the family or resident contributed to the plan of care.
- Test 2: The same nurse then tests whether a video that demonstrates family and resident participation in the plan of care is more effective than verbal teaching as a learning tool. The nurse uses the video with the same resident and family in Test 1, and also with a second resident and family who have not previously received Teach Back education.
- Test 3: The same nurse offers a third resident and family the choice of video or personal instruction and notes their preference. The nurse uses Teach Back to assess understanding of the plan of care.

Each test informs the next and helps identify problems with the process. Testing continues until all problems are addressed. Staff involved in the testing must then share the knowledge gained in a systematic fashion throughout the facility and with the cross-continuum team by sharing with staff, leaders, customers (both residents and family members), as well as the medical staff and their office personnel. See Step 7 for implementation and spread of the Teach Back process.

Institute for Healthcare Improvement. *Tips for Testing Changes*. Available at:

<http://www.ihl.org/IHI/Topics/Improvement/ImprovementMethods/HowToImprove/tipfortestingchanges>

Institute for Healthcare Improvement. *Testing Changes*. Available at:  
<http://www.ihl.org/IHI/Topics/Improvement/ImprovementMethods/HowToImprove/testingchanges.htm>.

### Step 5. Identify and Mitigate Failures or Problems and Redesign Process

#### 5a. Identify process failures.

To understand the current process, it's often helpful to start by documenting it using a flowchart. Then the team can begin to identify process failures or problems and promptly address them. For example, an optimal discharge from the hospital and transition into the SNF requires early assessment of post-hospital needs and reconciliation of the treatment plan and medication list based on the assessment of the resident's clinical status, information from the hospital, and past knowledge of the resident (if he or she was previously a resident at the facility). Failure to complete this assessment early in the SNF stay represents a process failure. Closely attend to or "swarm" failures as close to the moment they happen as possible. Seek to understand what caused the problem and why. Consider every problem to be a signal that the process doesn't work as it should. To improve transitions in care, interview residents and family members, clinicians in the community, home care agency staff, and nursing home staff. Ask about whether a transition could have been better and specific ways it could have been so.

When staff members work in a standard process, they will describe the way work gets done in a similar way. For example, interview staff members who regularly use the Teach Back process. Ask them to describe the goal of Teach Back and outline in detail the process used to teach and facilitate learning for residents and family members. Each time a staff member's description varies from the defined standard process, it represents an opportunity for process failure. Listen for words such as "it depends." Such conditionality indicates ambiguity and possible process variation, and signals the need for additional evaluation for process variation and opportunities to improve standardization. Clarify roles, tasks, and processes to improve standardization and reliability. Elicit staff improvement ideas and use them to conduct additional small tests of change.

For more information on flowcharts, see  
<http://www.ihl.org/IHI/Topics/Improvement/ImprovementMethods/Tools/Flowchart.htm>.

**5b. Identify outcome failures.**

Identify failures that hinder achieving the desired outcomes. An example of an outcome failure is a discharge for which the SNF did not have a written discharge summary or the resident and family did not have a written plan at the time of the transition. After identifying failures and redesigning the process to prevent an outcome failure, standardize the process and further assess its performance.

Nolan T, Resar R, Haraden C, Griffin FA. *Improving the Reliability of Health Care*. IHI Innovation Series white paper. Boston: Institute for Healthcare Improvement; 2004. Available at: <http://www.ihl.org/IHI/Results/WhitePapers/ImprovingtheReliabilityofHealthCare.htm>.

Institute for Healthcare Improvement. *On Demand: The Right Treatment for the Right Patient Every Time – Applying Reliability Science to Health Care*. Available at: <http://www.ihl.org/IHI/Programs/AudioAndWebPrograms/OnDemandPresentationReliability.htm>.

**5c. Redesign the process to mitigate the identified failures.**

There will be situations when the process is not completed as designed. A reliable process includes a step that ensures that the process is completed as designed at least 80 percent of the time.<sup>9</sup> Correct any failures that put residents at risk immediately upon discovery. For less serious failures in the system, ensure that the process includes a back-up plan; if the first step is not completed as designed, the contingency plan ensures that the step will be completed. For example, to address the situation in which there is no discharge summary or plan of care accompanying a resident who is returning to the SNF after a hospital stay, a change to the process might include adding a step to notify the attending physician and obtain a report on the resident from the discharging nurse.

