Vermont Medicare Accountable Care Organization Initiative

Three-Day Skilled Nursing Facility Rule Benefit Enhancement Waiver

Operations Manual

Version 9

Updated 12.22.20

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CARES Act Waiver Update

The Coronavirus Aid, Relief, and Economic Security (CARES) Act is the emergency funding passed in response to the outbreak of COVID-19 in March 2020. The stimulus package addresses topics such as healthcare delivery, state funding, small business and non-profit relief and overall economic stimulus. Due to the CARES Act and its impact on healthcare delivery systems, Medicare waiver participants should shift billing practices to those in alignment with the codes outlined in the CARES Act.

How to Use this Operations Manual

This operations manual was developed by OneCare Vermont (OneCare) to inform, educate, and offer tools to successfully implement and use the Three-Day Skilled Nursing Facility Rule Benefit Enhancement Waiver (3-Day SNF Rule Waiver) in Health Service Areas (HSA) participating in the Vermont Medicare Accountable Care Organization (ACO) Initiative program. This manual will be updated as new information is made available from the Centers for Medicare & Medicaid Services (CMS). This manual, along with other SNF Waiver materials and OneCare patient attribution lists, are available in the OneCare Secure Portal

Wherever possible, OneCare has attempted to align the suggestions in this manual with the CMS Office of Clinical Standards and Quality related to nursing homes.

Overview of the Three-Day SNF Rule Waiver

In traditional fee-for-service (FFS) Medicare, beneficiaries are eligible for Medicare covered skilled nursing facility (SNF) services if a patient is admitted within 30 days of either 1. an inpatient hospital stay of 3 days or more or 2. a previous SNF stay. Time spent in observation or in the emergency department before admission does *not* count toward the 3-day inpatient hospital stay.

The **3-Day SNF Rule Waiver** allows an ACO attributed Medicare beneficiary to be admitted to a SNF *without* a 3-day inpatient hospital or previous SNF stay. Under the SNF Waiver, ***a patient may be admitted from the following settings:***

- short inpatient (less than 3-days)

- observation
- emergency department
- medical provider's office
- patient's home

SNF's must be enrolled with OneCare as a Medicare Preferred Provider and be found eligible to use the Waiver by CMS. OneCare will report SNF eligibility to use the Waiver annually.

Suggested Timeline for Implementation

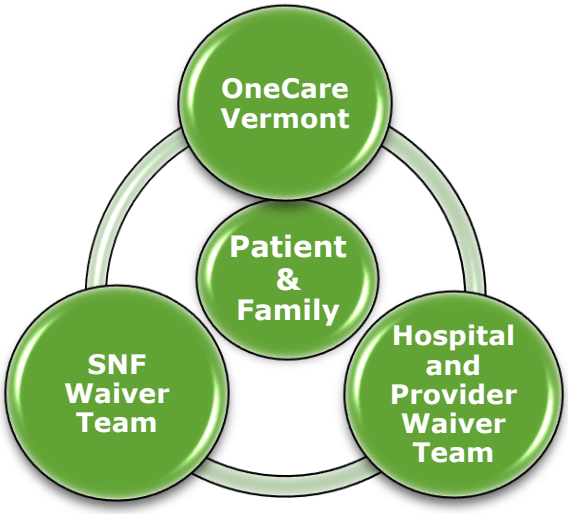
OneCare recommends a phased approach to implementing the SNF Waiver in communities, starting with admissions from the most to the least common medical setting for patients to receive care prior to a SNF admission. However, there are no barriers to admitting patients under the Waiver from all settings immediately. Please be aware that admissions from non-hospital settings may represent operational challenges, and admissions should always be clinically sound.

Suggested Timeline for Implementation

OneCare recommends that implementation begins during normal business hours when hospitalists, care coordinators, and SNF admissions teams are available to make the best possible clinical choices for patient admissions.

