



How-to Guide:

Improving Transitions from the Hospital to Skilled Nursing Facilities to Reduce Avoidable Rehospitalizations

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The Institute for Healthcare Improvement (IHI) is an independent not-for-profit organization that works with health care providers and leaders throughout the world to achieve safe and effective health care. IHI focuses on motivating and building the will for change, identifying and testing new models of care in partnership with both patients and health care professionals, and ensuring the broadest possible adoption of best practices and effective innovations. Founded in 1991 and based in Cambridge, Massachusetts, IHI mobilizes teams, organizations, and increasingly nations, through its staff of more than 100 people and partnerships with hundreds of faculty around the world.

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Note: Definition of “Skilled Nursing Facility”

For purposes of this How-to Guide and in IHI’s work to improve care transitions, “skilled nursing facility” (SNF) is used as an umbrella term representing several different types of post-acute care settings in which individuals receive care in the community, including the following:

- Nursing home
- Skilled nursing care center
- Long-term care facility
- Acute rehabilitation facility
- Post-acute care facility
- Assisted living facility

The term “skilled nursing facility” was identified by past participants in IHI programs as the most consistent and accurate way to describe these care settings, recognizing 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.

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I. Introduction

Delivering high-quality, patient-centered health care requires crucial contributions from many parts of the care continuum, including the effective coordination of transitions between providers and care settings. Poor coordination of care across settings too often results in rehospitalizations, many of which are avoidable. Working to reduce avoidable rehospitalizations is one tangible step toward achieving broader delivery system transformation.

The Institute for Healthcare Improvement (IHI) has a substantial track record of working with clinicians and staff in a variety of health care settings to improve transitions in care after patients are discharged from the hospital and to reduce avoidable rehospitalizations. IHI gained much of its initial expertise by leading an ambitious, system-redesign initiative called [Transforming Care at the Bedside \(TCAB\)](#). Funded by the Robert Wood Johnson Foundation, TCAB enabled IHI to work initially with a few high-performing hospital teams to create, test, and implement changes that dramatically improved teamwork and care processes in medical/surgical units. One of the most promising TCAB innovations was improving discharge processes for patients with heart failure (see the [TCAB How-to Guide: Creating an Ideal Transition Home for Patients with Heart Failure](#) for a summary of the “vital few” promising changes to improve transitions in care after discharge from the hospital and additional guidance for front-line teams to reliably implement these changes).

IHI is now leading the groundbreaking multi-state, multi-stakeholder initiative called [STate Action on Avoidable Rehospitalizations \(STAAR\)](#). The aim is to dramatically reduce rehospitalization rates in states or regions by supporting quality improvement efforts at the front lines of care while simultaneously working with state leaders to initiate systemic reforms to overcome barriers to improvement. Since 2009, STAAR's work in Massachusetts, Michigan, and Washington has been funded through a generous grant provided by The Commonwealth Fund, a private foundation supporting independent research on health policy reform and a high-performance health system.

The Case for Improving Transitions from the Hospital to Skilled Nursing Facilities to Reduce Avoidable Rehospitalizations

Hospitalizations account for nearly one-third of the total \$2 trillion spent on health care in the United States.^{1,2} Experts estimate that 20 percent of Medicare hospitalizations are rehospitalizations within 30 days of discharge.³ According to an analysis conducted by the

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Medicare Payment Advisory Committee (MedPAC), up to 76 percent of rehospitalizations occurring within 30 days in the Medicare population are potentially avoidable.⁴ Avoidable hospitalizations and rehospitalizations are frequent, potentially harmful and expensive, and represent a significant area of waste and inefficiency in the current delivery system.

Approximately 20 percent of Medicare beneficiaries are discharged from the hospital to a skilled nursing facility (SNF). Poorly executed care transitions negatively affect patients' health, well being, and family resources as well as unnecessarily increase health care system costs.

Continuity in patients' medical care is especially critical following a hospital discharge. Research highlights that nearly one-fourth of Medicare beneficiaries discharged from the hospital to a SNF are readmitted to the hospital within 30 days, costing Medicare \$4.34 billion in 2006.⁵ Adding to this problem is the financial environment within which rehospitalizations occur. Although preventable rehospitalizations negatively impact the health of patients, current reimbursement structures do not incentivize efforts to reduce these rehospitalizations. Payment reform is on the horizon, however, and future changes, such as shared savings through accountable care organizations (ACOs) or financial penalties for high rehospitalization rates through Medicare, will likely focus on realigning many incentives across the health care system to support optimal patient care.

Avoidable rehospitalizations may signal a failure in hospital discharge processes, patients' ability to manage self-care, and the quality of care in the next community settings (skilled nursing facilities, home health care agencies, and office practices).

Interventions for Improving the Transition from the Hospital to Skilled Nursing Facilities

In the course of the developmental work and further testing that informed this guide, IHI faculty discovered that the failures in care coordination between the hospital and SNF that led to rehospitalization within 30 days after discharge fell into two main categories: those related to care provided within the skilled nursing facility and those related to care provided during the transition from the hospital to the skilled nursing facility. Although it is helpful to consider these as two distinct categories, the problem areas are interdependent. Certain factors, such as the preferences of the resident regarding advance directives, influence care during the transition to and within the SNF. Conversely, addressing issues in one setting may improve care in the other.

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Through assessments in field learning sites, IHI faculty identified several defects in transitions related to care within the hospital that directly contributed to rehospitalization within hours or days of the transition to the SNF. These defects stem mainly from siloed care processes. Caregivers within both settings strive to deliver the best possible care to patients, but they are hindered by the lack of a patient-centered system that bridges care across settings. The focus of this guide is the transition of residents from the hospital to the SNF setting and the associated transfer of responsibility from the hospital to the SNF care team. Patients are most at risk for experiencing gaps in care that lead to rehospitalization during the transition between care settings. Based on a synthesis of the literature, interviews with experts, direct observations in SNFs, and workgroups with clinicians at field sites, this How-to Guide highlights three promising changes for an ideal transition and several other changes that merit further testing. The guide reflects the developmental and groundbreaking work of many dedicated individuals on the quest to better understand and address the underlying causes of rehospitalizations for residents recently discharged to SNFs.

A Roadmap for Improving Transitions from the Hospital to Skilled Nursing Facilities to Reduce Avoidable Rehospitalizations

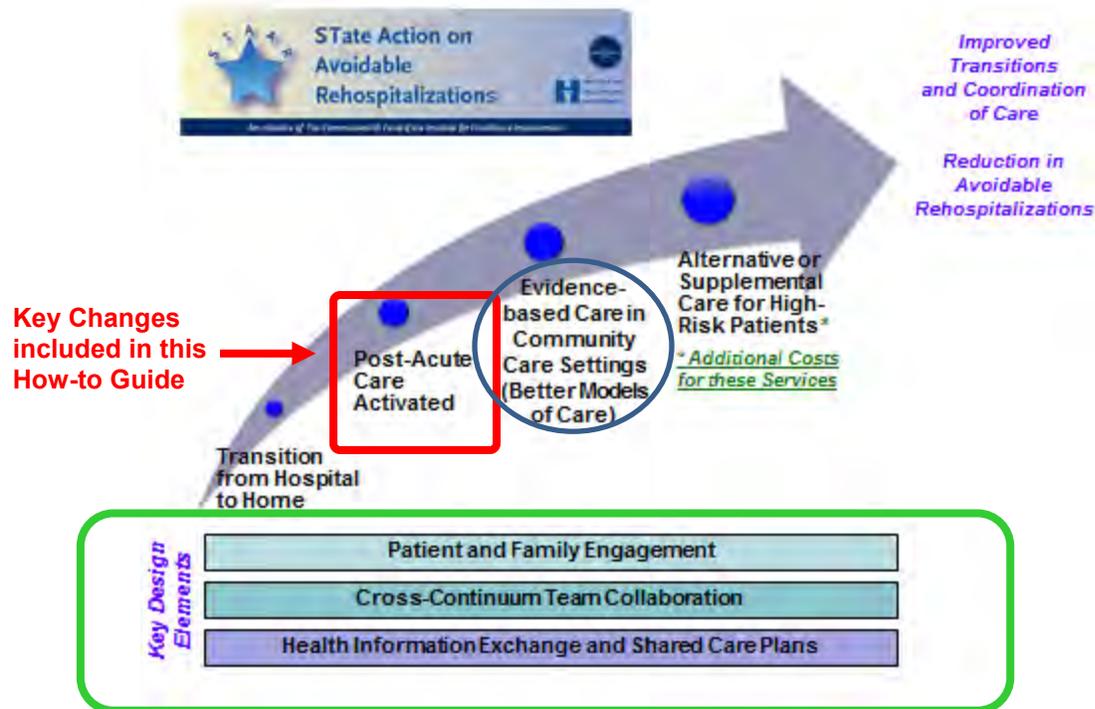
Based on the growing body of evidence and IHI's experience to date in improving transitions in care after a hospitalization and reducing avoidable rehospitalizations, IHI has developed a conceptual framework or roadmap (Figure 1) that depicts the cumulative effect of key interventions to improve the care of patients throughout the 30 days after patients are discharged from a hospital.

The transition from the hospital to post-acute care settings has emerged as an important priority in IHI's work to reduce avoidable rehospitalizations. Transitions in care after hospitalization (and from post-acute care and rehabilitation facilities) involve both an improved transition out of the hospital as well as an activated (i.e., patient is "actively received" by the next care setting) and reliable reception into the next setting of care such as skilled nursing facility, home health care agency, or office practice; this is depicted in the red box in Figure 1. This How-to Guide is designed to support SNF-based teams and their community partners to co-design and reliably implement improved care processes to ensure that residents have a safe and effective transition into and are actively received by the SNF. Guidance for leveraging the key design elements to

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improve care transitions (depicted in the green box in Figure 1) is also included in this How-to Guide.

Figure 1: IHI's Roadmap for Improving Transitions in Care after Hospitalization and Reducing Avoidable Rehospitalizations



In addition to this How-to Guide to create an ideal transition from the hospital to a SNF, IHI also provides separate How-to Guides for hospitals, clinical office practices, and home health care agencies:

- [How-to Guide: Improving Transitions from the Hospital to Community Settings to Reduce Avoidable Rehospitalizations](#)
- [How-to Guide: Improving Transitions from the Hospital to the Clinical Office Practice to Reduce Avoidable Rehospitalizations](#)
- [How-to Guide: Improving Transitions from the Hospital to Home Health Care to Reduce Avoidable Rehospitalizations](#)

It is important to note that SNFs may also look to create “better models of care” within their own setting to impact patient rehospitalizations (depicted in the blue circle in Figure 1). *The How-to Guide for Improving Transitions from the Hospital to Community Settings to Reduce Avoidable*

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Rehospitalizations includes four key changes that may be adapted and applied to skilled nursing. The key changes are:

1. Perform an Enhanced Assessment of Post-Hospital Needs
2. Provide Effective Teaching and Facilitate Enhanced Learning
3. Ensure Post-Hospital Care Follow-up
4. Provide Real-time Handover Communications

These key changes have been adopted by hospitals across all three states participating in the STAAR initiative. Hospitals report that their improvements have resulted in a better experience for patients and have impacted 30-day readmission rates in specific patient populations. In addition, we have learned that the key changes described above are being successfully adapted and implemented by skilled nursing facilities involved in STAAR.

Another important resource for providing more evidence-based care in the skilled nursing setting is Interventions to Reduce Acute Care Transfers (INTERACT).⁶ The INTERACT Quality Improvement Program is designed to assist front-line staff in early identification, assessment, communication, and documentation about acute change in resident condition. It includes clinical and educational tools and strategies for use in everyday practice in long-term care facilities.

SNFs across the country have implemented the INTERACT Quality Improvement Program and many facilities have been able to significantly reduce avoidable hospitalizations using these resources.⁷ Tools and resources may be accessed at www.interact2.net.

II. Key Changes

The *How-to Guide: Improving Transitions from the Hospital to Skilled Nursing Facilities to Reduce Avoidable Rehospitalizations* outlines three recommendations (Figure 2): 1) ensure that SNF staff are ready and capable to care for the resident; 2) reconcile the treatment plan and medication list; and 3) engage the resident and their family or caregiver in a partnership to create an overall plan of care.

Figure 2: Key Changes to Complete the Transition to Skilled Nursing Facilities

<p>1. Ensure That SNF Staff Are Ready and Capable to Care for the Resident</p> <ul style="list-style-type: none">A. Confirm understanding of resident's care needs from hospital staff.B. Resolve any questions regarding the resident's status to ensure fit between resident needs and SNF resources and capabilities.
<p>2. Reconcile the Treatment Plan and Medication List</p> <ul style="list-style-type: none">A. Re-evaluate resident's clinical status since transfer.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).C. Make a plan for timely consult when resident's condition changes.
<p>3. Engage the Resident and Their Family Caregivers in a Partnership to Create an Overall Plan of Care</p> <ul style="list-style-type: none">A. Assess the resident's and family caregivers' desires and understanding of the current plan of care as well as any possible next care settings.B. Reconcile the care plan developed collaboratively with the resident and family caregivers.

1. Ensure That SNF Staff Are Ready and Capable to Care for the Resident

Recommended Changes:

- 1A. Confirm understanding of resident care needs from hospital staff.*
- 1B. Resolve any questions regarding resident transition status to ensure fit between resident needs and SNF resources and capabilities.*

Flawless transitions across care settings require that all care providers share a common understanding of the resident's condition. Prior to transfer, an accurate and thorough assessment of a resident's needs based on standard criteria contributes to an effective transition plan. This crucial step reduces the likelihood of a rehospitalization within hours or days.

The crux of this intervention is to clearly specify what information SNF providers need in order to care for a resident who is transitioning from hospital care to the SNF setting. Providers 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 ensuring that SNF staff are ready and capable to care for the resident include:

- Lack of adherence to or confusion about the transfer criteria specified by hospital staff;
- Lack of complete clinical information — medications, labs, physician orders, additional treatments requiring transportation (e.g., radiation therapy);
- Lack of understanding of the resident's functional health status and a failure to assess the resident's physical and cognitive needs (e.g., identifying underlying depression), which may result in transfer to a SNF facility that does not meet the resident's needs; and
- Premature discharge from the hospital with unstable clinical condition.

How to identify your typical failures and opportunities for improvement:

- [IHI Diagnostic Tool for the Transition to Skilled Nursing](#) (How-to Guide Resources, page 53) – Use this tool to understand opportunities for improving the resident’s transition from the hospital to skilled nursing facility.
- [INTERACT II Quality Improvement Tool](#) (How-to Guide Resources, page 57) — Use this tool to understand opportunities for improvement associated with acute care transfers.

Recommended Changes

1A. 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 resident’s transfer from the hospital, should be involved when the inpatient care team formulates the transfer and transportation plan. When the transfer plan is being formulated, and based upon the standardized transfer criteria, providers at both the hospital and SNF should complete the following steps:

- Collaboratively plan and communicate the details of the resident’s transfer via phone or in person, including the expected time of transition.
- Review the resident’s current clinical and functional status.
- Ensure understanding of care needs and details required to implement immediate care needs (e.g., some SNFs cannot access new medication orders after 7 PM).
 - Have SNF and hospital staff use common transfer communication techniques, such as [SBAR](#) or read-back-and-confirm, to confirm mutual understanding.
- Compare the resident’s current status to the transfer criteria and resolve discrepancies and questions (e.g., the transfer criteria require a stable oxygenation status, but the resident’s oxygenation levels have decreased over the past six hours).
- Revise the standardized transfer criteria and transfer process as needed, as clinicians from both the hospital and SNF learn improved transfer processes.
- Obtain the name and contact information for the consulting physician in the hospital so that when questions arise the SNF staff know who to contact for clarification.

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Tips for Testing:

- Treat each transfer as an opportunity to learn new ways to care for residents. After each transfer, the SNF nurse should debrief (either via live conversation or virtually) with the transferring nurse from the hospital to identify the elements of the transfer that worked well and those that did not. The cross-continuum team can then test changes to address problems identified during the debrief on the next transition.
- SNF staff may use the INTERACT II Nursing Facility Capabilities List to confirm the facility has the capabilities to care for the resident prior to their admission.

