Home to Stay

Nursing Home Standardized Discharge Process Collaborative

Handbook

January 2016

Participant Name: _____

Quality Improvement Organizations

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Contacts at Qualis Health

In Idaho: **In Washington:**

System Leaders

Linda Rowe, MS
lindaro@qualishealth.org
208-383-5957

Selena Bolotin
selenab@qualishealth.org
206-288-2472

Subject Matter Experts

Traci Treasure, MS CPHQ LNHA
tracit@qualishealth.org
208-383-5947

Jeff West, MPH RN
jeffwe@qualishealth.org
206-288-2465

Aimee Ford, MS RN
aimeef@qualishealth.org
206-288-2567

Sharon Eloranta, MD
sharone@qualishealth.org
206-288-2474

Administrative Support

Paula Parsons
paulap@qualishealth.org
206-288-2470

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About This Handbook

The purpose of this *Handbook* is to help participants in Qualis Health's Home to Stay Collaborative make a successful start to an exciting year and a half of quality improvement work. While much of the content supports teams' early efforts, the *Handbook* will also serve as a reference for team members throughout the Collaborative and beyond.

- The **Introduction** sets the stage by providing background information on Collaboratives as well as a schedule of major events.
- The **Pre-Work Activities** section will walk your team step-by-step through preparing for the first learning session.
- A **Change Package** describes the evidence-based strategies that will be implemented by Collaborative participants.
- The **Measurement Strategy** section provides definitions and data sources for the measures to be collected as a means of tracking progress through the Collaborative.
- **References and Resources** and a **Discharge Checklist** are also included.

The goals of the Home to Stay Collaborative are:

1. *Each item on the Discharge Checklist will be completed for 90% of discharges to home, for three months running (Dec 2016- Feb 2017).*

2. *Each participating nursing home will achieve a 35% response rate for each of the CTM-3 items in the same time period.*

3. *Overall, participating teams will achieve 20% relative improvement in rehospitalizations of short-stay residents within 30 days of nursing home discharge to home.*

The Collaborative's population of focus is short-stay residents discharged to "home" (private residence with or without home care; assisted living; or adult family home).

Introduction

A "Collaborative" is a systematic, data-driven approach to healthcare quality improvement designed to accelerate learning and widespread implementation of best practices. Participants perform multiple, small, rapid tests of change then share their experiences.

The Institute for Healthcare Improvement (IHI) held the first Breakthrough Series Collaborative in 1996. Over the past 15 years, CMS and QIN-QIOs in every state have guided thousands of nursing homes through IHI-style Collaboratives focused on various clinical topics. The Home to Stay Collaborative brings together nursing home teams from across Idaho and Washington.

Timing and Structure

Our Collaborative is structured around "all teach – all learn" teleconferences, webinars, and in-person learning sessions. Teams will be notified as the dates, times, and locations are confirmed.

Jan – Feb 2016	Pre-Work
Boise: Feb 18 Seattle: Feb 22 9:00am – 4:30pm	Learning Session 1
Feb – Apr 2016	Action Period 1
May – July 2016	Learning Session 2 Action Period 2
Aug – Nov 2016	Learning Session 3 Action Period 3
Nov 2016 – Jan 2017	Learning Session 4 Action Period 4
Feb 2017	Outcomes Congress

Teams complete several important preparatory tasks during the **Pre-Work** phase. (Detailed instructions begin on the following page.)

Learning Sessions are the major interactive, in-person events of the Collaborative that emphasize an "all teach, all learn" culture. In each Learning Session, participants can expect to learn from faculty *and each other* about effective discharge practices, quality improvement methods, and real-world implementation techniques.

During the three-month **Action Periods**, teams work within their organizations to test changes. Teams share results of their efforts in quarterly reports and at learning sessions. All staff (not just those who attend the learning sessions) are encouraged to participate in the change work, as well as webinars, conference calls, and e-mail distribution lists.

At the **Outcomes Congress**, teams share findings and achievements. In-person celebration!

The Learning Sessions will be held at Qualis Health's offices:

Washington Group Plaza
720 E Park Boulevard
Boise, ID 83701

Northway West Building
10700 Meridian Ave N
Seattle, WA 98133

Pre-Work Activities

This section includes a checklist, instructions, and documentation worksheets. Each team is expected to complete the pre-work activities prior to Learning Session 1.