A Collaborative Approach to Implementation

OneCare's approach to the SNF Waiver emphasizes strong communication and collaboration amongst Waiver participants. Anchor hospitals, clinical providers and SNFs must take a collaborative approach for successful implementation and continued success of the SNF Waiver across Vermont communities.



Hospital and Medical Provider Waiver Team:

- Support the use of the SNF Waiver in their health service area (HSA)
- Educate clinical providers of SNF Waiver availability for attributed patients
- Develop and implement care transition process workflows with SNF
- Confirm patient attribution to OneCare prior to the start of the SNF Wavier admission processes

SNF Waiver Team:

- Work with hospitals and clinical providers to develop and implement care transition process workflows
- Verify patient attribution to OneCare (i.e. 2-step attribution check)
- Report data to OneCare quarterly, which is then reported to CMS per program requirements

OneCare Waiver Team:

- Provides education, information, and guidance for successful implementation and utilization of the SNF Waiver
- As additional data is collected, OneCare will be providing analysis of trends seen to guide collaborators in process improvement, increasing utilization, and successful patient outcomes

For a detailed list of **SNF Waiver Roles & Responsibilities**, see Appendix B.

For suggested **process workflows and map**, see Appendix D and Appendix E.

SNF Eligibility to Use the Waiver

Annually, participants and preferred providers are enrolled into the OneCare Vermont Network (Network). OneCare submits a list of all Network participants and preferred providers to CMS. After review, **CMS determines which preferred providers are eligible to bill for the SNF Waiver**; billing equating eligibility to use the Waiver. CMS reports SNF eligibility to OneCare in quarter four (Q4) of the performance year annually; OneCare communicates SNF Waiver eligibility shortly thereafter.

A SNF is required to maintain an overall rating of three (3) or more stars per the **CMS Quality Rating System** in seven of the previous twelve months to be eligible to use the Waiver. However, once a SNF has been approved to use the Waiver in a given performance year, it will not be removed during that same performance year if their star rating declines. For more information on SNF star ratings, please see Medicare Nursing Home Compare.

To assist SNFs in assessing their ability to successfully implement the SNF Waiver, OneCare has created the "3-Day SNF Rule Eligibility Criteria Checklist." **This checklist must be completed and received by OneCare before admissions under the Waiver can begin.** While SNFs do not need to satisfy all criteria listed on the checklist, SNFs must strive to meet and maintain those best clinical and operational practices identified.

The **3-Day SNF Rule Eligibility Criteria Checklist** can be found in Appendix A.

Patient Eligibility to Use the Waiver

A patient must be a Medicare beneficiary attributed to OneCare to be eligible for the SNF Waiver. Therefore, steps must be taken to verify the patient's attribution status prior to SNF admission, please see *Confirming Patient Attribution* in the next section of this manual for more information.

After confirming attribution to OneCare, the beneficiary must meet **the following eligibility criteria**:

- Is medically stable;
- Has a confirmed diagnoses;
- Has an identified skilled nursing or rehabilitation need that cannot be provided on an outpatient basis;
- Does not reside in a nursing home or SNF for long-term custodial care; the patient may reside at SNF for short-term or respite care;*
- Does not require inpatient *or* further inpatient hospital evaluation or treatment; *and*
- Has been evaluated by a provider within 3-days prior to SNF admission.

*Independent and assisted living facilities are *not* considered long-term care facilities for purposes of the SNF Waiver.

Below is a **list of examples when SNF Waiver admission MAY be appropriate** for a patient. *This list is not comprehensive and should not be used as a substitute for medical decision-making and clinical judgment.*

- Patient with a fall(s) without major injury, not needing more diagnostics and/or specialist consultation within 24 hours, without acute serious cardiac/neurological source, who cannot be managed at home.
- Patient with a "minor" injury/illness/chronic disease exacerbation causing functional decline with needs that exceed home supports.
- Patient with recent joint replacement surgery that has caused functional decline with needs that exceed home supports.
- Patient with a non-displaced pelvic fracture or lumbar compression fracture without spinal cord involvement that does not require surgical intervention and cannot be managed at home.
- Patient with need for wound care that cannot be provided at home.
- Patient with need for radiation therapy with inability to support at home; does not meet inpatient criteria.
- Patient with skilled needs and failed/failing home discharge plan, and not in need of acute care.
- Patient with skilled needs who may or may not be receiving home health services and does not have adequate supports at home. There is a clear expectation that they can resume prior functioning level and return to home.

