Pre-Admission, Admission and Discharge Clinical Best Practices for Skilled Nursing Facilities

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Introduction

When it comes to enhancing outcomes for individuals who are being admitted, cared for and ultimately discharged from skilled nursing facilities (SNFs), continuity of care is paramount for everyone involved.

First and foremost, continuity helps to ensure that residents receive the proper care in your facility as soon as they enter based on their unique circumstances. It also provides caregivers comprehensive and accurate information when it's time to discharge the resident—either to their home, another SNF, an acute-care hospital or, in some cases, an emergency room. And from the standpoint of your SNF, it helps you maintain Quality Measures at desirable levels, avoid costly penalties, function at optimal efficiency and build a winning culture for employees and residents alike.

Transition of care and continuity of care truly go hand in hand. Now, with the patient-driven payment model (PDPM), it's more important than ever to optimize continuity of care in all of your facility's transitional policies and processes. This e-book is designed to help you do just that. In it, we cover best practices for SNFs in relation to pre-admission, admission and discharge functions. It is organized in three chapters:

Chapter 1 – Pre-Admission Best Practices

Chapter 2 – Admission Best Practices

Chapter 3 – Discharge Best Practices

Conclusion and Resources

We hope you find this information useful as you think through your SNF's approach to care transitions. Richter's Consulting Team is always eager to answer your questions or discuss ways in which we can help your organization optimize continuity of care. We have included our contact information in the Conclusion.

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CHAPTER 1

Pre-Admission Best Practices

Best practice #1: Establish a framework to help you and your team effectively understand and quantify how patient outcomes and cost of care relate to one another for each potential resident.

As we said in our Introduction, continuity of care is essential—and with PDPM, it's even more so. Why? Because reimbursement under PDPM is intended to more accurately reflect the utilization of SNF resources over the course of the resident stay.

In the past, facilities were compensated based on the number of minutes of therapy that were used, as well as the types of therapy administered. With PDPM, facilities are no longer paid according to the amount of therapy services provided. Instead, they must assess a multitude of patient characteristics in order to understand how much they will be paid. This means basing payments on specific resident diagnoses and asking questions such as:

- What will this resident really need in our facility?
- What are the comorbidities we will have to face?
- How much will it cost us?
- Is it cost-effective to bring this person into our facility? Can we meet the resident's needs?

When SNFs are contacted about potentially admitting a patient, policies and processes must govern how decisions are made. These are big decisions for a SNF—and usually, they must be made in very short order…sometimes as quickly as 15 minutes from the initial referral. Therefore, prior to admitting any resident into your facility, you and your team should call upon written policies and procedures to help answer these and other questions and make pre-admission decisions that serve your facility and its residents well. Equally important, those policies and procedures should delineate specific responsibilities for each team member in the pre-admission process.

Whether circumstances are relatively normal or unusually complex, lots of important issues must be addressed:

- Who is responsible for evaluating the merits of the potential resident's admission?
- What will that evaluation be based on?

- When and where will it occur?
- How will that potential resident's information be obtained from an acute-care hospital or other health care provider? Electronically? Via paper records?
- How will you respond if potential residents or their loved ones choose your SNF, and through your process, it's determined that the fit isn't sufficient for either party? Certainly, a primary goal of any SNF is to fill beds; but sometimes, it's actually more cost-effective for an SNF to maintain an empty bed than to serve a resident whose needs can't be met sufficiently or profitably.

Woven into all of this is technology. When properly leveraged, technology can help optimize your pre-admission processes at every turn. Yet, when it's misunderstood, underutilized or not utilized at all, your facility will face an uphill climb in streamlining pre-admission processes in the age of PDPM.

At Richter, we highly recommend conducting a thorough and honest assessment of your current technology, as well as your facility's use of it. Do you have referral management software, and do you use it effectively? Does your software integrate with eReferral platforms? What are your paper processes, or do you use an electronic health record (EHR) solution exclusively? Are you analyzing all of the available information, or do you have other software that can enable you to flow pre-admission analyses of a potential patient through to the individual's actual admission?

As you can see, there are many questions and issues to be addressed at the outset of establishing a sound pre-admission process. Once you begin to get answers, you'll be better equipped to undertake our second pre-admission best practice…

Best practice #2: Establish comprehensive referral information requirements.