Checklist

1. **Form a team.** (See instructions, page 6.)

2. **Expand email and Internet access** to all team members if possible.
   We strongly urge widening email and Internet capabilities within your building so that multiple team members may access important Collaborative communication on our website (www.Medicare.QualisHealth.org/HometoStay) and through an email distribution list. The Collaborative leadership and participants will use the list to circulate information and tools, ask questions and receive replies, and conduct ongoing discussions of changes tested, barriers encountered, and lessons learned.

   At least one member from each team must join the e-mail list and distribute information to the rest of the team; however, we encourage all team members to join the list.

If at any point during the Collaborative there are changes to your team's membership or their email addresses, please update our administrative staff; the contact information is provided on page 1.

As a team, complete the following tasks before Learning Session 1.

3. **Review each section of this *Handbook***.

4. **Arrange to attend Learning Session 1**. At a minimum, the system leader, frontline champion, and day-to-day leader should attend this session and report back to the full staff. Boise's Learning Session 1 will be held on February 18 and Seattle's on February 22. (*See page 4 for details*.)

5. Determine whether to schedule an **optional pre-work teleconference with Qualis Health.** If your team would like a conference call, please indicate that when you submit your pre-work.

6. **Complete the following worksheets and send your responses to Qualis Health by February 5, 2016.** Submit your report at https://www.surveymonkey.com/r/M729QB8. If you have any difficulty with SurveyMonkey, please contact our administrative staff (see page 1).

   Required worksheets:

   - Team Member Contacts (page 8)
   - Goals and Status Check (page 9)

7. **Plan for data collection and reporting**. (See details, page 10.)

8. **Prepare materials for your first storyboard**. (See instructions, page 10.)

Forming a Team

Each participating nursing home must form a Collaborative team that will be actively involved throughout the Collaborative; test and implement system changes at your nursing home; document and submit related data; and share challenges and successes with other participating teams.

It is recommended to identify three leaders (a Senior Leader, System Leader, and Day-to-Day Leader) and, as needed, to include additional staff from work areas that will be affected by the changes.

- The Senior Leader is encouraged to attend all sessions; at a minimum, should attend Learning Session 1 and the Outcomes Congress.
- The System Leader and Day-to-Day Leader should attend all learning sessions and the Outcomes Congress.
- Other team members are encouraged, but not required, to attend the in-person meetings.

It is important to allow flexibility in staff schedules and coverage to attend learning sessions.

When considering which staff should fill leadership roles, keep in mind that enthusiasm, interpersonal skills, and commitment to the Collaborative process and goals are more important attributes than formal title or educational background.

Once your team has been established, record their information on the form provided at page 8.

Senior Leader

Team members will report progress to the Senior Leader. The ideal Senior Leader:

- Has ultimate authority to allocate the time and resources to achieve the team's aim
- Has ultimate authority over all areas affected by the change
- Will champion the spread of successful changes throughout the organization

Examples of building-level Senior Leaders include a nursing home administrator or director of nursing.

Nursing homes operated as part of a chain should identify a Senior Leader at the building level and are encouraged to name one at the managing organization level as well. At a minimum, the chain leadership should be apprised of progress throughout the Collaborative.

System Leader (in charge of the discharge process)

The ideal system leader:

- Has direct authority to allocate the time and resources to achieve the team's aim
- Has direct authority over the particular systems affected by the change
- Wants to drive improvements in the system
- Will champion the spread of successful changes throughout the facility

An example of a System Leader would be someone in charge of line staff operations, such as the director of nursing, social worker/discharge planner, or charge nurse.

Day-to-Day Leader

The ideal Day-to-Day Leader has the skills and available time to:

- Understand the affected systems
- Drive the project, ensuring that cycles of change are tested, implemented, and documented
- Coordinate communication between the team and the Collaborative
- Oversee data collection
- Write progress reports
- Work effectively with the System Leader

A quality improvement staff member, resident care manager, charge nurse, social worker, or staff nurse might serve as Day-to-Day Leader.

