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Heading Home from a Skilled Nursing Facility: Interventions and Tools for Improving the Transition

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Transitions of care, when a patient moves from one care setting to another, are a vulnerable time. Inadequate preparation for transitions frequently places frail and otherwise vulnerable older adults at risk of overuse of acute care services, declining health, permanent residency in a skilled nursing facility (SNF), and high levels of stress, anxiety, and dissatisfaction.

To address the historically limited focus on transitions of care from a short-term stay in a SNF to home, United Hospital Fund launched a two-year learning collaborative with eight SNFs in the New York City metropolitan region with the support of the Mother Cabrini Health Foundation. This project's primary purpose was to improve the quality of transitions for patients from skilled nursing facilities to home by engaging SNFs and the patients and family caregivers they serve.

This report and toolkit provides a description of our learning collaborative approach, profiles several interventions undertaken by the participating facilities, and provides resources that can be useful to SNFs and other health care organizations as they focus on ensuring successful transitions to home for patients and their caregivers.

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Introduction

Transitions of care, when a patient moves from one care setting to another, are a vulnerable time for elderly patients, particularly for frail elderly patients with multiple chronic conditions. While the health care community has focused on patients moving from an acute care hospitalization back home or to a skilled nursing facility (SNF), there has been less emphasis on the needs of patients and family caregivers returning home following a short-term stay in a SNF for rehab or subacute care. Nationally, fewer than 53% of short-stay patients at SNFs had a successful discharge home or to community-based services (defined as no hospitalizations or deaths within 31 days).[1]

Inadequate preparation for transitions frequently places frail and otherwise vulnerable older adults at risk of overuse of acute care services, declining health, permanent SNF residency, and high levels of stress, anxiety, and dissatisfaction. For Medicare beneficiaries with multiple chronic conditions, lower socioeconomic status, dual Medicare/Medicaid eligibility, cognitive impairment, or limited English proficiency, the risk of poor outcomes is even higher. As the population ages and the prevalence of chronic disease rises, safe, effective, and person-centered transitional care plans will become even more essential. To ensure that transitions succeed, SNFs will need to play a central role in developing and facilitating them so that patients and families are better equipped to manage their care.

UHF has a long-standing interest in and commitment to improving transitions of care. To address the historically limited focus on transitions of care from a short-term stay in a SNF to home, UHF launched a two-year learning collaborative with eight SNFs in the New York City metropolitan region with the support of the Mother Cabrini Health Foundation. This project's primary purpose was to improve the quality of transitions for patients from skilled nursing facilities to home by engaging SNFs and the patients and family caregivers they serve. A list of the facilities that participated in the initiative is provided in Appendix A. Participants in the collaborative sessions from the SNFs typically included leaders from social work, nursing, and administration.

This toolkit provides a description of our learning collaborative approach, profiles several interventions undertaken by the participating facilities, and provides resources that can be useful to SNFs and other health care organizations as they focus on ensuring successful transitions to home for patients and their caregivers. Also included are potential areas for future work that require attention from providers, policymakers, and other stakeholders.

1 CMS Nursing Home Compare – average based on data collection period 10/1/17-9/30/19.

Project Description

The collaborative was launched during the COVID-19 pandemic, which raised several challenges particular to this project: in addition to suddenly caring for many patients with COVID, SNFs were navigating staff shortages, lack of personal protective equipment, and fast-changing regulatory requirements—as well as restricted family visitation, which made transition planning and care conferences harder to arrange. The first year of the learning collaborative focused on engaging the SNFs and providing information on common challenges in transitions of care and discussing evidence-based practices and interventions that have been developed to address these challenges. Topics covered in the learning sessions during the two-year collaborative included quality improvement tools (e.g., process mapping, fishbone diagrams), medication management in the elderly, identifying and addressing social needs, transition of care tools, use of "teach-back"[2] for patient education, and implementing the age-friendly health systems framework in nursing homes. A complete list of learning sessions held during the collaborative can be found in Appendix B. Early in the collaborative, with the support of the UHF team and the program faculty, the SNFs mapped their discharge planning processes and identified a lack of standardization, gaps in team communication, limited patient and family engagement, and inadequate patient and family education about their conditions and care needs upon return to home. Engaging the interdisciplinary SNF teams in mapping their discharge planning process was a critical step in laying the groundwork for the interventions that followed.

In addition, UHF engaged a market research firm to conduct a survey of recently discharged patients and family caregivers from the eight SNFs in the collaborative to evaluate their experience with transitions of care. While the survey indicated that most patients understood discharge instructions and were receiving needed services, the pain points identified in their responses aligned with those found in the literature—managing complex medication regimens, inadequate education, problems managing symptoms, and limited follow-up. The findings from the survey can be found in a separate UHF report, *Pain Points Along the Journey from SNF to Home: Patient and Caregiver Perspectives*.

At the end of the first year of the collaborative, the SNFs had developed targeted intervention plans that included their aim, multidisciplinary team, actions, and measures. The focus of the second year was implementing steps of change, making refinements, and collecting data for measures to assess impact. Interventions were largely aimed at providing patient and caregiver education that addressed their specific needs, better coordination and communication among the care team and with the patient and caregiver during the discharge planning process, and providing consistent post-discharge follow-up that was timely and relevant. To support our SNF participants in their work, we continued to host learning sessions, coaching from UHF staff and advisory faculty, and opportunities to learn from peers. In addition to learning sessions focused on topics such as patient education techniques and medication management in nursing homes, sessions were devoted to reporting on the progress of interventions and sharing lessons learned. The coaching calls provided the SNFs with technical assistance related to the intervention approach, measure selection, data review, and feedback on how best to navigate

2 The teach-back method is a way of checking understanding by asking patients to state in their own words what they need to know or do about their health. It is a way to confirm that you have explained things in a manner your patients understand.

organizational and implementation challenges. In addition, a digital resource library was developed to assist SNFs as they worked on improving their processes. The resources provided are included in Appendix C. Given the continued impact of the pandemic, some participants had to adjust their project plans to address challenges that the pandemic posed.

The eight participating SNFs implemented facility-specific interventions based on their own quality improvement plans, as well as some common initiative-wide interventions and cross-cutting measures designed to address opportunities for improvements across all eight facilities (described in a separate section below). The SNFs in our collaborative varied greatly in terms of size, location, communities served, and resources; as a result, their areas of focus and their solutions to problems varied.

