When an elderly patient or a patient with a serious or complex illness is discharged from the hospital, that person is particularly vulnerable. As patients move from one care setting to another, problems such as lack of follow-up care and miscommunication among clinicians often occur and can put patients at risk for serious complications and hospital readmission. Some patients have additional problems such as depression, social isolation, or a lack of housing or transportation that may increase their risk of hospital readmission. Nearly one in five Medicare patients discharged from the hospital is readmitted within 30 days, at a cost of more than $26 billion every year.¹

Several Aligning Forces for Quality (AF4Q) Alliances have implemented or are partnering in care transitions programs using care transitions coaches to ensure patient care that is coordinated across care settings. Some of the patients who are enrolled in a 30-day care transitions program as hospital inpatients wind up being transferred to a skilled nursing facility (SNF). Typically, the coach will visit the patient in the SNF and provide support and tools to prevent the patient from being readmitted to the hospital.

Patients may encounter gaps in care when transferred to an SNF—for instance, important information like physician’s orders may not have been relayed from the hospital, some of the staff may lack adequate training, and there may be delays in obtaining medication because the SNF doesn’t have an onsite pharmacy. Care transitions programs are increasingly partnering with SNFs to work together to address these issues and provide patients with better continuity of care.

The following shows how three Alliances are improving care for patients discharged to SNFs.²
CASE STUDY
St. John Providence Health System

St. John Providence Health System (SJPHS) in southeast Michigan wanted to strengthen its relationships with the local SNFs they were already sending patients to, so in 2013 the health system established a Skilled Nursing Care Preferred Provider Network. To become part of the network, SNFs had to complete an RFP. They also had to commit to work with SJPHS on quality metrics and to use SJPHS physicians as providers at their facilities. SJPHS made this a requirement because they thought communication between facilities could be improved if the same physician who sees the patient in the hospital follows them at the SNF or at least knows the physician there. SJPHS is a partner in the Greater Detroit Area Health Council, which leads the AF4Q initiative in Detroit.

Representatives from the 28 SNFs that are now in the Preferred Provider Network meet with SJPHS staff to go over readmissions data and other metrics like patient satisfaction scores on a quarterly basis. Separate meetings are also held to discuss operational issues and specific patient cases that require additional follow-up.

Some of the SNFs in the network use an Interventions to Reduce Acute Care Transfers (INTERACT) tool to review acute care transfers (see "Reducing Avoidable Transfers from the SNF to the Hospital" sidebar). After a patient at the SNF is readmitted to the hospital, the SNF staff complete a form with questions about the patient’s previous hospital admissions and ED visits, health conditions, other factors that put the patient at risk for readmission, and changes in symptoms that were observed. The form also has sections for the staff to describe the steps they took to manage the patient’s change in condition before the hospital transfer and to note opportunities for improvement. For example, the staff might note that they could have detected a change in the patient's symptoms earlier or talked with the patient earlier about creating an advance directive. The SNFs send copies of the completed INTERACT form to Denise Robertson, RN, MSN, NP-C, regional director of care management and bed management for Providence Hospital and Providence Park Hospital (both part of SJPHS). This way, both the SNFs and the SJPHS hospitals can use the information to look for opportunities to improve care.

SNF patients sometimes insist on being readmitted to the hospital when there is a change in their condition, such as an increase in pain, because they assume that the SNF can’t provide the level of care they need. SJPHS is working with the SNFs to find ways to ensure that patients are better prepared for the transfer to the SNF and understand all the services that are available there. One option they are discussing is having an SNF employee greet patients when they arrive at the SNF, give them a brief orientation, and offer to answer any questions. Some of the SNFs are already sending a liaison to meet with patients at the hospital before they are discharged to the SNF. These liaisons check that the SNF can in fact provide the level of care the patient needs, and they tell the patient and family about the facility and the services they offer.

To improve continuity of care for patients, SJPHS’s home care agency, Reverence Home Health & Hospice, is following up with patients if needed when they are about to be discharged from an SNF. In addition, SJPHS is a partner in a Community-Based Care Transitions Program (CCTP)-funded care transitions program called Destination: Healthy at Home. The care transitions coaches employed by this program are following patients who are discharged from SJPHS hospitals to SNFs. Robertson says that all of these combined efforts have helped to reduce readmissions from SNFs to SJPHS hospitals and improve communication between the facilities.