Other Team Members

In order to ensure that the team leaders fully understand the system they are trying to redesign, and to promote buy-in, the team should also include members from the potentially affected departments. These additional team members will participate in implementing the system changes.

Effective teams work well together and include a combination of skills, styles, and competencies:

- Leaders
- Team players
- Specific skills and technical proficiencies relevant to the focus topic
- Excellent listening skills
- Communicate well verbally
- Problem-solvers
- Motivated to improve current systems and processes
- Believe it is possible to effect and sustain change
- Creative, innovative, and enthusiastic

Any of the following could serve on the team:

- Residents and family members
- Additional paraprofessional nursing and rehab staff (nursing assistants, COTA, etc.)
- Staff development personnel
- Medical director and/or attending providers
- Consulting pharmacist
- Nurses who administer meds and treatments
- Dieticians and dietary staff
- Professional rehabilitation staff (OT and PT)
- Health information managers
- Activities and social services staff
- Central supply staff
- Maintenance and environmental services

Worksheet 1: Team Member Contacts

See pages 6-7 for instructions about selecting team members. Have the completed form on hand to submit the report due Feb 5 (page 5).

Collaborative Role	Name and Credentials	Title	Email Address
Senior Leader, Building			
Senior Leader, Chain *(if applicable)*			
System Leader			
Frontline Champion			
Day-to-Day Leader			
Other Team Member			
Other Team Member			
Other Team Member			
Other Team Member			
Other Team Member			
Other Team Member			

Worksheet 2: Goals and Status Check

Discuss the following with your team; have the completed form on hand to submit the report due Feb 5 (page 5).

- With reference to your organization's goals and current discharge processes, please tell us briefly what your organization hopes to achieve by participating in the Home to Stay Collaborative.

- Please tell us about any recent quality improvement projects your organization has undertaken, including ones that may have focused on aspects of the discharge to home process.

- Please tell us about your organization's current approach to measuring short-stay residents' satisfaction with the discharge process.

Best Practices for Discharge	**Does your nursing home consistently and effectively execute this element?**	*For elements marked "No," rank each in order of priority for improvement (1= highest priority)* **Priority for Improvement**
Make appointments for follow-up medical care and post-discharge tests/labs.	Yes	No
Plan for the follow-up of results from the lab tests or studies that are pending at discharge.	Yes	No
Organize post-discharge outpatient services and medical equipment.	Yes	No
Identify the correct medications and a plan for the resident to obtain and take them.	Yes	No
Teach a written discharge plan that the resident can understand.	Yes	No
Educate the resident about his/her diagnosis.	Yes	No
Assess the degree of the resident's understanding of the discharge plan.	Yes	No
Review with the resident what to do if a problem arises.	Yes	No
Expedite transmission of the discharge summary to clinicians accepting care of the resident.	Yes	No
After discharge, provide telephone reinforcement of the discharge plan.	Yes	No

Prepare for Data Collection and Reporting

Each nursing home will be expected to track the team's progress and document the system changes tested.

Monthly Tracking

The data are to be tracked on a monthly basis, using Microsoft Excel templates that Qualis Health will distribute to all participants.

The Excel workbook includes templates for:

- Annotated run charts of each measure (the Collaborative's measures are described on page 13)
- A worksheet for recording Plan-Do-Study-Act (PDSA) cycles, which are the engine for system change

