Hospital and Skilled Nursing Facility Collaboration

Lauren Davis RN, WCC, DON-CLTC

Clinical Advisor

ldavis@leadingchoice.net

March 25, 2021

LeadingChoice NETWORK

Objectives

- Discuss the importance of a seamless transition of care from a Hospital to a Skilled Nursing Facility
- Review what practices SNFs are implementing to reduce avoidable hospital readmissions
- Discuss what stroke education is needed at the SNF level

Transition of Care

CMS defines **transition of care** as, “The movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another.”

Centers for Medicare and Medicaid Services, EHR Incentive Program. Transition of Care: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/8_Transition_of_Care_Summary.pdf

Transition of Care

- "Improving care transitions between care settings is critical to improving individuals' quality of care and quality of life and their outcomes. Effective care transitions:
  - Prevent medical errors
  - Identify issues for early intervention
  - Prevent unnecessary hospitalizations and readmissions
  - Support consumers preferences and choices
  - Avoid duplication of processes and efforts to more effectively utilize resources"

- Medicaid.gov. Improving Care Transitions: https://www.medicaid.gov/medicaid/quality-of-care/improvement-initiatives/care-transitions/index.html

Transition of Care Components

- Transition/Discharge Planning Care Plan
- Comprehensive Communication with other facilities
- Coordination of Care (designated staff member)
- Resident/Family Teaching with evidence of understanding
- Medication Education and Reconciliation
- Resident Follow-up
- Shared Accountability

AMDA Clinical Practice Guideline: Transitions of Care in the Long-Term Care Continuum http://www.amda.com

Transition Care

SHARED ACCOUNTABILITY

THE CARE TRANSITION PROCESS INVOLVES BOTH THE SENDER AND THE RECEIVER OF CRITICAL MEDICAL AND HEALTH-RELATED INFORMATION

Importance of Care Transitions

- Injuries
- Medication Errors
- Complications
- Infections
- Fall risk
- Cognition
- Clinical Outcomes

Why focus on transition of care?

- Can lead to adverse events
- Higher readmission rates
- Higher costs
- Miscommunication
- Can occur from any setting
- Patient satisfaction

Importance of Sharing a Complete Medical History

- Face sheet
- History & Physical within 15 days prior to admission or 48 after admission
- Discharge Summary
- Discharge Orders
- Current Medications and Treatments Signed Orders
- Admission Orders (SNF Specific Requirements)
- Results of MRIs, blood work, pre-existing conditions, original dx

Clinical Screening

- Pre-Admission Clinical Screening
  - Social Worker
  - Patient
  - Nurse to Nurse Report
- What will be needed at the SNF?
  - Mobility
  - Safety/ Cognitive Health of Patient
  - Functional level
  - Adaptive equipment needs/Ordering equipment
  - List of Medications and Treatments (including: CPAP and BiPaP, Oxygen orders, IV flush orders, medications have appropriate diagnoses)

Sample Admission Criteria

- Something similar may be used by referral teams to ensure the facility is able to meet the residents needs both clinically and financially

Needs Administrator Involvement

Expensive Medication –IV or Oral (≥$100/day or >$1000/week)
Unwilling to create active discharge plan
Homeless without a discharge plan
Unwilling to participate in hospital therapy or nursing care
Did not pass background check
1:1 Supervisor or "sitter"
Chemically Sedated within the last 24 hours
Active COVID or Recent Exposure

Needs RN Assessment and Potential DON Involvement

Clinically Complex
- Trach with >q4 hour needs
- Complicated Drains/Lines
- High Equipment Needs
- Bariatric requiring two or more assist >350 pounds

Frequent Wound Dressing Changes >3 times per day
Complicated Social History
Any rash that has unknown cause
Specialty Service Needs
PASRR is needed per guidelines
Difficult Family Dynamics

