Challenge
Traditional skilled nursing facilities (SNFs) may be associated with multiple ingrained cultural challenges. Discharging patients to SNFs may be based on social, not medical issues. Admitting a patient to a SNF because there is a Medicare allotment of 100 days or remaining in SNF until the patient reaches baseline may no longer be appropriate goals. A SNF is a part of the continuum of care that may also include outpatient services in the future. Undertaking the challenge of reducing the CMS national Spending per Beneficiary (MSPB) index to less than 0.98 created the action taken by Indiana University Heath (IU Health) after learning that IU Health Bloomington recorded a MSPB index of 1.04. Hospitals are being penalized for post-acute care selections even though they do not have direct influence on SNF admissions.
Strategies

IU Health determines the strategy to incorporate SNFs as a partner in patient care and providing information to patients so they make informed decisions. Transitional Care Managers and creating a Post-Discharge Collaborative Team were key developments.

Critical Success Factors

1. Transitional Case Manager
   - Implement utilizing the hospital’s Transition Care Manager (TCM) to monitor/follow/transition to a SNF for the key diagnoses.
   - Meet with therapy team weekly to promote realistic goals.
   - Identify and resolve discharge barriers early in the stay.
   - Encourage conversion to long-term care if measurable progress is not occurring.
   - Enter key information into CM software that is compiled in a weekly report.
   - Meet with hospital Care Manager weekly to discuss barriers.
   - Make sure handoff to PCP occurs and includes medication reconciliation by Pharmacist.

2. Stakeholder & Community Education
   - Formation of a Post-Discharge Collaborative Team including four SNFs with the highest readmissions rate for the targeted diagnosis, Hospice, Home Health Care, Inpatient Rehabilitation and Outpatient Rehabilitation.
   - Encourage SNFs to treat traditional Medicare patients as if they are Medicare Advantage by decreasing length of stay (LOS), preparing patients and families for quicker discharge, starting discharge planning immediately and preparing patients and families for conversion to long-term care if measurable progress is not being made.
   - Request scorecard that includes LOS and readmission rates from SNFs.
   - List outcomes on the SNF Option sheet given to patients.
   - Note on the SNF Options sheet those facilities that are allowing the TCM to participate.

Results

Based on IU Health’s findings, a handout for patients regarding different options for post-discharge care will be implemented with the goals of setting expectations for medical necessity need for SNF, shorter SNF LOS and preparation for an earlier discharge. If needs are not achieved from the collaborative team, the hospital will consider a contracted network which could reduce referrals to SNFs that do not meet the qualifications. IU Health is taking the team’s recommended actions and results to their regional post-acute care team.