Facility-Specific Interventions

Improving Medication Education Before Discharge

One facility identified that its medication education process during discharge planning was often inconsistent and did not involve all members of the team. Due to its smaller size and staffing challenges, a nurse was not always available to educate patients on their medications before discharge, which left patients and caregivers less confident about how and when to take medications properly. The SNF's aim was to improve understanding of discharge medications and treatments for 85% of the short-stay patients before discharge.

The facility worked to improve its process for teaching patients and caregivers about their discharge medications by having the nurse review medication with patients and caregivers within three days of admission and again before discharge. The education provided at discharge also involved the patient's family. A social worker assessed the patient's understanding by including questions related to medication education during the follow-up calls that were conducted within 72 hours of discharge. The patients' reporting of understanding of medications improved from 60% before the intervention to 94% after it.[3] The SNF also described patient anecdotes where the questions posed during the post-discharge follow-up calls allowed the facility to address problems such as difficulty picking up medications.

Team involvement across disciplines in medication education was crucial, especially having a nurse discuss the medications in detail with the patient before discharge. They also identified that frequently patients were not taking their medications properly before admission. Additionally, the SNF found that some patients were having challenges picking up medications once they were home, so it was important to address that during the follow-up phone calls to ensure that patients had access to their needed medications. In the future, the SNF staff plan to conduct an initial

3 This facility had, on average, a small number of subacute discharges each month (n < 10).

review of medications that the patients use at home and assess their medication knowledge.

Improving Patient Education on Chronic Illness Self-Management

Another facility found that patients were not always well equipped to manage their chronic diseases and the potential side effects of high-risk medications. There was no established curriculum for staff to provide to the patients and caregivers that consistently addressed condition-specific issues as well as medications. The SNF's aim was to improve patient knowledge of chronic illness self-management with the use of teach-back for 90% of the short-stay patients before discharge.

> *"Please give many thanks to the student nurse. With his encouragement, the patient was able to use her subcutaneous glucose monitor in front of me and another floor nurse and she was able to check her blood sugar. [The patient] was so happy.... She was jumping out of her chair. She said to me, "you are my hero," and she hugged me. It was a proud moment for me. I have a feeling that I did something that she wanted and I learned a new technology. Now I don't have to prick her fingertip four times a day, just scan her thigh monitor. I am so happy."*

The SNF's transitional educators adopted the teach-back method to provide chronic illness self-management to patients during their stay. The transitional educators used Zone Tools, a set of resources designed to aid in patient self-management by helping identify common symptoms, warning signs, and the appropriate patient response, using a simple green, yellow, and red color-coding system to help direct patient responses.[4] The educators at this SNF used the Zone Tools for chronic pulmonary obstructive disease, diabetes, heart disease, heart failure, kidney health, and stroke to help provide tailored educational materials to the patient. Additionally, the SNF made use of nursing students who had participated in clinical rotations on-site before the COVID-19 pandemic to provide virtual education sessions to patients. Topics for these sessions included diabetes management, pain management, heart failure management, and hypertension management. The SNF also engaged its on-site pharmacy to conduct medication reconciliation with the physician 48 hours before discharge and conduct education with the caregivers before discharge.

The use of the Zone Tools increased during the intervention period, from 17% to 77%. During the month that virtual education was provided by the nursing students, use of teach-back was successfully documented for 89% of patients. On average, each patient had at least two virtual educational sessions, and 72% of the patients received medication education. Overall, the SNF reported positive anecdotal feedback from patients about the use of nursing staff providing virtual education, but no formal data were collected on patients' experience of it.

The facility found that every department's involvement in process mapping helped identify strengths and gaps during care transitions, which ultimately led them

4 Health Services Advisory Group (HSAG) developed and published a set of downloadable resources called Zone Tools, intended to help patients manage various health conditions. The full set of resources (in English and Spanish, with some in Armenian as well) may be found on the HSAG website: https://www.hsag.com/zone-tools/

With HSAG's permission, UHF commissioned translations of some of these tools into Albanian, Italian, Russian, and Chinese; they are available on a resource page of UHF's website that accompanies this toolkit: https://uhfnyc.org/our-work/initiatives/quality-institute/snf-learning-collaborative/snf-resources/.

to bolster the chronic disease education provided to patients and caregivers. The chief quality officer, chief nursing officer, nursing administrator, and transitional educators' involvement in approval of chronic illness self-management tools and documentation guidelines was critical to developing and sustaining the intervention. Specifically for the Zone Tools, the SNF developed scripts on how to use them, prepared a process for documenting their use, and provided staff with real-time positive feedback via text. In addition, many tests of change were conducted to improve the interventions (e.g., use of built-in microphones for patients and student nurses for virtual education). The use of nursing students for virtual education was beneficial for the patients given the students' ability to spend more time with each patient. The students also benefited from this meaningful learning experience on how to support patient and caregiver needs during the transition home. One of the challenges with the virtual education sessions is sustainability given the dependence on nursing education students who rotate at the SNF and are there for only a short time.

Streamlining the Discharge Planning and Communication Process to Improve Patient Preparation for Discharge

One facility identified gaps in accountability for the patient's discharge plan and found that communication between staff members about activities to meet the patients' needs was often inconsistent. The SNF's aim was to improve staff accountability and engagement during the discharge process and to implement a staff communication tool to better coordinate patient and caregiver education and follow-up.

"The discharge planning meetings are good—the key piece is we put everything in writing, including what needs to be followed up."

The SNF repurposed an interdisciplinary discharge summary for the discharge planning meetings to close the loop on patient education and follow-up. They assigned a point person, the assistant director of nursing, to oversee following up with the different disciplines. The tool included information regarding the diagnosis, therapy plan, durable medical equipment needs, activities of daily living, referrals, and other notes pertinent to the discharge plan. Initially the assistant director of nursing reviewed and assessed each patient's educational needs upon admission; later this was shifted to the medical director. The interdisciplinary team was also alerted when families were coming to the facility for education so that they could plan their teaching sessions in advance. The SNF also developed a set of educational resources to provide patients with materials across all disciplines (nursing, social work, physical and occupational therapy). To assess the intervention, the SNF revised its pre- and post-discharge surveys to focus on the most important information that needed to be addressed before discharge, and then assessed whether those needs were met.

The pre-discharge and post-discharge surveys indicated overall satisfaction with meeting the patient's educational needs. Over a four-month period, 91% of patients indicated pre-discharge that they were given educational materials and/or teaching about their diagnosis and managing at home. This increased to 100% post-discharge, suggesting that gaps identified by the pre-discharge survey during the rehab stay were successfully addressed before discharge.