Another example of process redesign to mitigate failures involves assessing how often Teach Back is successfully completed. Ask the resident and family members if Teach Back was offered. If not, ensure that the nurse completes Teach Back. If Teach Back is not completed two or more times out of 10, examine the causes of the failure and consider redesigning the process. Likewise, the inability of a resident to teach back an important aspect of self-care indicates a higher risk of rehospitalization. Make sure to include in the transition process the resources to provide additional support for these residents or their family caregivers. Develop ways to signal resident inability to teach back important self-care concepts and address the knowledge gap prior to discharge.

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The goal for process reliability is to design and refine the ideal transition to the next care setting so that the most important processes work more than 95 times out of 100. In summary, this requires a way to identify each potential process failure, mitigate it, and measure process reliability in order to get important feedback about the process performance. Creating this level of reliability means that the team must identify where defects occur in the process, work diligently to understand all causes of failure, and test changes to improve the process. Remember to use aids and reminders, and build them into the system and use information technology to assist design. Make the desired action the default action, for example, all residents get Teach Back twice a day upon admission until the resident and family members can completely verbalize and support the plan of care. Take advantage of existing work habits and patterns, for example, at the end of the morning meal or after medication administration, the nurse conducts Teach Back.

### **Step 6. Display Measures Over Time to Assess Progress**

Display measures on a run chart. Begin with measuring the readmission data. Collect historic monthly 30-Day All-Cause Readmissions data for the past 12 months. Data viewed over time helps the team see whether improvement occurred. Continue to display readmission rates in a line chart during the improvement effort to understand whether and how changes result in improvement. Periodic review of the data over time after implementation of changes will help determine whether or not gains have been sustained.

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### Outcome Measures

- 30-Day All-Cause Readmissions
- Resident and Family Satisfaction: Willingness to Recommend the SNF
- Resident and Family Satisfaction: Best Possible Facility

Measure Name	Description	Numerator	Denominator
30-Day All-Cause Readmissions	Percent of residents admitted to the SNF from the hospital who are readmitted to the hospital within 30 days of SNF admission	Number of residents admitted to the SNF from the hospital who are readmitted to the hospital within 30 days of admission	The number of residents admitted to the SNF from the hospital in the measurement month
Resident and Family Satisfaction: Willingness to Recommend the SNF  [See: <a href="https://www.cahps.ahrq.gov/content/products/NH/NH_Loing-Stay_Instrument.pdf">https://www.cahps.ahrq.gov/content/products/NH/NH_Loing-Stay_Instrument.pdf</a> ]	Percent of residents and family members who respond “Definitely, yes” to the question, “Would you be willing to recommend this nursing home to others?”	Number of residents and family members who respond “Definitely, yes” to the question, “Would you be willing to recommend this nursing home to others?”	Number of residents and family members surveyed in the measurement month
Resident and Family Satisfaction: Best Possible Facility (overall rating)  [See: <a href="https://www.cahps.ahrq.gov/content/products/NH/NH_Loing-Stay_Instrument.pdf">https://www.cahps.ahrq.gov/content/products/NH/NH_Loing-Stay_Instrument.pdf</a> ]	Percent of residents and family members who rate the SNF an 8 or higher on a scale of 0 to 10 as the best possible nursing home	Number of residents and family members who select 8 or higher to the question: “Using any number from 0 to 10, where 0 is the worst care possible and 10 is the best care possible, what number would you use to rate the care at this nursing home?”	Number of residents and family members surveyed in the measurement month

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### **Process Measures**

Add relevant measures as you work on each key change. Remember that the goal of all interventions is for the residents to receive the desired intervention or action at least 95 percent of the time. Annotate line charts of your monthly data to indicate when specific changes were implemented. (For recommended process measures, see Step 4 above.)

Share data with unit staff, physicians, and senior leaders at the facility. Data reinforces positive change, demonstrates results, and can inspire a team to reach for greater achievement. Reflect on lessons learned from both successful and unsuccessful tests. Develop the habit of challenging assumptions. Use storytelling as a tool to share lessons learned from the project with staff.<sup>9-11</sup>

## **Step 7. Implement and Spread the Reliable Design and Processes**

### **7a. Implement reliable design.**

Implement the changes that work well under a variety of conditions and are reliable 99 out of 100 times. Learn from each test and refine changes through iterative Plan-Do-Study-Act (PDSA) cycles. Foster permanent change by creating new policies and procedures, developing a communication plan, training staff, updating new hire orientation, and monitoring data to maintain gains.

### **7b. Spread changes.**

Successful spread of reliable processes requires that leaders take responsibility for spread and commit sufficient resources to support spread. Leaders also must measure and monitor outcomes. Staff at pilot units must educate staff across the organization about the changes they made to improve transitions in care settings through a variety of methods (e.g., communication boards, emails to staff, newsletters, and town hall meetings).

