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CENTERS FOR MEDICARE & MEDICAID SERVICES

HSAG HEALTH SERVICES ADVISORY GROUP

Skilled Nursing Facility (SNF)

Shared Best Practices to Reduce Potentially Preventable Readmissions (PPRs)

Referral

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

Preadmission

- Use a consistent checklist to determine potential equipment needs or specialized service requirements, such as: fall precautions, oxygen, continuous positive airway pressure (CPAP), wound vacuum, continuous passive motion (CPM), scripts.
- Conduct a preadmission room huddle with admission nurse and nurse aide to determine that the room is set up with necessary equipment.
- Verify that required written prescriptions are completed and will accompany the resident on admission.
- Use a consistent process for "nurse-to-nurse" report immediately prior to resident transfer from acute for all admissions.
- Verify contact information from the discharging care provider point person in the event additional clarification is needed.
- Coordinate a handover clinical report from the hospitalist/physician to SNF physician for high-risk residents.

Admission Process

- Provide the resident/resident's representative with a facility call nurse number or extension for notification of resident change in condition, similar to the process a rapid response team uses at the acute care level.
- Use a communication tool for a nurse-to-nurse shift change report that has consistent clinical information.
- Include resident or resident's representative in the medication reconciliation process by:


- ✓ Requesting the resident or their representative bring in the resident's home medication list.
- ✓ Initiating a process where at least two nurses review and verify medication orders and the transfer medication sheet.
- ✓ Identifying/clarifying discrepancies, such as duplicate orders, dosages outside the recommended ranges, and/or unnecessary medications.
- ✓ Clarifying lab orders for high risk medications.

- Orient the resident and their representative to the unit with an explanation of the skill level and clinical services provided by the facility.
- Verify appropriate diagnosis or need for:
  - ✓ Foley catheter.
  - ✓ Anti-psychotic medications.
  - ✓ Psychotropic medications.
- Completing a thorough head-to-toe assessment and initiate a treatment plan.

During SNF Stay

- Discuss discharge goals with the resident or resident's representative and include those goals in the initial Plan of Care (POC) and subsequent reviews.
- Promote an interdisciplinary approach to the individualized POC and discharge plan, which includes nursing assistants, dietary staff, therapy staff, and other appropriate team members.
- Begin discharge education and support services needed for resident to reach goals within 48 hours of resident admission.
- Ensure physician completes physical exam within 48 hours of resident admission.
- Employ standardized documentation tools, e.g., ®Interact tools, to identify early changes in condition and best clinical practice to reduce the risk of readmissions, such as:
  - ✓ "Stop and Watch."
  - ✓ "Situation, Background, Analysis Response (SBAR)."
  - ✓ "Clinical Pathways."
- Discuss advance care plan with resident/family.
  - ✓ Determine wishes/goals.


  - ✓ Provide education regarding palliative care and hospice, as appropriate.
  - ✓ Share resources, including:
    - Honoring Choices Florida https://www.honoringchoicesfl.com/.
    - Five Wishes https://agingwithdignity.org/five-wishes/about-five-wishes.
    - The Conversation Project https://theconversationproject.org/.
- Promote consistent use of the warning/flags offered by electronic medical record (EMR) or facility software
- Review therapy notes daily to identify those residents who have a noted decrease in therapy minutes or participation.
  - ✓ Assess for change in medical condition.
- Engage and support development of daily huddles for residents with:
  - ✓ Changes in condition.
  - ✓ Recent or abnormal lab results.
  - ✓ Prescriptions for high-risk medications (opioids, blood thinners, diabetic agents).
  - ✓ High-risk diagnosis, such as sepsis, chronic obstructive pulmonary disease (COPD), and congestive heart failure (CHF).
  - ✓ Changes in therapy participation.
  - ✓ Increased complaints of pain.
  - ✓ Changes in behavior.
- Promote the use of resident/resident's representative educational tools that assist in disease management.
  - ✓ ®Project RED—Re-engineered Discharge
- Enforce nurse accountability for the use of evidenced-based clinical practices, such as:
  - ✓ Daily weights for residents with CHF.
    - Have any weight gain of two pounds or more in one day, or five pounds or more in one week reported to physician/cardiologist.
- Ensure medical directors/nurse practitioners conduct brief clinical review huddles with direct care givers to improve critical thinking skills regarding residents who are at high-risk for readmission.
- Work with pharmacy staff to ensure emergency medication box (E-box) has accurate medication supply to treat high-risk residents.


