Innovations to Reduce Hospital Readmissions and Avoidable Hospitalizations from Nursing Homes:
Implications for the Health Workforce

Project Completed by:
The Center for Health Workforce Studies

Prepared for:
Greater New York Hospital Association
Continuing Care Leadership Coalition

MARCH 2014

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EXECUTIVE SUMMARY

In an effort to examine the roles and functions of the health workforce responsible for managing care transitions between hospitals and nursing homes, GNYHA Foundation, with a grant from the New York Community Trust, commissioned the Center for Health Workforce Studies at the University at Albany, School of Public Health, to interview administrative and clinical staff at hospitals and nursing homes in the downstate New York region. Interview participants identified several critical gaps in care transitions, including needs for:

- information-sharing among hospitals, nursing homes, patients, families, and caregivers;
- better access to clinical providers in hospitals and nursing homes to provide essential information; and
- more active involvement of a team of professionals representing administration, social work, clinical, and non-clinical staff in efforts to improve outcomes for patients.

Those interviewed provided recommendations and potential interventions to address the barriers and gaps in care they identified. Participants also shared their views on different staffing roles and training needs that can improve transitions and reduce unnecessary hospitalizations and readmissions.

BACKGROUND

Improving population health, providing accessible, high-quality services, and lowering costs are goals that all in the health care system share. Many current initiatives are designed to increase system efficiencies and improve health outcomes for patients by delivering evidence-based services. One area of significant concern is finding effective methods to reduce avoidable patient admissions and readmissions to hospitals from post-acute care facilities, including nursing homes. Identifying and replicating promising practices related to improvements in care transitions that lead to reducing unnecessary hospitalizations is important in systematically addressing these concerns. Achieving these goals must be accomplished in the midst of significant health system change.

Hospitals and nursing homes are experiencing ongoing resource constraints arising from cost containment efforts and the restructuring of care delivery systems. The delivery of health care services is undergoing structural change as a result of the Affordable Care Act and parallel New York State initiatives, concerns about underserved and uninsured populations, rising health care costs that do not always yield better health outcomes, and the need to ensure a supply of health workers to address an expected surge in demand for services beginning in 2014. As a result, there are several synchronous initiatives impacting transition processes in New York, such as the increasing utilization of managed care for Medicaid-funded beneficiaries of long term care,[1] the creation of accountable care organizations,[2] the implementation of the NYS Partnership for Patients initiative,[3] as well as other focused initiatives, including the Community-based Care Transitions Program (CCTP),[4] and New York–Reducing Avoidable Hospitalizations (NY–RAH).[5]

THE STUDY

The Center for Health Workforce Studies at the University at Albany, School of Public Health, in collaboration with the Greater New York Hospital Association (GNYHA) and the Continuing Care Leadership Coalition (CCLC), conducted a study from July through September 2013 to better understand the roles and functions of the health workforce responsible for managing patient transitions to and from hospitals and nursing homes in New York's downstate region. The study was funded by a grant to the GNYHA Foundation from the New York Community Trust.

PROJECT GOALS

The goals of the project were:

- to identify facilitators and barriers to appropriate patient transitions from hospitals to nursing homes, and from nursing homes to hospitals;
- to describe effective workforce models for managing patient transition processes;
- to identify workforce training initiatives to address gaps in knowledge that affect the quality of transitions across care settings; and
- to identify promising practices that other health care organizations could replicate in whole or in part.

1. The New York State Department of Health is seeking to transition virtually all state Medicaid enrollees into managed care by April 2018. See: http://www.health.ny.gov/health_care/medicaid/redesign/care_management_for_all.htm.
2. An accountable care organization (ACO) is an entity that includes a broad range of providers working together to provide high-quality care to a defined populations. For information on Medicare ACOs, see: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html?redirect=/aco/.
3. The Partnership for Patients (PfP) is an initiative sponsored by the Centers for Medicare & Medicaid Services (CMS) to improve quality of care. One goal is a 20% reduction in hospital readmissions. To achieve this goal in New York, GNYHA and the Healthcare Association of New York State partnered to form NYS Partnership for Patients (NYSPFP), which serves as a hospital engagement network. More information about NYSPFP is available at: https://www.nyspfp.org/.
4. The Community-based Care Transitions Program, another CMS-sponsored initiative, tests models for improving patient transitions from the hospital to other settings to reduce hospital readmissions. See: http://innovation.cms.gov/initiatives/CCTP/.
5. NY–RAH is part of a CMS initiative to reduce avoidable hospitalizations for long-stay nursing home residents. See: http://innovation.cms.gov/initiatives/rahnfr/.

CASE STUDY METHODOLOGY

This qualitative research was conducted using a case study methodology, including 30 telephone and face-to-face interviews across 11 selected sites (five hospitals, six nursing homes). The study employed a convenience sampling technique. Although there was diversity in the size and geography of the organizations included in the study, there was no formalized stratification in the selected sample. In some cases, a particular site was selected because the hospital or nursing home had adopted an innovative approach to the patient discharge or transition process, or to managing hospital admissions and avoiding readmissions from nursing homes. Although the organizations selected to participate in the study were likely representative of hospital and skilled nursing providers in the New York City metropolitan area, these findings are specific to the organizations involved and may not be generalizable.

