



Skilled Nursing Facility and Rehabilitation Hospital Change Package

Provider Name: _____ Date: _____

Provider Number: _____ Name of Provider Contact Person: _____

Please Check One or More	Interventions	Targeted Population (Ex: Heart Failure, PN, or AMI Patients)	Planned Start Date	Actual Start Date
1. Patient/Family Education				
	1a. Promote the use of a Personal Health Record (PHR); give the patient a PHR and instructions for use.			
	1b. Promote resident- and family-focused care; include the resident and family in the development of a Plan of Care and in the subsequent updating of the Plan of Care.			
	1c. Educate families in the importance of improving care transitions between provider settings and the community-wide CT Initiative.			
	1d. Educate residents/families re: LTC care options, such as “Do Not Hospitalize, Palliative Care and/or Hospice Care.”			
	1e. Educate residents and families on progressive stages of chronic disease and care options available in the facility for the treatment of the exacerbations of chronic diseases.			
	1f. Involve facility’s resident counsel in expanding family education, as noted.			
2. Advance Care Planning				
	2a. Expand Comfort Care Services to institute a Palliative Care Program.			
	2b. Educate residents/families on care options available in the facility for exacerbation of chronic illness.			



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	2c. Educate residents/families re: LTC care options, such as “Do Not Hospitalize, Palliative Care and/or Hospice Care; Increase Percentage of Residents with Advance Directives.”			
	2d. Encourage staff to assist residents and families in advance care planning.			
3. Multidisciplinary Staff Education				
	3a. Introduce all staff to Care Transitions.			
	3b. Educate clinicians on the identification of residents at risk of re-hospitalization; implement a hospital risk assessment (HRA) tool.			
	3c. Introduce INTERACT; implement tools such as Early Warning Assessment and Early Warning Report.			
	3d. Provide skills update for nurses; utilize Polish Your Practice Series of educational programs for HF and other chronic diseases.			
	3e. Develop disease management care paths/protocols.			
4. Discharge Planning (usually from subacute services)				
	4a. Promote the use of a PHR; give the patient a PHR and instructions for use.			
	4b. Educate patient and family on self-care management.			
	4c. Educate patient and family on emergency care planning or “red flags.”			
	4d. Reinforce education to patient and family regarding post NH care; include “Teach Back” to assess patient’s/family’s understanding of information and instructions.			
	4e. Assess patient’s and family’s ability to manage oral medications and support medication reconciliation and simplification prior to discharge, and include medication list for patient/family and PCP at discharge.			

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5. Physician and Cross-provider Education				
	5a. Educate physicians and other providers re: LTC and subacute care services, criteria for admission to SNF, as well as opportunities, barriers, concerns, and commonalities.			
	5b. Educate and promote utilization of evidence-based communication tools such as SBAR.			
6. Patient- and Family-centered Handover Communication				
	6a. Promote effective communication channels with other care providers. <ul style="list-style-type: none"> • Provide transfer of customized, real-time critical information about the patient to other care providers (e.g., ED staff, hospital staff, home care staff, hospice staff) • Request timely information about the patient from other care providers (e.g., medications [including immunization status], laboratory results, advance care planning information) • Revise communication processes to encourage one-one, clinician-clinician discussion of information 			
7. SNF Quality Improvement				
	7a. Implement use of INTERACT tool kit and the Unplanned Transfer Review Tool. Both are interventions designed to reduce acute care transfers among nursing home residents and can be found at www.qualitynet.org . Click on the MedQIC tab and type “INTERACT” in the search box.			
	7b. Review QI process and team participation in supporting facility and staff in implementation of selected CT interventions.			
	7c. Review and revise (as needed) the facility’s process of monitoring the implementation of best practices. <ul style="list-style-type: none"> • Utilize a Best Practice Monitoring Tool (BPMT) or standard tracking form 			

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8. Other Facility-chosen Interventions				