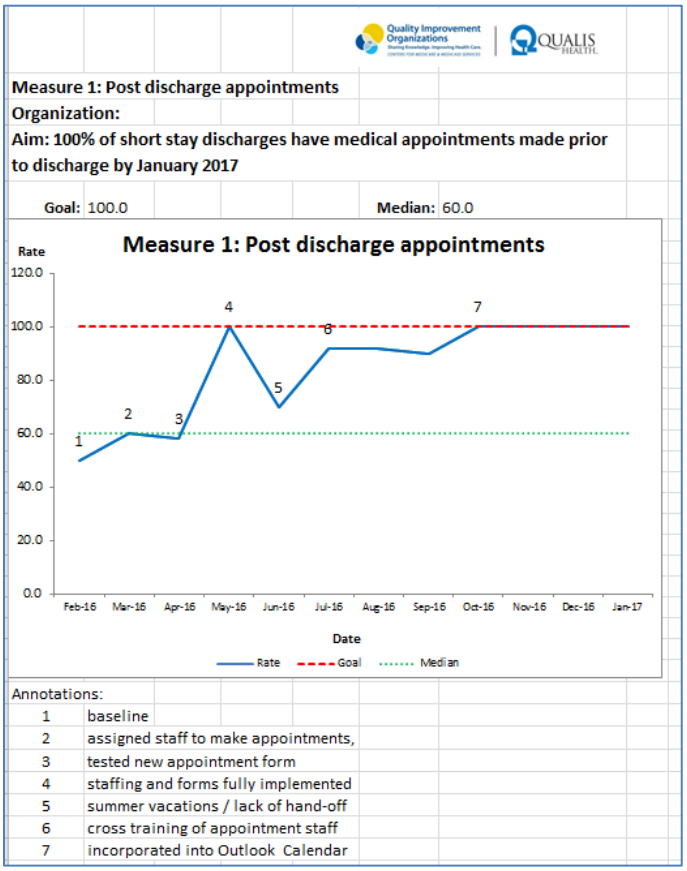
Related training will be provided at Learning Session 1.

Quarterly Senior Leader Reports

Progress overviews are to be reported to Qualis Health on a quarterly basis. The report will be submitted via SurveyMonkey (using a template that Qualis Health will provide after the first learning session).

The audience for the report should not be limited to the Collaborative faculty, however, but also include your own senior leadership and front-line staff.

Sample annotated run chart



Storyboard Preparation

At the learning sessions, each nursing home team will be provided a 30" x 40" foam core board, pushpins, tape, an easel, and other supplies, so that teams can present what they have accomplished and learned so far.

Storyboards help create an environment conducive to sharing and learning from the experiences of others. The storyboard should be as clear and concise as possible. The audience consists of other nursing home teams, Collaborative leadership and faculty, and session observers.

The storyboard presents an opportunity to have some fun and show the unique character of your nursing home and your team.

Suggested content includes:

- Brief description of your nursing home (and photos)
- Team name
- The names, titles, and photos of team members
- Description of your resident population
- Description of progress so far—including run charts for selected measures; copies, photos, or screenshots of tools developed; case examples of successes (and even case examples of failures that taught a valuable lesson)

You may wish to personalize your storyboard with pictures or other decorations that show your team spirit! Don't stress over this, however—start small and add on as the Collaborative progresses.

At Learning Session 1, the storyboards will by necessity be limited to baseline data (if any) and description of your organization, your resident population, and team members.

At Learning Sessions 2, 3, 4, and the Outcomes Congress, your storyboard will be a visual expression of the cumulative Senior Leader Reports, making it easy for others to understand your progress and the lessons learned in your journey. Annotated run charts are a standard feature of story boards, but teams can elaborate with other graphic props and creative ways to tell the story of your struggles and accomplishments. In some cases, a particular PDSA cycle deserves to be highlighted in detail; in other cases a bulleted summary of PDSA cycles is sufficient.