In order to admit an acute-care hospital or emergency room patient, a SNF must receive certain information from that provider. Yet all too often, that information transfer does not occur. Sometimes, SNFs receive hospital patients at their doorstep with no paperwork, or paperwork that is signed and dated but contains little or no medical information.

As a result, the SNF must now care for a resident with no background, diagnosis or qualitative information to guide that care. Even so, sending the patient back to the hospital can negatively impact Quality Measures, so the SNF faces a lose-lose proposition.

With PDPM, getting detailed patient information is a must for SNFs—and communication and collaboration among providers is the best strategy to make it happen. At a minimum, it's critical to obtain primary diagnosis and surgical information for the last 30 days. To obtain these and all other pertinent information from outside providers, it's important for pre-admission personnel to clarify and communicate specific criteria with your admission and acute staff members, including:

- Any additional information that will be needed from acute care to complete the minimum data set (MDS)
- Strategies to utilize EHR information to maximize reimbursement under the PDPM model

- A determination of whether the acute-care facility has packaged the appropriate clinical information in their referrals to conform with a SNF's pre-admission process/procedural criteria

Certainly, this best practice is in the best interests of your SNF. But hospitals now face fines for failing to provide required documentation to SNFs – upwards of $1 million per incident – so communicating and collaborating on this important area benefits them as well—not to mention residents who rely on your facility for proper care.

SNFs simply cannot undertake all this in a vacuum. They must build and nurture relationships with case managers and discharge planners at acute-care hospitals and other health care provider institutions, which leads to our third best practice…

Best practice #3: Communicate in a time-sensitive and meaningful way with real people at referring institutions.

Whoever is charged with accepting a patient from another facility – ideally a nurse or case manager – should bear the responsibility of picking up the telephone and calling a designated peer (e.g., hospital charge nurse) at the referring facility for a brief nurse-to-nurse update on the client. This doesn't need to be a lengthy call, or rely heavily on details and jargon. It could be as straightforward as confirming the name of the patient, the diagnosis, other medical conditions of note, medication allergies and any personal or family-related information that could be helpful in making pre-admission, admission and/or discharge decisions.

To make this best practice a reality, your SNF should establish defined procedures for hand-off communications at the point of transition. These should include how communications occur; who participates; timing; and specific client information.

Even with great communication and collaboration, your SNF must sometimes make difficult decisions with regard to non-network provider referrals. What to do? Our next pre-admission best practice has the answer…

Best practice #4: Spell out your facility's pre-admission requirements in writing.

Do you know what portion of service to a given resident you'll be able to carve out for additional reimbursement? Are you certain of what services you will be paid for—and does that make it feasible for you to accept the resident? Would an insurance company be willing to provide a single case management agreement if your facility is out of network? These and other issues should be clearly articulated in your pre-admission policies.

If you've followed our best practice recommendations so far, you'll be well-positioned to make good pre-admission choices for your facility and potential residents. Once you make the decision to admit a resident, you'll want to follow our fifth and final pre-admission best practice…

Best practice #5: Strive for 100 percent continuity of care in each transition of care you touch.

In this regard, there are five key steps that help to make this possible:

1) Encouraging communication with key stakeholders in your facility
2) Taking ownership of the transfer/discharge process
3) Obtaining all the necessary information regarding care essentials and PDPM requirements
4) Managing care effectively during the resident's stay (including obtaining additional authorizations for their continued stay, if appropriate)
5) Faithfully executing a discharge plan that includes responsibly handing off information for the next level of care—be it a hospital, emergency room, another LTPAC facility, home health or hospice. Again, continuity of care is the goal.