Because identifying variation in discharge planning and transitions processes across settings was an objective of the project, the non-directive, semi-structured interview research method was selected. Semi-structured interviews are designed to elicit focused responses based on the knowledge of each participant about the study topics. Although the interviews were guided by a protocol of key questions and common subjects (Appendix B), not all questions were addressed in every interview. The 30 participants differed in their perspectives on patient discharges and transitions to and from nursing homes, in part because of the varied positions they held in their organizations. Interview participants held a variety of positions in hospitals and nursing homes, including administration. Medical and nursing directors, social workers, and other clinical providers were interviewed. When possible, multiple interviews were conducted within each hospital or skilled nursing facility with staff who perform different roles and functions. An attempt was also made to interview similar staff at each hospital or skilled nursing facility participating in the project (e.g., a nurse manager in each organization, an administrator, etc.).

Each interview lasted approximately one hour, with group case studies lasting approximately two hours. For ease of discussion, the various nursing facilities will be referred to as "nursing homes" throughout this report.

ELEMENTS OF HIGH-QUALITY TRANSITIONS

The interview participants identified three key elements of high-quality transitions:

1. **Timely Feedback from the Patient's Care Team: Quality transitions require timely input from a variety of clinical and administrative staff working together to assist with discharge planning and transfer processes.**
   Interview participants noted that while there are predictable elements in the discharge planning and transition process, there are many points during the process where there is potential for disruption. For example, lack of an available bed or insurer authorization can delay a transfer. The complex array of workers within a hospital or nursing home, the structure of work schedules in health care organizations, and the administrative requirements of payers all affect the timeliness, appropriateness, and quality of patient transitions across settings.

2. **Effective and Meaningful Information Sharing: When nursing homes and hospitals exchange high-quality information with each other and with patients and families during transfers and episodes of care, the quality of transitions improves.**
   The interviews elicited important perspectives on problems related to having insufficient or incomplete information, or lacking an understanding of what information is needed, at a number of points during the patient's hospital stay, and

at transition to or from a nursing home. Quality information about the patient's health, social history, and usual presentation is essential for effective clinical decision making along the continuum of care. At the same time, to participate effectively in treatment and transition, patients and families must understand the patient's current condition and long-term prognosis, as well as available post-acute care options. Participants discussed some of the difficulties inherent in information transfer during transitions.

- Information obtained from a patient by a hospital or nursing home staff member that might affect discharge planning or care decisions is not always shared with other clinical and administrative staff at the patient's destination.
- Patients, families, and providers may have insufficient information about post-acute care options to make timely or well-informed decisions.
- A lack of available information or awareness of a patient's advance care directives affects decisions about medical interventions, particularly in the emergency room or during the night at nursing homes.
- Lack of information about palliative care options and lack of planning for end-of-life care results in inappropriate patient transfers from nursing homes to hospitals.
- Limited information about the clinical capabilities of specific nursing homes to meet the needs of medically complex patients can result in unnecessary disruption and readmissions.
- Lack of contact information for other provider organizations to facilitate discussion about a patient's history and current care creates delays and inefficiencies in the discharge or transition process.

A common theme among interview participants was the need to change the process of information transfer—typically a one-way transmission—to an interactive process that fosters information exchange. Interview participants suggested that a transition process guided by active communication exchange, also known as a "warm" hand-off, might improve outcomes and enhance collaborations across provider systems.

3. **Care Transition–Specific Roles That Interface Across Care Settings: Hospitals and nursing homes can use a variety of workforce-enabled strategies to improve outcomes for patients during and after patient transitions.**

   Some innovations include changing health workers' existing roles and responsibilities for patient transitions. Some organizations expressly have created new roles and responsibilities to improve transitions in care. These roles are described in greater detail in the next two sections, Workforce Innovations in Hospitals and Workforce Innovations in Nursing Homes. Organizations had different titles for staff who performed similar functions, so the following descriptions group titles with similar job responsibilities.

WORKFORCE INNOVATIONS IN HOSPITALS

Hospitals have created positions or strategically employed existing positions to improve care transitions between nursing homes and the community. This section summarizes how hospitals have used their workforce to address gaps.

Hospitalists as a Designated Clinical Contact for Nursing Homes

Some hospitals have identified a particular hospitalist physician to act as a designated clinical contact for nursing homes with high-volume admissions from the hospital. Clinical staff at the nursing home

have the hospitalist's direct contact information to ensure that problems arising during or after patient transitions are quickly resolved. This has improved the timeliness and appropriateness of communications related to patient clinical care across settings, and appears to have contributed to better patient management over the long term.

Nurse Case or Nurse Care Managers

Several hospitals have placed nurse case managers on designated units (e.g., a geriatric or cardiovascular care unit) to manage the care of patients with complex medical conditions and more complicated needs for post-discharge care. Hospitals have also used assessment criteria to determine which patients are at high risk for medical complications over the continuum of care (e.g., patients with multiple co-morbidities, multiple medications, and advanced age), and assigned nurse case managers to them based on individual patient acuity. The nurse case manager is the locus for communication and problem solving related to inpatient care and hospital discharge. Some of their responsibilities include coordinating care plans; ensuring that necessary testing occurs in a timely manner; communicating with physicians and others about changes in a patient's condition; and directing post-discharge planning. The use of nurse case managers is expected to improve the patient transition process and ultimately, outcomes from the episode of care.