Automatic Acceptance to Skilled Nursing Facility

Rehabilitation Resident (joint replacement)
Minimally Clinically Complex
- Trach <q8 cares or needs
- Non-complicated drains or lines
- Non-complicated wound treatments <2x/day

Straight Forward Surgery in need of recovery
Wound Vac or complex wound treatment
Low cost IV ATB
No behaviors/No previous behaviors
MA/MC uncomplicated patient
Already a Resident in another level of care at same organization

Additional Factors to be Considered

- Memory loss
- Cognitive impairment
- Visual impairment
- Hearing impairment
- English as a 2nd language/ Interpreter needs
- Reading impairment
- Depression/anxiety
- Religion
- Cultural practices
- Financial impact of care needs

Medication Reconciliation

"**Reconciliation of Medications**": "A process of comparing pre-discharge medications to post-discharge medications by creating an accurate list of both prescription and over the counter medications that includes the drug name, dosage, frequency, route, and indication for use for the purpose of preventing unintended changes or omissions at transition points in care."

- Example: Blue Bag Project

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf

Blue Bag Project

What if I can't get to a MedDrop location?

If you or a trusted family member cannot make it to a MedDrop location, and the medications are an urgent risk to your family, please:

- Mix the medications with liquid, or
- Grind the medications up, or
- Mix them with coffee grounds or kitty litter, and
- Put them in a second container or plastic bag and hide in your trash

Be sure to remove or mark over any labels identifying the medication, your personal information and the prescription Rx number.

Rev. 4-7-17

MedDrop

If you would like to learn more about the MedDrop program visit Safe Communities website at https://safercommunity.net/meddrop/.

DANE COUNTY
Transitions of Care

DANE COUNTY
Transitions of Care

Dane County Community-Based Care Transitions Coalition

Preventing Adverse Drug Events

Our agency is a member of the Dane County CommunityBased Care Transitions Coalition, and we are working together to help prevent Adverse Drug Events in Dane County. Accidental medication poisoning is now the number one cause of death from injury in Dane County, killing more people than automobile accidents.

In 2014, the Safe Communities MedDrop Program collected 7.5 tons of medication. Please use this blue bag to take your old and expired medications to a MedDrop box listed on the bag label.

What is an Adverse Drug Event? An Adverse Drug Event is an injury to the body that can happen from taking expired, wrong, or too much of a medication.

Falls, dizziness, confusion, overdoses, drug poisoning and allergic reactions are examples of Adverse Drug Events. The good news is that many Adverse Drug Events are preventable by getting unnecessary medications out of the home.

Why do I need to get rid of my old medications? I might need them again sometime in the future. Getting rid of unnecessary and expired medications is best for your own health and safety. We want you to be taking the ***right*** medications for you **right** now. We also want to keep children and pets safe. Please keep medications locked and out of children's reach. Pain medications can be especially dangerous.

Why can't I just keep my old medications at home?
Getting rid of old medications is an easy way to keep you and your family safe. Removing old medications from the home reduces the chance of you or a family member having an Adverse Drug Event.

Why can't I just flush my old medications or throw them away?
Medications are bad for our water and environment. Putting medications in the toilet, down the sink or in the landfill could be harming you, your family, your pets, wildlife and your water supply. When you take old medications to the medication drop boxes, they are safely disposed of.

Where can I get rid of sharps like needles, syringes and lancets?
Used needles and other sharps are dangerous to people and pets if not disposed of safely because they can hurt people and spread infections that cause serious health conditions. **Do not put any sharps in the blue bag.** Sharps containers and old laundry detergent jugs are the safest containers for storing used sharps at home.