Figure 3: [INTERACT II Nursing Facility Capabilities List](#) (How-to Guide Resources, page 59)

Name of Nursing Home: _____
 Contact Person and Title: _____
 Phone: _____ Email: _____

Available on Site*

Emergency interventions	Yes/No	Interventions	Yes/No
CPR – basic only		Drains and catheters	
Diagnostic Testing		Epidural catheters	
Stat EKG (within 4-6 hrs)		Suprapubic catheters	
Stat Xray (within 4-6 hrs)		Urostomy	
Stat lab work (within 4-6 hrs)		Surgical drains	
Bladder ultrasound			

1B. Resolve any questions regarding the resident’s clinical status to ensure fit between resident needs and the SNF resources and capabilities.

Gaps between the resident’s anticipated clinical status at the time of transfer and the resident’s actual status places the resident at risk for incomplete care at the SNF. When such discrepancies occur, SNF leaders may be unsure of whom to contact in the hospital to understand the root cause of the discrepancy and propose solutions. An effective cross-continuum team can mitigate this barrier. Open communication ensures a productive long-term relationship between care settings and better patient outcomes.

Avoiding such gaps requires providers to do the following:

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- Identify and discuss any concerns regarding the resident's clinical status prior to transfer to avoid care concerns that the SNF may not be equipped to address.
- Identify gaps between the resident's clinical status and the transfer criteria:
 - Collaboratively determine whether the resident's clinical status places that resident at risk for complications after transfer.
 - Resolve any concerns about the resident's status prior to transfer or defer transfer if a stable, safe transfer 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 problems are due to gaps in the transfer criteria or gaps in the information provided by hospital providers. Convey information about problems or surprises immediately to the identified hospital contact and to cross-continuum team members so they can learn about the issues and use the resulting information to redesign the transfer process.

2. Reconcile the Treatment Plan and Medication List

Recommended Changes:

2A. Re-evaluate the resident's clinical status since transfer.

2B. Reconcile the treatment plan and medication list based on an assessment of the resident's status, information from the hospital, and past knowledge of the resident (if he or she was previously a resident).

2C. Make a plan for timely consult when resident's condition changes.

When the resident arrives at the SNF, the care team's attention should shift from needs associated with the immediate transfer 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 and complications during hospitalization (e.g., *C. difficile* infection, pressure ulcers, urinary tract infection, delirium);
- Medication errors due to lack of clarity about the type, dose, and frequency of medications or failure to resume pre-hospitalization medications;
- Lack of timely delivery of medications;
- Variability of insulin protocols and blood glucose trigger points for alerting physicians;
- Incomplete warfarin management, delayed access to required lab results, and lack of follow-up plans or protocol to follow;

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- Lack of key information from social workers, nursing staff, hospitalists, and house staff;
- Lack of hard copy narcotic prescriptions sent with the resident;
- Lack of clear advance directives (i.e., information beyond the basic Do Not Resuscitate [DNR] status) or inadequate use of palliative or hospice care;
- Lack of experience of hospital staff with SNFs, and thus an inaccurate perception of the assets and limitations of a particular SNF; and
- Incomplete information sharing due to inaccurate interpretation of HIPAA regulations limiting transfer of crucial information.

How to identify your typical failures and opportunities for improvement:

- Use the [MassPRO Safe Medication Practices Workbook](#) (How-to Guide Resources, page 60). Pages 168-174 are dedicated to medication reconciliation in long-term care facilities.

Recommended Changes:

2A. Re-evaluate resident's clinical status since transfer.

Re-evaluate the resident's clinical status based on information from the hospital and use of a standard treatment plan. Use a standard SNF assessment process and incorporate changes in the resident's plan of care. The treatment and overall care plan should address the following:⁸⁻¹⁰

- Resident's expected clinical course throughout their stay;
- Resident and family caregivers' values and priorities relative to the resident's care;
- Medication and dietary restrictions;
- Cognitive status;
- Skin and wound care;
- Recommended activity level and limitations;
- Treatment;

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- Need for provider follow-up with contact information for those providers who are to be contacted.
- Psychological state;
- Cultural background; and
- Access to social and financial resources.

2B. 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).

Reconcile the resident's medication list, including medications taken prior to hospitalization but subsequently discontinued. Note: In a recent study, one of every five hospitalized patients experienced adverse events due to inadequate medical care after leaving the hospital. This gap is likely to also apply to patients transferring to SNFs. Confusion about medication administration, follow-through, and access are the largest contributors to rehospitalizations.¹¹⁻¹³

Reconcile any other aspects of the treatment plan, including mobility assistance, therapies, and advance directives, specifying which interventions are to be added, deleted, or modified in the SNF.

Tips for Testing:

- Involve the resident and their family caregivers when gathering information about the resident's medication and care history.
- 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.
- Work with the hospital to ensure the name and contact information for the consulting physician in the hospital is included in the discharge summary so that when questions arise the SNF knows who to contact for clarification.

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

2C. Make a plan for timely consult when resident's condition changes.

Timely access to providers who know the resident well and can respond appropriately to changes in the resident's condition is a challenge for most SNFs. This lack of access to providers often leads to reliance on the emergency department (ED) for further assessment and immediate care to the resident, which often ultimately results in admission to the hospital. Clinical teams have tested alternatives that contribute to better care without unnecessary transfer to the ED or hospitalization. Having a plan in place for responding to possible condition changes is a critical first step to reducing hospitalizations.

Tips for Testing:

- The INTERACT program has a number of resources to assist with planning for changes in condition, including change in condition file cards, early warning tools, and care pathways. These tools are available at www.interact2.net/tools.html.
- Test a rapid response team or "e-ICU" approach. Many hospitals are successfully using a rapid response team (also known as a medical emergency team) comprising hospital clinicians with critical care expertise to rush to a patient's bedside at the first sign that the patient's condition may be deteriorating. Consider adapting this concept for skilled

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nursing by identifying a clinical team available remotely (i.e., by phone) to guide SNF caregivers when a resident's condition deteriorates.

3. Engage the Resident and Their Family Caregivers in a Partnership to Create an Overall Plan of Care

Recommended Changes:

3A. Assess the resident's and their family caregivers' desires and understanding of the plan of care as well as any possible next care settings.

3B. Reconcile the care plan developed collaboratively with the resident and family caregivers.

Rather than being passive participants, residents and their family caregivers are key partners in ensuring optimal transitions from sites of care. The experiences of care teams working to improve transitions from hospitals to home demonstrate that active partnerships can lead to better care and outcomes. (For more information on improving transitions to home, see [How-to Guide: Improving Transitions from the Hospital to Community Settings to Reducing Avoidable Rehospitalizations](#).) Experts in the SNF field affirm that a cooperative partnership between providers and residents along with their family caregivers 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 their family caregivers 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.

Experience shows that when SNF staff interview the resident and their family caregivers 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 advance directives are key success factors. Enlisting residents and family caregivers as a consistent part of the care team helps to create clear care plans and support improved outcomes.

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

- Different expectations between the staff and the resident and his or her family caregivers regarding the short-term and long-term outcomes for SNF care, leading to gaps in care

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(e.g., family caregivers expect the resident to return home at some point, but the clinical providers do not).

- Lack of end-of-life conversations, including the options of palliative and hospice care.
- Assumption by the resident and family caregivers that a single individual (e.g., physician or nurse practitioner) 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.

How to identify your typical failures and opportunities for improvement:

- Use the [INTERACT II Advance Care Planning Tracking Form](#) (How-to Guide Resources, page 63) to document that advance care planning discussions are taking place with residents and family caregivers.
- Consider using the Care Transitions Measure (CTM), developed by Eric Coleman and colleagues, to assess the quality of care transitions experienced by SNF residents.¹⁴
- Consider using the Patient Activation Measure (PAM), developed and validated by Judith Hibbard and colleagues for understanding patient "activation," to determine and track the engagement of residents and families in your facility's care.¹⁵

Recommended Changes:

3A. Assess the resident's and family caregivers' desires and understanding of the plan of care as well as any possible next care settings.

- Identify expectations about short- and long-term clinical outcomes at the SNF and review options for care beyond the immediate post-acute time frame, including long-term care and return to home.
- Discuss desires regarding detailed advance directives beyond Do Not Resuscitate (DNR) and "do not hospitalize" status, including end-of-life care determination and the use of life-sustaining efforts.

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- Evaluate the resident's and family caregivers' understanding of the overall care plan.
- Provide the resident and family caregivers with the name of a SNF 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 Back¹⁶ to assess clarity and understanding during conversations with the resident and family caregivers.
- When indicated, partner with palliative care and hospice care team members for family care plan conversations. For example, Hebrew SeniorLife has instituted automatic palliative care consults (with consent) for residents who meet certain pre-determined criteria such as three or more hospitalizations in the past six months.¹⁷
- Use a tool to assist with the end-of-life portion of the care plan such as the MOLST/POLST tool.^{18,19}
- Learn from leading programs about advance care planning systems. Respecting Choices is a community-wide effort spearheaded by Gundersen Lutheran Medical Foundation to stimulate and support constructive ongoing conversations. The intent is a process of communication that helps individuals and their families understand choices for future health care; reflect on personal goals, values, and religious or cultural beliefs; and talk to physicians, health care agents, and other loved ones as needed. The program has resulted in a significant number of community members who are clear about their advance care plan, thus relieving the burden of any one provider or care setting to address these complicated issues. Respecting Choices is now a statewide model in Wisconsin, Kansas, Ohio, North Carolina, South Carolina, and Wisconsin, and is the end-of-life model for Australia.²⁰ More information is available at <http://respectingchoices.org>.
- Use the Five Wishes framework for guiding conversations with residents and family caregivers about care preferences. An online version of the framework is available at www.agingwithdignity.org/five-wishes.php.
- Use the INTERACT II Communication Guide (Parts 1, 2, and 3) for tips and suggested language to initiate and carry out conversations with residents and family caregivers

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when there has been a decline in health status. The Communication Guide is available at www.interact2.net.

- Consider developing individualized care plans or “i-care” plans with residents to shift care planning conversations from having a clinical voice to one that reflects the resident’s perspective. Information about creating individualized care plans is available through a variety of web-based sources. The Pioneer Network, a not-for-profit organization that advocates for person-centered long-term care, is one source of tools and resources for creating a more resident-focused culture within your facility. Information about The Pioneer Network is available at <http://pioneernetwork.net/>.

3B. Reconcile the care plan developed collaboratively with the resident and family caregivers.

Revise the overall care plan with the appropriate provider(s), including providers of primary care, specialty care, palliative care, and hospice care (when indicated), based on a partnership with the resident and their family caregivers.

- Communicate with the appropriate provider(s) to revise the clinical treatment plan and to ensure information about prognosis communicated to the resident and family caregivers is consistent with the information communicated in other settings.
- If appropriate, partner with staff from palliative care and hospice services to ensure thorough reconciliation of a care plan that complements SNF care.

III. Design Elements

The design elements or principles for improving care transitions and coordination of care after patients are discharged from the hospital include: 1) patient and family caregiver engagement, 2) cross-continuum team collaboration, and 3) health information exchange and shared care plans. These cross-cutting principles are catalysts for the successful implementation of the key strategies and changes to improve care transitions and to reduce avoidable rehospitalizations.

Patient and Family Caregiver Engagement

Engagement with patients and their family caregivers takes many forms, including partnerships in treatment and shared care planning, improving care across the continuum, redesigning care and service processes, and optimizing communication between health care providers and patients and their family caregivers.

At the annual IHI National Forum in 2002, Don Berwick asked, “Are patients and families someone to whom we provide care? Or, are they active partners in managing or redesigning their care?” If we truly want to transform care processes, patients and families know the “white spaces” between services and locations of care. Patients and family caregivers should be engaged in choices, planning, and decisions about their care. We also need them engaged in the redesign of care processes if we are to achieve patient- and family-centered care.

The challenges for health care leaders “Start Before You Are Ready!” has been stated by Jim Anderson, former Chairman of the Board at Cincinnati Children’s Hospital and Medical Center. Figure 4 is a document on which IHI collaborated with leaders at Cincinnati Children’s Hospital to develop a readiness assessment for *Partnering with Patients and Families to Accelerate Improvement*.

Figure 4. [Readiness Assessment](#) (How-to Guide Resources, page 65)

Partnering with Patients and Families to Accelerate Improvement Readiness Assessment				
Name of Organization _____				
Area	Current Experience: make a mark (an X, a circle, or anything that is easy to read) in the box that best describes your team or organization’s experience.			
Data transparency	<table border="1"> <tr> <td>We have not discussed the possibility of sharing performance data with</td> <td>Our team is comfortable with sharing improvement</td> <td>Th</td> </tr> </table>	We have not discussed the possibility of sharing performance data with	Our team is comfortable with sharing improvement	Th
We have not discussed the possibility of sharing performance data with	Our team is comfortable with sharing improvement	Th		

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At St. Luke's Hospital in Cedar Rapids, Iowa, the Patient and Family Advisory Council (FAC) for Heart Care Services is dedicated to helping the service fulfill its mission: "To give the health care we'd like our loved ones to receive" and to support the principles and practice of family-centered care. Functions of the FAC include providing input and feedback on ways to improve:

- Patient and family experience;
- Delivery of services for patients and families;
- Educational programs, classes, and written materials for patients;
- Program development such as for the transitions in care team;
- Education/orientation of hospital associates;
- Facility design or renovation;
- Reviewing accomplishments and setting goals; and
- Recruiting new members.

For more information on partnering with patients and families to transform care refer to:

Partnering with Patients and Families to Design a Patient- and Family-Centered Health Care System: A Roadmap for the Future. Institute for Healthcare Improvement. Available at www.ihl.org/knowledge/Pages/Publications/PartneringwithPatientsandFamilies.aspx.

Tools for Advancing the Practice of Patient- and Family-Centered Care. Institute for Patient- and Family-Centered Care. Available at www.ipfcc.org/tools/downloads.html.

Berwick D. What 'patient-centered' should mean: Confessions of an extremist. *Health Affairs (Millwood)*. 2009 Jul-Aug;28(4):w555-65. Epub 2009 May 19.

Taylor J, Rutherford P. The pursuit of genuine partnerships with patients and family members: The challenge and opportunity for executive leaders. *Health Services Management*. 2010 Summer;26(4):3-14. Available at www.ihl.org/knowledge/Pages/Publications/PursuitGenuinePartnershipswithPatientsFamily.aspx.

Cross-Continuum Team Collaboration

Cross-continuum team collaboration is a transformational hallmark of the STAAR initiative that promotes the paradigm shift from site-specific care to patient-centered care, where the focus is on the patient's experience over time. Understanding mutual interdependencies between care settings, the hospital-based teams co-design care processes with their community-based clinicians and staff and collaborate to improve patients' transition out of the hospital and reception into community settings of care. This collaborative teamwork reinforces that readmissions are not solely a hospital problem.

Leadership for successful cross-continuum teams varies. Some are initiated by hospital executives who invite representatives from community-based sites of care and community agencies that received their patients to learn and test changes in collaboration with hospital-based teams. Quality Improvement Organizations (QIOs) are bringing together hospitals, nursing homes, patient advocacy organizations, and other stakeholders in community coalitions where in many cases leadership arises from a community-based leader. Regardless of the initial leadership, the purpose of the cross-continuum team collaboration is to work together toward a common goal and to co-design care transition processes that keep patients safe during the transitions between care settings and to coordinate the care of patients.

The cross-continuum team should meet regularly to facilitate communications and collaboration, assess progress, remove barriers to progress, and support improvement efforts of the front-line teams in all clinical settings. In the STAAR initiative, a few key roles for cross-continuum teams are emerging and are delineated below.

Oversight Role

- Identify opportunities and establish aims to improve care transitions.
 - Surface failures and diagnose systemic gaps in care transitions and identify and/or test new ideas;
 - Review and analyze the readmission data and data about patient/family experiences;
 - Complete periodic diagnostic reviews of cases where patients have been readmitted to engage all clinicians and staff in the community and to continually learn about opportunities for improvement; and

- Create a common aim and look at linkages of processes where cooperation is required.
- Build capability to partner with patients and family caregivers.
 - Add patients and family caregivers to the cross-continuum team to enhance the focus on patient/family experiences and to enable their participation in improving care processes.
- Build capability and capacity in partnering across organizational boundaries.
 - Develop mutual familiarity with the characteristics and needs of each setting by having members from the cross-continuum team visit each others' sites to observe patient care processes during transitions (e.g., hospital and home care nurses shadow each other in the hospital and home visits); and
 - Rotate meetings in the different sites.