Nursing Home Clinical Liaisons

Another strategy hospitals have used is to designate a clinical professional (e.g., nurse or physician assistant) in the Emergency Department (ED), or sometimes hospital-wide, as a liaison to nursing homes. These workers have titles such as clinical liaisons, care managers, nurse navigators, or nursing home liaisons, but all are responsible for coordinating care for all patients coming to the ED from a nursing home. The liaison receives the information transmitted by the nursing home with the patient, communicates with ED clinicians about the patient's condition and disposition, and facilitates real-time communications with nursing home staff and hospital clinical providers about the next steps in patient care. The nursing home liaison is knowledgeable about the clinical capabilities of all nursing homes in the geographic area and helps ED clinicians decide whether the patient's clinical needs can be met by the nursing home from which they came, rather than by admission or readmission to the hospital.

In some hospitals, the liaison helps answer nursing home clinicians' questions after a patient returns to the facility from the hospital, and provides assistance with follow-up appointments for those patients. The nursing home liaison facilitates access to laboratory and imaging test results, helps to communicate advance directive goals across settings, and facilitates conversations about palliative care. The liaison also facilitates educational opportunities for nursing home and hospital staff to convene and learn about specific clinical issues affecting common patients, and to review general problems with transitions among care settings.

Transition Nurse Coordinator Who Follows High-Risk Patients

A transition nurse coordinator follows high-risk patients as a case manager in the hospital and then after discharge. The nurse is responsible for coordinating the discharge to the community or another facility, and for post-discharge contact with the patient or the nursing home on a predetermined schedule to ascertain if appropriate follow-up care is being provided and if discharge instructions are implemented. The transition nurse interfaces with the patient in the community, or with the nurse or other personnel on the nursing home unit to determine if there are any questions or problems related to the patient's medical conditions that can be helped by hospital staff. The transition nurse also ascertains if care protocols suggested by hospital providers are being followed, such as special diets,

glucose monitoring, periodic weight checks, etc. In one hospital, the transition nurse follows the patient periodically and may even participate in planning for the patient's eventual discharge from the nursing home to the community.

Placement Coordinator to Help with Authorizations

One hospital created a placement coordinator position staffed by a social worker. The placement coordinator works closely with the primary social worker assigned to a patient, and is responsible for overseeing authorizations for post-acute care services, eliciting placements in post-acute care facilities, and coordinating all inputs to the discharge process. The position is recognized as an important resource system-wide. Staff at the hospital and nursing home consults the placement coordinator as needed during patient transitions. A care assistant supports the clerical components of the position (e.g., follow-up appointments), obtaining approvals for durable medical equipment, and managing discharge-related logistics.

WORKFORCE INNOVATIONS IN NURSING HOMES

Nursing homes recognize the critical roles of all staff in identifying early changes in residents that might signal emergent medical problems. Nursing homes are training different types of employees, including certified nursing assistants (CNAs), housekeeping staff, and food service staff, to use the "Stop and Watch" form from INTERACT (Interventions to Reduce Acute Care Transfers), a quality improvement program for long term care facilities that focuses on managing acute changes in resident conditions. In these nursing homes, any staff member can use the Stop and Watch form to alert a registered nurse of a possible change in a resident and to trigger a clinical assessment. Nursing homes have also created new positions or strategically employed existing positions to improve care transitions to and from hospitals. Some nursing homes have designated clinical or non-clinical staff to act as liaisons with hospitals during a patient's hospital discharge, or during a nursing home resident's admission to a hospital. The staff designated to fill these positions may vary, depending on whether the patient is incoming or outgoing.

Nursing Home Liaisons to Facilitate Care Transitions

In some nursing homes, a staff member may be involved with the admissions process and designated as an onsite evaluator or nursing home liaison to a hospital for patients in transition to post-acute care. In some nursing homes, there are multiple liaisons, with each assigned to manage admissions from a particular hospital or a set of hospitals. The liaisons manage communications between hospital and nursing home staff about patient admissions, act as clearinghouses for questions from staff within the nursing home, and as necessary, conduct visits to the hospital when the nursing home receives a request to admit complex patients. The liaison or evaluator reviews hospital medical records, talks with hospital staff caring for the patient, and occasionally meets the patient to determine if a nursing home can address the patient's post-acute care needs. An in-depth evaluation better ensures that a nursing home can furnish the required care. This is an important strategy to reduce rehospitalization that are due to incomplete information about complex needs when the admission is originally accepted. Liaisons and evaluators may visit the hospital daily to review patient records and to inform hospital staff regarding availability of beds.

Nurse Liaisons Who Serve as Advocates for Nursing Home Residents

Another strategy in nursing homes is to identify a liaison charged with advocating for and managing the transitions of nursing home residents being sent to hospitals for acute problems, diagnostic testing, or infusion therapies that a nursing home cannot

furnish. This position typically is filled by a nurse or a nurse practitioner. A nurse liaison coordinates the patient's transition to the hospital, as well as the patient's return to the nursing home. The nurse liaison also functions as an ambassador for the nursing home to help hospital staff understand the nursing home's clinical capabilities. The nurse liaison promotes care for the patient in the most appropriate setting relative to current or emergent needs.

