# Implementation Guide

## What is this tool?

This guide details strategies for hospitals collaborating with skilled nursing facilities to reduce hospital readmissions by focusing on care transitions. This approach also improves the patient experience and establishes a foundation for ongoing effective collaboration with post-acute care partners.

## Who should use this tool?

The readmission team at your hospital.

## How to use the tool:

1. Use this implementation guide to identify and select which strategies will optimize processes at your hospital and the SNF(s) as you collaborate to reduce readmissions.
2. Refer to the guide for implementation tools and strategies, which are organized using the following four key steps:

**Step 1:** Build relationships and collaborate with SNFs

**Step 2:** Establish standardized processes for information sharing between facilities to improve care
 transitions

**Step 3:** Engage the patient and care partner in care transitions

**Step 4:** Understand the capabilities of the emergency department

| **Process step** | **Interventions** | **Notes/work plan** |
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| Step 1: Build relationships and collaborate with SNFs |
| Create an internal multidisciplinary team | Assemble a multidisciplinary team to include key stakeholders from the hospital and SNF. Consider including ED and frontline staff to help build the foundation and infrastructure of the SNF program by supporting a culture of:* patient and care partner engagement; and
* SNF and hospital coordination aimed at reducing avoidable readmissions from SNF to hospital.

**Tool:** * [Unit-based safety quality improvement toolkit](https://qualityimprovementcollaborative.org/focus_areas/ubs/docs/NYSPFP_PatientSafety_Toolkit.pdf)
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| Identify and invite SNFs to collaborate and partner with your team | Use data reports to identify the rehabilitation and SNF organizations most frequently referred to or where patients are received from. Identify one or two SNFs with the highest number of hospital readmissions and/or ED encounters.Consider a formal invitation in writing or contact through verbal outreach.**Tools:** * EQIC SNF partner contact list
* [EQIC Transitional care community resource list](https://qualityimprovementcollaborative.org/focus_areas/readmissions/docs/2022-06-13_transitional_care_community_resource_list.docx)
* EQIC SNF data abstraction tool
* [AHRQ Data analysis tool](https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/medicaidreadmitguide/mcaidread_tool1_data_analysis_final.xlsx)
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| Define program goals and measures | Establish goals and identify both process and outcome measures. Consider the following:Outcome measures:* reduce readmission rate between hospital and SNF by X %; or
* reduce SNF ED visits by X %.

Process measure: * [HCHAPS questions 16, 20, 21 and 22](https://hcahpsonline.org/globalassets/hcahps/quality-assurance/2022_survey-instruments_english_mail.pdf)
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| Understand the capabilities of the SNF | Hospital and SNF teams conduct site visits to SNFs and EDs to gain a better shared understanding of capabilities.Identify services provided by the SNF, including:* provider availability;
* on-site diagnostic testing;
* on-site social worker;
* on-site therapies;
* nursing capabilities;
* interventions; and
* pharmacy.

**Tool:** * [INTERACT Nursing home capabilities list](https://leadingageil.org/resources/3%20INTERACT%20Nursing_Home_Capabilities_List%20SAMPLE.pdf)
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| Develop staff education for the SNF program to reduce readmissions | Create staff education including: * goals;
* staff roles;
* who to contact when a SNF patient presents or is admitted; and
* an EMR notification trigger.

Create workflows that include identifying SNF patients upon presentation to ED or inpatient admission.  |  |
| Step 2: **Establish** standardized processes for information sharing between facilities to improve care transitions |
| Develop data sources for reports | Use EQIC’s SNF data abstraction tool as a guide to help your team create hospital-specific reports aimed at identifying SNF patients.Work with your IT team to create data reports identifying SNF patients and make any necessary EMR modifications.**Tool:*** EQIC SNF data abstraction tool
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| Identify contributing factors for readmission | Review the trends and volume of SNF patients to determine risk factors for readmission. Stratify data by patient-specific characteristics and trends to assist with the development of standardized, coordinated interventions among hospital and SNF partners. Teams should consider:* disease-specific diagnoses;
* comorbidities;
* age;
* gender;
* discharge planning/inadequate care transitions;
* SNF capabilities;
* ADLs/functional status; and
* adverse drug events.