Portfolio Management

- Review the comprehensive results and progress over time and support the work of front-line clinicians and staff in the hospital, office practice settings, home health care, and skilled nursing facilities in the co-design and implementation of processes to improve transitions in care.
- Manage a portfolio of community-wide improvement initiatives and review progress of each initiative. Examples of community-wide initiatives include:
 - Create universal handover forms/formats to improve communication and coordination of patient care among all clinical settings;
 - Develop a common evidence-based patient education approach in all clinical settings (e.g., health literacy strategies);
 - Create universal teaching materials for the most common clinical conditions for use in all clinical settings; and
 - Create universal self-management tools to be used in all clinical settings to support patients and family caregivers.
- Facilitate collaboration along with payers and post-acute care providers to determine eligibility criteria for intensive care management and how to determine the clinical provider who is “in charge of coordinating care” for various patient populations (Care Transitions Intervention, APN Transitional Care, HF Clinic, Patient-Centered Home, Evercare, etc.).

Health Information Exchange and Shared Care Plans

Health information technology (HIT) and the systems to enable the exchange of electronic information within and across settings in a community (i.e., interoperability) can have a dramatic effect on the coordination and communication of information among providers and between providers and patients. While hospitals have had electronic systems to support financial and management systems for a long time, fewer have electronic clinical information systems that support quality of patient care.²¹ Other settings across the continuum of care have only recently begun to adapt and implement HIT systems that include clinical information.²² Recent national initiatives — such as the Health Information Technology for Economic and Clinical Health (HITECH) Act (P.L. 111-5) that has as its goal the adoption of HIT in hospitals and office practices around the country — are helping to accelerate the use of HIT more broadly across the health care system. Some insights about the current and potential impact of HIT on the components of IHI's Roadmap for Improving Transitions in Care after Hospitalization and Reducing Avoidable Rehospitalizations (Figure 1) are addressed in this section of the How-to Guide.

Transition from Hospital to Home

During the hospitalization, the ability of clinicians and staff to complete an enhanced assessment and create a post-discharge care plan can be done more consistently and easily if they have immediate access to information about the patient from a number of sources, including primary care and other community providers as well as from members of the care team within the hospital. Medication reconciliation is more effectively accomplished with shared access to patient records across providers. Information gained about the patient during Teach Back sessions, whether conducted in the hospital or in the primary care office, can become part of a continuous documentation of a patient's and their family caregivers' ability to understand how to take care of the patient with the use of shared information systems. Shared care plans, such as the Patient Powered system developed in Whatcom County, Washington, can be the vehicle for engaging patients in the development of their care plans and also in the active management of their health in an ongoing way. With shared care plans, patients have direct access to their medical information and designate others with whom they want to share the information.

Post-Acute Care Patient Activation

The ability of clinicians and staff in skilled nursing facilities, home health care, and primary care practices to effectively receive the patient following a hospitalization depends on their having access to information about the patient's course of treatment and the care plan developed during the hospitalization. The timely transmission of the discharge summary is often a key roadblock that can be addressed through shared access to the patient's medical record and the key recommendations for follow-up care by the discharging physician.

HIT systems can also play a role in standardizing patient-focused information about the illness and ensuring that the patient receives complementary information across settings and sites of care. In addition HIT has the potential to capture how effectively the patient and family caregivers are able to Teach Back what they are learning, share that information with clinicians across settings, and link engagement strategies to the level of patient activation.

Evidence-Based Care in Community Care Settings (Better Models of Care)

Information technology enables clinicians and staff in all settings to better manage care for their patients by having access to information about medication history, past treatments, outstanding tests, patient and family understanding of and ability to care for the patient, and patterns of hospitalization and ED use. For example, information technology enhances the ability of primary care practices to practice population management (i.e., to understand the needs of entire populations of patients with specific clinical conditions or multiple clinical conditions and provide proactive care to meet those needs).

Alternative or Supplemental Care for High-Risk Patients

Technology and information systems can be used to provide enhanced care to those at high risk of readmission by enabling not only daily monitoring of key clinical information about the patient, but also daily contact between the patient and his or her care team. For example, a number of approaches to providing enhanced or supplemental care to high-risk patients combine intensive contact and support with some type of telemedicine.

In spite of the potential that HIT has to impact improvements in transitions in care, there are a number of limitations of current HIT systems, including the lack of connectivity between different HIT systems in different settings (e.g., between hospitals and practices or skilled nursing facilities). Even within a single care setting such as a hospital, the systems for data exchange

are not transparent and do not encompass all of the elements. Most hospitals have fragmented care plans by discipline (different ones for MDs, RNs, pharmacists, etc.). While the HITECH Act also provides funding to support the state and regional efforts that will enable the transfer of electronic data across all settings and sites of care, fully functioning systems are not widespread. The Office of the National Coordinator recently released a Request for Information (RFI) on Governance of the Nationwide Health Information Network to a common set of “rules of the road” for privacy, security, business and technical requirements that will help create the necessary foundation to enable the nation’s electronic health information exchange capacity to grow.²³

In addition to the technical issues that need to be solved, there are other challenges that need to be addressed in order to fully maximize these systems to help providers and patients improve transitions, including better partnership between IT vendors and quality improvement experts and overcoming the conflict between vendor business strategies and the needs of providers within and/or across regions.

IV. Infrastructure and Strategy to Achieve Results

Step 1. Executive Leadership

The role of the Executive Sponsor is to link the goals of improving transitions in care and reducing readmissions to the strategic priorities of the organization as well as provide oversight for their team's work. The Executive Sponsor will also provide guidance for the quality improvement initiative to achieve breakthrough levels of performance. Depending on the size and organizational structure of the SNF, typical Executive Sponsors may include the SNF administrator, director of nursing, or medical director. When framing the improvement initiative, Executive Sponsors should ask the following strategic questions for improving transitions and reducing rehospitalizations:

- Do you know the facility's readmission rate for all residents?
- Is reducing the readmission rate a strategic priority for the facility? Why?
- Have you declared your improvement goals?
- What will help you drive success in your quality improvement initiatives?
- What initiatives to reduce readmissions are already underway or planned in your organization, and how could they be better aligned?
- How much experience do your executive leaders, mid-level managers, and front-line providers and staff have in process improvement? What resources (e.g., expertise in quality improvement, data analysis) are available to support improvement efforts?
- How will you provide oversight for the improvement projects, learn from the work, and spread successes?
- What other provider organizations should be engaged in this work?

An optional but highly recommended activity for the SNF administrator is to conduct a financial analysis of the current impact of readmissions on the facility and the projected impact of reducing readmissions over the course of the initiative. Key issues to consider in this financial analysis may include the following:

1. Financial and staffing implications of occupied versus empty beds and bed holds

2. Cost in terms of staff time, number of steps, and number of ancillary staff involved in completing the entire discharge process as well as the entire admission process
3. Cost in terms of business staff time involved in preparing and submitting final bill(s)
4. Cost in losing rehospitalized residents to another SNF
5. Cost of unused medications and supplies that cannot be returned
6. Implications of poor patient and family satisfaction for reputation

The Executive Sponsor should also select a Day-to-Day Leader who will coordinate project activities, help to foster and develop cross-continuum partnerships, and provide guidance to the front-line providers and staff (see Step 4b). The Day-to-Day Leader is often a nursing director or quality improvement leader. Finally, the Executive Sponsor is responsible for eliminating or mitigating barriers identified by the front-line providers and staff to ensure success. A proposed system for a strategic and successful quality improvement initiative as outlined in IHI's white paper, *Execution of Strategic Improvement Initiatives to Produce System-Level Results*, contains four components:

1. Setting priorities and breakthrough performance goals;
2. Developing a portfolio of projects to support the goals;
3. Deploying resources to the projects that are appropriate for the aim; and
4. Establishing an oversight and learning system to increase the chance of producing the desired change.²⁴

Step 2. Develop Cross-Continuum Partnerships

A critical part of improving transitions in care is the partnership with other continuum providers to co-design the care transition processes that cut across care settings (for example, developing mutually agreed upon standardized transfer criteria). One way that communities accomplish this work is through convening and/or participating in a multistakeholder team with representatives from across the care continuum, including patients and family caregivers, that provides leadership and oversight for the initiative to reduce readmissions and improve transitions in care. By understanding mutual interdependencies and identifying customer and supplier relationships at each step of the patient journey across the care continuum, the team will co-design processes to improve transitions in care. Collectively, team members will explore the

ideal flow of information and patient encounters as the patient moves from one setting to the next and then home. Recommendations for cross-continuum team members include:

- Patients, family members, or other designated caregivers
- Staff from the SNF, hospital, and other care settings, such as nurse managers, staff nurses, case managers, pharmacists, or quality improvement leaders
- Executive Sponsors from participating organizations such as directors of nursing, administrators, or other leaders supporting this work
- Physicians including the SNF Medical Director, hospitalists, primary care physicians, ED physicians
- Home health care nurses
- Palliative care or hospice nurses
- Area agency on aging representatives and representatives from other social services agencies
- Staff from community-based organizations
- Pharmacist (hospital, community, and/or other involved pharmacists)
- Case managers from health plans

Patients and families bring invaluable contributions to improvement teams.^{25,26} For more information on including residents and families in your work, please refer to the following resources:

- *Partnering with Patients and Families to Design a Patient- and Family-Centered Health Care System: A Roadmap for the Future*. Institute for Healthcare Improvement. Available at www.ihf.org/knowledge/Pages/Publications/PartneringwithPatientsandFamilies.aspx.
- *Tools for Advancing the Practice of Patient- and Family-Centered Care*. Institute for Patient- and Family-Centered Care. Available at www.ipfcc.org/tools/downloads.html.

At its first meeting, the cross-continuum team should discuss the purpose and goals of the improvement initiatives and the team's role in providing guidance and oversight. A suggested initial activity for the cross-continuum team includes participation in an in-depth review of the

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last five rehospitalizations. In addition to learning from the review of readmitted patients, SNFs should review their last five admissions to understand specific opportunities for improving the resident's transition into their facility (see Step 3).

Following is an example of a patient story that emerged from one cross-continuum team's diagnostic review near Boston, Massachusetts.

Robert, a 66-year-old male, was admitted to the hospital on the Friday before Super Bowl weekend with a bone infection in his previously amputated foot. Robert had undergone surgery to perform a resection of his amputation a few days prior to his hospital admission. Prior to this recent surgery, he suffered from chronic foot ulcers and had three previous surgeries related to these ulcers. He also has complicated polycystic kidney disease (and had a kidney transplant as a result), suffers from cardiac issues (including coronary artery disease), and has a number of other co-morbidities.

While Robert was in the hospital, he was given two IV antibiotics to treat the infection, had multiple dressing changes, had lab work conducted, and received pain management requiring medication oversight. Robert's case was discussed in rounds and his care team expressed concern about the bleeding from his amputation that had been going on for several days post-surgery. By Sunday afternoon, the case manager responsible for his transfer to skilled nursing was assured that Robert was ready for transfer per a consult with orthopedics. The SNF nursing supervisor was alerted to the incoming resident and the hospital care team began working on the paperwork for discharge.

Robert's discharge paperwork was sent over to SNF admissions. Unfortunately, the admissions coordinator had left for the day and he did not realize this paperwork was coming in Sunday evening. There were some back-and-forth discussions between the hospital case manager and the SNF nurse supervisor regarding Robert's planned discharge. The discharge was cancelled, and then re-activated when the SNF admissions coordinator drove back to the facility to get paperwork. The hospital case manager was not comfortable with this abrupt change in plans and the late time of day for discharge. However, given the admissions coordinator had just driven back to the facility from home to get the paperwork, she felt compelled to allow the discharge.

Robert also reported being happy either to stay in the hospital or be transferred to the SNF, as long as it did not interrupt his watching of the Super Bowl. No one noticed that Robert had not yet received his 4PM antibiotic dose prior to his discharge. Amidst all of

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the confusion, Robert was discharged without his antibiotics and with blood on his dressing.

Robert arrived at the SNF at 4:30PM. He had missed his 4PM dose of antibiotics and the SNF nurse did not have access to his medications. Ideally, the SNF would like to have known about the planned admission and had the antibiotics ready upon the patient's arrival. However, in some cases, hospital discharges are postponed indefinitely because of a change in patient clinical status, leaving the facility with unused medications. The facility has abandoned this practice because of its financial implications. In addition to the missed dose of antibiotics, Robert was also sent to the facility without a narcotic script for pain management. To complicate matters, Robert's foot dressing was soaked in blood, and the notes received said the dressing had been "changed overnight and was intact." There was also a physician note reporting "some bleeding from the wound." The amount of blood present, along with the confusing messages included in the note, concerned the SNF nurse and she was not sure how to proceed.

The SNF did not have a physician or nurse practitioner on duty at the time of Robert's admission, as is standard for this facility on Sundays. To address the concerns regarding bleeding, the nurse contacted the hospital to clarify with staff what the wound looked like before Robert left to determine whether the status was new or the same. To reconcile the medication discrepancies, the SNF nurse contacted the facility's on-call physician. This physician did not know Robert but ordered the narcotic to treat his pain. The medications came from an external pharmacy and so there was a delay in getting these to the facility. Robert was sent to his surgeon the next day to check on the wound.

Lessons learned from Robert's patient story:

- In Robert's transition from the hospital to a skilled nursing facility, he experienced several "near misses," any one of which could have resulted in his readmission to the hospital. These near misses represent a few unreliable processes all failing at the same time, often referred to by quality experts as the "Swiss Cheese" effect.
- The hospital staff were having a busy weekend and felt obligated and rushed to discharge Robert.
- There was poor communication of information about Robert's condition status and a lack of coordination amongst the care team as they transferred Robert from one setting to the next.

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- The providers at both the hospital and the skilled nursing facility were not able to plan well for Robert’s care because of gaps in service present on weekends and during changes in shift.
- In the end, there was a lack of clarity about the resident’s care needs and the facility’s ability to meet those needs at the time of this transition.
- As a result, no one felt empowered to “stop the line” in Robert’s transition.

Step 3. Identify Improvement Opportunities

At its first meeting, the cross-continuum or multistakeholder team defines its aspirations and purpose. It develops a plan to manage the portfolio of improvement projects and clarifies its aim (e.g., to reduce rehospitalizations by 30 percent). Early team tasks include a diagnostic assessment (see Step 3a, below) and review of historic data like readmission rates, transfers from long-term care centers to hospitals, patient perception data, home health admissions to acute care, and the like.

Step 3a. Perform an in-depth review of the last five residents that have been admitted to your facility to identify opportunities for improvement.

Conduct chart reviews on the last five residents that have been admitted to your facility, transcribing key information. It is recommended that SNFs utilize the IHI Diagnostic Tool for the Transition to Skilled Nursing (Figure 5) for this review to learn about opportunities for improving the transition into their facility. An additional recommended resource is reviewing recent resident transfers to the hospital using the INTERACT II Quality Improvement Tool for Review of Acute Care Transfers (Figure 6). This tool identifies opportunities to improve processes related to responding to changes in the resident’s condition.

Figure 5: [IHI Diagnostic Tool for Transition to Skilled Nursing](#) (How-to Guide Resources, page 53)

IHI Diagnostic Tool for SNFs

Worksheet A: Chart Reviews of Admitted Residents

Conduct chart reviews of the last five residents admitted to your facility from an acute care hospital. Reviewers should be nurses or physicians that are actively involved in reviewing potential new admissions and would have access to screening documents for new admissions. Reviewers should not look to assign blame, but rather to discover opportunities to improve the care of residents.

Question	Resident #1	Resident #2	Resident #3	Resident #4	Resident #5
Did the SNF admissions nurse					

Figure 6: [INTERACT II Quality Improvement Tool](#) (How-to Guide Resources, page 57)



Step 3b. Review your organization’s resident experience data to identify opportunities for improvement.

Evaluate trends in your organization’s resident experience data, with a focus on the informal feedback and any survey data obtained over the last year. If your organization does not survey residents for this information, work with your Executive Sponsor to develop and institute a resident experience survey tool or other mechanism to obtain this feedback and track this data over time.

Of particular interest is data that provides information about the resident’s experience with their transition to and from skilled nursing. The Care Transitions Program, a program focused on providing health care services for improving quality and safety during care handoffs, offers the Care Transitions Measure (CTM) for obtaining information about the patient’s experience with the transition from hospital to home or post-acute care. Two versions of the CTM are available at www.caretransitions.org/getdocctm.asp and may serve as an example for developing or adding to your resident survey tools.

Step 3c. Review 30-day all-cause readmission rates to identify opportunities for improvement.