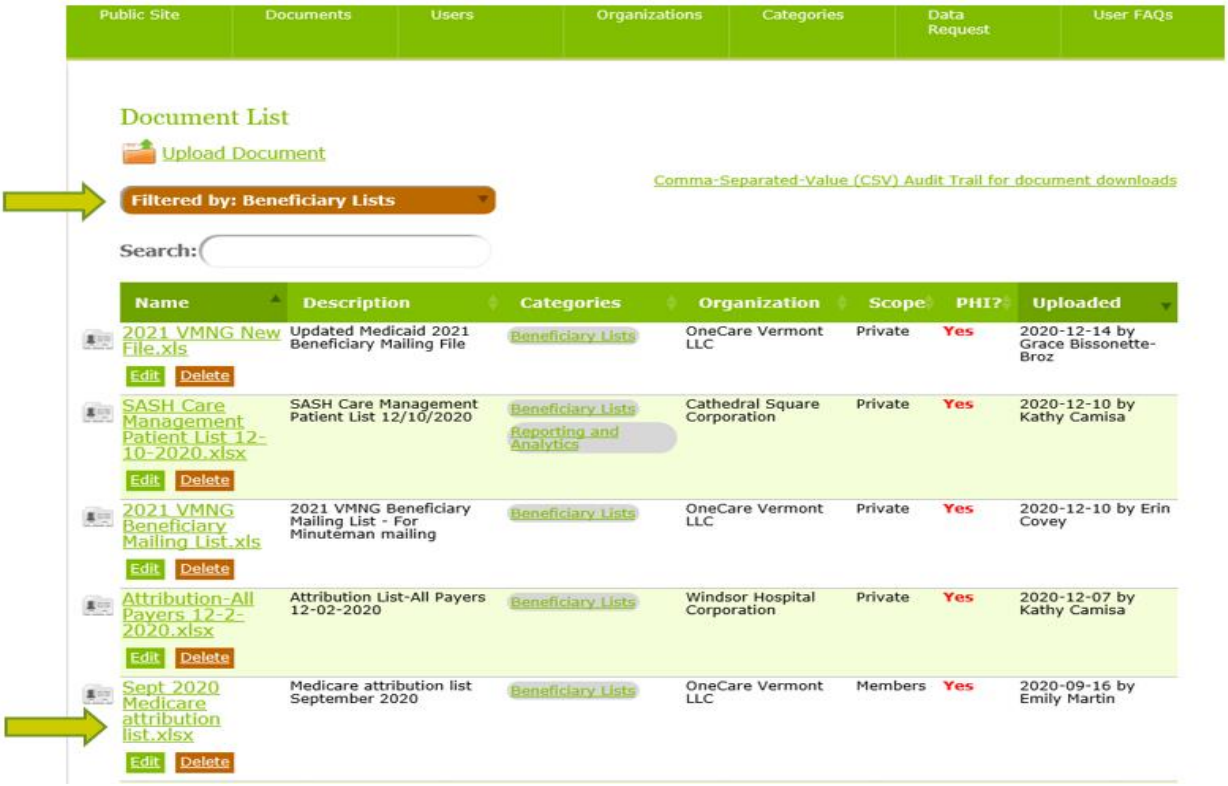
- Patient with an acute change in functional status.
- Patient with an infection and a clear treatment plan, without the need for a physician on site to monitor, and not a candidate for home management (i.e. stable Urinary Tract Infection, Cellulitis). Note: if on IV antibiotics, diuretics, or steroids, preferably will have a line in place and first dose given prior to SNF transfer.