The SNF found that a weekly review of a tool that identifies all patients, their needs, and their discharge plans has helped improve team communication and close the loop on patient education and needs. This review, coupled with designating a point person for follow-up, has also been crucial to ensuring that there

aren't any gaps in communication. The SNF's use of a comprehensive pre-discharge survey has enabled it to identify and address patient needs promptly. The SNF has also automated the pre- and post- discharge surveys via the use of SurveyMonkey®, which has made analysis of the results much more expedient. The SNF plans to continue its participation in person-centered projects that continue to place the patient and the caregiver as the focus of any intervention.

> *"We had one issue with one of the patients [during the follow-up phone call] over the weekend—her legs looked very swollen and we were able to reach out to her physician and he was able to do the follow-up and that worked out awesome."*

Supporting Patient Education with Video Technology

1. Developing Videos In-House

At one facility, patient education materials were not always clear to the patients and caregivers and did not meet their needs. This included having a clear understanding of their condition as well as potential warning signs and symptoms that could arise after discharge. The SNF's aim was to ensure that all short-stay patients received better patient education with teach-back techniques and improved access to engaging patient education materials using videos. The goal was to enhance the patient education system so patients could receive effective and continuous educational resources at their convenience, helping them stay actively engaged in managing their own conditions during and after their stay.

The facility's focus for the intervention was creating in-house educational videos that were easy to understand and involved the facility staff. An interdisciplinary team developed the content of the patient education video scripts, and staff members narrated the videos. The videos covered fall prevention, use of medical equipment, diabetes care, managing hypertension, managing the transition to the SNF, skin care, managing medications, meal preparation, heart failure, recovery after hip and knee surgery, the importance of home care, and making the transition to home. The videos were deployed in multiple ways—via iPads on the floor, via a television channel dedicated to patient education, and on the SNF website and YouTube channel so that patients and caregivers could access the videos at their convenience after discharge. The SNF assessed the intervention by administering an open-ended patient survey to assess perceptions of the videos' educational value.

There was positive feedback from the survey on the use of the educational videos; patients felt they were "very informative," and "very clear and very helpful on how to use the equipment." This intervention facilitated both patient and staff engagement—staff were actively engaged in developing the videos, and patients were able to see the staff members who cared for them. In addition, the facility tracked which videos were being watched. While there was widespread use of the fall prevention video, limited utilization of the condition-specific videos did not reflect the education gaps that were identified early in the project. This project initially involved the executive staff, but as the project progressed the SNF found that it was an opportunity to have front-line staff step up and participate. The SNF plans to add more topics to the video collection and will actively train nursing staff on how best to use the videos to reinforce patient education. In the future, the SNF plans to offer patients a complimentary primary care follow-up visit within seven days of discharge to ensure better care continuity.

2. Using a Video Library from an Outside Source

Another facility took a different approach, after finding that patients were not always engaged in their own care and that they sometimes lacked a clear understanding of their condition and what they would need to do when they went home. Their needs were not identified in a systematic way within the first few days of admission. The SNF's aim was to identify patient education needs for 90% of short-stay patients within the first few days of admission and provide additional education before discharge via videos.

The SNF's intervention was to implement video-based educational technology using an external vendor that had a comprehensive educational library. The SNF's leadership selected over 300 topics to include in the educational offerings to the patients. In addition, the SNF identified gaps in patient educational needs and utilized the information to identify appropriate video content within the first three days upon admission. Staff would then take tablets to the patient's bedside for them to view the educational videos.

The SNF conducted a pre-discharge survey on the video educational materials and asked related questions during the post–discharge follow-up phone calls. On average, 28% of patients reported they watched an educational video via the tablet. However, upon hiring a public health intern who provided additional resources for this effort, 75% of patients had utilized the educational videos based on 1 month of data. Patient feedback on the videos was generally positive—though patients with technological limitations or hearing issues made only limited use of the video technology.

The facility found it helpful to have interdisciplinary huddles to organize the patient's educational needs and specifically discuss the video content during discharge planning meetings, tailoring the video selection for each patient. A broad challenge identified, especially given the initial low uptake in viewing of the videos, was that video technology was not appropriate for all their patients and other forms of educational materials (e.g., written material and demonstrations) were needed as well. The SNF also plans on meeting with the patients more than twice for education before discharge to help with their comprehension and retention of the material. The SNF will also incorporate additional types of educational material via brochures, handouts, and signage throughout the facility.

Increasing Participation in the Discharge Planning Process

At one facility, a lack of communication among team members, patients, and caregivers was causing delays and gaps in the discharge planning process. The SNF's aim was to better coordinate and communicate the discharge plan with the involvement of the patient and caregiver at a discharge planning care conference.

The SNF's intervention was to implement a weekly meeting to address each patient's discharge planning needs. It included an interdisciplinary team to review the proposed discharge plan of care with patients and caregivers, providing them an opportunity to ask questions and bring up any previously unidentified needs. Each meeting covered all the patients slated for discharge the following week.

Over a seven-month period, on average 98% of patients being discharged to the community and 96% of caregivers attended the meeting. Caregivers attended the discharge planning meetings virtually when needed due to COVID-19. The meeting provided staff an opportunity to better coordinate patient

care in advance of discharge, and to allow ample time for follow-up questions from patients and caregivers. Efforts were made to include the specific rehab and nursing staff working with the patients, as they were the most familiar with the patients' functional capabilities that needed to be considered in planning a safe discharge to home.

The SNF found some initial resistance toward the discharge review meetings from the team, since some ended up being very time-intensive. In addition, the SNF faced challenges due to staffing during the COVID-19 pandemic. In addition to discussing discharge planning needs, the meeting was also used as a forum to provide instruction and education to the patient and family and address unresolved questions and issues.

Cross-Cutting Measures and Initiative-Wide Outcomes

In addition to the facility-specific interventions described above, UHF identified some common, cross cutting issues for all eight participating SNFs and suggested measures for all of them to collect. These initiative-wide interventions covered patient education, consistent follow-up with patients and caregivers after discharge, and other common areas of post-discharge concern regarding medications and concerning signs and symptoms that they may experience at home. These measures are provided below:

- Teach-back of discharge education documented by nursing
- Follow-up phone call conducted within 72 hours of discharge
- Survey questions asked during post-discharge follow-up phone call:
    - ◊ "Staff explained what medication they should take and how and when to take it"
    - ◊ "During discharge planning, I received information I could understand about what symptoms or problems I may experience"

The two statements that all facilities asked during the post-discharge call were taken directly from the patient and caregiver survey conducted in 2020. We chose to include these questions because the 2020 survey results indicated important opportunities for improvement for all participants.