Collect historical data and display monthly 30-day all-cause readmission rates or acute care transfer rates (Figure 7) for the SNF over time; include at least 12 months of data, preferably more. In addition to tracking the 30-day all-cause readmission rate, SNFs may choose to also look at various segments of the population (e.g., residents readmitted to the hospital within the first five days, residents readmitted due to infection, residents with emergency vs. planned readmission to the hospital).

Figure 7: Outcome Measures: 30-Day All-Cause Readmissions and Acute Care Transfers

Measure Name	Description	Numerator	Denominator
30-Day All-Cause Readmissions to the Hospital from SNF	Percent of all SNF residents admitted to the SNF from the hospital who are then readmitted to the hospital within 30 days	Number of residents admitted to the SNF from the hospital who are then readmitted to the hospital within 30 days Exclusion: Planned readmissions	Total number of residents admitted to the SNF from the hospital in the measurement month
Acute Care Transfers	Number of SNF residents transferred to acute care, divided by the number of patient days and multiplied by 1,000	Number of SNF residents transferred to acute care	Patient days

Step 3d. Develop mutually agreed upon standardized transfer criteria with cross-continuum partners.

Clinicians in both hospitals and SNFs frequently work in isolation, unaware of the information required by providers in each setting to coordinate a successful transfer. Employing a cross-continuum team to co-design and test transfer criteria to guide the transfer process provides a means to optimize care across settings. Through the team (or through cross-continuum partnerships if a team does not yet exist), commit to regular meetings and a means to efficiently address barriers. Follow these steps to develop a standardized transfer process and standardized transfer criteria:

- If possible, shadow one another in each care setting to observe the transfer process in real time.
- Together, draft a process map of an ideal transfer from the perspective of each care setting. For more information on process mapping, see the IHI website at www.ih.org/knowledge/Pages/Tools/Flowchart.aspx.
- Make the expectations of each care site explicit rather than assumed. The key is to ban assumptions — if needs and requests are not specified, process failures will likely occur.

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- Develop “standardized transfer criteria” with your colleagues in the other setting to help guide the transfer process; ensure that each is able to provide the information requested. For example, the staff of one SNF initially identified that they wanted to know whether the resident they were receiving was stable when he or she left the hospital. When pressed to specify the meaning of “stable,” the director of nursing was able to easily generate a list: no unassessed or untreated fever, no signs of recent deterioration, oxygenation levels unchanged or improving in the previous 24 hours, etc.
- Test the criteria with the next transfer, and review what worked and what did not. Implement a disciplined means of debriefing — such as an in-person or virtual (by phone) huddle immediately following the transfer — to capture learning in real time. For example, a debrief may address a major frustration frequently reported by SNFs: who to call to problem-solve when a transfer goes poorly? Waiting until the next meeting sacrifices the immediate rich learning that can take place.

In developing the transfer criteria and process, keep in mind that the transfer may need to be timed to the availability of certain special skills within the SNF. For example, the transfer may need to occur on a day/time when the physician will be in attendance or when the wound care nurse is in the building.

Figures 8 and 9 are examples of Universal Transfer Forms developed to assist with the transfer of patients from the hospital to post-acute settings. Figure 8 depicts a Universal Transfer Form developed by Akron Regional Hospital Association in partnership with 26 skilled nursing facilities within the Akron, Ohio, community. Figure 9 is a Universal Transfer Form developed by the Massachusetts Department of Public Health with input from providers across the state.

Figure 8: [Akron Regional Hospital Association: Universal Transfer Form](#) (How-to Guide Resources, page 67)

AKRON REGIONAL HOSPITAL ASSOCIATION

Affinity Doctors
 Affinity Massion
 Akron City Hospital
 Akron Children's Hospital
 Akron General Medical Center
 Barberton Citizens Hospital
 Cuyahoga Falls General
 Edwin Shaw Rehab
 Lodi Community Hospital
 Medina General Hospital

Meroy Medical Center
 Regency Hospital - Barberton
 Regency Hospital - Ravenna
 Robinson Memorial Hospital
 Saint Thomas Hospital
 Select Specialty - Meroy
 Select Specialty - AGMC
 Select Specialty - SHS
 WRH Health System

POST-ACUTE TRANSFER FORM - PHYSICIAN ORDERS

MEDICAL INFORMATION

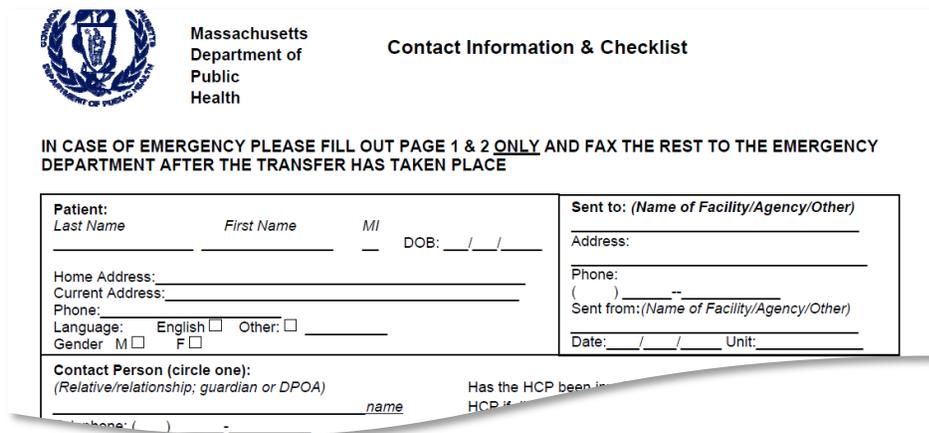
Patient's Name
 Last First

SPECIAL CARE ORDERS

ENEMAS PRN
 O2 LITER FLOW: _____
 IV CARE/PICC Date: _____
 Length: _____ Site: _____

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Figure 9: [Massachusetts Department of Public Health: Universal Transfer Form](#) (How-to Guide
Resources, page 71)



The image shows a form titled "Contact Information & Checklist" from the Massachusetts Department of Public Health. The form includes a header with the state seal and the department name. Below the header is a bold instruction: "IN CASE OF EMERGENCY PLEASE FILL OUT PAGE 1 & 2 ONLY AND FAX THE REST TO THE EMERGENCY DEPARTMENT AFTER THE TRANSFER HAS TAKEN PLACE". The form is divided into two main columns. The left column contains fields for patient information: Last Name, First Name, MI, DOB, Home Address, Current Address, Phone, Language (English/Other), and Gender (M/F). The right column contains fields for contact information: Name of Facility/Agency/Other, Address, Phone, and Date. At the bottom, there is a section for the contact person, including a field for name and a checkbox for "Has the HCP been in...".

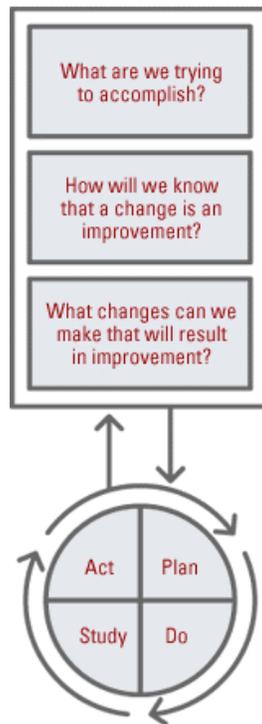
Step 4. Use the Model for Improvement

Developed by Associates in Process Improvement, the Model for Improvement (Figure 10) is a simple yet powerful tool for accelerating improvement that has been used successfully by hundreds of health care organizations.

The model has two parts:

- Three fundamental questions that guide improvement teams to 1) set clear aims, 2) establish measures that show if changes lead to improvement, and 3) identify changes that are likely to lead to improvement.
- The Plan-Do-Study-Act (PDSA) cycle to conduct small-scale tests of change in real work settings — by planning a test, trying it, observing the results, and acting on what is learned. This is the scientific method, used for action-oriented process improvement.

Figure 10: The Model for Improvement



Learn more about the Model for Improvement at www.ihl.org.

Question 1: What are we trying to accomplish?

Craft an aim statement to guide the work. Aim statements communicate what a team hopes to accomplish and the magnitude of its change. Aim statements have four parts to them: what the team expects to do; by when; for whom, and states the measurable goals.

Sample aim statements:

- 1) *By December 2011, Maryfree Skilled Nursing Facility will reduce readmissions for all residents as measured by a decrease in 30-day all-cause readmission rate from 17 percent to 13 percent or less. The facility will focus on identifying early changes in patients' condition, standardized communication, and teamwork.*
- 2) *General Nursing Home will improve transitions for patients discharged from the hospital and admitted to the nursing home as measured by a reduction in unplanned 30-day readmissions of patients from 25 percent to 15 percent or less by December 31, 2011. We will focus on coordination with the hospital, determining resident care goals, and assessment of changes in the patients' condition.*

For more on setting aims, please refer to:

www.ihl.org/knowledge/Pages/HowtoImprove/ScienceofImprovementSettingAims.aspx.

How to Select Pilot Units or a Pilot Population

Based on what is learned about 30-day all-cause readmission data, select one or two skilled nursing units where readmissions occur the most. If one resident population accounts for a large percent of the readmissions (e.g. residents with infections) it may help to focus initially on this patient segment.

How to Form an Improvement Team

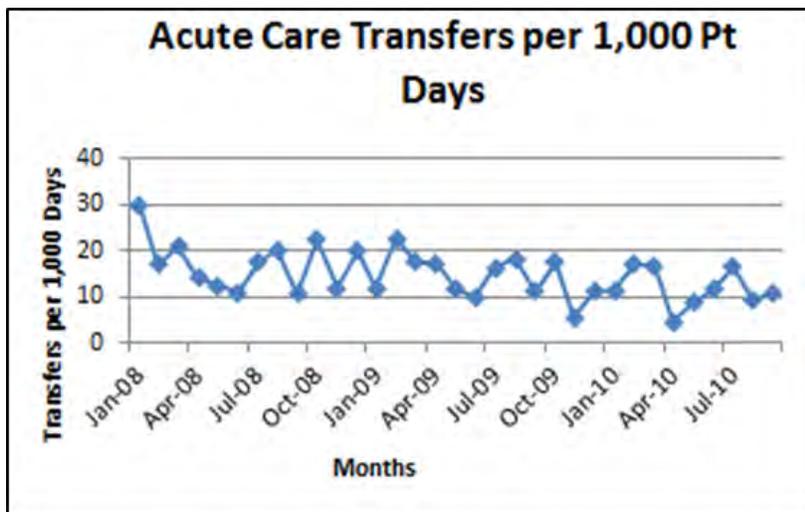
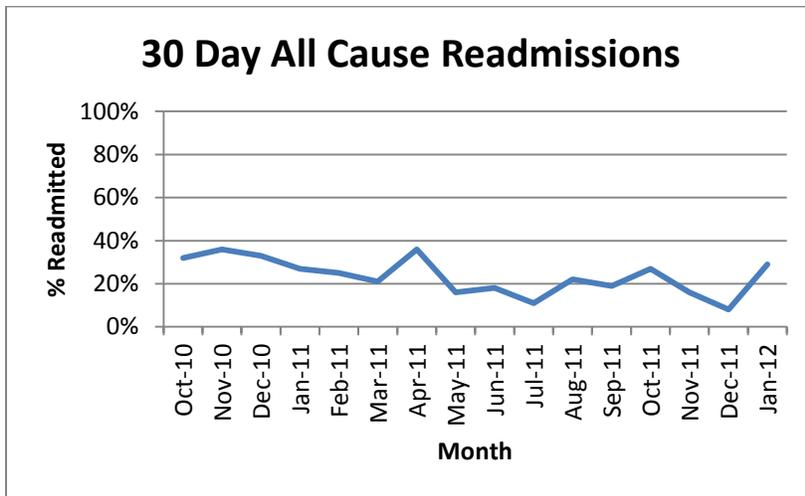
Front-line improvement team(s) vary from organization to organization. Ideally, involve individuals who actively assess residents, teach and facilitate resident education, communicate essential information during handovers to/from the other care settings, and arrange post-SNF care follow-up. Front-line improvement team(s) will initially test the three Key Changes on the unit(s). A typical front-line improvement team includes:

- A Day-to-Day Leader for each pilot unit who will drive the work on their respective unit(s)
- Residents, family members, or resident caregivers
- Physician or nurse champion
- Nurse practitioner or physician assistant (if applicable)
- Nurse manager/supervisor, staff nurses, case manager, certified nursing assistant, nurse educators
- Dietician
- Physical therapist/occupational therapist
- Social workers and/or discharge planners
- Clinicians and staff from other care settings and/or community-based organizations (e.g., acute care, home health care, area agency on aging, other SNFs)

Question 2: How will we know that a change is an improvement?

Data to reduce readmissions and rehospitalizations is best for learning not judgment. Outcome, process, and balancing measures inform improvement. Outcome measures directly relate to the aim — in this case, to reduce readmissions or rehospitalizations. Process measures reflect how work gets done around the key changes. Balancing measures help ensure that we are not causing detriment to an important part of the system. When data is displayed in a time series graph or in a run chart trends and improvement are easy to observe (see Figure 11).

Figure 11: Example Run Chart: Outcome Measures for Readmission and Acute Care Transfers

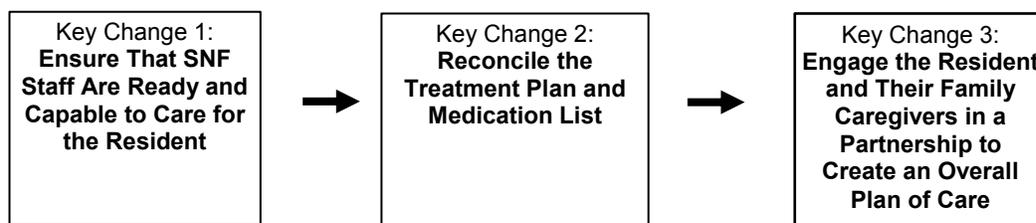


Question 3: What changes can we make that will result in improvement?

Select the changes needed to bring about improvement from among the Key Changes outlined in section II.

The key changes in this guide represent the temporal journey of a resident's transition from the hospital to skilled nursing. First, the SNF assesses (either by phone or in person) the resident's condition while they are in the hospital to determine overall fit and to ensure the capability and readiness of staff to care for the resident. The second key change, occurring once the resident is admitted, involves re-assessing the resident and reconciling their treatment plan and medication list so that SNF staff are set up to provide ideal care. The third key change is engaging the resident and their family caregivers in creating an overall plan of care. This change often occurs within the first few days of the resident's stay in the SNF. All changes should be reliably implemented and scaled up across the SNF to ensure a safe and effective transition from the hospital to skilled nursing.

Figure 12: Flow Chart of Key Changes to Create an Ideal Transition from the Hospital to the SNF



Using PDSA Cycles for Learning and Improvement

The engine of improvement is the Plan-Do-Study-Act (PDSA) cycle. A team conducts small-scale tests of change in real work settings — by planning a test, trying it, observing the results, and acting on what is learned. This is the scientific method, used for action-oriented process improvement.

Additionally, observation may inform improvement because it yields significant learning as a team tests and then implements changes.²⁷⁻³² The key change descriptions include suggestions for observation.

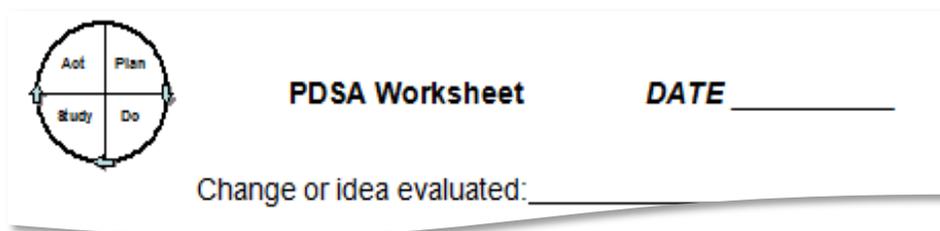
Why Test Changes?