REDUCING AVOIDABLE TRANSFERS FROM THE SNF TO THE HOSPITAL

INTERACT tools are designed to improve the early identification, assessment, documentation, and communication about changes in the status of residents in skilled nursing facilities (SNFs). The staff at SNFs can use these tools to reduce the frequency of potentially avoidable transfers to the acute hospital. Some of the tools facilitate communication between SNF staff and hospital staff. Care transitions teams can recommend the INTERACT tools to SNFs that aren’t already using them. Download the free tools at: http://interact2.net/tools.html.
CASE STUDY
Kansas City Bi-State Community-Based
Transitions of Care Program

The coaches in the Kansas City Bi-State Community-Based Transitions of Care Program (CCTP) work with patients at more than 30 SNFs. They have observed that these patients frequently get transferred to SNFs that can’t address all their needs. Patients who have a combination of needs—for instance, those who require a specialized diet, are on dialysis, or have mobility issues—should ideally be sent to an SNF that can provide more comprehensive care. Some SNFs, however, accept patients they can’t adequately care for because they don’t want to turn down business.

The Kansas City Quality Improvement Consortium (KCQIC) launched the Kansas City Bi-State Community-Based Transitions of Care Program and leads the Greater Kansas City area’s AF4Q initiative. Cathy Lauridsen, RN, who works for KCQIC as the clinical director for the Kansas City Bi-State Community-Based Transitions of Care Program, says the coaches on her team are trying to collaborate with the hospital social workers and case managers who call in the referrals to the SNFs to check that each patient is appropriately screened for acuity level and sent to a facility that can provide the right level of care. Once an acutely ill patient is transferred to an SNF, the coaches often ask their families to assist with tasks like making phone calls to coordinate with various care providers because the patient may be unable to do so on his or her own.

Many SNFs allow patients to choose what they eat from a varied menu and also permit their families to bring them food. The staff members at the SNFs, however, usually aren’t trained to advise patients with conditions like diabetes or heart disease on making healthy food choices. Some of these patients wind up eating a lot of take-out pizza. As a result, the coaches make an effort to talk with the patients at SNFs about what to eat to help manage their condition.

In addition, the coaches tell the patients who need regular assessments—like those with respiratory conditions—to be proactive about asking the staff to conduct assessments at the proper intervals. The same nurse should be completing a baseline assessment at the beginning of his or her shift and another assessment to compare it to before the shift ends. Lauridsen’s team has told the staff at the SNFs when they’ve noticed that assessments aren’t being conducted twice by the same nurse during the same shift.

A few of the SNFs use INTERACT tools (see “Reducing Avoidable Transfers from the SNF to the Hospital” sidebar) that guide staff members through a series of steps they can take before they call 911 when there is a change in a patient’s condition. The tools are called “Care Paths,” and each one focuses on a specific symptom like fever or shortness of breath. The steps that are listed can include, for example, taking vital signs, ordering tests, and notifying the physician or nurse at the SNF about the change in condition. “These Care Paths have proven to be good tools to keep staff from automatically calling 911,” said Lauridsen.

CMS reimburses care transitions programs for one visit to either the patient’s home or SNF after hospital discharge during the 30-day intervention period. But the Kansas City Bi-State Community-Based Transitions of Care Program recently started offering one SNF visit and one home visit for some high-risk patients. Although they won’t get reimbursed for the second visit, they are providing it to enhance care for the patients who are at the greatest risk of hospital readmission.

CASE STUDY
St Mary Mercy Hospital

At St. Mary Mercy Hospital in Livonia, MI, approximately 39 percent of readmitted patients came back from an SNF in 2013. Carrie Hays McElroy, RN-Gero-BC, MSN-HCA, ACM, service line administrator for senior services and director for case management at St. Mary Mercy Hospital, says one reason for these readmissions is that patients don’t trust that the SNF can manage their condition and ask to be transferred back to the hospital. Like Denise Robertson and her colleagues at St. John Providence Health System, Hays McElroy’s team is trying to help patients and families understand that the SNFs can provide them with a higher level of care than they may realize. They are also asking the emergency department staff at St. Mary Mercy to talk with patients about the services the SNFs can provide and reassure them when necessary.