Registered Nurse Care Coordinators to Assist in Training and Implementing Interventions

As part of a recently implemented Federal demonstration project, known as the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents (the local project is called New York–Reducing Avoidable Hospitalizations (NY–RAH) and coordinated through the GNYHA Foundation), 30 nursing homes in New York have a registered nurse care coordinator (RNCC) who assists with implementing evidence-based interventions to improve outcomes for long-stay nursing home residents at risk for hospitalization. The RNCC's role is to help the nursing home implement quality improvement initiatives, enhance care coordination and communication, and increase the number of patients with advance directives. While the RNCCs are placed in the nursing home with outside funding, they are integrated into the facility and work with existing staff to improve the quality of patient outcomes and find opportunities to reduce the number of avoidable hospitalizations.

Nurse Practitioners Trained in I-SNP Competencies

Some nursing homes have contracts with Medicare Advantage plans that insure dual eligible patients through institutional special needs plans (I-SNPs) and provide care coordination and primary care health services for nursing home residents. Other nursing homes have a nurse practitioner (NP) assigned to a particular unit within the facility caring for long term residents enrolled in an I-SNP. The presence of the NP enables immediate access to health care services for residents with complex, long-term medical needs. These NPs function not only as clinical staff, but also as educators who teach patients and families about their medical conditions and help other nursing home staff better understand care pathways as patients' conditions evolve.

The NP's presence permits unit staff to respond quickly to changes in patient status and provides patients and families with added support. Interview participants remarked that the NP's role is to bolster staff involvement with family members, provide ongoing education, increase the confidence of patients and families that needed care is available in the nursing home, and help patients and families build realistic expectations about an illness' or disability's outcomes.

Nursing Home Personnel Staffing a Dedicated Hot Line

One nursing home has a dedicated "hot line" so hospital personnel can reach nursing home clinical staff to ask questions about a nursing home resident who is transferred to the hospital. The hot line number is provided in the information transmitted to the hospital with the patient. Hospitals that receive frequent transfers from the nursing home have embraced the hot line as an efficient way to obtain patient information and reduce avoidable hospitalizations. Those who dial the hot line reach a cell phone carried by a nurse or other designated staff member during every shift, including on nights and weekends.

Training CNAs for Different Roles: Patient Care Technicians, "Concierges"

One nursing home has completed a training program to move some CNAs to roles as patient care technicians (PCTs). The PCTs work with nursing staff to monitor vital signs, draw blood, and perform EKGs. The PCTs may alert staff to subtle changes in patients with whom they regularly interface.

Another nursing home has trained two CNAs, each of whom is assigned to a particular sub-acute nursing home unit, to greet every new resident upon arrival from the hospital and to visit with the resident for at least five consecutive days. The CNA orients the resident to the facility and keeps the resident apprised of the planned schedule for therapy services. They rotate weekend and evening shifts to ensure full coverage. Interviewees reported that this strategy has improved residents' comfort level with the facility, and has improved the staff's knowledge of the resident. Getting to know new residents quickly was cited by many participants as important to reducing readmissions during the early stages of post-acute care.

EDUCATION AND TRAINING OPPORTUNITIES

Interview participants said the more the health care workforce knows about the transition process' goals, the more they can do to effect positive outcomes. Interviewees commented that a well-trained, knowledgeable workforce at all levels enables smooth transitions and enhances quality. They also emphasized the importance of training both "from the bottom up and from the top down" so that employees throughout the health care organization are learning from others within the organization.

The INTERACT quality improvement program in nursing homes, for example, encourages nursing homes to train all staff who interface with patients to recognize signs of concerning changes in residents and to report them for further evaluation. This includes clinical, non-clinical, therapeutic, rehabilitative, and administrative staff, as well as engineering, nutrition, housekeeping, and security staff who interact with residents. Staff education was cited as fundamental in efforts to reduce rates of avoidable hospitalization; interviewees frequently recommended more learning opportunities about the quality of care transitions and the impact of transitions on health outcomes.

Some health care organizations use educational and training initiatives to improve relationships between provider organizations and to increase the familiarity of professionals with the competencies of other health care organizations. One hospital hosts a yearly seminar to which they invite staff from the hospital and the nursing homes where hospital patients receive post-acute care. The program includes training on a clinical issue (e.g., treating a patient with diabetes, obesity, or congestive heart failure) common to patients in either setting. The seminar includes time for discussing how the hospital and nursing homes can better communicate with or respond to staff concerns about patient transitions.

Those who participated in the interviews suggested a number of areas that would benefit from additional staff training. Participants indicated that organizations should provide opportunities for continuous learning through in-person training or Web-based education in several subject areas. The table on page 12 lists training initiatives interviewees suggested, as well as the type of staff person who could benefit from each.