- To increase your belief that the change will result in improvement
- To decide which of several proposed changes will lead to the desired improvement
- To evaluate how much improvement can be expected from the change
- To decide whether the proposed change will work in the actual environment of interest
- To decide which combinations of changes will have the desired effects on the important measures of quality
- To evaluate costs, social impact, and side effects from a proposed change
- To minimize resistance upon implementation

How to Test a Change

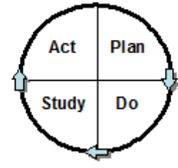
A first test of change usually happens on a small scale (e.g., conducting a “warm handover” communication between the hospital and SNF with one incoming resident, or for one day). Use a Plan-Do-Study-Act format and predict what will happen as a result of trying something different. Observe the results, learn from them, and continue to the next test. Use iterative PDSA cycles to test under a variety of conditions. This improves the team’s belief that the change will work reliably when implemented. See the PDSA Worksheet (Figures 13 and 14).

Figure 13: [PDSA Worksheet](#) (How-to Guide Resources, page 77)



The image shows a worksheet template for a PDSA cycle. On the left is a circular diagram divided into four quadrants labeled 'Act', 'Plan', 'Study', and 'Do', with arrows indicating a clockwise cycle. To the right of the diagram, the text 'PDSA Worksheet' is followed by 'DATE' and a blank line for writing. Below this, the text 'Change or idea evaluated:' is followed by a long blank line for writing.

Figure 14: [Example Completed PDSA Worksheet](#) (How-to Guide Resources, page 78)



PDSA Form - EXAMPLE

Change or idea to be tested:
Warm hand-over communication with the hospital to confirm/clarify condition and treatment plan for patients admitted to skilled nursing from the hospital.

Objective for this PDSA cycle:
Hold a direct conversation with the hospital nurse (or case manager) knowledgeable about the patient's treatment in the hospital to discuss his/her condition and confirm/clarify treatment plan and care needs.

The diagram shows a circular PDSA cycle with four quadrants: Act (top-left), Plan (top-right), Do (bottom-right), and Study (bottom-left). Arrows indicate a clockwise flow from Plan to Do, Do to Study, Study to Act, and Act back to Plan.

Most changes require a series of successive tests before implementation. Testing may include adding more staff to try the change, adding a variety of types of residents and family caregivers, or testing on different shifts, on the weekdays and on the weekends, when short staffed, well staffed, on days with many admissions, few admissions, etc. The point is to learn as much as possible and create a process that is failure-proof (i.e., that works as reliably as possible). A series tests are outlined below.

Example of a Series of PDSA Cycles

During a cross-continuum team meeting, staff from the orthopedics unit at the hospital and the staff from the subacute unit at the local SNF agree to test a verbal handover conversation using a standard communication template they had developed together.

Aim: Test a warm handover conversation using a standard communication template with the nurse at the hospital to clarify information about patients transferred to skilled nursing.

- Cycle 1: One SNF nurse calls the staff nurse on the hospital orthopedics unit on the day prior to one patient's discharge and utilizes the communication template to guide discussion. She finds that many of the questions on the communication template are redundant and the conversation takes more than 10 minutes to complete. Both nurses agree that 4 questions can be eliminated.
- Cycle 2: The SNF nurse uses the revised communication template to communicate with the staff nurse from the hospital orthopedics unit on the next planned discharge from the hospital to the SNF. After this test, they agree that no further revisions to the template need to be made.

- Cycle 3: The SNF nurse uses the revised communication template to communicate with the hospital staff nurse for all transfers over the next two weeks.
- Cycle 4: The SNF nurse trains three other nurses on the SNF subacute unit on how to use the revised standard communication template to communicate with nurses on the hospital orthopedics unit and the template is used on all transfers from the orthopedic unit to the subacute unit.
- Cycle 5: The SNF nurse gathers feedback from the other nurses who have used the standard communication template and brings it to the next cross-continuum team meeting with the hospital.
- Cycle 6: Testing continues with additional hospital units.

Suggestions for Conducting PDSA Cycles

- Keep tests small; be specific.
- Make a prediction about what will happen if the tests succeeds.
- Each test informs the next.
- Expand test conditions to determine whether a change will work under a variety of conditions:
 - Different times of day (e.g., day and night shifts, weekends, holidays) when the unit is adequately staffed;
 - At times of staffing challenges; or
 - Different types of patients (those with lower health literacy, non-English speaking patients, short stay or long stay patients).
- Collect sufficient data to evaluate whether a test has promise, was successful, or needs adjustment. Compare data to findings to learn more and design future tests.

Test to Increase Process Reliability

David Garvin defines reliability as failure free operation over time. Processes should get desired results every time, for every appropriate patient. As PDSA cycles ramp up, make sure

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to precisely specify the work, who does what, when, how, where, etc. To make processes more reliable make use of human factors principles (e.g., build on existing habits, use checklists to avoid relying on memory, foolproof the process so that it is impossible to do the wrong thing, use standard protocols and training). To increase reliability, for example, use a checklist to ensure all pre-determined and standardized transfer criteria are met. If the responses vary, this may reveal a lack of reliability in how the work is done.

Make sure there is a process in place that identifies failures (e.g., a patient is ready for discharge from the hospital but the SNF admission nurse has not yet received information to determine appropriateness for admission to the facility). Learn where failures occur and then design redundancies or remedies if they occur.

The following is an example of how to plan for testing based upon the recommended Key Change 3: “Engage the Resident and Their Family Caregiver in a Partnership to Create and Overall Plan of Care.”

Example: When redesigning your process for determining resident’s goals of care, including end-of-life preferences, work with staff who conduct the tests to precisely describe the work, including information regarding the following:

- *Who will do it? (be specific — e.g., include the name of the nurse assigned to the resident)*
- *What will they do? (e.g., use the INTERACT Communication Guide as a resource to improve discussions with residents and their family members about their care goals)*
- *When will they do it? (e.g., during the care conference with newly admitted residents)*
- *Where will they do it? (e.g., in family meeting room or the resident’s room)*
- *How will they do it? (e.g., outline an agenda and framework for discussion based on the INTERACT Communication Guide)*
- *How often will they do it? (e.g., with every resident during their care conference that occurs within 72 hours of admission)*
- *Why should they do it? (e.g., to improve understanding of resident care goals, improve SNF staff relationship with resident and family caregivers, ensure care is aligned with resident’s preferences and goals)*

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Continue to test the process under a variety of conditions (e.g., different nurses, different kinds of patients). Adapt the change iteratively until it optimally meets the needs of both patients and staff and a high level of reliability is achieved (i.e., the process works as designed at least 95 percent of the time).

Learn from failure as well as from success. Understanding common failures (situations when a process is not executed as expected) helps the team to (re)design the new processes to eliminate those failures.

Learning from a failed test:

The process being tested required nurses to reconcile the medication lists received from the hospital, primary care physicians, as well as information about medications provided by the resident. During the initial testing of this process, the admitting nurse did not know how to obtain an accurate list of medications from the resident. The improvement team at the SNF met and decided that for the next three admissions, they would request that the resident's family bring in all of the medications that the resident was taking prior to the hospital admission as well as the medication schedule (if available) that they followed at home.

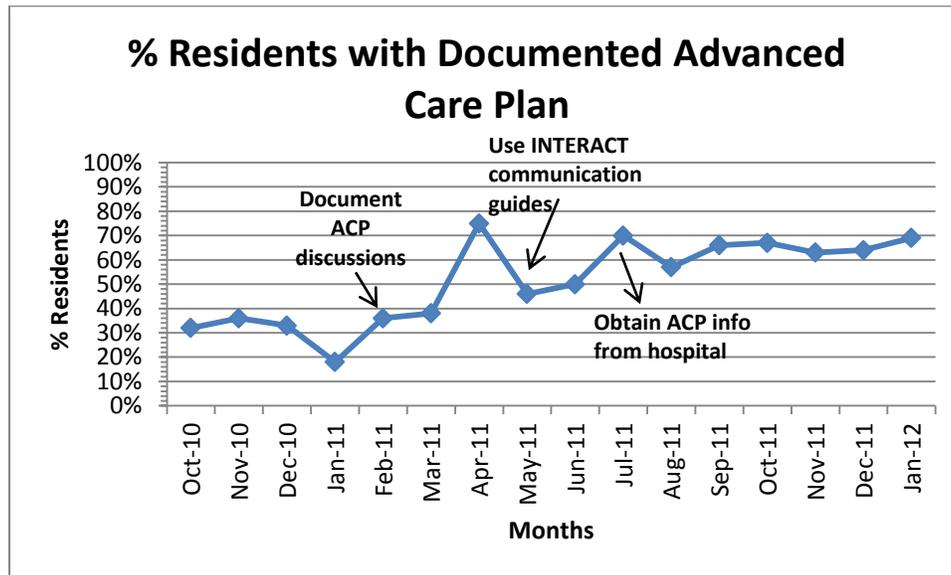
After successful testing under varying conditions with desired results, document the process so there is no ambiguity and all involved can articulate the exact same steps in the process.

Use Data, Displayed Over Time, to Understand Progress

Use data to assess process reliability. For example, display in a time series graph the percentage of residents with an advanced care plan documented. Annotate graphs to note when specific changes are implemented. Continue to collect and display this data to see whether your changes result in improvement. Augment quantitative data with information from asking patients about their experience (consider using the [IHI Diagnostic Tool for SNFs](#), page 53, and the [INTERACT Quality Improvement Tool for Review of Acute Care Transfers](#), page 57).

Track whether new and improved processes are executed as expected with process measures. Learn whether and how specific changes work as planned. Figure 15 shows an example of an annotated time series graph for a process measure for Engaging the Resident and Their Family Caregivers in an Overall Plan of Care. The annotations show when specific changes were tested or implemented.

Figure 15: Example Time Series Graph for Process Measure



When data suggest a lack of process reliability — ask the people who do the job what barriers they face. Identify opportunities to execute the new processes more reliably. Avoid blaming staff who do the work. Assume the problem is from poor process design. Work with the team to fix it. For example, if the team observes that nurses are not providing care consistent with the resident's care goals, the team should ask nurses about barriers that prevent them from doing so. By eliminating these barriers, the team will improve the likelihood that resident care goals will be met.

Note, for example, how the data in the graph above (Figure 15) enables the team to see when performance declined and test new interventions to improve reliability. Share data with unit staff, physicians, and senior leaders. Reflect on lessons learned from both successful and unsuccessful tests of change.

Step 5. Implementation, Scale-up, and Spread

Implementation of Changes

After testing a change on a small scale, learning from each test, and refining the change through several PDSA cycles, the team should broadly implement the change to make it permanent and routine. This usually requires revisions to written policies, hiring, training, compensation, equipment, and other aspects of the organization's infrastructure that were not engaged in the testing phase. Pay attention to communication (i.e., publicizing the benefits of

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the change), documenting improvement, as well as keeping in contact with the pilot team to support it during implementation.

Example: During the testing process, a few nurses may be trained in the redesigned handoff processes like using a phone call with the discharging hospital nurse to confirm understanding of the resident's care needs. Once the processes and support materials have been adapted so that this handoff involving SNF and hospital nurses occurs effectively over 90 percent of the time, the process should be implemented across the facility. Making this process the default system (i.e., the way the work is done rather than the way a few nurses do the work from time to time) requires a training system for all nurses, and changes to orientation programs for new nurses. It might also require changes to an IT system where information about the resident is documented and shared. Communication to all staff about the revised expectations for teaching and learning might be developed to start to generate interest in implementing the redesigned process in other parts of the SNF or in other facilities (e.g., in other units or other facilities within the system or community) or with other disciplines (e.g., physicians or pharmacists) in preparation for spread.

During implementation, attend to social aspects of the change as well as the technical infrastructure. Leaders need to communicate the *why* as well as the *how* of the change, and address questions and concerns. It is common for processes to work reliably during testing and less reliably, temporarily, during implementation because a larger group, some unfamiliar and/or unsympathetic with the purpose, must implement a change.³³ There may be resistance, or simply confusion. It may take some cycles of testing to put in place an effective infrastructure to support the change(s). After implementation, continue to monitor whether processes are reliable and act on that information to adapt the processes and the related infrastructure to support the change. Make it easy to do the right thing, and hard to do the wrong thing.

Tips for Sustaining Improvements

- Communicate aims and successful changes that achieved the desired results (e.g., newsletters, storyboards, patient stories, etc.).
- “Hardwire” processes so that the new processes are difficult to reverse (e.g., IT template, yearly competencies, role descriptions, policies and procedures).
- Assign ownership for oversight and ongoing quality control to “hold the gains.”
- Assign responsibility for ongoing measurement of processes and outcomes.

Scale-up of Changes

Scale-up involves overcoming system and infrastructure issues that arise during implementation. For example, after pilot testing a new process for determining resident care goals, a SNF unit identified this as a successful improvement. The SNF leadership then undertakes a deliberate implementation of this change in the whole facility. The infrastructure required to sustain this process on a unit may be different from the infrastructure required for implementation throughout the facility (i.e., documentation in the electronic medical record or annual competency training). If there are barriers to scale up they should be noted and removed, if possible.

An important leadership consideration is whether staff have adequate time and resources to adopt the changes. Are the changes developed at the pilot level scalable to the entire organization? For example, having conversations with residents about their advance care plan may mean that nurses and other staff develop communication competencies and free up time to reliably implement this new competency.

Spreading Changes

Leaders should plan for spreading the improvement developed in the pilot population or unit during the early stages of the initiative. After successful implementation of the key changes, leaders develop a spread plan. Even though the changes have been tested and implemented, spread efforts benefit from testing and adaptation (using PDSA cycles) in new resident populations or organizations.

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Successful spread of reliable processes requires leaders to commit sufficient resources to support spread. Pilot unit staff also play an important role in spread activities by 1) making the case that the changes contribute to better patient transitions and reduced readmissions, and 2) generating information and materials that leaders can package to ease spread. They may teach and mentor others.

A key responsibility of leaders is to develop a plan and timetable for spread and then to measure and monitor progress. Figure 16 shows an example of a tool to monitor spread of changes. This tool allows a leader to visualize spread progress of each change and the spread of changes across the locations.

Figure 16: [Spread Tracker Template](#) (How-to Guide Resources, page 80)

<i>Spread Tracker Template</i>					
<i>A=Planning B=Start C=In Progress D=Fully Implemented</i>					
	Pilot Unit 1	Pilot Unit 2	Spread Unit 1	Spread Unit 2	Spread Unit
Change 1	D	C			

Leaders would want to determine if further guidance and support might accelerate progress and results. It is recommended that outcome measures be reported and tracked at the hospital or system level as well as at the unit level in order to provide leaders, unit managers, and front-line staff with regular feedback on their progress.

Recommended Readings and Resources on Quality Improvement

Books and articles:

Berkowitz RE, Schreiber R, Paasche-Orlow MK. Team improvement and patient safety conferences: Culture change and slowing the revolving door between skilled nursing and the hospital. *Journal of Nursing Care Quality*. 2012 Feb 22. [Epub ahead of print]

Berkowitz RE, Jones RN, Rieder R, et al. Improving disposition outcomes for patients in a geriatric skilled nursing facility. *Journal of the American Geriatrics Society*. 2011;49(6):1130-1136.

Gozalo P, Teno JM, Mitchell SL, et al. End-of-life transitions among nursing home residents with cognitive issues. *New Engl J Med*. 2011;365:1212-1221.

Kenagy J. *Designed to Adapt: Leading Healthcare in Challenging Times*. Bozeman, MT: Second River Healthcare Press; 2009.

Langley GJ, Moen R, Nolan KM, Nolan TW, Norman CL. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance*. San Francisco: Jossey-Bass; 2009.

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 on www.IHI.org)

Nolan KM, Schall MW (editors). *Spreading Improvement Across Your Health Care Organization*. Oakbrook Terrace, IL: Joint Commission Resources and the Institute for Healthcare Improvement; 2007:1-24.

McCarthy D, Beck C. *Summa Health System's Care Coordination Network*. The Commonwealth Fund; 2007.

Mor V, Intrator O, Feng Z, Grabowski DC. The revolving door of rehospitalization from skilled nursing facilities. *Health Aff (Millwood)*. 2010;29:57-64.

Ohno T. *Toyota Production System: Beyond Large-scale Production*: Productivity Press; 1988.

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Ouslander JG, Berenson RA. Reducing unnecessary hospitalizations of nursing home residents. *New Engl J Med*. 2011;365:1165-1167.

Ouslander JG, Lamb G, Tappen R, et al. Interventions to reduce hospitalizations from nursing homes: Evaluation of the INTERACT II collaborative quality improvement project. *Journal of the American Geriatrics Society*. 2011;59:745-753.

Spear S. *The High Velocity Edge* (released in its first edition as: *Chasing the Rabbit: How Market Leaders Outdistance the Competition*). McGraw Hill; 2009.