KEY TAKEAWAYS AND ADDITIONAL POINTS:

- **Clear written policies and procedures help to ensure an efficient pre-admission process.** PDPM compels SNFs to carefully evaluate each potential admission with regard to payment and ability to provide effective service. Oversights and errors can negatively impact your facility's Quality Measures and profitability.
- **Evaluate your facility's technology capabilities thoroughly and honestly.** Do you have the right tools in place? Is your staff properly trained to use them—and do they trust them? Are you using those tools in ways that optimize efficiency and help ensure continuity of care during care transitions? The depth and breadth of today's LTPAC technology can be intimidating; but when properly utilized, it can super-charge your facility's efforts to streamline transitions and enhance patient outcomes.
- **PDPM impacts pre-admission screening criteria.** It's imperative to obtain the resident's primary diagnosis and any other active diagnosis information prior to admission. This includes identifying PDPM clinical categories and gathering data for the MDS Section GG functional items, as well as surgical history.
- **Communication is key.** Just as with admission and discharge, communication in the pre-admission stage is a crucial element in helping ensure continuity of care. Personal and meaningful communication between your staff and staff members at acute-care hospitals (or emergency rooms) is in the best interests of patients, your SNF and the referring institution.

In our next chapter, we'll highlight admission best practices.

CHAPTER 2

Admission Best Practices

Once your pre-admission team has done its due diligence on a potential resident and determined that admission is feasible and advisable, several admission-related best practices can help your SNF ensure a smooth process for residents and team members alike.

Best practice #1: Understand what your contract with insurance payers says.

You'd think this would be a no-brainer. But we've encountered lots of individuals in the SNF admissions realm who don't even know what contracts they have—let alone what's in them.

SNF clients have choices when it comes to which facility they seek admittance. Yet, insurance companies utilize preferred providers, and if your SNF isn't in their preferred provider network (PPN), residents may be liable for self-payment. It's up to specified individuals on your admissions team to understand the details of your contracts and be prepared to discuss implications with residents and/or their loved ones. Additionally, financial discussions with the resident and/or responsible party should be fully documented and signed off on.

We also recommend that the organization prepare a matrix of contracts and payer requirements for staff reference. Staff should have a clear understanding of what products are included in the contract and what services are covered. Documentation requirements should be discussed prior to admission to ensure that clinical documentation fully supports the claims. Payers may require multiple authorizations for specific services or carve-outs and staff must be knowledgeable about these requirements to avoid payment denials or recoupment.

Best practice #2: Empower designated clinical staff to make decisions.

Patient acuity and clinical screening are vitally important elements that help to determine payment under PDPM. Accordingly, we at Richter believe strongly in giving experienced clinical personnel – oftentimes a nurse liaison – the authority to manage the admissions process. This includes autonomy to make clinical decisions based on the appropriateness for admission—knowing what cases should and should not be

admissible under facility guidelines. Many experienced nurses have been "in the trenches" for years and understand these issues as well as anyone in a SNF. They should know the basic details of their contracts; be able to articulate the resident's and facility's needs to the insurer and/or hospital; understand the patient's acuity; negotiate carve-outs; and more. That's not to say this isn't a collaborative endeavor; but again, we believe clinical staff should have autonomy to make these key decisions.

Best practice #3: Get the correct diagnosis.

A diagnosis drives a patient's potential admission, as well as payment. Without the correct diagnosis, your facility could face significantly adverse circumstances—from underpayment to non-payment.

Primary and admitting diagnoses are often the same—*but not always*. The admission diagnosis for a given resident should be the condition that required the resident's admission to your facility, and the reason that individual needs care. The preceding hospital's principal diagnosis may not be the reason long-term care is needed. SNFs should assign after-care codes or a condition code with a seventh digit indicating subsequent care.

Best practice #4: Establish a clear division of labor.

Just as with pre-admission, each member of the admission team should have clear responsibilities for specific items and tasks. Take the example of a care plan…who is responsible for completing it? Who's responsible for the assessment? Is it the admitting nurse, or the next shift? For every resident, there must be a specific understanding of who owns what. If it's not currently included in your policies and procedures, we strongly encourage you to add it.

Best practice #5: Make sure your restorative nursing program and therapy department work collaboratively, and that restorative service begins on day one of the admission to keep the patient moving.

Prior to PDPM, it was customary for therapy personnel to spend time with a given resident for up to three hours per day. The resident likely would spend the day's remaining 21 hours in a wheelchair, or in bed. Joint and muscle stiffness naturally sets in under this scenario, so when therapy returns the next day, there's little progress being made. To rectify this, restorative personnel should work with residents during evenings and weekends. This can actually help to decrease the length of stay and enhance patient outcomes.

Best practice #6: Embrace the use of case management.