Suggested Training Initiatives for Hospital and Nursing Home Staff

SUGGESTED TRAINING INITIATIVES	PHYSICIANS	NPs, PAs	RESIDENTS/ MEDICAL STUDENTS	NURSING STAFF	CNAs	SOCIAL WORKERS	ADMINISTRATIVE PERSONNEL	THERAPY REHABILITATION STAFF	NUTRITION STAFF
To Increase Competency in Palliative Care and End-of-Life Planning Tools									
Advance directives, including the differences between each (e.g., DNH, DNR, DNI, DNT)	✓	✓	✓	✓		✓	✓		
Communication skills to discuss end-of-life care with patients and families	✓	✓	✓	✓		✓	✓		
To Increase Competency in Managing Chronic or Debilitating Illnesses									
Managing escalating behaviors in dementia patients				✓	✓			✓	
Clinical management of chronic diseases (e.g., diabetes, heart failure, stroke)				✓	✓	✓		✓	
Importance of immunizations (e.g., influenza, pneumonia)				✓					
Signs and symptoms of chronic illness exacerbation (e.g., signs of heart failure, vascular impairment)				✓	✓	✓	✓	✓	✓
NIH Stroke Scale Certification education				✓					
Importance of healthful behaviors, like dietary and medication compliance, and the importance of monitoring indicators of disease progression like weight, glucose levels, or swelling in the extremities			✓	✓	✓	✓		✓	✓
Treating and managing diseases (e.g., CHF or pneumonia)		✓		✓					
To Increase Competency with Various Processes Intended to Reduce Avoidable Hospitalizations									
Root causes of readmission	✓	✓	✓	✓		✓	✓		
The discharge process, including hospital staff roles and functions, and variation in patients' access to post-discharge care	✓	✓	✓			✓	✓		
Essential elements of a nursing report and how to give a good report to other clinical providers				✓					
How to construct a robust and concise discharge summary	✓	✓	✓	✓		✓	✓		

APPENDIX A.
Issues in Care Transitions, Suggested Interventions, and Self-Assessment

Throughout the interviews, participants offered feedback on barriers to quality transitions, along with strategies to address those barriers.

The table below lists barriers to successful transitions and suggested interventions for hospitals and nursing homes. The barriers and interventions described are a distillation of this report's themes.

The problems cited are paraphrased from comments of the interview participants. The suggested interventions also were mentioned by participants as strategies to improve the quality of care transitions.

Issues in Care Transitions and Suggested Interventions for Hospitals and Nursing Homes

This table summarizes issues in care transitions and suggested interventions for hospitals and nursing homes. The columns labeled "Hospital" and "Nursing Home" on the right indicates whether the suggested intervention is specific to a hospital or nursing home. The table can be used as an assessment for a facility, and the rightmost column, labeled "Your Facility" can be used as a checkbox for a facility to evaluate whether these interventions are in place.

ISSUE AND SUGGESTED INTERVENTIONS	HOSPITAL	NURSING HOME	YOUR FACILITY
ISSUE #1 : Gaps in Communication and Information Exchange Across Care Settings			
Build relationships within and across care settings.			
Set up regular meetings with hospital and nursing home representatives to discuss ways to reduce readmissions and avoidable hospitalizations.	✓		
Annually convene nursing home and hospital staff at a joint event that provides training in a clinical topic of mutual interest and to discuss ways to improve the patient transfer process.	✓	✓	
Ensure all workers feel comfortable problem-solving at different levels within the organization's reporting structures and across care settings.	✓	✓	
Develop a system for communicating across care settings.			
Create contact lists so providers know who to call when a question arises; strategically place lists throughout the hospital and nursing home (e.g., on nursing units, admissions office, the discharge planning office, the social work department, and in the ED).	✓	✓	
Create a process map that delineates who to call at a hospital or nursing home when a question arises. Designate clinical staff as direct contacts for nursing homes (see pages 7–11 for more information on these types of staff).	✓	✓	
Establish a hot line for nursing home or hospital staff to call at any time to obtain information or answer questions about a patient. The hot line could reach a cell phone assigned to designated staff 24/7.	✓	✓	

ISSUE AND SUGGESTED INTERVENTIONS	HOSPITAL	NURSING HOME	YOUR FACILITY
Initiate post-discharge outreach soon after the patient is discharged, such as a social worker calling the nursing home the day after a patient is transferred to check in. If needed, the social worker could connect a nursing home clinician with appropriate hospital clinical staff to answer any questions.	✓	✓	
Encourage a "warm" handoff between hospital clinical staff and nursing home staff to verbally communicate via phone to discuss the care provided and the patient's disposition post-treatment.	✓	✓	
Maximize the use of technology to facilitate information sharing.			
Use electronic health records and interoperable systems to facilitate transfer of electronic information between providers.	✓	✓	
Use Web-based platforms that use MDS data to provide information to improve quality and manage risk.		✓	
Ensure forms are easily accessible, reflect current information, and clearly delineate key information about managing a patient's care.			
Regularly review and assess forms for their utility in sharing information. Forms should include critical information such as: • Hospital or Nursing Home staff contact information • Key patient information (e.g., language, family contacts, immunizations, medical history, advance directives) • Lab tests, medications, and medication administration history • Discharge disposition (e.g., diagnosis, mental status, behavior, skin integrity, pain status, vital signs, respiratory status) • Special needs (e.g., wound and ostomy care, catheters, pic lines, diet, follow up needs) and medical or assistive devices • Current assessment and recommendations for subsequent care • Copies of social work notes that contain patient's demographic and psychosocial information • Appropriate directions for patients with special needs (e.g., a tracheotomy tube)	✓	✓	
Make sure the PRI is accurate and as complete as possible, as it provides nursing homes important information that affects its decision about its capacity to meet patient need. Create a protocol to consistently assign nurses or other staff from the nursing home admissions department to particular hospitals to review PRIs coming from those hospitals and ease patient transitions.	✓		
ISSUE #2: Managing patient, family, and caregiver expectations with respect to a patient's medical condition and potential outcomes.			
Ensure staff are equipped to have difficult conversations with patients, families, and caregivers.			
Offer training in discussing the management of terminal diagnoses and communicating the importance of advance directives, end-of-life care, naming health care proxies, the "Do Not Hospitalize" option, and their impact on quality of life and care trajectories.	✓	✓	
Create an infrastructure and protocols that supports advance care planning.			
Encourage attending physicians to initiate conversations about palliation and hospice care with patients and families prior to a patient being discharged from the hospital.	✓	✓	
Begin discharge discussions early (e.g., when a patient is first admitted) in building a care plan; include multidisciplinary input so that the staff and patient have a common understanding of the goals of care.	✓	✓	