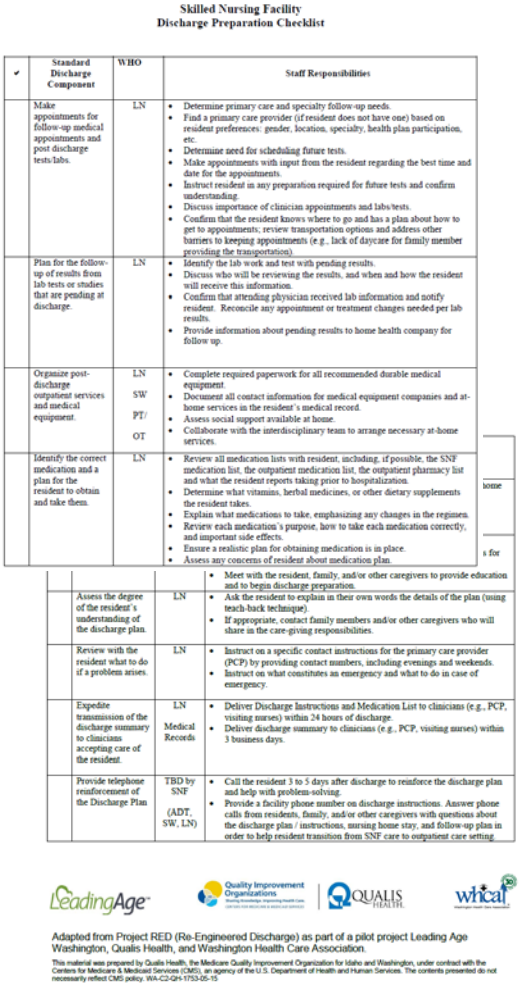
Change Package

A change package is a menu of evidenced-based change ideas.

Discharge Preparation Checklist

This Collaborative's change package is based on the 10-item Project RED list of practices for acute care discharges originally developed by Brian Jack, MD at Boston University Medical Center. The Project RED checklist has been pilot tested by subject matter experts in skilled nursing facilities; the checklist to be used in the Collaborative is attached at the end of this *Handbook*.

Participants will discover new strategies to implement and improve upon the Change Package. The shared learning of practical implementation strategies is a key objective of the Collaborative.



Skilled Nursing Facility
Discharge Preparation Checklist

✔	Standard Discharge Component	WHO	Staff Responsibilities
	Make appointments for follow-up medical appointments and post discharge tests/labs.	LN	• Determine primary care and specialty follow-up needs. • Find a primary care provider (if resident does not have one) based on resident preferences: gender, location, specialty, health plan participation, etc. • Determine need for scheduling future tests. • Make appointments with input from the resident regarding the best time and date for the appointments. • Instruct resident in any preparation required for future tests and confirm understanding. • Discuss importance of clinician appointments and labs/tests. • Confirm that the resident knows where to go and has a plan about how to get to appointments; review transportation options and address other barriers to keeping appointments (e.g., lack of daycare for family member providing the transportation).
	Plan for the follow-up of results from lab tests or studies that are pending at discharge.	LN	• Identify the lab work and test with pending results. • Discuss who will be reviewing the results, and when and how the resident will receive this information. • Confirm that attending physician received lab information and notify resident. Reconcile any appointment or treatment changes needed per lab results. • Provide information about pending results to home health company for follow up.
	Organize post-discharge outpatient services and medical equipment.	LN SW PT/ OT	• Complete required paperwork for all recommended durable medical equipment. • Document all contact information for medical equipment companies and at-home services in the resident's medical record. • Assess social support available at home. • Collaborate with the interdisciplinary team to arrange necessary at-home services.
	Identify the correct medication and a plan for the resident to obtain and take them.	LN	• Review all medication lists with resident, including, if possible, the SNF medication list, the outpatient medication list, the outpatient pharmacy list and what the resident reports taking prior to hospitalization. • Determine what vitamins, herbal medicines, or other dietary supplements the resident takes. • Explain what medications to take, emphasizing any changes in the regimen. • Review each medication's purpose, how to take each medication correctly, and important side effects. • Ensure a realistic plan for obtaining medication is in place. • Assess any concerns of resident about medication plan.
			• Meet with the resident, family, and/or other caregivers to provide education and to begin discharge preparation.
	Assess the degree of the resident's understanding of the discharge plan.	LN	• Ask the resident to explain in their own words the details of the plan (using teach-back technique). • If appropriate, contact family members and/or other caregivers who will share in the care-giving responsibilities.
	Review with the resident what to do if a problem arises.	LN	• Instruct on a specific contact instructions for the primary care provider (PCP) by providing contact numbers, including evenings and weekends. • Instruct on what constitutes an emergency and what to do in case of emergency.
	Expedite transmission of the discharge summary to clinicians accepting care of the resident.	LN Medical Records	• Deliver Discharge Instructions and Medication List to clinicians (e.g., PCP, visiting nurses) within 24 hours of discharge. • Deliver discharge summary to clinicians (e.g., PCP, visiting nurses) within 3 business days.
	Provide telephone reinforcement of the Discharge Plan	TBD by SNF (ADT, SW, LN)	• Call the resident 3 to 5 days after discharge to reinforce the discharge plan and help with problem-solving. • Provide a facility phone number on discharge instructions. Answer phone calls from residents, family, and/or other caregivers with questions about the discharge plan / instructions, nursing home stay, and follow-up plan in order to help resident transition from SNF care to outpatient care setting.