Preparation for Transfer/Discharge

- Use teach-back methodology with resident education for both primary and secondary diagnosis.
- Follow up with documentation of resident's ability to participate in the teach-back methodology.
  - ✓ Document areas of outstanding educational opportunities, as well as what has already been covered.
- Schedule therapy services for a home visit to evaluate home and/or make recommendations for additional safety needs, as appropriate.
- Assist and provide information to the resident and/or their representative regarding available post-discharge community services based on resident goals and needs, such as:
  - ✓ Transportation services.
  - ✓ Equipment needs (durable medical equipment).
  - ✓ Medication management (availability, medication cost, alternatives, and education).
  - ✓ Special dietary needs (availability, cost, alternatives, and education).
- Facilitate resident/resident's representative and Interdisciplinary Team (IDT) exit meeting to discuss any concerns/questions, and identify any outstanding educational opportunities.
  - ✓ A family member/caregiver and a representative from next level of care (LOC), such as the home health nurse or hospice nurse, should be included.
- Educate resident/caregiver about pharmacies that provide transitional care services and compliance packaging assistance.
- Arrange and schedule follow-up appointments for residents prior to discharge.
  - ✓ Assist with transportation arrangements, as necessary.
- Complete a discharge summary and provide copies to primary care physician and resident/resident's representative.
- Develop a consistent process for nurse-to-nurse report in real time for all transfers/discharges, including physician office and dialysis facility.
- Schedule follow-up calls with resident post-discharge, and when involved with care, the home health agency, on days 5, 14, and 28 to identify any changes in condition that require a readmission to the SNF LOC.
- Ensure the following are provided at time of transfer to emergency department (ED) from the SNF:
  - ✓ Nurse-to-nurse report handoff with a standardized verbal communication tool.
  - ✓ Completed transfer form, such as the ®Interact tool.

- ✓ Adequate information to ensure the emergency physician has a thorough understanding of the resident's:
  - Change in condition.
  - Current medications.
  - Medical management.
  - Current treatment plan.
  - Recommendations for ED.
  - Documented readmissions within last 30 days.
- ✓ Communication of SNF's level of service capabilities to ensure a smooth and safe transition back to the SNF setting.

Education

- Incorporate clinical education in nurse orientation and periodically assess competency for:
  - ✓ Critical thinking.
  - ✓ High-risk diagnosis.
  - ✓ High-risk medications.
  - ✓ Advanced care planning.
  - ✓ Dementia care.
- Utilize expertise of contracted healthcare providers to support additional staff education, including:
  - ✓ Medical Director.
  - ✓ Nurse Practitioner.
  - ✓ Respiratory Therapist.
  - ✓ Pharmacy Staff.
  - ✓ Therapist.
- Provide resources and education/training that will support additional services, such as IV therapy and specialized units.
- Set up clinical skills practice labs for nursing staff.
- Train and educate key staff on all shifts to promote a peer-to-peer approach to training.
- Educate and empower nursing assistants to provide best practice preventative measures, such as:
  - ✓ Ambulation programs.
  - ✓ Cough and deep breathing techniques.


- ✓ Catheter care.
- ✓ Identifying changes in resident's condition.
- ✓ Fluid intake.
- ✓ Proper body alignment and frequent position changes.

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

- All hospital readmissions within 30 days of SNF admission, necessitate that:
  - ✓ An action plan based on chart audits, data, gaps, trends, and drivers of readmissions be completed.
  - ✓ SNF leadership meet with acute care providers to partner in improving transitions of care in reducing preventable readmissions.
- Additionally, if a resident is readmitted to the hospital within 7 days of SNF admission, a 7-day huddle to evaluate the root cause of readmission must be completed within 48 hours.

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