DRAFT
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Transitions from the Hospital to Skilled Nursing Facilities
Process Steps, Best Practices and Tools

Plan to discharge patient to SNF

- Identify patient's discharge needs and discharge destination early.
- Tool - risk assessment tool.

Patient and care giver engagement

- Discuss plans and options with the patient and family.

Identify the SNF who can accept the patient

- Know the services provided by the SNFs in the community.
- Tool - INTERACT Nursing Facility Capabilities List.
- Provide patients and caregiver a list of agencies to choose from.

Documents for referral to SNF (Via fax or electronic referral system)

- ED and Inpatient progress notes
- Other relevant consults, therapy, palliative care/consult notes
- Medication list
- Contact details of clinician from the hospital

Obtain insurance approval

- Timely request for insurance authorization
- Timely approval for the insurance authorization

Complete verbal handover prior to patient transfer

- MD to MD or RN to RN
- Tool - Verbal warm handover guide

Send these documents prior to patient transfer

- PASRR (**NOT OPTIONAL**)
- H&P, progress notes, consults
- Transfer orders – must be signed by a physician within 72 hours of admit
- Discharge summary
- Reconciled medication list
- Contact details of clinician from the hospital

Schedule regular meeting with SNFs

- Identify the elements of the transfer that worked well and those did not
- Perform case studies and chart review if the patient is readmitted
- Tool – IHI diagnostic worksheet
- Discuss opportunities for improvement

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