Massoud MR, Nielsen GA, Nolan K, Schall MW, Sevin C. *A Framework for Spread: From Local Improvements to System-Wide Change*. IHI Innovation Series white paper. Cambridge, MA: Institute for Healthcare Improvement; 2006. Available at: <http://www.ihl.org/IHI/Results/WhitePapers/AFrameworkforSpreadWhitePaper.htm>.

## **Section Three**

This section includes tools that teams in skilled nursing facilities can use to improve the transition process.

### **Worksheet A: Interviews with Residents and/or Family Members about a Recent Rehospitalization**

#### **I. Ask Resident and/or Family Members:**

1. How do you think you became sick enough to be readmitted to the hospital?
2. Did you have a physician office visit before returning to the hospital? Yes\_\_\_\_ No\_\_\_\_
  - If yes, which physician (PCP or specialist) did you see? \_\_\_\_\_
  - If not, why not? \_\_\_\_\_
3. Describe any difficulties you or the SNF staff encountered in scheduling or getting to that office visit.
4. Has anything gotten in the way of taking your medicines?

#### **II. Ask SNF Care Team Members:** (physicians, nurses, or others who know the resident)

1. What do you think caused this resident to be readmitted to the hospital?
2. Write a brief descriptive story about the resident's circumstances that contributed to the readmission.

**Worksheet A:  
Interviews with Residents and/or Family Members about a Recent Rehospitalization  
(page 2)**

**III. Summary**

Develop an overall summary of all of your reviews and discuss with your team.

1. What did you learn?
  
2. What were the most common failures discovered?
  
3. What trends or themes emerged?
  
4. What, if anything, surprised you?
  
5. What new questions do you have?
  
6. What are you now curious about?
  
7. What do you think you should do next?
  
8. What previous assumptions about readmissions are now challenged?



## **Section Four**

This section includes two case studies that illustrate how organizations have implemented changes to improve transitions to skilled nursing facilities after residents are discharged from the hospital.

### **Case Study #1: Iowa Health System**

This case study from Iowa Health System provides practical, working examples of how to develop and use transitions criteria. The director of nursing in a 99-bed acute and long-term care SNF and the director of nursing of the SNF's hospital partner collaborated to solve problems associated with transitions. Despite a historically low rehospitalization rate at the SNF and a strong partnership with the hospital, rehospitalizations within 6 to 48 hours after a stay in the SNF was a concern for leaders in both the SNF and the hospital.

The directors of nursing began by investigating data on recent rehospitalizations. The director of nursing and the Medicare oversight nurse at the SNF reviewed the three charts of the three residents who were most recently rehospitalized. Several key elements associated with rehospitalization for each case were identified:

- The resident was not ready to transfer but there was a sense of urgency from hospital staff to discharge him or her.
- Complications developed during the hospital stay that precipitated later rehospitalization.
- The attending physician was not on call and the on-call physician was unfamiliar with the resident, resulting in a "send to the ED" order when other options to continue care in the SNF existed.
- Discharge information was routed through social workers rather than nurses, resulting in key information being inadvertently missed before transfer that might have changed the course of care.
- Flowcharts of the current process for SNF transitions showed numerous steps that did not add value to the resident's care and where key information could be missed.

To assess a transition in greater detail, the team reviewed the case of a current resident with complex needs (recent amputation, diabetes, pressure ulcer) and found that key pieces of information regarding the transition were missing, which required several follow-up phone calls.

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The deep and immediate review of a current transition, in addition to the previous rehospitalization chart reviews and the recollections of caregivers closely involved with rehospitalizations, provided the director of nursing with an opportunity to identify the gaps in transitions from the SNF's perspective and to define the "ideal transition." The SNF staff and hospital team members held a monthly rehospitalization problem-solving meeting that included key stakeholders: SNF leaders, hospital leaders, visiting nurses, social services staff, and hospital care managers. The meeting provided a useful venue for SNF members to define and communicate an ideal transition from their perspective. Team members began by agreeing on a definition for an ideal transition: a safe, stable transfer with no unnecessary readmissions. The team also identified the specific needs of the SNF and hospital staff during a transfer, as shown in the table below.