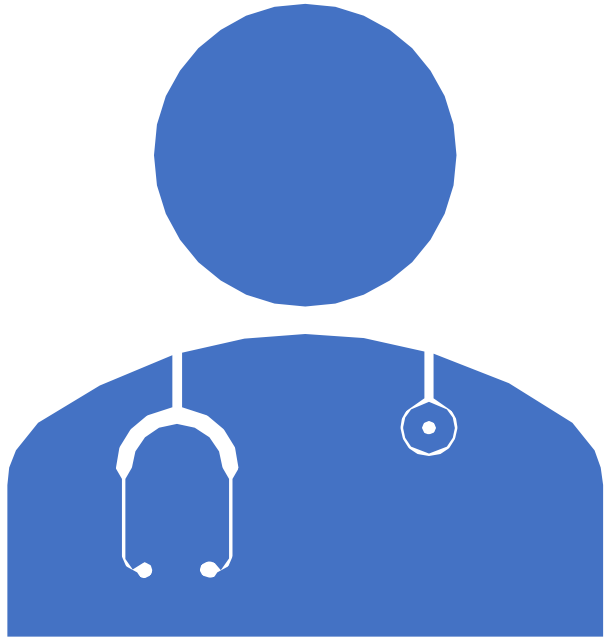
There are over 50 sites in Dane County where you can safely dispose of your sharps. You can look up the closest one to you on the DNR website http://dnr.wi.gov/topic/Waste/documents/faclists/SharpsCollection.pdf

What are all my medications for anyway?
It is best to ask your own doctor or pharmacist about your medications. Many senior centers and community pharmacies offer a medication review appointment where you can talk about your medications with a pharmacist who can explain what each medication is for.

For more information on how to make an appointment, contact the United Way of Dane County at 608 -246-4350 or your local pharmacy.

Admitting to a SNF

- Baseline care plan is developed within 48 hours of admission
- The SNF needs as much accurate information on the new resident to meet their needs and preferences to create a person-centered care plan



Cardiac Temporary Nursing Care Plan

Resident Name: _____ Room Number: _____
Nurse Signature: _____ Date Initiated: _____
Nurse Signature: _____ Date Resolved: _____

Problem	Goal	Interventions
Ineffective Cardiac Output **manifested by** ☐ *Congestive Heart Failure* ☐ *Hypertension* ☐ *Arterial fibrillation* ☐ *Arrhythmias* ☐ *History of MI or stroke* ☐ *Pacemaker placement* o *Date placed: _____* ☐ *Other: _____*	*Resident will be free of signs and symptoms of decreased cardiac output.* *Resident will maintain free of injury related to decreased cardiac output.* *Other:* *Date: _____* ☐ *Throughout admission*	☐ *Cardiac Assessments PRN* ☐ *Respiratory Assessments PRN* ☐ *Monitor VS as ordered—Notify MD if VS are outside of parameters:* o *Temp >100.5* o *Apical heart rate >100 or <50* o *Respiratory rate >28/min or <10/min* o *SBP <90 or >200* o *Oxygen Saturation <90%* o *Blood glucose level <70 or >300* o *New or worsening chest pain* ☐ *Chest X-ray as ordered* ☐ *Administer cardiac medications as ordered* ☐ *Administer diuretics as ordered* ☐ *Obtain labs as ordered* ☐ *Monitor weight as ordered and notify MD if outside of parameters:* _____ o *Weekly* o *Daily* o *Other* ☐ *Administer oxygen as ordered* ☐ *Manage edema as ordered* o *Tubigrips* o *Compression devices* o *Other: _____* ☐ *Elevate legs when resting* ☐ *Administer diet as ordered* ☐ *Monitor intake and output* ☐ *Fluid restriction: _____mL/day* ☐ *Monitor pacemaker function as ordered* ☐ *Keep HOB elevated for easier breathing*

Reducing Avoidable Readmissions to Hospitals

- Implementation of new Performance Improvement Projects
- Addressing residents with a high risk of hospital readmissions in their Plans of Care
- Starting education and discharge planning early after admission
- Use of Interact Tools, such as: Stop and Watch, Care Paths, SBARs and Change in Condition File Cards
- Use of Root Cause Analysis Interact Tool to review with hospital partner