Adapted from Project RED (Re-Engineered Discharge) as part of a pilot project Leading Age Washington, Qualis Health, and Washington Health Care Association.

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CTM-3 Survey

The Collaborative adds to the Project RED checklist by using the **Care Transition Measures-3®** to incorporate resident-centered information into the evaluation of discharge processes. (The survey and instructions are available at www.QualisHealth.org/CTM3)

The CTM-3 are obtained by way of validated survey questions; the measures have been endorsed by the National Quality Forum and have been included in the Hospital Consumer Assessment of Healthcare Providers and Systems surveys since 2010.

For our purposes, the wording of the CTM-3 questions have been adapted to the nursing home setting by substituting the words "nursing home" and "resident" for "hospital" and patient." All three questions are answered on a 5-point scale.

1. The nursing home staff took my preferences and those of my family or caregiver into account in deciding what my health needs would be when I left the nursing home.
2. When I left the nursing home, I had a good understanding of the things I was responsible for in managing my health.
3. When I left the nursing home, I clearly understood the purpose for taking each of my medications.

Collaborative participants are encouraged to seek and use the insights of residents (and their families) as they make improvements in discharge processes.

Measurement Strategy

Performance measurement is not an end in itself, but is integral to systematic process improvement. Measuring performance during the Collaborative will enable the team to evaluate and adapt, abandon, or adopt process changes in real time. Measurement should accelerate improvement, not slow it down.

Typically, about 10% of the effort for the project should be devoted to measurement—too much measurement gets in the way of improvement while too little measurement leaves a team without the necessary feedback to know if they are advancing towards their goals.

Measure Specifications and Sources

Measure	Specifications	Source
Rehospitalization Measures	1. Rehospitalization of short-stay residents within 30 days of hospital discharge. 2. Rehospitalization of short-stay residents within 30 days of nursing home discharge to home.	Medicare FFS claims analysis provided by Qualis Health
Post-Discharge Physician Office Visit	Denominator: Number of short-stay discharges to home. Numerator: Number of denominator cases that have a physician office visit within 10 calendar days of discharge.	Medicare FFS claims analysis provided by Qualis Health
Post-Discharge Home Health Visit	Denominator: Number of short-stay discharges to home. Numerator: Number of denominator cases that have a home health visit within 5 calendar days of discharge.	Medicare FFS claims analysis provided by Qualis Health
Discharge Checklist Implementation	Denominator: Number of short- stay discharges to home. Numerator: Number of denominator cases for which each Discharge Checklist element was completed.	Health records / discharge planning documentation
CTM Attempts	Denominator: Number of short-stay discharges to home. Numerator: Number of denominator cases for which an attempt was made to gather a response (from the resident or proxy).	CTM-3 documentation
CTM Response Rate	Denominator: Identical to the *CTM Attempts* numerator. Numerator: Number of denominator cases in which any response (including Don't Know/Don't Remember/Not Applicable) was made for at least one CTM question.	CTM-3 documentation
CTM Results	Denominator: For each CTM question, the number of responses (including Don't Know/Don't Remember/Not Applicable). Numerator: For each CTM question, the number of denominator cases with a response of "Strongly Agree."	CTM-3 documentation

References and Resources

Berkowitz, RE, et al. Project ReEngineered Discharge (RED) Lowers Hospital Readmissions of Patients Discharged From a Skilled Nursing Facility. JAMDA. 2013;14(10):736-740.
http://www.bu.edu/fammed/projectred/publications/projectredlowershosptialreadmissions.pdf

The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement. IHI Innovation Series white paper. Boston: Institute for Healthcare Improvement; 2003.
http://www.ihi.org/resources/Pages/IHIWhitePapers/TheBreakthroughSeriesIHIsCollaborativeModelforAchievingBreakthroughImprovement.aspx

Coleman, Care Transition Intervention
http://caretransitions.org/tools-and-resources/

CTM-3 Forms and instructions, specifically for use in the Home to Stay Collaborative
www.QualisHealth.org/CTM3