The following charts show individual facilities' performance on the initiative-wide cross-cutting measures, as well as the overall aggregated performance. Some caveats should be considered when analyzing and comparing the pre- and post-intervention results. For the first measure considered, pre-intervention data were not available. Pre-intervention data were self-reported by patients, and post-intervention data were self-reported by facilities, based on patient responses.

The patient and caregiver survey utilized a multi-modal approach—surveys were administered online, by written survey, and by phone; post-intervention data were collected by phone only.

Additionally, we recognize that patients may respond to questions differently when they are

called directly by facility staff as opposed to a caller from a market research company, with whom results would be anonymous.

Teach-Back from Nursing Staff

The overall rate of teach-back across the facilities was 85%. While pre-intervention data are not available for teach-back, we know that not all facilities at the beginning of the collaborative used teach-back techniques to educate patients about their care by ensuring that staff were communicating in a way in which patients could understand.

One of the learning collaborative sessions focused on how to conduct teach-back and provided the facilities with the tools to teach their staff. Teach-back documentation varied across the facilities—some recorded it in the EMR while others recorded it in nursing progress notes.

Follow-Up Phone Calls

The overall rate for follow-up phone calls increased from 59% to 74%; seven of the eight facilities improved this rate. The follow-up calls were an important intervention

FIGURE 1. PERCENT OF PATIENTS WITH DOCUMENTED TEACH-BACK FROM NURSING STAFF

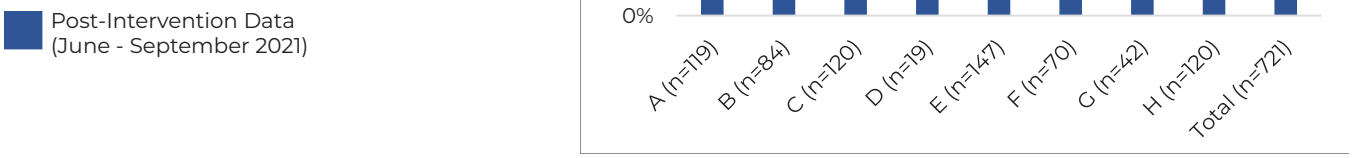


FIGURE 2. PERCENT OF PATIENTS REACHED BY A FOLLOW-UP PHONE CALL

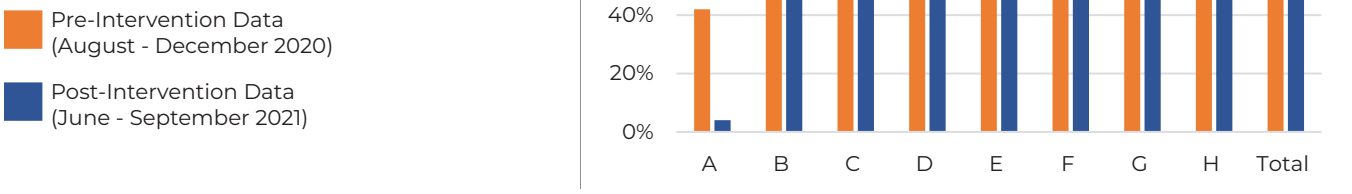


FIGURE 3. PERCENT OF PATIENTS REACHED WITHIN 72 HOURS OF DISCHARGE

to assess whether patients felt prepared to be home post-discharge and provided an opportunity for patients to ask the SNF staff any follow-up questions regarding their care.

Facilities were encouraged to develop processes to conduct the post-discharge follow-up call within 72 hours of discharge to ensure that any issues immediately following discharge could be addressed. Overall, 74% of the successful post-discharge calls occurred within 72 hours, with considerable variation among facilities. Staff members from one SNF noted that they "have had success in reaching patients within 72 hours and are very proud of that progress, and actually found it easier to connect with people when [the calls are] done sooner.

Patient Understanding of Medications and Symptoms

Patient understanding of prescribed medication increased from 57% to 98%, and patient understanding of symptoms and problems they may experience at home increased from 70% to 93%. Both measures improved at all eight facilities following the interventions.

FIGURE 4. PERCENT OF PATIENTS REACHED WHO SAID STAFF EXPLAINED WHAT MEDICATION THEY SHOULD TAKE AND HOW AND WHEN TO TAKE IT

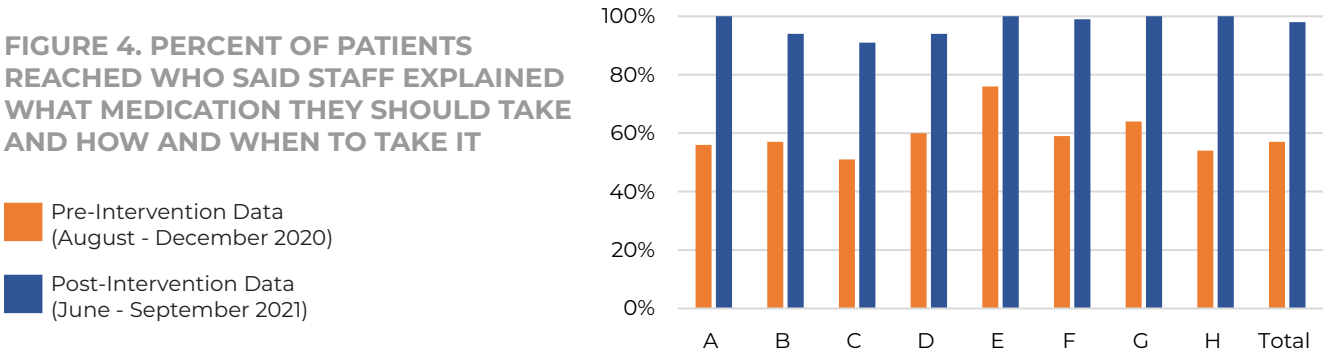
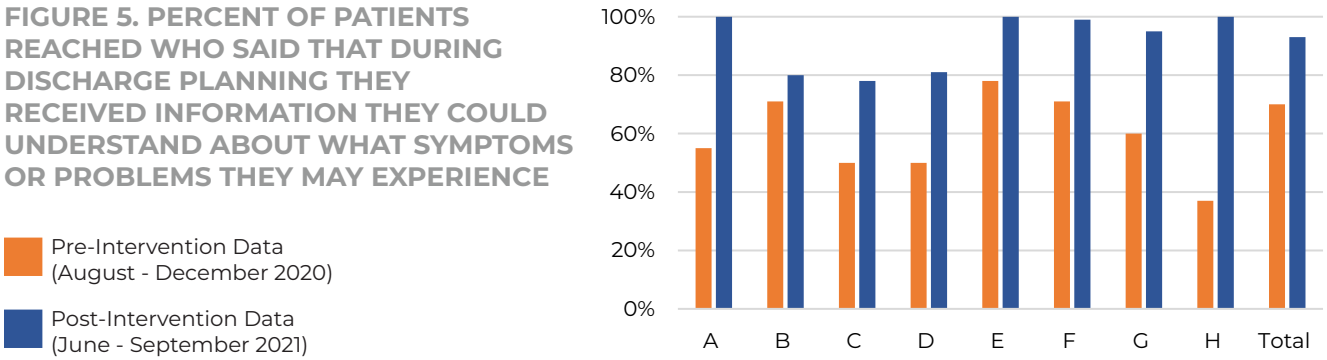