St. Mary Mercy Hospital is a partner in the CCTP-funded Community Care Transitions Program of Southern and Western Wayne County and works closely with five local
SNFs. Hays McElroy has found that a benefit of having care transitions coaches work with patients transferred to SNFs is that they can help empower patients to achieve goals that will allow them to be discharged from the facility—for instance, knowing which medications to take and when. Coaches should also coordinate with the social workers and other staff at the SNF to make sure that everyone is on the same page about the patient’s goals.

In some cases, Hays McElroy and her colleagues have identified gaps in staff knowledge at the SNFs and provided training. They are teaching the staff at the SNFs about early warning signs of the development of sepsis, for example. Hays McElroy’s team has also partnered with SNFs to work on operational issues like having physicians onsite more frequently.

Another way that the Community Care Transitions Program of Southern and Western Wayne County is trying to improve care for patients discharged to SNFs is by communicating with each patient’s primary care provider (PCP). In the past, the PCPs often didn’t know when one of their patients had been transferred to an SNF. Now the care transitions coaches notify the PCPs about it right away and make sure patients have an appointment with the PCP within 3-5 days after they leave the SNF and an up-to-date list of their medications to bring to that appointment.

Hays McElroy is exploring ways to improve transfers not only in her role at St. Mary Mercy Hospital, but also as an executive chair of the Care Transitions Improvement Coalition (CTIC), an organization devoted to reducing hospital readmissions in southeast Michigan. The CTIC is a partner in the Greater Detroit Area Health Council, which leads the AF4Q initiative in Detroit.

**HOW TO PARTNER WITH SNFS TO IMPROVE CARE FOR PATIENTS**

1. Meet regularly with representatives from the local SNFs to discuss opportunities for quality improvement and review data including readmission rates.
2. Tell the SNF staff when you discover problems with care, for instance, if nurses aren’t conducting respiratory or general cognitive assessments at appropriate intervals.
3. Work with SNF staff to educate patients and families about the services the SNF can provide so they don’t assume they need to be transferred to back to the hospital if there is a change in their condition.
4. When you identify gaps in the SNF staff’s knowledge, offer to provide training in those areas.
5. Suggest to the SNFs that they use INTERACT tools if they are not doing so already.
This “peer-to-peer” meeting about care transitions was held on August 21, 2014, in Detroit. Aligning Forces for Quality organized and funded the meeting, with a goal of sharing strategies and tools for sustainability planning, staffing, physician engagement, and serving patient subsets. Attendees and subsequent interviewees were involved in the Center for Medicare & Medicaid Services (CMS) Community-Based Care Transitions Program. Attendees included Lisa Mason from the Greater Detroit Area Health Council; Caitlin Gerlach from MPRO; Tina Abbate Marzolf and Barbara Lavery from Area Agency on Aging 1-B; Sandy Kiesel from Go Lean, Inc.; Micheline Sommers from Oakland Family Services; Carrie Hays McElroy and Cathy Ponder from St. Mary Mercy Livonia Hospital; Dave Wilson and Jason Maciejewski from The Senior Alliance/Area Agency on Aging 1-C; Barbara Bremer and Denise Robertson from St. John Providence Health System; Susan Miller and Sara Gleicher from Adult Well-Being Services; Cathy Davis, Trent DeVreugd, and Cathy Lauridsen from the Kansas City Quality Improvement Consortium; Lori O’Connor from Elder Services of the Merrimack Valley; Melissa Pessefall from Akron Canton Area Agency on Aging; Dee Moore from Brewster Place Topeka Kansas; Megan MacDavey from the P2 Collaborative of Western New York; Sharon Mathe from Healthy Community Alliance; Jerry Bartone from Community Concern of WNY; Deanna Ruff from the York County Area Agency on Aging; Amy Shuttlesworth, Winnie Reineberg, and Mandi Waltemyer from WellSpan Health.

REFERENCES