Care Transitions

Skilled Nursing Facility (SNF) Care Transitions Assessment

Facility Name: _____ **CCN:** _____ **Assessment Date:** _____ **Completed by:** _____

Work with your department leadership team to complete the following assessment. Each item relates to care transition elements that should be in place for a program to improve care transitions within your facility. This Care Transitions Implementation Assessment is supported by published evidence and best practices including, but not limited to, the Joint Commission (TJC), National Quality Forum (NQF), Project RED (Re-Engineered Discharge from the Agency for Healthcare Research and Quality [AHRQ]), Project BOOST (Better Outcomes to Optimize Safe Transitions from the Society of Hospital Medicine), and the Care Transitions Model ([CTM®] also known as the Coleman Model). Select the level of implementation status on the right for each assessment item. Once this form is complete, please go online and enter your answers.

Assessment Items	Not implemented/ no plan	Plan to implement/no start date set	Plan to implement/ start date set	In place less than 6 months	In place 6 months or more
A. Care Continuum					
1. Your facility uses a mechanism for bi-directional feedback with acute care partners to address transition communication gaps of key clinical information during resident transfers (e.g., discharge summary, outstanding tests/lab results, medication list discrepancies).[i]	☐	☐	☐	☐	☐
2. Your facility regularly meets with acute care partners to identify and review care transition plans of: [ii] **a.** Super-utilizers (residents with four admissions in one year—**or**—six emergency department visits within one year).	☐	☐	☐	☐	☐
b. 30-day acute care readmissions of residents on high-risk medications (anticoagulants, opioids, antidiabetics, and antipsychotics)	☐	☐	☐	☐	☐
3. Your facility monitors the timeliness of provider (medical director, SNFist, etc.) response for resident change-of-condition events.[iii]	☐	☐	☐	☐	☐
4. Your facility uses a risk stratification tool to identify residents who are high risk for readmission to the hospital.[iv]	☐	☐	☐	☐	☐
B. Discharge Planning					
5. Your facility provides focused case management for residents at high risk for readmissions to coordinate care addressing: [v] **a.** Ability to pay for medications.	☐	☐	☐	☐	☐
b. Scheduling of physician follow-up visits.	☐	☐	☐	☐	☐
c. Transportation to follow-up visits.	☐	☐	☐	☐	☐

Assessment Items	Not implemented/ no plan	Plan to implement/no start date set	Plan to implement/ start date set	In place less than 6 months	In place 6 months or more
d. Availability of family/friends to assist resident at time of discharge.	☐	☐	☐	☐	☐
6. Your facility provides residents with medication-specific education (i.e., purpose, frequency, administration, and potential side effects) for high-risk medications: [vi] **a.** Anticoagulants	☐	☐	☐	☐	☐
b. Opioids	☐	☐	☐	☐	☐
c. Antidiabetics	☐	☐	☐	☐	☐
d. Antipsychotics	☐	☐	☐	☐	☐
7. Your facility has a process in place to validate staff proficiency using evidence-based education methodology (e.g., teach-back) during discharge instruction.[vii]	☐	☐	☐	☐	☐
8. Your facility performs follow-up calls within 48–72 hours post-discharge to ensure: [viii] **a.** Medications were obtained (from pharmacy or delivered).	☐	☐	☐	☐	☐
b. Status of follow-up visits.	☐	☐	☐	☐	☐
c. Transportation is arranged for follow-up visits.	☐	☐	☐	☐	☐
d. Home health services were initiated.	☐	☐	☐	☐	☐
C. Quality Improvement of Care Transitions					
9. Your facility maintains a multidisciplinary readmission team that reviews and reports data to your Quality Assurance & Performance Improvement (QAPI) committee regarding: [ix] **a.** 30-day acute care readmissions (where "day one" refers to when residents discharged from acute care and counting 30 days thereafter, regardless of the SNF discharge date).	☐	☐	☐	☐	☐
b. Gap analyses identifying trends in unmet needs leading to readmission (e.g., social determinants of health, unfilled prescriptions, undelivered durable medical equipment [DME], delay of home-based services).	☐	☐	☐	☐	☐

Open Response:

1. **What do you believe is going well in your organization related to care transitions (please provide any tools you are using)?**

2. **Where are opportunities for improvement regarding care transitions?**

3. **What are your organizational goals for this calendar year surrounding care transitions?**