FIGURE 5. PERCENT OF PATIENTS REACHED WHO SAID THAT DURING DISCHARGE PLANNING THEY RECEIVED INFORMATION THEY COULD UNDERSTAND ABOUT WHAT SYMPTOMS OR PROBLEMS THEY MAY EXPERIENCE



Notes on the charts in this section: On the x-axis, A through H represent individual anonymized participating facilities. The sample sizes varied among facilities and between pre- and post-intervention surveys; pre-intervention, the number of respondents ranged from 8 to 82 at varying facilities (total of 263 across all facilities); and post-intervention, while generally larger, the numbers of respondents ranged from 5 to 147 (total of 721 across all facilities for the "follow-up phone call" question and 532 for the "signs and symptoms" question).

Note that on Figure 4 and 5, Facility A showed improvement but also had a small number of responses.

Challenges

Effectively meeting the transition needs of short-stay SNF patients must be considered in the much broader context of the challenges facing our entire long-term care system. Many of the barriers identified in the interventions described above will be difficult to overcome in the long-term without also addressing existential challenges in the system. It is widely acknowledged that there has been underinvestment in long-term care in the U.S., which has been highlighted and magnified during the COVID-19 pandemic. A key issue is the fragmented system for financing of nursing home care. Medicaid is the largest payer for long stay nursing home care; however, Medicaid payments for long-term patients often fall below the cost of providing care for these frail older adults. Medicare is a more generous payer for beneficiaries who are admitted to the nursing home for a short stay for rehabilitation following surgery or illness; therefore, the financial stability of many nursing homes rests on their ability to admit enough Medicare short-stay patients to subsidize the care of long-stay Medicaid residents.[5] As a result, the shrinking number of short-stay nursing home patients during the pandemic has put a significant financial strain on many nursing homes.

Adequate staffing is key to providing high-quality care, and staff shortages and high turnover have long been problematic for nursing homes. Staffing structures can be hierarchical with direct caregivers, many of whom are paid near the minimum wage and hold little power to effect change at their employer.[6] This challenging environment for staff has contributed to chronically high turnover and staffing shortages which have only been exacerbated during the pandemic. Nationally, staff turnover rates for certified nursing assistant, a large component of the nursing home workforce, jumped to a staggering 51.4% in 2021, and the turnover for all nursing home employees.[7]

Securing adequate staffing is even more problematic in underresourced nursing homes located in economically disadvantaged neighborhoods serving diverse communities, several of which participated in our collaborative.

The COVID-19 pandemic affected our collaborative in numerous ways. During the initial months of the collaborative, SNFs were overwhelmed with the challenges of caring for large numbers of patients with COVID, restricted visitation, staff illness and resulting shortages, lack of personal protective equipment, and numerous and constantly changing regulatory requirements. While the number of COVID cases declined during the first half of 2021, our SNFs continued to care for frail, elderly COVID patients, while also prioritizing the distribution of vaccines to patients, staff, and the communities they serve. Family visitation remained restricted due to ongoing COVID cases, creating persistent challenges for conducting care conferences, education, and transition planning.

5 Grabowski, David. August 2020. *Strengthening Nursing Home Policy for the Postpandemic World: How Can We Improve Residents' Health Outcomes and Experiences?* The Commonwealth Fund, Issue Brief.

6 Grabowski, David. August 2020. *Strengthening Nursing Home Policy for the Postpandemic World: How Can We Improve Residents' Health Outcomes and Experiences?* The Commonwealth Fund, Issue Brief.

7 Hospital and Healthcare Compensation Service, 44th annual report.

Participating facilities also faced tremendous COVID-related staffing challenges due to unplanned staff departures, and they had to adjust to manage existing priorities with even fewer resources and team members than usual. The tremendous impact of staff illness, resignations, early retirement, and burnout cannot be overstated. In the early months of the pandemic, some SNFs reported having difficulty arranging home health care, and some patients were hesitant to have home health staff in their homes, resulting in additional challenges for transitions of care.

In addition, short-stay volumes were low because of widespread curtailment of elective procedures—and, in some cases, patient hesitancy to be admitted to a nursing home.

In light of these numerous challenges, the efforts of nursing home staff to care for patients during the pandemic has been nothing short of heroic. Despite these challenges, the SNFs remained committed to participation in the collaborative, demonstrating their commitment to improving transitions of care for the patients and families they serve.

Lessons Learned

When we began the collaborative, our team anticipated that many SNFs would focus their interventions on improving transitions to home by identifying and addressing social needs and forging closer collaboration with community-based organizations to ensure these needs were met. While our SNFs acknowledged the importance of screening for social needs and connecting patients with resources in the community, we quickly learned that much work needed to be done within the four walls of the SNF before these larger outside issues could be tackled. Communication breakdowns, lack of standardized discharge planning processes, and inadequate patient and family education were problems that led to patients lacking confidence and skills to manage their conditions at home; such issues were more realistically achievable than broader external challenges within the scope of this collaborative. The SNFs were all able to identify opportunities for improvement in their internal discharge planning processes that could benefit the patients and families they serve.

Four important lessons emerged from the collaborative:

1. Value of process mapping. First, most of our participants expressed that they benefited greatly from the use of the process mapping exercise that was conducted early in the collaborative. Process mapping, when done with the interdisciplinary team and front-line staff, enabled SNFs to better understand the gaps in their discharge planning process and develop specific interventions to address them. The SNFs reported that it was particularly helpful to understand each discipline's role in the process and where communication between the members of the team can break down. For some of the SNFs, it was the first time that they had used this tool, and they expressed the intent to utilize process mapping in all future quality improvement efforts.

2. Standardization of processes. As a result of the process mapping, the teams were able to identify improved workflows, and specify staff roles and accountability for key processes. By standardizing processes such as conducting

the follow-up phone calls using scripts, and identifying educational needs upon admission, more consistent and effective education and post-discharge follow-up could be provided.