OneCare has created a **SNF Admission Decision Making Tool** to assist medical providers and staff in making SNF admission decisions in fast-paced medical care environments, see **Appendix C.**

Confirming Patient Attribution

A patient must be a Medicare beneficiary attributed to OneCare to be eligible to use the SNF Waiver. To verify attribution, the patient must be included in the Medicare patient attribution list. Patient attribution lists are available in the OneCare Secure Portal. The lists are updated quarterly (i.e. 90-days), and released after the quarter of attribution. Help navigating the Secure Portal is available by contacting the OneCare Helpdesk, see email contact under OneCare Data Resources.

OneCare Secure Portal Attribution Lists

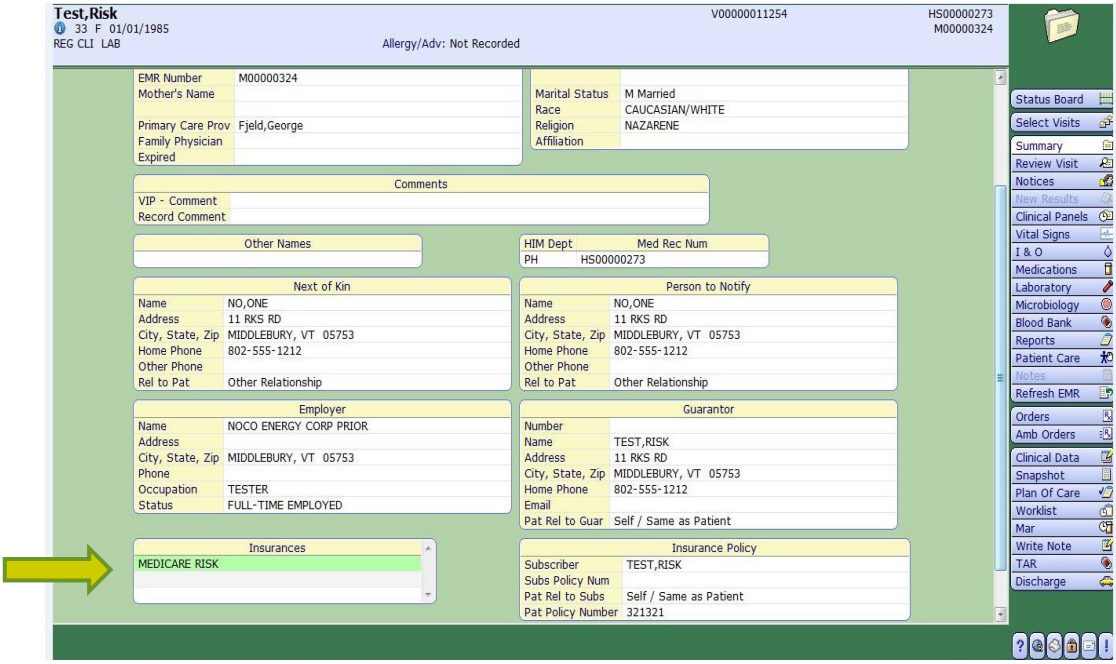


Within the Secure Portal, navigate to the "Administration" tab. Click on "Documents" within the drop down menu. Select "Beneficiary Lists" as the filter. Search for **Medicare Attribution**.

The 90-day delay in patient attribution list updates does not impact the process of confirming patient attribution as the SNF Waiver has a built in **90-Day Grace Period for Excluded Beneficiaries**. This grace period allows a former Medicare attributed patient who was aligned to the ACO at the start of the *performance year*, but who is later excluded from attribution during the *performance year*, to be eligible for the SNF Waiver provided that admission occurs within 90 days following the date of the alignment exclusion and all other eligibility requirements of the SNF Waiver are met. This grace period applies only within a performance year. Therefore, at the beginning of a new performance year, you will need to use the new year's attribution list. If you have questions about the 90-Day Grace Period, please contact the Medicare Waiver Administrator at CareCoordination@onecarevt.org.