ISSUE AND SUGGESTED INTERVENTIONS	HOSPITAL	NURSING HOME	YOUR FACILITY
Consult the in-house or on-call palliative care team to meet with patients who may need advance care planning or end-of-life care, especially after an admission for a major medical event, after repeated readmissions, or when the medical prognosis suggests the need for end-of-life planning or compassionate care.		✓	
When a patient arrives in the nursing home, discuss the patient's wishes regarding possible medical interventions and hospitalizations related to the patient's long-term prognosis.		✓	
Use stickers on the resident's chart to indicate he or she is a "comfort care" resident who prefers not to be hospitalized. This will remind the staff of the patient's wishes when there is an emergent medical problem.		✓	
Appropriately document patient's wishes			
Use the MOLST (Medical Orders for Life Sustaining Treatment) form to convey patients' wishes to all clinical providers. Ensure that the form is transported with the patient across health care settings.	✓	✓	
Be clear in transfer paperwork that a patient is or may be a candidate for palliative care or a consultation for end-of-life planning.	✓	✓	
ISSUE #3 Misperceptions between hospitals and nursing home regarding a patients' care trajectory when a patient is transferred.			
Build awareness and educate hospital staff on nursing home capabilities.			
Encourage hospital staff (especially ED clinical staff) to conduct site visits of nursing homes, and nursing homes to visit EDs.	✓	✓	
Encourage collaborations between nursing homes and hospitals to identify what services might be performed in the ED or scheduled in outpatient settings so nursing home residents could be returned to the nursing home after a hospital treatment or intervention, instead of being admitted to the hospital (e.g., change in PEG tube, blood transfusion, treatment for hypoglycemia, etc.).	✓	✓	
Regularly survey nursing homes in the hospital catchment area to ask about changes in clinical services available to patients and to update insurance participation information. Disseminate information to all hospital units.	✓		
ISSUE #4 Resolving delays in the hospital discharge process.			
Create processes and protocols that enable staff to plan ahead for discharge.			
Use nurse care managers to ensure timely completion of required medical approvals, discharge documents, and testing.	✓		
Schedule pre-discharge testing to ensure as little testing as possible occurs on the day scheduled for discharge or transfer.	✓		
Complete authorizations for weekend discharges by close of business on Fridays.	✓		
Train multiple evaluators to expedite PRI completion.	✓		
When possible, encourage physicians to authorize discharges as early in the day as possible.	✓		

ISSUE AND SUGGESTED INTERVENTIONS	HOSPITAL	NURSING HOME	YOUR FACILITY
Build relationships with external parties critical to the discharge process.			
Reach out to external parties (e.g., insurance companies and transportation providers) to better understand their workflow and determine ways to expedite approvals necessary to complete patient discharges.	✓	✓	
ISSUE #5 Understanding causes for readmissions to prevent them in the future.			
Analyze readmission cases to learn ways they could have been avoided.			
Perform a root cause analysis (RCA) to identify ways readmissions could have been prevented. RCA tools include: • GNYHA RCA Book • The New York State Preventable Readmission Interview Tools • The Modified Morisky Scale • The Yale-New Haven Hospital Center for Outcomes Research Outcomes Readmission Risk Calculator	✓	✓	
Discuss the possible reasons for a hospital readmission or resident's admission to a hospital during multidisciplinary rounds that include all members of the care team. Have the discussion on the morning after the patient admission.	✓	✓	
Use retrospective chart reviews to identify missed opportunities to intervene in the course of an illness.	✓	✓	
Use other evaluation tools, (e.g., INTERACT QI Tool and Transfer Log) to track and evaluate resident transfers to hospital. Use an electronic risk assessment tool to generate care alerts and help hospital staff understand a patient's risk or exposure of readmission.	✓	✓	
ISSUE #6 Lack of formal education on effective and high-quality care transitions.			
Ensure staff are educated on the facets of high-quality care transitions.			
Integrate staff education into daily routines, such as multidisciplinary rounds.	✓	✓	
Provide in-service training in clinical pathways for treating high-risk diagnoses and managing chronic disease.	✓	✓	
Provide training to improve communication and enable upstream and downstream communication to report on a patient's status.	✓	✓	
Train nursing home staff on caring for patients with special needs (e.g., care of pic lines, IV Lasix, and outpatient infusions).		✓	
Identify appropriate clinical protocols and educate staff to use them.	✓	✓	
Provide direct care staff with ongoing education about disease-specific issues.	✓	✓	
Train direct care staff to document changes in a resident (e.g., INTERACT's Stop and Watch form).	✓		
Train staff on how to effectively report a patient's status (e.g. the INTERACT Situation, Background, Assessment, Request [SBAR] form).	✓	✓	
ISSUE #7 Missing early warning signs in a resident's change in medical condition or mental health status, resulting in a hospital admission or readmission.			
Encourage communication between providers as soon as possible.			
Have a clinical meeting about each new admission as soon as possible after transfer.		✓	