Womack JP, Jones DT. *Lean Thinking*. Simon & Schuster Audio; 1996.

Web tools and resources:

Spreading Changes. Institute for Healthcare Improvement. Available at www.ihl.org/knowledge/Pages/HowtoImprove/ScienceofImprovementSpreadingChanges.aspx.

On Demand Presentation: An Introduction to the Model for Improvement. Institute for Healthcare Improvement. Available at www.ihl.org/offerings/VirtualPrograms/OnDemand/ImprovementModelIntro/Pages/default.aspx.

Transforming Care at the Bedside (TCAB). Institute for Healthcare Improvement. Available at www.ihl.org/offerings/Initiatives/PastStrategicInitiatives/TCAB/Pages/default.aspx.

Transforming Care at the Bedside How-to Guide: Engaging Front-Line Staff in Innovation and Quality Improvement. Institute for Healthcare Improvement. Available at www.ihl.org/knowledge/Pages/Tools/TCABHowToGuideEngagingStaff.aspx.

How to Improve. Institute for Healthcare Improvement. Available at www.ihl.org/knowledge/Pages/HowtoImprove/default.aspx.

Quality Improvement 101-106. IHI Open School for Health Professions. Available at www.ihl.org/offerings/IHIOpenSchool/Pages/default.aspx. The Institute for Healthcare Improvement offers online courses, through the IHI Open School for Health Professions, that are available free to medical students and residents and for a subscription fee for health care professionals.

V. How-to Guide Resources

		<u>Return to:</u>
IHI Diagnostic Tool for the Transition to Skilled Nursing	p. 53	p. 8 , 32 , 45
INTERACT Quality Improvement Tool	p. 57	p. 8 , 33 , 45
INTERACT Nursing Facility Capabilities List	p. 59	p. 9
MassPro Medication Reconciliation Tool	p. 60	p. 12
INTERACT Advance Care Planning Tracking Form	p. 63	p. 17
Readiness Assessment/Partnering with Patients and Families to Accelerate Improvement	p. 65	p. 20
Akron Regional Hospital Association Universal Transfer Form	p. 67	p. 35
Massachusetts Department of Public Health: Universal Transfer Form	p. 71	p. 36
PDSA Worksheet	p. 77	p. 41
Example Completed PDSA Worksheet	p. 78	p. 42
Spread Tracker Template	p. 80	p. 49

Note: All INTERACT II tools may also be accessed at <http://interact2.net/tools.html>.

IHI Diagnostic Tool for the Transition to Skilled Nursing

Worksheet A: Chart Reviews of Admitted Residents

Conduct chart reviews of the last five residents admitted to your facility from an acute care hospital. Reviewers should be nurses or physicians that are actively involved in reviewing potential new admissions and would have access to screening documents for new admissions. Reviewers should not look to assign blame, but rather to discover opportunities to improve the care of residents.

Question	Resident #1		Resident #2		Resident #3		Resident #4		Resident #5	
Did the SNF admissions nurse or admission coordinator assess and confirm the clinical needs of the resident prior to admission either by visiting the patient in the hospital or by consulting with hospital staff by phone? If yes, please describe how.	Yes	No								
Was the resident's clinical status re-evaluated once they were admitted and in the facility? If yes, please describe how.	Yes	No								

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Question	Resident #1		Resident #2		Resident #3		Resident #4		Resident #5	
Was the resident's clinical status different from expected as based upon the pre-transfer assessment?	Yes	No								
How many discrepancies in the medication list and treatment plan were identified on admission? Note: Discrepancies represent gaps in our processes. The goal is to better understand discrepancies that occur and to test changes that will eliminate their occurrence.	Total number:									
Was a clear treatment plan documented?	Yes	No								
Was a plan for responding to possible condition changes documented?	Yes	No								

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Question	Resident #1		Resident #2		Resident #3		Resident #4		Resident #5	
Was evidence of resident care goals documented?	Yes	No								
Were end-of-life care preferences documented?	Yes	No								
Other important notes										

IHDI Diagnostic Tool for the Transition to Skilled Nursing

Worksheet: Reflective Summary of Chart Review Findings

What did you learn?

What themes emerged?

What, if anything, surprised you?

What new questions do you have?

What are you curious about?

What do you think you should do next?

What assumptions that you held previously are now challenged?

QUALITY IMPROVEMENT TOOL



The goal of this tool is to review transfers in order to identify opportunities to improve the identification, evaluation, and management of changes in resident condition and other situations that commonly result in transfers, and when feasible and safe, to prevent transfers to the hospital. This tool is intended to be completed retrospectively after the transfer to look back and identify opportunities for improvement in reducing preventable transfers.

Section 1: BACKGROUND INFORMATION

Resident's Last Name	First Name	Age	Unit/Room #
a. Date of <i>most recent</i> admission to nursing home: _____ / _____ / _____			
b. Resident hospitalized in the past 12 months? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, list dates and reasons below:			

Section 2: DESCRIBE THE ACUTE CHANGE IN CONDITION THAT LED TO TRANSFER

Date the change in condition first noticed: _____ / _____ / _____

a. Check *all* that apply:

CHANGE IN:	NEW CONDITION:	NEW SYMPTOM(S)/SIGNS OF:	OTHER CHANGE:
<input type="checkbox"/> Appetite/intake	<input type="checkbox"/> Bleeding	<input type="checkbox"/> Altered mental status	<input type="checkbox"/> Abnormal lab value(s)
<input type="checkbox"/> Behavior	<input type="checkbox"/> Breathing difficulty or SOB	<input type="checkbox"/> Congestive heart failure	<input type="checkbox"/> Abnormal vital signs
<input type="checkbox"/> Function	<input type="checkbox"/> Constipation	<input type="checkbox"/> Dehydration	<input type="checkbox"/> Family concern
<input type="checkbox"/> Skin or a wound	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Fever	<input type="checkbox"/> Other (specify) _____
	<input type="checkbox"/> Fall	<input type="checkbox"/> Lower respiratory infection	
	<input type="checkbox"/> Pain (new or worsened)	<input type="checkbox"/> Urinary tract infection	
	<input type="checkbox"/> Other (specify) _____		

b. Briefly describe the symptom, sign or change in condition that led to the transfer:

Section 3: EVALUATION AND MANAGEMENT

a. Check *all* that apply:

TOOLS USED:

- Stop and Watch
- SBAR Progress Note
- Care Path
- Change in Condition Cards

MEDICAL EVALUATION:

- Telephone only
- On-site visit - MD
- On-site visit - NP or PA

TESTING:

- Blood tests
- Urinalysis or culture
- Xray
- Other (specify)

INTERVENTIONS:

- New medication
- IV or SC fluids
- Other (specify)

b. Briefly describe how the symptoms, signs, or change was evaluated and managed before hospital transfer:

c. Was advanced care planning (e.g. DNR, DNH, palliative or hospice care) discussed? No Yes

d. Was the resident transferred to the hospital? No (skip to Section 5) Yes (complete Sections 4 and 5)

Section 4: TRANSFER INFORMATION

Date of transfer: ____/____/____ Day (circle): M T W Th F Sa Sn Time of transfer: ____:____ a.m./p.m.

MD authorizing transfer: Primary MD Covering MD Other (_____)

a. What contributed to the transfer? (Check *all* that apply):

- Abnormal vital signs
- Abnormal lab(s)
- Injury
- Worsening condition despite intervention
- MD insisted on transfer
- Resident preference or insistence
- Family preference or insistence
- Other (specify)

b. Briefly describe the main reason(s) for transfer:

Section 5: OPPORTUNITIES FOR IMPROVEMENT

a. After review of how the new symptoms, signs, or other change were evaluated and managed, has your team identified any opportunities for improvement? No Yes If yes, describe briefly

b. In retrospect, does your team think this transfer might have been prevented?

No Yes If yes, check all that apply and describe briefly

- The new sign, symptom, or other change might have been detected earlier
- The condition might have been managed safely in the facility without transfer
- Advance directives and/or palliative or hospice care could have been discussed
- Other (specify)

 Name of person completing form

 Date of completion

Institute for Healthcare Improvement
 How-to Guide: Improving Transitions from the Hospital to Skilled Nursing Facilities to Reduce Avoidable
 Rehospitalizations



Name of Nursing Home: _____
 Contact Person and Title: _____
 Phone: _____ Email: _____

Available on Site*

Emergency interventions	Yes/No	Interventions	Yes/No
CPR – basic only		<i>Drains and catheters</i>	
Diagnostic Testing		Epidural catheters	
Stat EKG (within 4-6 hrs)		Suprapubic catheters	
Stat Xray (within 4-6 hrs)		Urostomy	
Stat lab work (within 4-6 hrs)		Surgical drains	
Bladder ultrasound		<i>Pulmonary</i>	
Cardiac Echo		O2 management	
Venous duplex		Suction q2hr	
Physician/NP Services		Suction q4hr	
7 day/wk visits		Suction q shift	
5 day/wk visits		Tracheostomy management	
1-2x/wk visits		Nebulizer treatments	
Consultation		CPAP	
Psychiatry		<i>Wound care program</i>	
One on one		VAC dressings	
Therapies		Debridement	
Physical therapy		<i>IV capabilities</i>	
Occupational therapy		PICC insertion	
Speech therapy		PICC management	
Isolation		IV Fluids	
VRE, MRSA, c. diff		IV antibiotics	
		Q4 hrs	
Typical turnaround time when new Meds are ordered:	____ hrs	Q 8 hrs	
		Q 12 hrs	
Nursing Services		IV meds – other (e.g., furosemide)	
		CAD pumps	
Vital sign monitoring Q 2 hrs		<i>Other</i>	
Vital sign monitoring Q 4 hrs		G/J tube feeding	
O2 saturation monitoring		NG tube feeding	
Peak flow		TPN	
Glucose monitoring at least Q 6 hrs			

**Availability of certain equipment/services may have changed since this form was updated. Please contact the nursing home directly at the number provided for the most up to date information.*

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Tab 12 – Reconciliation

STEP 1
Quality Improvement Form: Medication Reconciliation

Facility: _____ Month Covered: _____ Initials _____

Week	Date:	# Admissions	# Yes responses re: discrepancy	# Discrepancies not resolved
Week 1				
Week 2				
Week 3				
Week 4				
Total			% of 2 =	% of 3 =
Goal				

Instructions: Tally responses from Medication Reconciliation Tool on Admission and fill in columns above.

Tab 12 – Reconciliation

STEP 2



Find area free of distraction

- Assemble all relevant documentation: dc summary, page 1, most recent MAR

1. List full patient name, allergies, d.o.b. or use addressograph stamp or sticker list what allergy is to medication (i.e. rash, hives, GI upset)
2. List date and time of admission and from where patient was admitted. Include name of community PCP or previous MD in nursing home.
3. Copy medications listed on page 1, reported by patient, family or written on prescription bottle onto this column.
4. Using all available documentation, compare list of medications in Column 1 to admission orders, dc summary, MAR. Compare all elements and note if they match on each source: admission orders, dc summary, previous MAR.

List all medications identified on page 1 reported by family, patient, med bottles, include dose, frequency, route and prn medications Lasix 60 mg p.o.qd	Do all medication elements match?			If "No," which element requires review?				Outcome of review of discrepancy (orders written on physician order sheet)		
	Admitting Orders	DC Summary	MAR if resident	Drug	Dose	Frequency	Route	Continue Drug	Discontinue Drug	Modify Order
	Y	Y	N		✓					✓

Mark "Y" for Yes. Mark "N" for No.

5. If "No" response to any aspect of Step 4, note which element does not match.
 - a. Example, Lasix 60mg previous MAR dose 40mg -- New Dose
 - b. Cipro 250 mg not on previous MAR because started in hospital—New Drug
6. Discrepancy must be reviewed and any changes in medications written on physician order sheet. Sources for review: patient, family, community or hospital physician, ordering provider in NH
7. Look at page 1, diagnosis summary, previous MAR if available. Is there a corresponding diagnosis to support medication ordered?
 - a. ✓ "Y" for Yes ✓ "N" for No
8. If no diagnosis to support use of medication, utilize all available sources including patient, family, hospital and community physicians. If diagnosis identified, add to diagnosis list.
9. Are any labs or monitoring parameters ordered?
 - a. Reconciliation Tool should be completed within 24 hours.
 - b. Reconciliation Tool should be completed by individual with demonstrated competency and knowledge about medication process. Consider focused training for charge nurses, supervisors and have specific individuals responsible for doing.



ADVANCE CARE PLANNING TRACKING FORM

RESIDENT NAME: _____

Residents and/or their responsible health care decision makers should be provided the opportunity to discuss advance care planning with appropriate staff members and medical providers within the first few days of admission to the facility, at times of change in condition, and periodically for routine updating of care plans.

The purpose of this form is to provide a tool to document that these discussions are taking place. Improving advance care planning is now a goal of the *Advancing Excellence in America's Nursing Homes Campaign*. This form has been adapted from the campaign's website: http://www.nhqualitycampaign.org/files/impguides/6_AdvanceCarePlanning_TAW_Guide.pdf

AT ADMISSION (within about a week of admission or readmission)

Check one of the following:

Resident and/or responsible party do NOT want to have this discussion

Discussion about advance care planning held with (check one or both of the following):

___ Resident

___ Resident's surrogate; name: _____

Staff or healthcare provider completing this form:

Name _____ Title _____

Signature: _____

Date of Discussion: ____/____/____

Location of Advance Care Plan documentation (i.e., medical record, plan of care, progress notes):

**Use Continuation Pages to document additional Advance Care Planning
Reviews and Discussions**

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ADVANCE CARE PLANNING TRACKING FORM

Continuation Page (copy as needed)

ADVANCE CARE PLAN REVIEW AND/OR DISCUSSION

Purpose of review: Care Planning (routine update) Change in Condition Other (specify):

If Discussion was held, with whom (check those that apply):

- Resident
 Resident's surrogate; name: _____
 No discussion held

Staff or Health Care Provider Name: _____ Title: _____

Signature: _____ Date: ____/____/____

Location of Advance Care Plan documentation (plan of care, progress notes, other): _____

ADVANCE CARE PLAN REVIEW AND/OR DISCUSSION

Purpose of review: Care Planning (routine update) Change in Condition Other (specify):

If Discussion was held, with whom (check those that apply):

- Resident
 Resident's surrogate; name: _____
 No discussion held

Staff or Health Care Provider Name: _____ Title: _____

Signature: _____ Date: ____/____/____

Location of Advance Care Plan documentation (plan of care, progress notes, other): _____

ADVANCE CARE PLAN REVIEW AND/OR DISCUSSION

Purpose of review: Care Planning (routine update) Change in Condition Other (specify):

If Discussion was held, with whom (check those that apply):

- Resident
 Resident's surrogate; name: _____
 No discussion held

Staff or Health Care Provider Name: _____ Title: _____

Signature: _____ Date: ____/____/____

Location of Advance Care Plan documentation (plan of care, progress notes, other): _____

Partnering with Patients and Families to Accelerate Improvement Readiness Assessment

Name of Organization _____

			
Area	Current Experience: Make a mark (an X, a circle, or anything that is easy to read) in the box that best describes your team or organization's experience.		
Data transparency	We have not discussed the possibility of sharing performance data with patients and family members.	Our team is comfortable with sharing improvement data with patients and families related to the current improvement project.	This organization has experience with sharing performance data with patients and families.
Flexibility around the aims and specific changes of the improvement project	We have limited ability to refine the project's aims or planned changes.	We have some flexibility to refine the project's aims and the planned changes.	We are open to changing both the aims and specific changes that we test based on patient and family team members' perspectives.
Underlying fears and concerns	We have not discussed our concerns about involving patient and families on improvement teams.	We have identified several concerns related to involving patients and families on improvement teams, but have no plan for how to address or manage them.	We have a plan to manage and/or mitigate issues that may arise due to patient and family member involvement on our team.
Perceived value and purpose of patient and family involvement	There is no clear agreement that patient and family involvement on improvement teams is necessary to achieve our current improvement aim.	A few of us believe patient and family involvement would be beneficial to our improvement work, but there is not universal consensus.	There is clear recognition that patient and family involvement is critical to achieving our current improvement aim.