Today, case managers aren't as readily used in skilled nursing environments as we at Richter believe they should be. Most minimum data set (MDS) nurses currently are charged with completing a large number of assessments—upwards of nine in some cases. With PDPM now in place, that number has decreased to two (one of which is a discharge assessment). As that administrative burden has decreased, MDS coordinators generally have taken on more of a case management role—monitoring length of stay, barriers to discharge and assisting with discharge planning. This may be a somewhat different role than they're used to, but we believe it's a necessary evolution, and we encourage your SNF to facilitate it.

Best practice #7: Understand interrupted stay vs. readmission.

Interrupted stay is a new policy that was implemented at the same time as PDPM. It basically determines if your facility is required to undertake a new assessment for a given resident. If that resident's stay in your facility is interrupted for more than three consecutive midnights, you're required to perform a new assessment. If the patient is only gone for 24-48 hours, no new assessment is needed.

With regard to readmission, SNFs receive penalties every time they send a resident to a hospital or an emergency room. Hospitals also are penalized when patients are readmitted from their homes or a SNF. Therefore, we encourage your SNF to be proactive and establish routine check-ins with discharged residents. There may be an opportunity to avoid a rehospitalization if you are able to identify a decline or other post-discharge issue. For example, if you send someone home for 15 days, and they're not doing well, you could suggest to them or their loved ones that they return to your facility. You'll still have points deducted, but the penalty won't be as acute as it would be if they returned to the hospital or emergency room.

Best practice #8: Conduct SBAR assessments to minimize emergency room returns.

SBARs are thorough patient assessments conducted at SNFs in cases where there is a change in condition. They are conducted before contacting the resident's primary physician. Assuming there is adequate time to conduct it (i.e., no imminent medical condition such as a heart attack, stroke or severe bleeding), a typical SBAR includes a description of the patient's situation and background, as well as the treatment approach and physician response. Owing to their inclusive nature, SBARs compel nurses to compile all available data. This, in turn, provides physicians with information they need to determine whether treatment can be administered on-site at a SNF. In the absence of such data, many physicians simply send patients to an emergency room, which is an undesirable outcome for any SNF.

Best practice #9: Use root-cause analysis to analyze high rates of readmission.

Just as many young children pose the question *why* to appease curiosities far and wide, we encourage SNFs to take a similar approach to readmissions. Perhaps you're sending patients to the hospital. *Why is that?* Are some physicians making more hospital referrals than others? If so, *why?* Keep digging and asking *why* until patterns appear, or answers reveal themselves.

KEY TAKEAWAYS AND ADDITIONAL POINTS:

- **Capable and qualified clinical personnel should manage the admission process.** They should be given proper autonomy to make clinical decisions regarding appropriateness of admission.
- **Resident acuity and clinical screening are among the most important factors to consider in the admission process.**
- **Get the correct diagnosis.** The diagnosis drives a patient's potential admission, as well as payment. As we said in Best practice #3, primary and admitting diagnoses are often the same—but not always.
- **Hospital documentation should arrive with the resident.** If it doesn't, that could mean penalties for the referring hospital. Regardless, your staff should work to build relationships with key personnel at referring hospitals so that when documentation is missing, diagnosis codes are needed or other questions arise, answers are a phone call away.
- **Obtain the referring physician's certification within 72 hours of admission.**
- **Communication is key.** This applies to communication channels and processes within your facility, as well as communication with referring hospitals and emergency rooms. (By this time, it should be obvious that good communication underlies all care transition phases and enhances continuity of care.)

In our next chapter, we'll look at discharge best practices.

CHAPTER 3

Discharge Best Practices

Best practice #1: Get prepared early on.

It may surprise you to learn that optimal discharge practices begin before a resident is even admitted to your SNF. Facility personnel tasked with discharge responsibilities should try to learn as much as they can about that resident's situation from the outset. That entails gathering information about how that specific discharge will likely unfold. Will the resident return home? Does he/she even have a home to return to? What kind of equipment needs are there at that landing spot? Who is the resident's primary care giver and primary physician? Your discharge staff should have answers to these and other relevant questions before residents are even admitted into the facility. In a broader sense, you should avoid situations where individuals are admitted to your SNF and then discharged into unsafe circumstances.

Best practice #2: Establish ownership of discharge responsibilities, including oversight.