ISSUE AND SUGGESTED INTERVENTIONS	HOSPITAL	NURSING HOME	YOUR FACILITY
Ensure a physician interfaces with patient as soon as possible following admission to the nursing home.		✓	
Coordinate with the hospital's laboratory to facilitate timely results reporting and enable a timely intervention in the nursing home.		✓	
Equip all staff, including direct care staff, housekeeping, and engineering with the skills necessary to identify early warning signs.			
Use INTERACT Stop and Watch or the American Medical Directors Association's (AMDA) Acute Change of Condition forms.		✓	
Use a staffing model that consistently assigns CNAs to the same unit when possible.		✓	
Train CNAs as Personal Care Attendants (PCAs) to do blood pressure checks, obtain laboratory test samples, and do glucose testing. The PCAs will come to know a patients' usual presentation and recognize changes in health status.		✓	
Use NPs on nursing home units to improve care coordination, particularly those units with high-intensity patients. The presence of an NP enables earlier identification of problems, and an improved likelihood of appropriate care in the appropriate place.		✓	
Identify the need to transfer a resident to the hospital early enough so it can be scheduled and the resident can return to the hospital from which he or she was discharged.		✓	
ISSUE #8 Medication Reconciliation and differences between hospital and nursing home formularies.			
Include a pharmacist in the discharge planning and transfer process.			
Work with the pharmacist in medication reconciliation activities to ensure that every patient is given equivalent dosing and appropriate substitutions, when necessary.	✓	✓	
Reconcile differences in hospital and nursing home formularies to avoid unnecessary or inappropriate medication.	✓	✓	
Provide clear medication dose instructions.			
When preparing transfer instructions, include the time that the next dose of medicine should be taken.	✓	✓	
ISSUE #9 Managing patients, family, and caregivers' expectations of nursing home capabilities.			
Educate and orient patients, family, and caregivers to the facility soon after their arrival.			
Meet with patients and families as soon after admission as possible to discuss care plans and expected outcomes.		✓	
Include information in the facility's welcome packet on available clinical services and why hospitalizations may be counterproductive.		✓	
Establish a "concierge" program in which each new nursing home resident is greeted by a CNA and oriented to the nursing facility.		✓	
Continuously provide feedback to patients, family, and caregivers throughout a patient's stay.			
Use cluster assignments for staffing nursing home units so that the residents see the same nurses and aides every day.		✓	
Ensure that staff provides patients, family, and caregivers with ongoing updates about a patient's condition; encourage patient feedback.		✓	

APPENDIX B.
Hospital and Nursing Home Interview Guides

The following are the protocols that guided the hospital and nursing home interviews.

Workforce Strategies to Improve Care Coordination between Hospitals and Nursing Homes
Hospital Interview Guide

Introduction

The Center for Health Workforce Studies at the University at Albany School of Public Health is working with the Greater New York Hospital Association to conduct a study in the metropolitan New York region to understand and identify effective workforce strategies that can improve care coordination between facilities and reduce readmissions to hospitals; workforce training needs to improve care coordination between hospitals and nursing homes; and best practices in reducing hospital readmissions from nursing homes. This initiative is funded by the New York Community Trust.

This case study includes a series of individual and group interviews of multiple stakeholders in hospitals and nursing homes. Information provided during the interviews is confidential. Interviewees will not be identified by name in the final report, although the name of the hospital or nursing home and any benchmark programs will be listed with other participating organizations to describe the diversity of organizations participating in the research. The report of the research will discuss system design innovation, process change, and innovative use of hospital staff and nursing home personnel to effect reductions in the rate of readmissions to a hospital after an acute episode of care.

Interview Guide

1. Please tell me about your role in the hospital. Is this role unique, or are there others in the hospital who perform identical or similar roles?

2. We are interested in understanding in detail the patient discharge process to nursing homes. Please describe that process with special emphasis on the staff who is involved in each step. Begin by telling me about the initial conversation with the patient or family about the need for transition to a nursing home, how a nursing home is selected, and ending with the process to arrange transfer to a nursing home, describing which staff are involved in each part of the process.

3. What works well in the current discharge process? What challenges or barriers impede the process?

4. What changes in staff roles and responsibilities, in communication or authorization channels, or in current hospital policy would improve the discharge process?

5. Tell me about the patient transition process to a nursing home. Please describe the nursing home staff you work with at the hospital, their responsibilities in accomplishing patient transfers, and how information is shared between the hospital and nursing home.

6. Please list the top 10 nursing homes to which you discharge the most patients. Do certain facilities have higher rates of readmissions than others?

7. Are you or other staff members notified when a patient who has been discharged to a nursing home from your facility is readmitted to your hospital within 30 days? Other hospitals?