Senior leadership support for patient and family involvement	Senior leadership do not consider patient and family involvement a top priority.	Senior leaders are aware of and communicate support for patient and family involvement in our team.	Senior leaders consider our participation in this program as a pilot for organizational spread.
Experience with patient and family involvement	Beyond patient satisfaction surveys or focus groups, our organization does not have a formal method for patient and family feedback.	We have an active patient and family advisory panel.	Patient and families are members of standing committees and make decisions at the program and policy level.
Collaboration and teamwork	Staff in this organization occasionally work in multidisciplinary teams to provide care.	Staff in this organization work effectively across disciplines to provide care to patients.	Patients and families are included as valued members of the care team in this organization.
<ol style="list-style-type: none"> 1. What supports moving in this direction? 2. What are your current challenges? 3. How confident are you on successfully involving patients and families on your team (1-10 scale)? 			

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DEMOGRAPHICS ON PATIENT			
PATIENT INFORMATION			
TRANSFERRED TO FACILITY/AGENCY _____			
PATIENT'S NAME LAST: _____ FIRST: _____		TELEPHONE _____	
ADDRESS _____			
CITY _____		STATE _____	ZIP CODE _____
AGE _____	BIRTHDATE _____	SEX <input type="checkbox"/> M <input type="checkbox"/> F	MARITAL STATUS <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W
SOCIAL SECURITY # _____		MEDICARE # _____	MEDICAID # _____
OTHER INSURANCE _____		INS # _____	AUTH # _____
IN PATIENT _____		FROM _____	TO _____
HOSPITAL ADMISSION DATES _____			
PREVIOUS LIVING ARRANGEMENTS			
<input type="checkbox"/> Lives Alone		<input type="checkbox"/> Hospice	
<input type="checkbox"/> Family		<input type="checkbox"/> Home/ Home Care	
<input type="checkbox"/> Home with Care Giver		<input type="checkbox"/> Passport	
AGENCY _____ # _____			
PRIMARY CONTACT			
<input type="checkbox"/> DPOA/HC			
<input type="checkbox"/> DPOA			
<input type="checkbox"/> Legal Guardian			
RELATIONSHIP TO PATIENT _____			
ADDRESS _____			
CITY _____		STATE _____	ZIP CODE _____
HOME PHONE _____		WORK _____	CELL PHONE _____
SECONDARY CONTACT/NEXT OF KIN			
NAME _____		PHONE _____	
WHO WAS NOTIFIED OF TRANSFER ? _____			
TREATMENT RECEIVED WITHIN LAST 14 DAYS DATE LAST RECEIVED			
Chemotherapy <input type="checkbox"/> YES			
Dialysis <input type="checkbox"/> YES			
IV Medications <input type="checkbox"/> YES			
Oxygen therapy <input type="checkbox"/> YES			
Transfusions <input type="checkbox"/> YES			
Radiation <input type="checkbox"/> YES			
Ventilator <input type="checkbox"/> YES			
Tracheotomy Care <input type="checkbox"/> YES			
Suctioning <input type="checkbox"/> YES			
Pneumonia Vaccine <input type="checkbox"/> YES			
Flu Vaccine <input type="checkbox"/> YES			
Mantoux YES			
Vital Signs Range: _____			
Last Blood Sugar Result: _____			
Date: _____			
Last Pulse Ox (SaO2) Result: _____			
Date: _____			
PAIN ASSESSMENT			
<input type="checkbox"/> None <input type="checkbox"/> Acute <input type="checkbox"/> Chronic <input type="checkbox"/> Intermittent <input type="checkbox"/> Sharp <input type="checkbox"/> Dull			
<input type="checkbox"/> Other (explain) _____			
LOCATION: _____			
INTENSITY (1 - 10) _____			
ISOLATION		SITE	
<input type="checkbox"/> MRSA <input type="checkbox"/> VRE <input type="checkbox"/> CDIFF <input type="checkbox"/> ESBL			
Site: _____			
Other Instructions: _____			
PERSONAL POSSESSIONS SENT WITH PATIENT ON DAY OF TRANSFER			
<input type="checkbox"/> Glasses <input type="checkbox"/> Purse/ Wallet			
<input type="checkbox"/> Dentures/ Partials <input type="checkbox"/> Medications			
<input type="checkbox"/> Hearing Aid <input type="checkbox"/> Walker/ Cane			
<input type="checkbox"/> Other _____			
Signature of Person Completing Form: _____		Date: _____	
SW/ Case Manager Signature: _____		Date: _____	
Unit Phone Number: _____			

Activities of Daily Living				
Activity	Independent	Supervision	Assist/ # Persons	Unable to Do
Turns Self				
Sits				
Bed to Wheelchair				
Transfers				
Ambulation				
Bathing				
Feeding				
Dressing				
Dental Care				
Bedpan				
Bathroom				
Bedside Commode				
HEIGHT _____ WEIGHT _____ DATE _____				
CONTINENT BLADDER <input type="checkbox"/> YES <input type="checkbox"/> NO				
<input type="checkbox"/> CATHETER	SIZE _____	TYPE _____		
<input type="checkbox"/> SUPRAPUBIC	SIZE _____	TYPE _____		
DATE INSERTED/ CHANGED _____				
CONTINENT BOWEL <input type="checkbox"/> YES <input type="checkbox"/> NO LAST BM _____				
OSTOMY - TYPE _____ DATE CHANGED _____				
APPLIANCE _____				
APPETITE/ NUTRITIONAL			DISABILITIES	
<input type="checkbox"/> GOOD			<input type="checkbox"/> AMPUTATION	
<input type="checkbox"/> FAIR			<input type="checkbox"/> PROSTHESIS	
<input type="checkbox"/> POOR			<input type="checkbox"/> PARALYSIS	
<input type="checkbox"/> HYPERALIMENTATION			<input type="checkbox"/> PARESIS	
<input type="checkbox"/> FEEDING TUBE			<input type="checkbox"/> CONTRACTIONS	
MENTAL STATUS			BEHAVIOR	
<input type="checkbox"/> ALERT			<input type="checkbox"/> COOPERATIVE	
<input type="checkbox"/> ORIENTED			<input type="checkbox"/> BELLIGERENT	
<input type="checkbox"/> DISORIENTED			<input type="checkbox"/> COMBATIVE	
<input type="checkbox"/> FORGETFUL			<input type="checkbox"/> NOISY	
<input type="checkbox"/> UNRESPONSIVE			<input type="checkbox"/> ABUSIVE	
<input type="checkbox"/> DEPRESSED			<input type="checkbox"/> PASSIVE	
SENSORY IMPAIRMENTS				
VISION <input type="checkbox"/> ADEQUATE <input type="checkbox"/> POOR <input type="checkbox"/> BLIND				
HEARING <input type="checkbox"/> ADEQUATE <input type="checkbox"/> POOR <input type="checkbox"/> DEAF				
HEARING AID <input type="checkbox"/> L <input type="checkbox"/> R				
SPEECH <input type="checkbox"/> CLEAR <input type="checkbox"/> DIFFICULT <input type="checkbox"/> APHASIA				
<input type="checkbox"/> SPEAKS ENGLISH				
<input type="checkbox"/> INTERPRETER REQUIRED				
SKIN CARE				
SKIN INTACT? <input type="checkbox"/> Y <input type="checkbox"/> N				
DESCRIBE DECUBITUS/ WOUND - SIZE (CMs) SITE, DRAINAGE _____				

DNR: TRANSFERRING FACILITY [ATTACH COPY]				
<input type="checkbox"/> YES <input type="checkbox"/> NO				
DNR STATUS <input type="checkbox"/> CC <input type="checkbox"/> CCAREST <input type="checkbox"/> OTHER DRN				
ADVANCE DIRECTIVES [ATTACH COPY]				
LIVING WILL <input type="checkbox"/> YES <input type="checkbox"/> NO				
DURABLE POWER OF ATTORNEY/HC <input type="checkbox"/> YES <input type="checkbox"/> NO				
SMOKING CESSATION ADDRESSED <input type="checkbox"/> YES <input type="checkbox"/> NO				



AKRON REGIONAL HOSPITAL ASSOCIATION

**AKRON REGIONAL HOSPITAL ASSOCIATION****POST ACUTE TRANSFER FORM**

COPY AND SEND TO THE NURSING FACILITY IN THE ORDER LISTED

Chart Form	Content Needed for Admission	Check Off
Post Acute Skilled Transfer Form	Make sure the secondary payer source area is completed	
MARs	Include the most recent MAR and MARs that have the last dose of an IV med, injections or any chemo (IV or PO). Documentation of blood transfusions	
PT, OT, Speech & Respiratory Therapy	Include the evaluation and notes for last week of stay	
Nutrition Evaluation Form		
Medications	If not individually listed on form, attach computerized listing	
DNR Order Sheet	Either the state form or the hospital form if applicable	
Advanced Directives	Copies of Living Will and/or Durable Power of Attorney for Health Care if on chart	
Physician's Progress Notes	Notes from last 3-4 days	
Nurse's notes/Social Work Notes	Notes from last 2 days; include discharge planning notes; notes including detail on PICC line insertion	
Consultations	A copy of each consult	
Laboratory Results	Most recent labs, including U/A, C&S, CBC, electrolytes, labs used to track dosing of meds (ex; Theophylline/Dilantin level, INRs), MANTOUX	
CXR, EKG	Include most recent	
Cookie Swallow, MRIs, CT Scans	If done, most recent	
H&P and Nursing Assessment with home med sheet	If H&P is dated prior to 5 days before discharge, physician must review, sign, and date	
PASARR ID	Completed Form & results	



Massachusetts
Department of
Public
Health

Instructions for Completion of the Universal Transfer Form

1. This new *Universal Transfer Form* **takes the place** of the 3 page patient care referral form or other transfer forms or systems currently in use at your institution.
2. The Transfer Form has the following sections:
 - a. Contact Information & Checklist (page 1)
 - b. Physician Orders & Nursing Assessment (pages 2-3)
 - c. Therapy & Behavioral Information (page 4)
 - d. Medication List (page 5)
 - e. Tests, Appointments & Additional Notes (page 6)
 - f. Anticoagulation Referral Form and Warfarin Flow Sheet (page 7). Note that for many patients, this page will be marked "N/A."

Depending on the type of patient, additional documentation may be required for a safe and effective transfer (e.g., specific instructions related to high risk OB patients, transplant patients, etc.). Determining which additional documents are needed is left to the discretion of the sending and receiving clinical teams.

3. Unlike some previous forms, the new form does not necessarily have separate pages for each clinician to complete (e.g., page for RN, page for MD, page for SW). While page 2 of the form is primarily designed for physician's orders, clinical teams within each institution must determine who will complete each page of the form. Ultimately the MD/NP/PA *must* sign the attestation on page 1, indicating that he/she has reviewed all of the pages for accuracy and completeness. (Note: during off hours in institutions such as nursing homes, rest homes or home health agencies, when an MD/NP/PA may not be available, an RN may complete the form and send with the patient, pending review by the MD during a verbal report with the next set of providers).
4. *In a true emergency, e.g., when a patient who has become acutely ill is being sent from home health or a skilled nursing facility to the emergency department (ED), there may only be time to complete the essential information on a patient (the checklist on page 1 and page 2); the rest of the packet may be faxed to the ED after EMS has transported the patient for emergency care (within 2 hours).*



Patient Name: _____ Date: _____

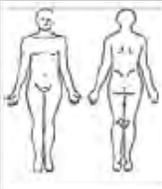
Physician Orders & Nursing Assessment

PHYSICIAN ORDERS (MD/NP)		
Advance Directive: <input type="checkbox"/> No <input type="checkbox"/> Yes If not addressed why not? _____ <input type="checkbox"/> DNR <input type="checkbox"/> DNI <input type="checkbox"/> DNH(Do Not Hospitalize) <input type="checkbox"/> Full Code _____		
Goals of Care: _____ <div style="text-align: right;">Hospice: <input type="checkbox"/> Yes <input type="checkbox"/> No</div>		
<div style="text-align: center;">BRIEF SUMMARY (See D/C Summary for more detail)</div> Reason for transfer: Summary: _____ _____ _____		
Heads Up: (Clinical Issues Requiring Attention; Special Circumstances or Potential Complications) <div style="text-align: right;">Pregnant: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A</div>		
Principal Diagnosis at Discharge: _____ Additional Diagnoses: _____ Allergies: _____ VS: BP _____ HR _____ RR _____ T _____ pO2 _____ FS blood glucose _____ Pulse OX Range: _____ Current Weight: _____ Time VS Taken: _____ AM/PM Medications: see attached Medication List	<div style="text-align: center;">PAIN ASSESSMENT</div> Pain Score: _____ out of _____ Pain Scoring System used: _____ Location/s: _____ Pain Medication/s: _____ Script/s sent: <input type="checkbox"/> Y <input type="checkbox"/> N Other treatment modalities: _____ _____	
NURSING ASSESSMENT (RN)		
Mental Status at Discharge: <input type="checkbox"/> Alert, oriented, follows instructions <input type="checkbox"/> Alert, disoriented, but can follow simple instructions <input type="checkbox"/> Alert, disoriented, but cannot follow simple instructions <input type="checkbox"/> Not alert	Functional Status at Discharge: <input type="checkbox"/> Ambulates independently <input type="checkbox"/> Ambulates with assistance <input type="checkbox"/> Ambulates with assistive device <input type="checkbox"/> Not ambulatory	
IMMUNIZATIONS: Influenza: Date: ___/___/___ Tetanus Booster Date: ___/___/___ Tetanus Tet-Diphtheria Date: ___/___/___ Pneumococcal Date: ___/___/___ Other (H1N1 etc.): _____ Date: ___/___/___		
DEVICES/ SPECIAL TREATMENTS: <input type="checkbox"/> IV/PICC line/Portacath <input type="checkbox"/> Pacemaker <input type="checkbox"/> Foley Catheter <input type="checkbox"/> Internal Defibrillator <input type="checkbox"/> TPN <input type="checkbox"/> Other: _____ <input type="checkbox"/> If on anticoagulation, see page 7	AT RISK ALERTS: <input type="checkbox"/> Pain <input type="checkbox"/> Seizure <input type="checkbox"/> Falls <input type="checkbox"/> Pressure <input type="checkbox"/> Restraints <input type="checkbox"/> Ulcer <input type="checkbox"/> Aspiration <input type="checkbox"/> Wanderer <input type="checkbox"/> Limited/non-weight bearing <input type="checkbox"/> Left <input type="checkbox"/> Right, see page 4 <input type="checkbox"/> Elopement <input type="checkbox"/> Other: _____	ISOLATION/ PRECAUTION: <input type="checkbox"/> MRSA <input type="checkbox"/> VRE <input type="checkbox"/> C-Diff <input type="checkbox"/> Other: _____ Site: _____ Comment: _____ _____