One suggestion to assist facilities in confirming patient attribution is to build an icon or data field into your Electronic Health Record (EHR). Below is a screen shot of patient demographic page in a Meditech EHR. Notice in the bottom left hand corner, in the Insurances box, "Medicare Risk" is highlighted indicating that the patient is attributed to the Vermont ACO Medicare Initiative.

Patient Attribution Identification in EHR Example



Patient Medical Documentation

All patients admitted under the SNF Waiver require the same medical documentation as a traditional SNF admission. Ideally, the hospital and/or medical provider and the SNF's EHR interact allowing for patient documentation to be shared electronically. Utilization of CareNavigator, a care coordination software platform, is suggested for use to communicate and to develop a shared care plan, please see *OneCare Data Resources* in a later section in this manual for more information. To ensure best clinical practices, patient documentation should always include the following:

- Referring Provider note
- Clearly documented current medication lists and orders including dose/indication

- Any follow up appointments provided to SNF
- Any pending lab/imaging results
- PASRR-1 (Preadmission Screening and Resident Review)
- Advanced directives and their location
- Initial Care Management Plan

Discharge Planning

Patient medical documentation should contain a discharge plan which addresses the patient's post-discharge care needs. To assist in discharge planning, the **SNF Discharge Planning Checklist** is available, see **Appendix F.**

A discharge strategy, promoted by the Institute of Health Improvement (IHI), is to utilize a risk stratification tool to identify preventable readmissions. The LACE Index Scoring Tool for Risk Assessment of Hospital Readmission (LACE Tool) identifies patients that are at risk for readmission or death within thirty days post-discharge. The LACE Tool incorporates four parameters.

- "L" = length of stay of the index admission.
- "A" = acuity of the admission. Specifically, if the patient is admitted through the ED vs. an elective admission.
- "C" = co-morbidities, incorporating the Charlson Co-Morbidity Index.
- "E" number of ED visits within the last 6 months.

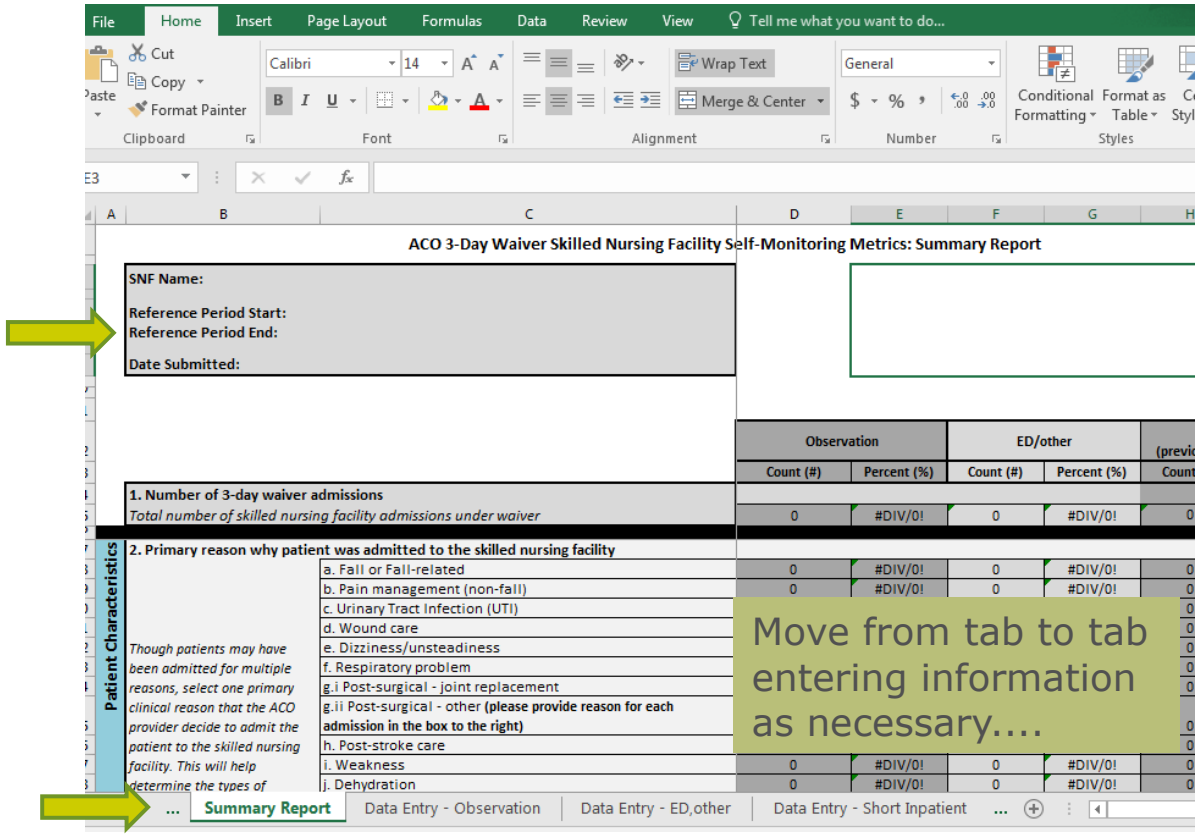
LACE scores range from 1-19, a score of 0 – 4 = Low; 5 – 9 = Moderate; and a score of ≥ 10 = High risk of readmission. For a copy of the **LACE Tool**, please contact the Medicare Waiver Administrator at Carecoordination@onecarevt.org.