8. Are there any ED interventions at your facility targeted at reducing readmissions through the ED?

9. What happens at your facility when a patient is readmitted?

10. What types of data do you and your staff have available regarding readmissions? (Prompts: does your hospital use readmissions data to understand the root causes of each readmission? Is this data shared with the staff? If so, how is it used to inform and impact staff behavior?)

11. What are the readmission reduction initiatives at your hospital? Please describe these initiatives and how they relate to staff's job responsibilities.

12. What education or training programs targeted to reduce hospital readmissions or improve care coordination are available to staff? If none, is there a need for extra training to help staff with changes in the discharge process related to initiatives to reduce readmissions?

Workforce Strategies To Improve Care Coordination Between Hospitals And Nursing Homes

Nursing Home Interview Guide

Introduction

The Center for Health Workforce Studies at the University at Albany School of Public Health is working with the Greater New York Hospital Association and Continuing Care Leadership Coalition (CCLC) to conduct a study in the metropolitan New York region to understand and identify effective workforce strategies that can improve care coordination between facilities and reduce readmissions to hospitals; workforce training needs to improve care coordination between hospitals and nursing homes; and best practices in reducing hospital readmissions from nursing homes. This initiative is funded by the New York Community Trust.

This case study includes a series of individual and group interviews of multiple stakeholders in hospitals and nursing homes. Information provided during the interviews is confidential. Interviewees will not be identified by name in the final report, although the name of the hospital or nursing home and any benchmark programs will be listed with other participating organizations to describe the diversity of organizations participating in the research. The report of the research will discuss system design innovation, process change, and innovative use of

hospital staff and nursing home personnel to effect reductions in the rate of readmissions to a hospital after an acute episode of care.

Interview Guide

1. Please tell me about your role in the nursing home. Is this role unique or are there others in the nursing home who perform identical or similar roles?

2. We are interested in understanding in detail the patient admission process to nursing homes, especially the roles of nursing home staff. Please begin by telling me about the initial contact with a hospital requesting a patient be transferred to your facility and ending with the patient's admission to your facility. Please describe which staff is involved at each point. Is there sufficient information to provide care to the patient? Is the information in an easy to understand format? How does information vary across the hospitals that you work with?

3. What information from the hospital is shared with the nursing home upon admission to the facility?

4. What works well in the current admission and transition process? What challenges or barriers impede the process?

5. What changes in nursing home staff roles and responsibilities, in communication or authorization channels, or in current policy would improve the transition process from the hospital to the nursing home? On the flip side, what changes in hospital staff roles and responsibilities would improve the transition process from the hospital to the nursing home?

6. Please describe the staff you work with at the hospital, their responsibilities in accomplishing patient transfers, and how information is shared between the hospital and nursing home. Are there any established communication channels with any discharging hospital that are especially helpful to the patient transfer process?

7. How is the decision to transfer a nursing home resident to a hospital reached? What are the roles of nursing home staff at each point in the transfer process to a hospital?

8. How is information about the patient who is being transferred from the nursing home shared with the hospital? What information is shared from your facility with the hospital? Does the nursing home communicate with the hospital ED or attending physician about the patient, or with the inpatient unit from which the patient was previously discharged? Are there communication barriers that, if addressed, would improve the patient transfer process?

9. Do any nursing home staff follow up with the patient while in the hospital?

10. Are there special initiatives at your facility to reduce preventable hospital admissions and readmissions? Have any particular problems been identified that contribute to readmissions?

11. Does the nursing home participate in any formal care transition program focused on reducing unnecessary transfers between hospitals and nursing homes (e.g., NY–RAH, Community-Based Care Transitions Program, The INTERACT Program, etc.)?

12. What education or training programs are available to nursing home staff to help improve care coordination and prevent avoidable hospital admissions or readmissions? What additional training would be helpful to staff?

13. Is there other staff within the nursing home who have insights about the patient admission and transition processes that might be willing to be interviewed for this project?

14. Are there any concerns about the patient admission to a nursing home, transition between facilities, or transfer processes that were not addressed in this interview that you would like to discuss?

APPENDIX C.
Interview Participants

The researchers are grateful to the interview participants from the following hospitals and nursing homes who provided their insights about avoidable hospitalizations and recommended strategies to more effectively manage patient transitions.

HOSPITALS

Jacobi Medical Center
Bronx, New York

North Central Bronx Hospital
Bronx, New York

John T. Mather Memorial Hospital
Port Jefferson, New York

Lutheran Medical Center
Brooklyn, New York

Maimonides Medical Center
Brooklyn, New York

Mt. Sinai Roosevelt Hospital
New York, New York

Mt. Sinai St. Luke's Hospital
New York, New York

NURSING HOMES

Amsterdam Nursing Home
New York, New York

Gurwin Jewish Nursing and Rehabilitation Center
Commack, New York

Isabella Geriatric Center
New York, New York

Lutheran Augustana Center for Extended Care and Rehabilitation
Brooklyn, New York

Parker Jewish Institute
New Hyde Park, New York

St. James Rehabilitation and Healthcare Center
St. James, New York

ABOUT CHWS

The Center for Health Workforce Studies is a not-for-profit research organization whose mission is to provide timely, accurate data and conduct policy-relevant research about the health workforce. The Center's work assists health, professional, and education organizations; policy makers and planners; and other stakeholders to understand issues related to the supply, demand, distribution, and use of health workers.

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