### Ideal Transition Needs for the SNF and the Hospital

	<b>SNF needs when a resident is transferred from the hospital</b>	<b>Hospital needs when a resident is transferred from the SNF</b>
Medications	<ul style="list-style-type: none"> <li>• Clear medication reconciliation</li> <li>• Easily understandable paper or electronic forms</li> </ul>	<ul style="list-style-type: none"> <li>• Which medications</li> <li>• Dosage and administration</li> <li>• Frequency</li> <li>• Timing of most recent dose</li> </ul>
Precautions and special treatments	<ul style="list-style-type: none"> <li>• Treatment for pressure ulcers</li> <li>• Catheter care needs</li> </ul>	<ul style="list-style-type: none"> <li>• Dietary needs</li> <li>• Aspiration risk</li> <li>• Need for hip fracture precautions</li> <li>• Need for physical therapy</li> <li>• Current mobility level</li> </ul>
Regular assessments	For residents with diabetes: Blood sugar range and guidelines for physician notification	Weight – especially for residents with heart failure
Other	Appointments: <ul style="list-style-type: none"> <li>• Which are required?</li> <li>• Have the appointments been scheduled?</li> <li>• Has transportation has been coordinated?</li> </ul>	Mental status – baseline and recent

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Upon review, the hospital team discovered that the resident information they needed for an ideal transition was currently being sent with the SNF resident on transfer. However the essential information often did not make the transition from the emergency department to the inpatient unit when the resident was admitted. The team worked collaboratively to address this gap.

### **Key Learnings**

- Keep the aim focused on the mutual interests of both SNF and hospital staff - ensuring a safe, stable transfer with no unnecessary readmissions.
- Work to find quick, easy, low-cost solutions for the tests of change. For example:
  - Instead of using a separate admission medication reconciliation form, list and reconcile medications on the discharge form, thus reducing two forms to one.
  - Provide the SNF director of nursing with a current contact list of the patient care coordinators who coordinate discharges for all inpatient units, thus supporting direct nurse-to-nurse communication.
- Ensure that hospital nursing leaders meet regularly with the nursing administration from each SNF and develop relationships to support problem solving. Encourage front-line staff at the hospital to communicate with the bedside staff at the SNF. Ensure that hospital unit case managers meet directly with the key nurses at the SNF to address core day-to-day issues and identify specific problems.

### **Case Study #2: Grandview Health Homes, Danville, PA**

This case exemplifies highly effective cross-boundary planning initiated by the SNF prior to transition from the hospital and highlights potential tests of change for other settings.

Grandview Health Homes is fortunate to have a highly respected geriatric clinician with experience as both a SNF clinician and director of nursing. For over a decade she has acted as the admissions coordinator (AC) for the 172-bed SNF. Over time, she has developed a unique process for improving transitions. Social services staff at the hospital contact the AC regarding potential transfers to the SNF. The AC reviews the resident's chart online (the SNF has access to the hospital's electronic medical record system). Through the review, she gains a clear picture of the resident and their hospital course; because of her extensive experience, she is able to focus on key elements that impact successful transitions. She then visits the resident, family, and staff in the hospital. The AC identifies essential clinical and administrative

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information to facilitate the transition such as the use of treatments, medications, and total parenteral nutrition; insurance coverage and co-pay requirements; and short- and long-term equipment needs. She assesses the resident's needs and clarifies with the resident and family both the care and financial issues.

Frequently, the AC identifies changes in the resident's clinical status that, if not detected and addressed before transition, could result in prompt readmission to the hospital. She defers transitions if she believes that the resident does not meet "stable for transition" criteria. Her ability to defer transitions reflects two qualities of the collaboration between the SNF and the hospital:

- Clear support from the director of nursing and SNF administration to defer admissions if the resident is not stable (frequently in many facilities, SNF staff and administrators feel the need to accept admissions or risk losing future referrals); and
- The AC's familiarity with hospital team members who may disagree with her assessment of the transition, but respect her clinical judgment and are able to engage in constructive conversations about residents with difficult needs.

### Key Learnings

The current system is effective, but it relies on the skills and experience of a single individual. To address this issue, the SNF director of nursing has begun to develop other team members to provide this valuable service when the AC is unavailable.

To capture, teach, and spread the skills demonstrated by an individual with unique skills, it can be helpful to "decode" the individual's thinking and actions by doing the following:<sup>12</sup>

- Closely observe the individual going through the process and ask him or her to "think out loud" and *describe what he or she is doing and why*.
- Write down in detail information from the observation and then use the information gathered to develop the skills of others. (This activity takes a currently invisible process and makes it visible, allowing individuals to better help one another and move closer to expert-like behavior.)

An alternate option to decoding is to enlist a new person to perform the expert's work while the expert coaches the novice on each step. Documentation of the coaching makes the process visible and available for others to learn. Once the initial observation is completed, observing the

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process with different resident conditions can help to deepen the knowledge available to others. Further testing of these approaches may yield valuable lessons for SNFs that have individuals with a unique set of skills, and may benefit residents and systems of care if replicated.

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