3. Interdisciplinary nature of discharge planning. Before the initiative, some facilities' discharge planning was considered to be in the purview of social work, and involvement of the interdisciplinary team was not prioritized. Increased participation of the interdisciplinary team in identifying and addressing patients' educational needs was a valued outcome of the collaborative. Utilization of various modes of education—verbal, written, and video—with emphasis on the use of the teach-back method to ensure that staff communicated clearly in a way that patients and families could understand, resulted in patients reporting better preparation for return home.

4. Early and tailored contact after discharge. While most facilities were conducting post-discharge calls before the initiative, many were not conducting those calls within 72 hours. The facilities learned that early identification of issues helped avert exacerbation of symptoms and rehospitalization. In addition, they found that including questions about the preparation and education that patients had received during their stay helped them to evaluate the success of these efforts. Some of our SNFs began to utilize pre-discharge surveys that served as an effective tool to identify gaps in patient education that could be addressed before discharge.

A list of questions used for the pre- and post-discharge surveys is provided in the resource section this toolkit in Appendix D.

Future Directions and Policy Implications

Our project focused on small interventions aimed at improving discharge planning, patient education, and post-discharge follow up for patients being discharged home from a short stay in a skilled nursing facility. In this project, we saw marked improvement in the SNFs' ability and commitment to complete timely post-discharge follow-up calls and to ensure that patients' needs are met in the immediate post-discharge period as they go home. However, there are systemic challenges that need to be addressed as part of any large-scale effort to improve the quality of care for older adults going home from a SNF. Long-term care in this country is inadequate to support the needs of older adults, and both facility-based care and home- and community-based services (HCBS) are underfunded. As a result, coordination with primary care in the community and the strengthening of relationships with community-based organizations providing social services are difficult for underresourced nursing homes with ever-increasing staffing challenges, which have only been exacerbated by the pandemic. The difficulties that patients experience when transitioning home from care in a skilled nursing facility are only a small example of the lack of a comprehensive and sustainable long-term care strategy.

While there are many challenges that need to be addressed when a patient is discharged from an acute care hospital to a SNF, a "warm

handoff" of the patient to the receiving health care provider is possible and has been identified as a successful transition of care strategy. This type of handoff to a health care provider rarely occurs when a patient is being discharged home. In some cases, SNFs with strong connections to home health services can facilitate this handoff. While SNFs make efforts to ensure that patients have visits with their primary care physicians arranged before discharge, this can often be challenging and delayed, as care in the community may be fragmented and it may not be clear who is chiefly responsible for managing the patient's care. This uncertainty may exacerbate problems being experienced by frail elder patients with multiple chronic conditions being discharged from the SNF. Such fragmentation often contributes to a lack of coordinated care, inaccurate medication reconciliation, and resulting medication management problems for the patients when they return home. Value-based payment methodologies, especially for Medicare patients, provide financial incentives for SNFs with low rates of rehospitalization; however, SNFs with limited staff are likely unable to devote scarce resources to the ongoing management of patients' complex needs after discharge.

While there has been an increase in the percentage of Medicaid dollars spent on HCBS, including recent state and federal investments, navigating the various programs is complicated and remaining gaps in services largely fall to family caregivers who may not have the capacity to manage the patient's complex care at home. Further investment in home- and community-based services is needed, as well as funding mechanisms to ensure the coordination of medical and needed social services. It will be essential that patients, caregivers, advocacy groups, providers, payers, and policymakers work together to develop and fund services that further support the needs of frail elderly patients across the continuum of care and facilitate coordinated care to ensure their ongoing health and well-being in the community.

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Appendix A: SNF Profiles

Skilled Nursing Facility	Total # of Short-Stay Beds	County
Ferncliff Nursing Home	40	Dutchess
Gurwin Jewish Nursing and Rehabilitation Center	80	Suffolk
Jamaica Hospital Nursing Home	80	Queens
Parker Jewish Institute for Health Care & Rehab	180	Nassau
Schulman and Schachne Institute for Nursing and Rehabilitation	66	Kings
Sea View Hospital, Rehabilitation Center and Home	40	Richmond
Terence Cardinal Cooke Health Care Center	102	New York
The New Jewish Home, Sarah Neuman	56	Westchester

Appendix B: SNF to Home Collaborative Topics (July 2020 to December 2021)

Year 1

Learning Session 1: Family Caregivers and Transition Planning

Learning Session 2: Introduction to the Model for Improvement & Process Mapping

Learning Session 3: SNF Presentations of Process Maps

Learning Session 4: Addressing Patient's Health-Related Social Needs: The Role of Community Based Organizations

Learning Session 5: Improving Nursing Home Discharges Back to the Community & SNF Presentations of Proposed Interventions

Learning Session 6: Patient and Caregiver Survey Results Overview Year 2

Learning Session 7: Improving Transitions through Patient Education

Learning Session 8: Nursing Homes and Medication Management: Strategies for Success

Learning Session 9: SNF Presentations on Progress of Interventions

Learning Session 10: Age Friendly Health Systems & The 4 M's in Nursing Homes

Learning Session 11: Successes and Challenges of Intervention Implementation

Learning Session 12: Final Presentations from SNFs on Intervention Results

Appendix C: Resource Library for SNF to Home Collaborative

These resources were provided to participants on a private website during the project; they are also now available on UHF's public website, here: https://uhfnyc.org/our-work/initiatives/quality-institute/snf-learning-collaborative/snf-resources/

Improve Discharge Planning Processes

Care Transitions Toolkits

Society of Hospital Medicine – Project BOOST: Implementation Guide to Improve Care Transitions
https://www.hospitalmedicine.org/globalassets/professional-development/professional-dev-pdf/boost-guide-second-edition.pdf

AHRQ – Care Transitions from Hospital to Home: IDEAL Discharge Planning Training.
https://www.ahrq.gov/patient-safety/patients-families/engagingfamilies/strategy4/index.html

Communication Tools

Always Use Teach back
http://www.teachbacktraining.org/home

AHRQ – Health Literacy Universal Precautions Toolkit
https://www.ahrq.gov/health-literacy/improve/precautions/index.html

UNC – The Teach Back Method Videos
https://hsl.lib.unc.edu/health-literacy/videos-tutorials/

Discharge Checklists

For Patients/Families:

CMS – Your Discharge Planning Checklist
https://www.medicare.gov/Pubs/pdf/11376-discharge-planning-checklist.pdf

RWJF – Discharge Preparation Checklist
https://www.rwjf.org/en/library/research/2013/01/care-about-your-care-discharge-checklist---care-transition-plan.html