Patient Name: _____ Date: _____

Patient Assessment: RN/CM/DP may complete this page

<p>TREATMENT ORDERS AND FREQUENCY <i>(include special treatments such as dialysis, chemo-therapy, transfusions, radiation, TPN, fluid restriction, fingersticks, wt checks and freq. attach detail as needed)</i></p>	<p>INSURANCE INFORMATION Company: _____ Patient Insurance Number: _____ Provider Phone: () _____ - _____ Medicare: Type: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> D <input type="checkbox"/> N/A # _____ Medicaid <input type="checkbox"/> N/A # _____</p>												
<p>SKIN / WOUND CARE ORDERS Pressure ulcers: <i>(stage, location, appearance, treatments)</i></p> <div style="text-align: center;">  </div> <p>Other Wounds : <input type="checkbox"/> Yes <input type="checkbox"/> No if yes, describe:</p> <p>Wound care sheet attached: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>ACTIVITIES OF DAILY LIVING: <i>(mark I=Independent; D=dependent; A=needs assistance)</i> _____ Bathing _____ Toileting/Transfers _____ Dressing _____ Ambulation _____ Eating</p> <p>Mobility _____ Can ambulate _____ (distance) with _____ (Assistive Device or Independent)</p> <p>Upper extremities <input type="checkbox"/> Normal <input type="checkbox"/> Impaired: _____ Lower extremities <input type="checkbox"/> Normal <input type="checkbox"/> Impaired: _____</p>												
<p>DIET ORDERS Needs assistance with feeding: <input type="checkbox"/> Yes <input type="checkbox"/> No Trouble swallowing: <input type="checkbox"/> Yes <input type="checkbox"/> No Special diet or consistency: <i>(thicken liquids, crush meds, etc)</i></p> <p>Tube feeding: <input type="checkbox"/> Y <input type="checkbox"/> N Pump _____ Bolus _____ If yes, type of formula: _____ ml/hr water flush _____ ml/hr Additional Diet Orders: <i>(diabetic, low sodium etc)</i> _____ _____ _____</p>	<p>CONTINENCE:</p> <table style="width: 100%; border: none;"> <tr> <td></td> <td style="text-align: center;">Bowel</td> <td style="text-align: center;">Bladder</td> </tr> <tr> <td>Continent</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Occasionally Incontinent</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Incontinent</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table> <p>Last bowel movement: _____ Catheter last changed: _____ Date: ___/___/___ Date: ___/___/___ Foley Type/Balloon Size: _____</p> <p>Vision: <input type="checkbox"/> Sees Adequately <input type="checkbox"/> Impaired – sees large print but not regular print. <input type="checkbox"/> Moderately impaired – limited vision cannot see headlines. <input type="checkbox"/> Severely impaired – no vision or only sees light, color shapes</p> <p><input type="checkbox"/> Uses Visual Aid Type: _____</p>		Bowel	Bladder	Continent	<input type="checkbox"/>	<input type="checkbox"/>	Occasionally Incontinent	<input type="checkbox"/>	<input type="checkbox"/>	Incontinent	<input type="checkbox"/>	<input type="checkbox"/>
	Bowel	Bladder											
Continent	<input type="checkbox"/>	<input type="checkbox"/>											
Occasionally Incontinent	<input type="checkbox"/>	<input type="checkbox"/>											
Incontinent	<input type="checkbox"/>	<input type="checkbox"/>											
<p>Auditory: <input type="checkbox"/> Hears Adequately <input type="checkbox"/> Minimal Difficulty <input type="checkbox"/> Intermittently Impaired <input type="checkbox"/> Highly Impaired</p>	<p><input type="checkbox"/> Uses Auditory Aid Type: _____</p>												
<p>Communication Primary Language: _____ Able to: <input type="checkbox"/> Understand <input type="checkbox"/> Speak <input type="checkbox"/> Read <input type="checkbox"/> Write</p> <p>Secondary Language: _____ Able to: <input type="checkbox"/> Understand <input type="checkbox"/> Speak <input type="checkbox"/> Read <input type="checkbox"/> Write</p> <p>Aphasia: <input type="checkbox"/> Expressive <input type="checkbox"/> Receptive Sign language use: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>													



Massachusetts
Department of
Public
Health

Universal Transfer Form

Patient Name: _____ Date: _____

Therapy & Behavioral Health Information

RESTRICTED ACTIVITIES and RESUME DATE/ORDERS	
<p>Bath <input type="checkbox"/> _____</p> <p>Shower <input type="checkbox"/> _____</p> <p>Lifting <input type="checkbox"/> _____</p> <p>Walking <input type="checkbox"/> _____</p> <p>Climbing Stairs <input type="checkbox"/> _____</p>	<p>Sexual Activity <input type="checkbox"/> _____</p> <p>Doing Housework <input type="checkbox"/> _____</p> <p>Driving <input type="checkbox"/> _____</p> <p>Going to Work <input type="checkbox"/> _____</p> <p>Sports <input type="checkbox"/> _____</p>
<p>WEIGHT BEARING STATUS</p> <p><input type="checkbox"/> Non-weight <input type="checkbox"/> Partial weight <input type="checkbox"/> Full weight</p> <p> _L _R _L _R _L _R</p> <p><input type="checkbox"/> Amputee</p> <p><input type="checkbox"/> Prosthesis use: _____</p> <p><input type="checkbox"/> Equipment needed at time of transfer: _____</p>	<p>PHYSICAL/OCCUPATIONAL/SPEECH THERAPY</p> <p>Evaluations:</p> <p>PT: <input type="checkbox"/> Yes <input type="checkbox"/> No OT: <input type="checkbox"/> Yes <input type="checkbox"/> No ST: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Interventions/Notes: _____</p> <p>_____</p> <p>_____</p> <p>Detail Attached <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>RESPIRATORY CARE</p> <p><input type="checkbox"/> Nebulizers <input type="checkbox"/> O2 _____ liters via _____</p> <p><input type="checkbox"/> Tracheostomy</p> <p><input type="checkbox"/> Other: _____</p>	<p>MEDICAL SUPPLY (DME) NEEDS:</p> <p>Were supplies ordered? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>If yes, were they sent? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>FOR MEDICATIONS AT TIME OF DISCHARGE</p> <p>PLEASE SEE ATTACHED LIST</p>
<p>BEHAVIORAL HEALTH, SOCIAL, or FAMILY ISSUES & INTERVENTIONS</p>	
<p>Discharge Teaching Completed: <input type="checkbox"/> Y <input type="checkbox"/> N Teach Back <input type="checkbox"/> Y <input type="checkbox"/> N</p>	
<p>I have participated in and understand the development of this discharge plan. I have received a copy of the plan.</p> <p>Patient/Representative Signature _____ Date _____</p> <p>Patient is not able to understand the information and the representative is not available to sign this form <input type="checkbox"/></p> <p>Signature _____ (RN/CM/DP) Date _____</p>	

Universal Transfer Form



Patient Name: _____ Date: _____ Height: _____ Weight: _____
 _____ DOB: _____

Medication List

Prescribed by/Phone	Medication <small>(including trade and generic names)</small>	Reason for medication	Dose/Times taken/How taken <small>(Example: 100 mg three times a day by mouth)</small>	Other Directions or Notes
Prescribed by: _____ <input type="checkbox"/> N/A Over-The-Counter Phone: () _____			Last Taken: am/pm	
Prescribed by: _____ <input type="checkbox"/> N/A Over-The-Counter Phone: () _____			Last Taken: am/pm	
Prescribed by: _____ <input type="checkbox"/> N/A Over-The-Counter Phone: () _____			Last Taken: am/pm	
Prescribed by: _____ <input type="checkbox"/> N/A Over-The-Counter Phone: () _____			Last Taken: am/pm	
Prescribed by: _____ <input type="checkbox"/> N/A Over-The-Counter Phone: () _____			Last Taken: am/pm	
Prescribed by: _____ <input type="checkbox"/> N/A Over-The-Counter Phone: () _____			Last Taken: am/pm	
Prescribed by: _____ <input type="checkbox"/> N/A Over-The-Counter Phone: () _____			Last Taken: am/pm	

Medication Reconciliation completed Yes _____ No _____



PDSA Worksheet

Date _____

Change or idea to be tested:

Objective for this PDSA cycle:

What question(s) do we want to answer on this PDSA cycle?

Plan:

Plan to answer questions (described above):

Who, What, When, Where

Plan for collection of data (information needed to answer questions):

Who, What, When, Where

Predictions (for each question listed above, what will happen if plan is carried out? describe your theories):

Do:

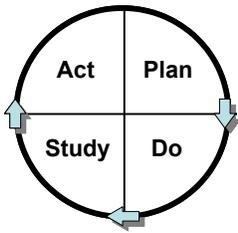
Carry out the plan; document problems and unexpected observations; collect data and begin analysis.

Study:

Complete analysis of data; What were the answers to the questions in the plan (compare to your predictions)? Summarize what was learned.

Act:

What changes are to be made? Plan for the next cycle.



PDSA Form – EXAMPLE Completed Form

Change or idea to be tested:

Warm handover communication with the hospital to confirm/clarify condition and treatment plan for patients admitted to skilled nursing from the hospital.

Objective for this PDSA cycle:

Hold a direct conversation with the hospital nurse (or case manager) knowledgeable about the patient's treatment in the hospital to discuss his/her condition and confirm/clarify treatment plan and care needs.

What question(s) do we want to answer on this PDSA cycle?

- Can SNF nurse reach someone who is knowledgeable about the resident?
- Will the conversation yield new and valuable information about the resident's condition?
- Will the SNF be able to provide better care to the resident with this information?

Plan:

Plan to answer questions (described above):

Who, What, When, Where

By next Tuesday, the nursing director at the SNF will draft a set of questions for a warm handover communication.

- Ideas for inclusion: What is the patient's current status? What do we need to know about the his/her treatment and any complications during hospitalization? Do you have any concerns about this patient? How is the patient's family involved? Who are the key learners? What do they understand and not understand about their condition and treatment plan? What co-morbidities should we be concerned about? What conversations have you had with the patient and family about their desires and wishes related to care?

On the next resident being admitted from the hospital, the SNF admitting nurse receiving the patient from the hospital will review transfer material and call the discharge coordinator at the hospital and ask to speak with the nurse or case manager most recently caring for the patient being discharged. The SNF admitting nurse will use the developed outline to obtain information about the patient.

Within 24 hours of the transfer, team will convene to review the learning from the test.

Plan for collection of data (information needed to answer questions):

Who, What, When, Where

SNF nursing director and admitting nurse will collect the responses to the questions below and meet 24 hours after the transfer to review.

- Did the warm handover communication occur?
- Did the SNF obtain all information needed to adequately care for the resident?
- What information was not obtained through the warm handover communication?

Predictions (For each question listed at the top of the form, what will happen if plan is carried out? Describe your theories.)

Can SNF nurse reach someone who is knowledgeable about the resident?	We predict that this will go smoothly on daytime shifts during the week. We anticipate it will be more difficult on nights and weekends and during shift changes.
Will the conversation yield new and valuable information about the resident's condition?	We predict we will be able to better resolve any discrepancies in the treatment plan and medication list, as well as obtain additional insight into the patient's treatment during their stay in the hospital.
Will the SNF be able to provide better care to the resident with this information?	We predict that the nurses and nursing assistants will be able to provide better care to the resident with a more accurate treatment plan and a better understanding of the resident's history, insight into his/her social support network, and his/her care preferences as may have been communicated while in the hospital.

Do:

Carry out the plan; document problems and unexpected observations; collect data and begin analysis.

The SNF team (nursing director, admitting nurse, and resident care team) carried out the test. The admitting nurse contacted the hospital with the next incoming resident (occurred on Tuesday at 1PM) and was able to speak with a floor nurse about the resident. She learned that the patient fell while in the hospital, resulting in a broken femur. The patient was very concerned about regaining mobility in time to attend her granddaughter's wedding in three month's time. The admitting nurse also learned that the resident's family (two sons and a daughter) lived in other parts of the country and so she did not have a local support network.

Study:

Complete analysis of data; What were the answers to the questions in the plan (compare to your predictions)? Summarize what was learned.

Each of our predictions (described in the table above) were true in the case of this test. We do anticipate that there may be difficulty reaching the floor nurse in the evening, weekends, or during changes in shift.

Act:

What changes are to be made? Plan for the next cycle.

We will continue to run this test with the next five admissions from the hospital to see how the process works in varying conditions. We are particularly interested in testing with an admission that occurs at night, on the weekend, or during shift change.

VI. References

1. Fazzi R, Agoglia R, Mazza G, Glading-DiLorenzo J. The Briggs National Quality Improvement/Hospitalization Reduction Study. *Caring: National Association for Home Care magazine*. 2006;25(2):70.
2. Alliance for Health Reform. Covering Health Issues 2006-2007: Available at: <http://www.allhealth.org/sourcebooktoc.asp?sbid=1>.
3. Jencks SF, Williams MV, Coleman EA. Rehospitalizations among patients in the Medicare fee-for-service program. *New England Journal of Medicine*. 2009;360(14):1418-1428.
4. Hackbarth G, Reischauer R, Miller M. *Report to Congress: Medicare Payment Policy*. Washington, DC: Medicare Payment Advisory Committee; March 2007.
5. Mor V, Intrator O, Feng Z, Grabowski DC. The revolving door of rehospitalization from skilled nursing facilities. *Health Affairs*. 2010;29(1):57.
6. INTERACT II. INTERACT II Tools. Available at: <http://interact2.net/>.
7. Ouslander J, Lamb G, Tappen R, Herndon L. Interventions to Reduce Hospitalizations from Nursing Homes: Evaluation of the INTERACT II Collaborative Quality Improvement Project. *Journal of the American Geriatrics Society*. 2011.
8. Adams KF, Lindenfeld J, Arnold JMO, et al. HFSA 2006 Comprehensive Heart Failure Practice Guideline. *Journal of Cardiac Failure*. 2006;12(1).
9. Zwicker D, Picariello G. Discharge planning for the older adult. *Geriatric Nursing Protocols for Best Practice (2nd ed)*. New York: Springer Publishing Company, Inc; 2003:292.
10. *Safe Practices for Better Healthcare—2006 Update: A Consensus Report*. Washington, D.C.: National Quality Forum; 2006.
11. Forster A, Murff H, Peterson J, Ghandi T, Bates D. The incidence and severity of adverse events affecting patients after discharge from the hospital. *Annals of Internal Medicine*. 2003;138:161-167.
12. Happ MB, Naylor MD, Roe-Prior P. Factors contributing to rehospitalization of elderly patients with heart failure. *Journal of Cardiovascular Nursing*. 1997;11(4):75-84.
13. Coleman E, Smith J, Raha D, Min S. Posthospital medication discrepancies. *Archives of Internal Medicine*. 2005;165(16):1842-1847.
14. Coleman E, Smith J, Eilertsen T, et al. Development and Testing of a Measure Designed to Assess the Quality of Care Transitions. *International Journal of Care Integration*. 2002;2.
15. Hibbard JH, Stockard J, Mahoney ER, Tusler MR. Development of the Patient Activation Measure (PAM): Conceptualizing and Measuring Activation in Patients and Consumers. *Health Serv Res*. August 2004 2004;39(4 pt 1):1005-1026.
16. American Medical Association Foundation. Health Literacy Kit. Available at: <http://www.ama-assn.org/ama/pub/about-ama/ama-foundation/our-programs/public-health/health-literacy-program/health-literacy-kit.page>.
17. Berkowitz R, Jones R, Rieder R. Improving Disposition Outcomes for Patients in a Geriatric Skilled Nursing Facility. *Journal of the American Geriatrics Society*. 2011;49(6):1130-1136.
18. Compassion and Support. Medical Orders for Life-Sustaining Treatment (MOLST). 2009; Available at: http://www.compassionandsupport.org/index.php/for_patients_families/molst.
19. Centers for Ethics in Health Care. Oregon Health & Science University. Physician Orders for Life-Sustaining Treatment Paradigm (POLST). 2008; Available at: <http://www.ohsu.edu/polst/>.

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20. Gunderson Lutheran Medical Foundation. Respecting Choices. 2011; Available at: <http://respectingchoices.org/>.
21. Ashish K, Jha MD, et al. Use of Electronic Health Records in U. S. Hospitals. *New England Journal of Medicine*. 2009;360:1628-1638.
22. DesRoches DM, Campbell EG, et al. Electronic Health Records in Ambulatory Care — A National Survey of Physicians. *New England Journal of Medicine*. 2008;359:50-60.
23. Nationwide Health Information Network: Conditions for Trusted Exchange. *Federal Register*. 2012.
24. Nolan T. *Execution of Strategic Improvement Initiatives to Produce System-Level Results*. IHI Innovation Series white paper. Cambridge, MA: Institute for Healthcare Improvement; 2007.
25. Conway J, Johnson B, Edgman-Levitan S, et al. Partnering with patients and families to design a patient-and family-centered health care system: A roadmap for the future: A work in progress. *Institute for Healthcare Improvement, unpublished work, available at: <http://www.ihl.org/NR/rdonlyres/B4DC702C-FC27-4BF1-9FFDD83681B1B0E6/0/IHIFCCPartneringwithPatientsandFamilyPaperJune06.pdf>*.
26. Institute for Patient- and Family-Centered Care. Free Downloads: Reports/Roadmaps. Available at: <http://www.ipfcc.org/tools/downloads.html>.
27. Ohno T. *Toyota production system: beyond large-scale production*: Productivity Press; 1988.
28. Womack JP, Jones DT. *Lean thinking*: Simon & Schuster Audio; 1996.
29. Kenagy J. Adaptive Design. Available at: <http://kenagyassociates.com/adaptive.what.php>.
30. Womack JP, Jones DT, Simon, Audio S. *Lean thinking*: Simon & Schuster Audio; 1996.
31. Spear SJ. *Chasing The Rabbit; How Market Leaders Outdistance the Competition and How Great Companies Can Catch Up and Win*. Vol 25. 1 ed. USA: McGraw-Hill; 2009.
32. Kenagy J. Adaptive Design. <http://kenagyassociates.com/adaptive.what.php>. Accessed April 12, 2011.
33. Langley GJ, Moen R, Nolan KM, Nolan TW, Norman CL. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance*: Jossey-Bass; 2009.