Data Collection and Submission

Important Update: Due to the COVID-19 pandemic, CMS has suspended the requirement of data collection and submission for the remainder of the 2020 year. OneCare will not be requesting data from participating SNFs on a quarterly basis or reporting data to CMS. OneCare anticipates an update on this status in Quarter 1 of 2021. There will be a broad communicate to all participating SNF's at that time.

CMS requires ACO's to submit SNF Waiver data on a quarterly basis. To capture this data, a standard Excel spreadsheet, referred to as the Data Collection Tool. The Tool is updated quarterly, and is available for download from the Secure Portal (navigate to "Documents" and search for "Data Collection").

Data Collection Tool



When completing the Tool, make sure all applicable fields are completed including the SNF Name, Reference Period Start and End Date, as well as the Date Submitted on the Summary Report tab. Also, it is very important that date of admission and date of discharge for each patient listed within the tabs for Observation, ED Other, and Short Impatient are entered accurately. Missing and inaccurate information provided will result in a return of Tool to the SNF for updates and edits. OneCare suggests that SNFs develop an internal quality assurance process to assure that Tools submitted to OneCare are complete and accurate.

Some important clinical data measures captured in the Tool are the following:

- Number of waiver admissions

- Primary reason for each admission
- Secondary reasons for each admission
- Patient's location before admission
- Care transition processes:

Warm hand-off:
Clinician from hospital or outpatient setting provides verbal report to SNF clinician within 24 hours after the patient's arrival at the SNF

Timely admitting exam:
SNF admitting team completes timely exam or admitting physical within 24 hours after patient's arrival at the SNF

Preliminary care plan:
SNF develops patient care plan within 48 hours after the patient's arrival

Discharge notes:
SNF sends discharge notes to the patient's PCP within 7 days after SNF discharge

SNF's are responsible for accurately completing the Data Collection Tool for all SNF Waiver patient discharges that occurred within the reporting quarter and uploading completed Tools to the OneCare Secure Portal by submission deadlines.