HealthCentric Advisors – My After Nursing Home Care Plan
https://healthcentricadvisors.org/wp-content/uploads/2019/08/AfterCarePlan.pdf

For Staff:

AHRQ – IDEAL Discharge Planning Checklist
https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/engagingfamilies/strategy4/Strat4_Tool_1_IDEAL_chklst_508.pdf

Society of Hospital Medicine – Project BOOST. The 8P Screening Tool Identifying Your Patient's Risk for Adverse Events After Discharge
https://www.hospitalmedicine.org/globalassets/clinical-topics/clinical-pdf/8ps_riskassess-1.pdf

HealthCentric Advisors – Re-engineered Discharge for SNFs Checklist
https://healthcentricadvisors.org/wp-content/uploads/2019/08/Pt-Level-RED-Checklist.pdf

Medication Management Tools

For Staff:

Eric Coleman – Medication Discrepancy Tool
https://caretransitions.org/wp-content/uploads/2015/08/MDT.pdf

For Patients/Families:

UHF Next Step in Care – Medication Management Form
https://www.nextstepincare.org/Caregiver_Home/Medication_Management_Guide/

AARP – Family Caregiver's Video Guide to Managing Medications
https://www.aarp.org/ppi/info-2016/family-caregiver-video-guide-to-managing-medications.html

Social Needs Screening Tools and Assessments

Health Leads - Social Needs Screening Toolkit
https://healthleadsusa.org/resources/the-health-leads-screening-toolkit/

CMS – The Accountable Health Communities Health-Related Social Needs Screening Tool
https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf

Enhancing Patient Education

Disease-Specific Information

Alzheimer's Disease

NIA – Alzheimer's Caregiving: Changes in Communication Skills
English – https://www.nia.nih.gov/health/alzheimers-caregiving-changes-communication-skills

Spanish – https://www.nia.nih.gov/espanol/cambios-habilidades-comunicacion-relacionados-enfermedad-alzheimer

Alzheimer's Association – Caregiver Health *(various topics on caregiver health)*
https://www.alz.org/help-support/caregiving/caregiver-health

Alzheimer's Association – Care Training Resources *(video courses in English and some in Spanish on warning signs, understanding the disease, conversations, effective communication, healthy living, legal and financial planning, different stages)*
https://www.alz.org/help-support/resources/care-training-resources

Atrial Fibrillation

AHA – What is A Fib?
https://www.heart.org/en/health-topics/atrial-fibrillation/what-is-atrial-fibrillation-afib-or-af

AHA – A Fib Symptom Tracker
https://www.heart.org/en/health-topics/atrial-fibrillation/what-are-the-symptoms-of-atrial-fibrillation-afib-or-af

Chronic Kidney Disease

NIDDK – Chronic Kidney Disease
https://www.niddk.nih.gov/health-information/kidney-disease/chronic-kidney-disease-ckd/all-content

NIDDK – Eating Right for Chronic Kidney Disease
https://www.niddk.nih.gov/health-information/kidney-disease/chronic-kidney-disease-ckd/eating-nutrition

ARA – Kidney Disease 101
https://www.americanrenal.com/for-patients-and-caregivers/what-you-need-to-know#

ARA – Nutrition
https://www.americanrenal.com/for-patients-and-caregivers/nutrition-and-wellness

Kidney School *(learning modules in English and Spanish with videos and educational guides)*
https://kidneyschool.org/

Chronic Obstructive Pulmonary Disease (COPD)

ALA – My COPD Action/Management Plan *(English and Spanish)*
http://action.lung.org/site/DocServer/ala-copd-management-plan.pdf

ALA – How to Use a Nebulizer and How to Clean a Nebulizer video *(video)*
https://www.lung.org/lung-health-diseases/lung-disease-lookup/copd/patient-resources-and-videos

Dementia

CaringKind – Family Caregiver Guide
https://www.caringkindnyc.org/_pdf/CaringKind_FCG-English_webv.pdf

Diabetes

ADA – What is Diabetes?
https://www.diabetes.org/diabetes

ADA – Understanding A1C
https://www.diabetes.org/a1c

ADA – Prediabetes
https://www.diabetes.org/diabetes-risk/prediabetes

ADA – Healthy food choices
https://www.diabetes.org/nutrition/healthy-food-choices-made-easy

ADA – Online Community
https://community.diabetes.org/home

Heart Failure

AHA Rise Above Heart Failure – Toolkit *(includes patient discharge checklist, lifestyle changes, medication, symptom monitoring)*
https://www.heart.org/en/health-topics/heart-failure/heart-failure-tools-resources/rise-above-heart-failure-toolkit

AHA Rise Above Heart Failure – Self Check Plan *(English and Spanish)*
https://www.heart.org/-/media/Files/Health-Topics/Heart-Failure/HF-Symptom-Tracker.pdf

Parkinson's Disease

Parkinson's Foundation – About Parkinson's Disease
https://www.parkinson.org/understanding-parkinsons/what-is-parkinsons

Stroke

AHA/ASA – About Stroke
https://www.stroke.org/en/about-stroke

AHA/ASA – Risk Factors for Stroke (English and Spanish)
https://www.stroke.org/en/about-stroke/stroke-risk-factors

AHA/ASA – Caregiver Guide to Stroke
https://www.stroke.org/-/media/stroke-files/caregiver-support/caregivers-guide-to-stroke/caregiverguidetostroke_2020.pdf?la=en

AHA/ASA: Your Stroke Discharge Checklist
https://www.stroke.org/-/media/stroke-files/stroke-resource-center/recovery/patient-focused/stroke-discharge-list-for-patients-and-caregivers-ucm_463810.pdf?la=en

Wound Care

AARP - General Principles of Wound Care *(video)*
English - https://videos.aarp.org/detail/video/5597247508001/family-caregiving-series:-general-principles-of-wound-care-%E2%80%94-aarp
Spanish - https://videos.aarp.org/detail/video/5593516484001/serie-para-cuidadores-familiares:-principios-generales-para-curar-una-herida-%E2%80%94-aarp

Falls

NIA – Prevent Falls and Fractures *(general explainer for patients)*
English – https://www.nia.nih.gov/health/prevent-falls-and-fractures
Spanish – https://www.nia.nih.gov/espanol/prevenga-caidas-fracturas

NIA – Fall-Proofing Your Home
English - https://www.nia.nih.gov/health/fall-proofing-your-home
Spanish - https://www.nia.nih.gov/espanol/caidas-fracturas

CDC – STEADI Older Adult Fall Prevention
https://www.cdc.gov/steadi/materials.html