CTM-3 FAQ
http://caretransitions.org/wp-content/uploads/2015/08/CTM_FAQs.pdf

Project BOOST Implementation Guide to Improve Care Transitions
http://tools.hospitalmedicine.org/Implementation/Workbook_for_Improvement.pdf

Project RED Re-engineered Discharge
http://www.bu.edu/fammed/projectred/

Throughout the Collaborative, additional resources will also be posted to
www.Medicare.QualisHealth.org/HometoStay

Discharge Checklist

Skilled Nursing Facility
Discharge Preparation Checklist

✔	Standard Discharge Component	WHO	Staff Responsibilities
	Make appointments for follow-up medical appointments and post discharge tests/labs.	LN	• Determine primary care and specialty follow-up needs. • Find a primary care provider (if resident does not have one) based on resident preferences: gender, location, specialty, health plan participation, etc. • Determine need for scheduling future tests. • Make appointments with input from the resident regarding the best time and date for the appointments. • Instruct resident in any preparation required for future tests and confirm understanding. • Discuss importance of clinician appointments and labs/tests. • Confirm that the resident knows where to go and has a plan about how to get to appointments; review transportation options and address other barriers to keeping appointments (e.g., lack of daycare for family member providing the transportation).
	Plan for the follow-up of results from lab tests or studies that are pending at discharge.	LN	• Identify the lab work and test with pending results. • Discuss who will be reviewing the results, and when and how the resident will receive this information. • Confirm that attending physician received lab information and notify resident. Reconcile any appointment or treatment changes needed per lab results. • Provide information about pending results to home health company for follow up.
	Organize post-discharge outpatient services and medical equipment.	LN SW PT/ OT	• Complete required paperwork for all recommended durable medical equipment. • Document all contact information for medical equipment companies and at-home services in the resident's medical record. • Assess social support available at home. • Collaborate with the interdisciplinary team to arrange necessary at-home services.
	Identify the correct medication and a plan for the resident to obtain and take them.	LN	• Review all medication lists with resident, including, if possible, the SNF medication list, the outpatient medication list, the outpatient pharmacy list and what the resident reports taking prior to hospitalization. • Determine what vitamins, herbal medicines, or other dietary supplements the resident takes. • Explain what medications to take, emphasizing any changes in the regimen. • Review each medication's purpose, how to take each medication correctly, and important side effects. • Ensure a realistic plan for obtaining medication is in place. • Assess any concerns of resident about medication plan.

✔	Standard Discharge Component	WHO	Staff Responsibilities
	Teach a written discharge plan the resident can understand.	LN	• Create an easy-to-understand discharge plan / instructions to be sent home with resident. • Review and orient resident to all aspects of written discharge plan / instructions. • Encourage residents to ask questions.
	Educate the resident about his or her diagnosis.	LN	• Review medical history and current condition with the resident. • Communicate with the interdisciplinary team regarding ongoing plans for discharge. • Meet with the resident, family, and/or other caregivers to provide education and to begin discharge preparation.
	Assess the degree of the resident's understanding of the discharge plan.	LN	• Ask the resident to explain in their own words the details of the plan (using teach-back technique). • If appropriate, contact family members and/or other caregivers who will share in the care-giving responsibilities.
	Review with the resident what to do if a problem arises.	LN	• Instruct on a specific contact instructions for the primary care provider (PCP) by providing contact numbers, including evenings and weekends. • Instruct on what constitutes an emergency and what to do in case of emergency.
	Expedite transmission of the discharge summary to clinicians accepting care of the resident.	LN Medical Records	• Deliver Discharge Instructions and Medication List to clinicians (e.g., PCP, visiting nurses) within 24 hours of discharge. • Deliver discharge summary to clinicians (e.g., PCP, visiting nurses) within 3 business days.
	Provide telephone reinforcement of the Discharge Plan	TBD by SNF (ADT, SW, LN)	• Call the resident 3 to 5 days after discharge to reinforce the discharge plan and help with problem-solving. • Provide a facility phone number on discharge instructions. Answer phone calls from residents, family, and/or other caregivers with questions about the discharge plan / instructions, nursing home stay, and follow-up plan in order to help resident transition from SNF care to outpatient care setting.

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