Data Collection Tool Submission Deadlines

Quarter	Quarter Reference Period	**Submission Deadline from SNF to OneCare**	OneCare Submission Deadline to CMS
2021 Q1	1/1/21 – 3/31/21	**TBD**	**TBD**
2021 Q2	4/1/21 – 6/30/21	**TBD**	**TBD**
2021 Q3	7/1/21 – 9/30/21	**TBD**	**TBD**
2021 Q4	10/1/21 – 12/31/21	**TBD**	**TBD**

Completed Tools are submitted to OneCare by uploading the spreadsheet to the Secure Portal. When uploading Tools, please use the following naming convention:

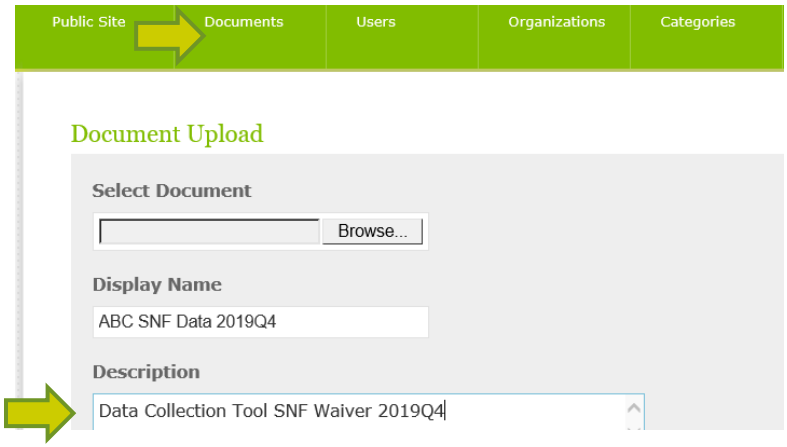
SNF Facility Name, Data Year Quarter

ex: ABC SNF Data 2021Q1

If no patients were discharged within the reporting quarter, please email the OneCare Medicare Waiver Administrator to indicate a "zero patient report."

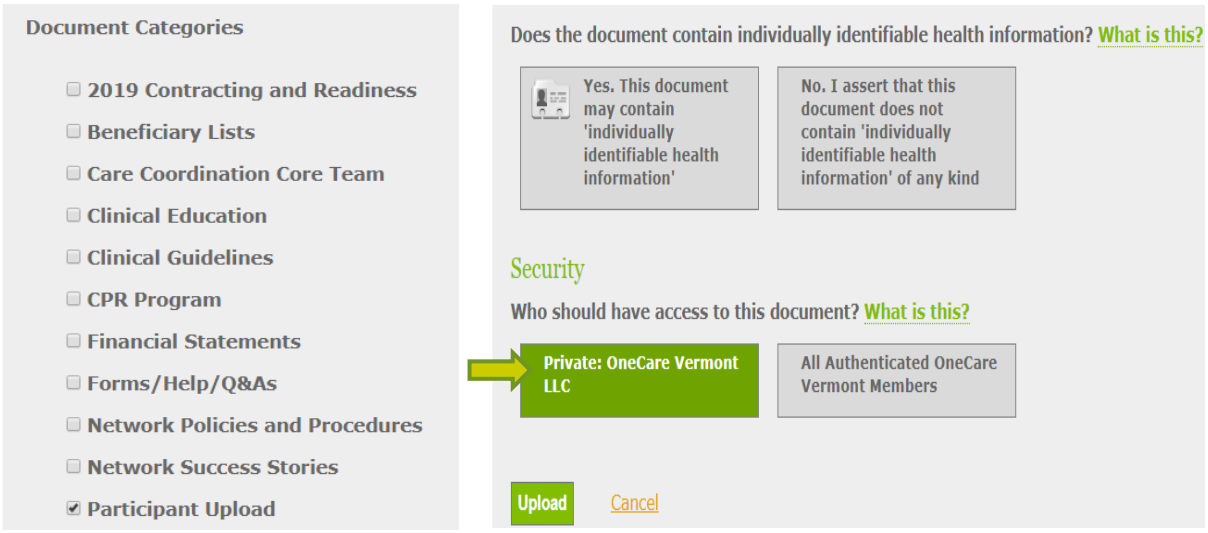
If you have questions when completing the Data Collection Tool, please contact the Medicare Waiver Administrator at Carecoordination@onecarevt.org.