**Tools:*** EQIC SNF data abstraction tool
* [EQIC High-risk factors for readmission tracking tool](https://qualityimprovementcollaborative.org/focus_areas/readmissions/docs/mitigating_risk_factors_for_readmission.pdf)
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| Develop communication tools for patient and care partner feedback | Interview patients and care partners to understand their perspectives and challenges as part of the readmission risk assessment at each admission. Build a discussion focused on patient and care partner reasons for each hospital admission into the routine workflow.Optimize discharge plans to address patient concerns and identify recurring opportunities for improvement in the discharge process. Evaluate, adapt or adopt the EQIC [Patient and care partner interview tool](http://qualityimprovementcollaborative.development.hanysnt.local/focus_areas/readmissions/docs/2023_patient_and_care_partner_interview_tool.docx). |  |
| Create a transitional care plan | Include the patient and care partner in the discharge plan.Address all risk factors identified and reasons for readmission as communicated by the patient and care partner.Involve community-based organizations in the SNF team meetings. Customize patient-specific, post-discharge interventions at SNF team meetings. Tools:* [AHRQ IDEAL discharge process](https://www.ahrq.gov/patient-safety/patients-families/engagingfamilies/strategy4/index.html)
* [INTERACT Nursing home capabilities list](https://leadingageil.org/resources/3%20INTERACT%20Nursing_Home_Capabilities_List%20SAMPLE.pdf)
* [EQIC Transitional care community resource list](https://qualityimprovementcollaborative.org/focus_areas/readmissions/docs/2022-06-13_transitional_care_community_resource_list.docx)
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| Create a plan for healthcare team communication | Encourage SNF program discussion among care teams, including patient and care partner involvement as part of the healthcare team. Identify SNF patients in the shift report and rounding tool and consider adding this information to the whiteboard.Identify best practices and interventions to hardwire into daily workflows (i.e., medication reconciliation).Tools:* [Medications at transitions and clinical handoffs (MATCH) toolkit for medication reconciliation](https://www.ahrq.gov/patient-safety/settings/hospital/match/index.html)
* [Society of Hospital Medicine's MARQUIS Medication Collaborative](https://www.hospitalmedicine.org/clinical-topics/medication-reconciliation/marquis-med-rec-collaborative/)
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| Ensure follow-up communication with post-discharge provider(s) | Develop a feedback mechanism between hospital and SNF staff. Consider data collection based on post-discharge follow-up aimed at identifying trends in opportunities for improvement. **Tool:** * [EQIC Circle back interview tool](https://qualityimprovementcollaborative.org/focus_areas/readmissions/docs/2023_circle_back_interview_tool.docx)
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| Enhance the discharge process by providing post-discharge support and follow up | Conduct post-discharge follow-up calls to patients. Consider:* a call to both the patient and care partner;
* review of each patient-specific intervention and support arranged through the SNF team;
* using a patient and care partner interview tool or standardized risk assessment tool as a guide for these discussions; and
* calling the SNF admission coordinator or charge nurse.