CDC – A Home Fall Prevention Checklist for Older Adults
https://www.cdc.gov/steadi/pdf/check_for_safety_brochure-a.pdf

CDC – Talking about Fall Prevention with Your Patients *(communication steps based on stages of change for providers)*
https://www.cdc.gov/steadi/pdf/Talking_about_Fall_Prevention_with_Your_Patients-print.pdf

CDC – Family Caregivers: Protect Your Loved Ones from Falling
https://www.cdc.gov/steadi/pdf/patient/customizable/Caregiver-Brochure-Final-Customizable-508.pdf

CDC – MyMobility Plan
https://www.cdc.gov/transportationsafety/older_adult_drivers/mymobility/index.html

Family Caregiver Tools

HealthCentric Advisors – Caregiver assessment
https://healthcentricadvisors.org/wp-content/uploads/2019/08/Assessing-Family-Caregivers.pdf

UHF Next Step in Care – Make Sure All of Your Family Member's Doctors and the Home Care Nurse Know All the Over-the-Counter and Herbal Medications Your Family Member Is Taking
https://www.nextstepincare.org/uploads/File/NSIC_Medication_Management_4.24.pdf

UHF Next Step in Care – Going Home: What You Need to Know
https://www.nextstepincare.org/Caregiver_Home/Going_Home/

UHF Next Step in Care – Rehab-to-Home Discharge Guide
https://www.nextstepincare.org/uploads/File/Guides/Rehabilitation/Going_Home/Rehab_to_Home.pdf

UHF Next Step in Care – When Home Care Ends: A Family Caregiver's Guide
https://www.nextstepincare.org/Caregiver_Home/When_Home_Care_Ends/

AARP – Home Alone Alliance: Training and Support for Caregivers
http://www.aarp.org/ppi/initiatives/home-alone-alliance/

AARP – How-To Videos Assist Caregivers Performing Medical Tasks
https://www.aarp.org/ppi/initiatives/home-alone-alliance/family-caregiving-videos/

Eric Coleman – Family Caregiver Activation in Transitions (FCAT) Tool *(written permission required before use)*

Family Caregiver Alliance – Resources *(numerous resources in English, Spanish, Mandarin, Vietnamese, Tagalog, and Korean on several health topics, caregiving issues, and strategies; they also host videos and support groups)*
https://www.caregiver.org/fact-sheets

Caregiver Action Network – Toolbox *(several resources for caregivers including videos and support team)*
https://caregiveraction.org/family-caregiver-toolbox

Other

AHA – Watch, Learn and Live videos on cardiovascular conditions, treatments, and procedures related to hear disease and stroke
https://watchlearnlive.heart.org/?moduleSelect=welcom

AHA – Monitoring Your Blood Pressure at Home
https://www.heart.org/en/health-topics/high-blood-pressure/understanding-blood-pressure-readings/monitoring-your-blood-pressure-at-home

Quality Improvement Organizations Health Services Advisory Group – Zone Tools for several chronic diseases in English, Spanish, and Armenian
https://www.hsag.com/zone-tools/

UHF-commissioned translations of select Zone Tools in Albanian, Italian, Russian, and Chinese
https://uhfnyc.org/our-work/initiatives/quality-institute/snf-learning-collaborative/snf-resources/

Improve Post-Discharge Follow-up

HealthCentric Advisors – Post-Discharge Call Script
https://healthcentricadvisors.org/wp-content/uploads/2019/08/Script-Fol-Phone-Call-2Day.pdf

HealthCentric Advisors – 2-Day Follow-up Phone Call Documentation
https://healthcentricadvisors.org/wp-content/uploads/2019/08/2dayCall-Followup.pdf

HealthCentric Advisors – 30-Day Follow-up Phone Call Documentation
https://healthcentricadvisors.org/wp-content/uploads/2019/08/30dayCall-Followup.pdf

Appendix D: Measures for Assessing Impact of Interventions

Pre-Discharge Survey General Questions

Were you given educational materials regarding the type of diet that is recommended for you when you are discharged?

Did you see your physician, and did they speak with you regarding your condition, medications, and care?

Did nursing staff keep you informed about your plan of care?

Were you given educational information and/or teaching about your diagnosis and managing at home?

Did you receive any teaching or education from your therapist regarding equipment that you will be receiving or living with your diagnosis and/or home safety?

How well did your social worker address your discharge plan with you and your family?

Do you have any questions or issues you would like to be resolved prior to your discharge?

% of patients who understood purpose of medications

% of patient who understood how and when to take medications

% of patients who understood possible side effects of some of their medications

% of patients who understood the equipment they will use

% of patients who understood dietary needs

% of patients who understood follow up needs (e.g., Keeping medical appointment)

Post-Discharge Follow-up Calls/Survey Questions

General Discharge Education

Were you provided with educational information on your diagnosis, home safety, and nutrition prior to discharge?

Medication Education

Did you pick up your medications from the pharmacy?

On a scale of 1-10, how would you rate your level of understanding of how and when to take your medications?

Are you having any problems with your medications? List problems experienced with medication.

Chronic Disease Education

The ZONE tool was reviewed with the patient

Number of virtual educational sessions conducted

Did the information you receive help prepare you to care for yourself at home?

% of patients who said the information about primary diagnosis was useful

% of patients who said primary diagnosis information was easy to understand

% of patients who said nursing staff explained care needs

% of patients who said the rehab department explained their treatment goals

% of patients who said dietary department educated them on their dietary needs

Follow-Up Care

Do you have a follow-up appointment with physician in the community?

Has the homecare agency been in to see you?

If you have home care services, how quickly did they begin?

Pre-Discharge Video Content Questions

When you first arrived, did someone speak to you about your specific medical and social needs?

Did the patient watch an educational video via the tablet?

How much did the educational information presented via the tablet help you better understand your condition?

How much did the information presented via the tablet help you to feel prepared for your discharge home?

Please tell us what you think about the video(s) you watched by indicating how much you agree or disagree with each of the statements below.

- I enjoyed the educational video.
- The video was just the right length to watch.
- The video helped me understand how to manage my daily activities given my condition.
- I found the video content to be practical and useful.
- The video was easy to follow and understand.
- The video has prompted me to consider changing my health care behavior.
- The video made learning about health a better experience than I would have had otherwise.
- The staff took my preferences and those of my family into account in deciding what my health care needs would be when I left the facility.
- After watching the video, I feel more confident in caring for my condition.
- After watching the video, I clearly understood the purpose of taking each of my medications.
- After watching the video, I had a good understanding of the things I was responsible for in managing my health.
- After watching the video, I feel more confident about symptoms and health problems to look for when I leave the facility.