LeadingChoice Network Cardiac Protocol

Table of Contents

Reducing Readmissions to Hospitals- SBAR communication changes

Situation

Background

Appearance

Review and Notify

Reducing Readmissions to Hospitals- SBAR communication changes

- SBAR Communication Form and Progress Note:
- Evaluate the Resident/Patient: Complete relevant aspects of the SBAR form below
- Check Vital Signs: BP, pulse, and/or apical heart rate, temperature, respiratory rate, O2 saturation and finger stick glucose for diabetics
- Review Record: Recent progress notes, labs, medications, other orders
- Review an INTERACT Care Path or Acute Change in Condition File Card, if indicated
- Have Relevant Information Available when Reporting (i.e. medical record, vital signs, advance directives such as DNR and other care limiting orders, allergies, medication list)

Reducing Readmissions to Hospitals

- Tracking of current discharges to the hospital and reason discharged. Evaluate whether resident could have been treated at SNF. Use of Interact's "Hospital Tracking Tool".
- Discussions with residents and families about Palliative/Comfort Care that can be provided at SNF
- Med Reconciliation Reports done upon admission and prior to discharge.
- Educational teaching/handouts for residents and families to review before discharge (i.e: catheter care, diabetic teaching, CHF).
- Follow up phone calls after discharge
- Person-centered care plans
- Nurse Practitioners who visit with residents throughout the week to follow up on POC and any acute changes

Stroke Education Needed at the SNF Level

Stroke kills nearly 150,000 of the 860,000 Americans who die of cardiovascular disease each year—that's 1 in every 19 deaths from all causes.

Stroke is the fifth leading cause of death in the United States and the leading cause of serious long-term disability. This is disturbing because about 80% of strokes are preventable.

Every year, about 800,000 people in the United States have a stroke—and about 1 out of 4 of those strokes are recurrent strokes.

References

- Centers for Medicare and Medicaid Services, EHR Incentive Program. Transition of Care: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/8_Transition_of_Care_Summary.pdf
- AMDA Clinical Practice Guideline: Transitions of Care in the Long-Term Care Continuum http://www.amda.com
- https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf
- Centers for Medicare & Medicaid Services State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities (Rev. 173, 11-22-17): https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf

References

- Wisconsin Administrative Code Chapter DHS 132 Nursing Homes http://docs.legis.wisconsin.gov/code/admin_code/dhs/110/132
- Centers for Medicare & Medicaid Services. State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities (Rev. 173, 11-22-17): https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf
- Centers for Medicare & Medicaid Services. Long Term Care Critical Element Pathways: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html
- Centers for Medicare and Medicaid Services, EHR Incentive Program. Transition of Care: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/8_Transition_of_Care_Summary.pdf
- Medicaid.gov. Improving Care Transitions: https://www.medicaid.gov/medicaid/quality-of-care/improvement-initiatives/care-transitions/index.html

References

- Forster AJ, Murff HJ, Peterson JF, et al. The incidence and severity of adverse events affecting patients after discharge from the hospital. Ann Intern Med 2003;138(3):161–7.
- Jencks SF, Williams MV, Coleman EA. Rehospitalizations among patients in the Medicare fee-for-service program. N Engl J Med 2009;360(14):1418–28.
- Kripalani S, Jackson AT, Schnipper JL, et al. Promoting effective transitions of care at hospital discharge: a review of key issues for hospitalists. J Hosp Med 2007;2(5):314–23.
- Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999–2017 on CDC WONDER Online Database website. http://wonder.cdc.gov/ucd-icd10.html. Accessed January 7, 2019.
- Lackland DT, Roccella EJ, Deutsch AF, et al. ; American Heart Association Stroke Council; Council on Cardiovascular and Stroke Nursing; Council on Quality of Care and Outcomes Research; Council on Functional Genomics and Translational Biology. Factors influencing the decline in stroke mortality: a statement from the American Heart Association/American Stroke Association. Stroke 2014;45:315–53.