Determine a feasible and appropriate post-discharge timeframe for follow up.**Tool:** * [AHRQ RED toolkit: How to conduct a post-discharge follow-up call.](https://www.ahrq.gov/patient-safety/settings/hospital/red/toolkit/redtool5.html)
* [EQIC Patient and care partner interview tool](https://qualityimprovementcollaborative.org/focus_areas/readmissions/docs/2023_patient_and_care_partner_interview_tool.docx)
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| Step 3: **Engage** the patient and care partner in care transitions |
| Identify readmission risks  | Review and modify your existing readmission risk tool to ensure targets align with the SNF program. Adapt or adopt the [EQIC High-risk factors for readmission tracking tool.](https://qualityimprovementcollaborative.org/focus_areas/readmissions/docs/mitigating_risk_factors_for_readmission.pdf)Include the patient and care partner in the readmission risk assessment. |  |
| Gather information from the patient and care partner  | Interview the patient and care partner as part of the readmission risk assessment at each admission. Build a discussion focused on patient and care partner reasons for each hospital admission and readmission into the routine workflow.Evaluate, adapt or adopt the [EQIC Patient and care partner interview tool.](http://qualityimprovementcollaborative.development.hanysnt.local/focus_areas/readmissions/docs/2023_patient_and_care_partner_interview_tool.docx) |  |
| Regularly review risk data to identify and mitigate risk trends | Collect, stratify and review available data from both the readmission risk assessment and patient and care partner interviews to identify trends and/or high-leverage opportunities revealed in the data. **Tool:** * [EQIC Readmissions surveillance tool](https://qualityimprovementcollaborative.org/focus_areas/readmissions/docs/readmissions_surveillance_tool.xlsm)
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| Identify and address any health equity and social determinants of health concerns for the patient | Use readmission risk assessment tool findings and additional screening tools to identify health equity and SDOH opportunities. Address these opportunities in coordination with CBOs that support these needs. **Tools:*** [EQIC Health equity tools and resources](https://qualityimprovementcollaborative.org/focus_areas/health_equity/tools_resources/)
* [AHC Health-related social needs screening tool](https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf) and [PRAPARE](https://prapare.org/)
* [AHRQ Hospital guide to reducing Medicaid readmissions](https://www.ahrq.gov/sites/default/files/publications/files/medread-tools.pdf) *(See Tool 10, pg. 24 Whole-Person Assessment)*
* [IFDHE Community partnerships: Strategies to accelerate health equity](https://ifdhe.aha.org/health-equity-resources)
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| Step 4: **Understand** thecapabilities of the ED |
| Create an individualized plan for each patient  | Create a patient-centered individualized transition plan for each SNF patient.SNF and ED work to understand healthcare capabilities of each facility to assist with development of transition plan.**Tools:*** [AHRQ ED care plan](https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/medicaidreadmitguide/mcaidread_tool13_ed_care_plan.docx)
* [INTERACT Nursing home capabilities list](https://leadingageil.org/resources/3%20INTERACT%20Nursing_Home_Capabilities_List%20SAMPLE.pdf)
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| Engage ED staff in the SNF program  | Use SNF program notifications/flags created by IT.Share patient-specific SNF program discharge plans, including information on all involved CBOs. Consider modifying ED EMR to include SNF discharge instructions/plans.Create workflows including notification/consult of SNF program contact upon presentation.Provide the ED team with a completed [EQIC Transitional care community resource list.](https://qualityimprovementcollaborative.org/focus_areas/readmissions/docs/2022-06-13_transitional_care_community_resource_list.docx)Continue communication between the SNF program team regarding patient-specific support and continued or additional patient needs. **Tool:** * [EQIC Circle back interview tool](https://qualityimprovementcollaborative.org/focus_areas/readmissions/docs/2023_circle_back_interview_tool.docx)
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| Leverage observation status | Educate ED staff and providers on alternatives to inpatient admission where medically appropriate:* holding patient pending communication with SNF, case management; or
* use observation status where appropriate.
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# References

Centers for Medicare and Medicaid Services Quality Improvement Organizations <https://qioprogram.org/>

Designing and Delivering Whole-Person Transitional Care. Content last reviewed June 2017. Agency for Healthcare Research and Quality, Rockville, MD.

[https://www.ahrq.gov/patient-safety/settings/hospital/resource/guide/index.html](https://www.ahrq.gov/patient-safety/settings/hospital/resource/guide/index.html%20%20%20)

Re-Engineered Discharge (RED) Toolkit. Content last reviewed February 2020. Agency for Healthcare Research and Quality, Rockville, MD.

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Strategy 4: Care Transitions From Hospital to Home: IDEAL Discharge Planning. Content last reviewed December 2017. Agency for Healthcare Research and Quality, Rockville, MD.

[https://www.ahrq.gov/patient-safety/patients-families/engagingfamilies/strategy4/index.html](https://www.ahrq.gov/patient-safety/patients-families/engagingfamilies/strategy4/index.html%22%20%5Co%20%22https%3A//www.ahrq.gov/patient-safety/patients-families/engagingfamilies/strategy4/index.html)

INTERACT (Interventions to Reduce Acute Care Transfers) is a quality improvement program that focuses on the management of acute change in resident condition.

[INTERACT Tools - Interventions to Reduce Acute Care Transfers](https://www.med-pass.com/interact-4)