This material was prepared by Health Services Advisory Group (HSAG), a Quality Innovation Network-Quality Improvement Organization (QIN-QIO) under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS). Views expressed in this material do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a specific product or entity herein does not constitute endorsement of that product or entity by CMS or HHS. Publication No. QN-12SOW-XC-12092021-03

[i] **Rationale:** Building and maintaining a successful partnership with acute care providers requires effective communication, collaboration, and commitment. Regular, bi-directional communication allows both settings to share care planning information and identify gaps to improve resident outcomes.
References: http://tools.hospitalmedicine.org/Implementation/Workbook_for_Improvement.pdf
https://www.jointcommission.org/resources/patient-safety-topics/sentinel-event/sentinel-event-alert-newsletters/sentinel-event-alert-58-inadequate-hand-off-communication/
- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6069909/

[ii] **Rationale:** Collaboration among SNF and acute care partners improves the quality and safety of care transitions between settings. Through a collaborative approach, admission patterns can be identified among shared high-risk populations providing the opportunity to review and customize resident-centered care transition plans.
References: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5693352/
- https://onlinelibrary.wiley.com/doi/abs/10.1111/jgs.14557
- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5063303/
- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6069909/

[iii] **Rationale:** Timeliness of provider response to change-of-condition events decreases the risk of residents readmitting to the hospital. Monitoring the response time for these events can help identify opportunities for improvement.
References: https://www.hsag.com/globalassets/care-coordination/snfreadmissionstoolkit508.pdf
- https://www.ahrq.gov/patient-safety/settings/long-term-care/resource/facilities/ltc/mod1.html
- https://academic.oup.com/innovateage/article/2/2/igy017/5049201

[iv] **Rationale:** A risk-assessment tool is an evidence-based approach to stratify residents who are at high risk for readmission. Residents who are identified as high risk should be "flagged" to receive targeted interventions throughout their care and before discharge.
References: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5283071/
- https://www.jamda.com/article/S1525-8610(19)30164-1/fulltext
- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5018668/

[v] **Rationale:** Residents at high risk for readmission require increased care coordination planning to address social determinants of health. Focused coordination efforts for this population reduces the probability for subsequent rehospitalization.
References: https://www.ahrq.gov/patient-safety/settings/hospital/red/toolkit/index.html
http://tools.hospitalmedicine.org/Implementation/Workbook_for_Improvement.pdf
- https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/OMH_Readmissions_Guide.pdf
- https://www.ajmc.com/journals/issue/2018/2018-vol24-n2/community-navigators-reduce-hospital-utilization-in-superutilizers

[vi] **Rationale:** Proper medication use by residents is one of the most important factors contributing to better outcomes and decreased utilization. Resident education is a key intervention to assist older adults with medication management. This is especially important for residents on high-risk medications (e.g., anticoagulants, opioids, antidiabetics, and antipsychotics) who are at higher risk for adverse drug events and readmissions.
References: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5404806/
- https://www.ncbi.nlm.nih.gov/books/NBK2670/
- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4346059/

vii **Rationale:** Effective use of evidence-based education methodologies (such as teach-back) ensures residents and family have the skill sets and knowledge needed to be compliant with their follow-up care and manage their conditions at home.
References: https://www.ahrq.gov/patient-safety/settings/hospital/red/toolkit/index.html
http://tools.hospitalmedicine.org/Implementation/Workbook_for_Improvement.pdf
- https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrdr/dataspotlight-health-literacy.pdf
- http://www.ihi.org/resources/Pages/Tools/AlwaysUseTeachBack!.aspx

viii **Rationale:** Timely follow-up phone calls help ensure quality of care and reduce readmission rates by providing an opportunity to reinforce the discharge plan and resolve post-discharge issues.
References: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3128446/
- https://www.ahrq.gov/patient-safety/settings/hospital/red/toolkit/index.html
http://tools.hospitalmedicine.org/Implementation/Workbook_for_Improvement.pdf

ix **Rationale:** A multidisciplinary task force establishes shared responsibility and opens lines of communication for improvement of current processes. Having a dedicated readmissions review committee assists with identifying system failures that exist, trends in data, and opportunities for improvement.
References: http://tools.hospitalmedicine.org/Implementation/Workbook_for_Improvement.pdf
- https://www.ahrq.gov/sites/default/files/publications/files/redtoolkit.pdf
- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6069909/