Who's responsible for what tasks and roles in the discharge process? How does discharge occur, and under what conditions? Your SNF's policies and procedures should provide clear answers.

Best practice #3: Communicate with PPNs around discharge to remain a preferred provider.

Communication with PPNs is key—and at no time is this truer than during discharge. If you're sending a resident home, let your PPN contacts know when that resident will be discharged, and how well that resident fared in your facility. Conversely, if it's necessary to send a resident back to the hospital, specified personnel should call the report to the acute-care nurse or case manager at that hospital.

Best practice #4: Be proactive in communicating with each resident post-discharge.

While this has long been an industry best practice, we've found that few SNFs actually follow it. Given the negative consequences of hospital readmission for everyone involved, post-discharge communication is a simple and effective step to help ensure continuity of care.

It’s not complicated. In fact, it can be as simple as a designated staff member calling a discharged resident within 48 hours of their discharge and just checking in. For example: “Ms. Jones, how’s it going? How are you doing at home? Have you received your medication? Has your home health person been out to see you?” Too often, medications and/or home health personnel don’t arrive at a discharged resident’s home, and that individual winds up in the hospital as a result. Basic communication can resolve problems early on, before they become serious.

Beyond the initial post-48-hour communication, we at Richter recommend that SNFs continue periodic follow-up with discharged residents for up to 30 days.

CONCLUSION

We hope this e-book has helped you understand best practices as they relate to pre-admission, admission and discharge at your SNF. With PDPM now firmly in place, we believe there's a prime opportunity to integrate these best practices for use in the years ahead. We also encourage you to carefully examine and evaluate policies and procedures in every facet of your SNF operations. Too many SNFs overlap staff responsibilities, which causes inefficiencies, as well as poor time management. Streamlining processes wherever possible can save time and money, boost efficiency and enhance patient outcomes.

When it comes to making your pre-admission, admission and discharge practices the best they can be, there's great value in leveraging experienced outside partners. Clinical consulting services from an industry leader can help you develop and implement proven processes and policies to promote clinical health today, and well into the future. Your mission is all about serving patients and residents and enhancing outcomes; clinical excellence makes this possible.

The team at Richter specializes in comprehensive clinical, financial and revenue cycle management services for LTPAC and senior living providers nationwide. Each member of our leadership team possesses more than 20 years of experience in the health care industry and offers specialized expertise in clinical consulting…

- We know the LTPAC landscape;
- We understand the challenges that LTPAC organizations like yours face;
- We develop and deploy customized clinical programs for LTPAC organizations like yours, including PDPM and QAPI training, PointClickCare® workflow training and more;
- We can establish monitoring points for each project over specified time periods and measure performance based on established goals;
- We are always available to answer questions, discuss issues or help you and your staff navigate complex clinical challenges.

If you'd like to learn more about our clinical consulting services and the approach we could recommend for your organization, please contact Jennifer Leatherbarrow, RN BSN, RAC-CT, IPCO, QCP, CIC, for a free, no-obligation consultation. You can also learn more about us by visiting www.richterhc.com.

ABOUT THE AUTHOR

Jennifer Leatherbarrow, RN, BSN, RAC-CT, IPCO, QCP, CIC

Manager of Clinical Consulting

In her role as Manager of Clinical Consulting Services for Richter, Jennifer helps clients gain efficiencies and knowledge in order to navigate through increasingly complex clinical compliance regulations. Jennifer has a long tenure in health care and skilled nursing, including over 20 years in the LTPAC sector, having served as a VP of Clinical Services, Corporate Reimbursement Nurse, DON, MDS Coordinator and Staff Development Coordinator.

Jennifer is a well-known and highly regarded state and national level speaker, trainer and author with a focus on LTPAC communities. She is also a regular contributor to the Richter ShareSource Resource page offering blogs and downloads on the most current topics in the LTPAC industry.

About Richter

Led by a CPA and staffed with a team of over 70 professionals, Richter serves the entire LTPAC spectrum—from small and midsize organizations through large, multi-facility, multi-state groups. Whatever your challenges may be, our trusted and experienced professionals listen, analyze, strategize, quantify, then devise and deploy customized solutions to *ENHANCE OUTCOMES* in every facet of your organization.

For more information on Richter, call us at (866) 806-0799 or visit richterhc.com.