Uploading the Data Collection Tool to the Secure Portal



Select **Documents** then select "Upload Document". **Use the following naming convention: SNF Name, Data, Year and Quarter** for "Display Name". In the "Description" box, enter other relevant information as needed.

For "Document Organization/Participant" enter the SNF name. Your facility name will appear in the search box. Select **Vermont Medicare ACO Initiative Program** for "Document Programs".

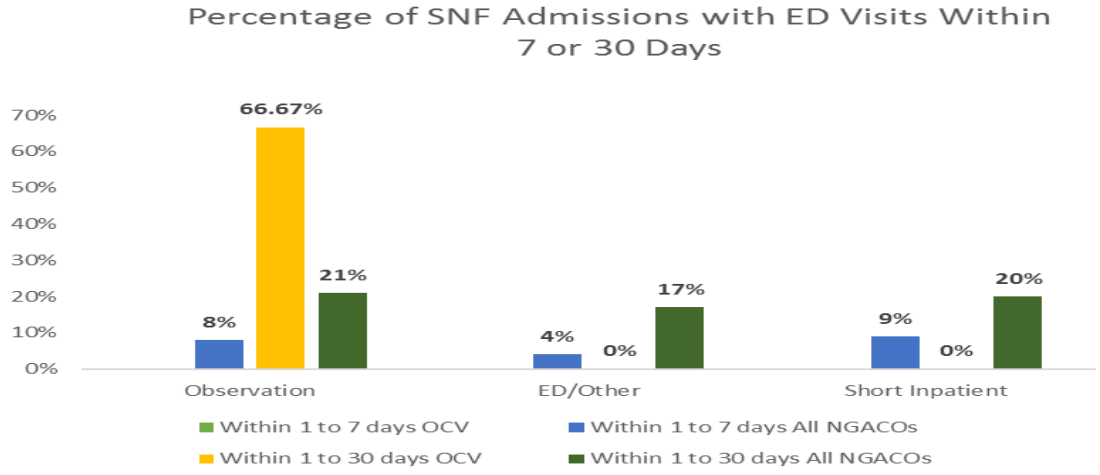


For "Document Categories" select **Participant Upload**. Select "Yes" for PHI and "Private" for security levels, and then select "Upload".

Data Measures and Analytics

OneCare reviews and compiles all data reported by SNF into one master Data Collection Tool spreadsheet which is submitted to CMS. Protected health information (PHI) is removed prior to submission and kept secure throughout the process. OneCare's Analytics team then reviews the data to obverse trends in patient care and program success, including average length of stay, average per diem payment (i.e. proxy for patient complexity of care), and readmissions. As utilization of the SNF Waiver increases, additional data will be available to analyze the impact of the Waiver on patient care and total costs of care.

Example of SNF Waiver Data Analytics



OneCare Data Resources

OneCare Secure Portal

A secure OneCare participant only internal website with financial, patient attribution lists, and network information.

CARE NAVIGATOR

A secure care management software system that supports greater alignment and integration in the work of complex care coordination in our network. CareNavigator is designed to support quality care management, population health, and improved outcomes by utilizing a single and secure platform that supports communication, shared care planning and collaboration among care team members.

Workbench One™

An innovative population health data platform powered by up-to-date clinical and claims data. Workbench One utilizes Advanced Analytics Applications ("Apps") that allows it's users to generate timely utilization and financial queries and reports across provider, practice, patient(s) and clinical service.

OneCare Vermont Contact Information

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Appendix A: 3-Day SNF Rule Waiver Facility Eligibility Criteria Checklist

OneCare Vermont

3-Day Skilled Nursing Facility (SNF) Rule Waiver Eligibility Criteria Checklist

Name of SNF: _____

Name/Title of staff completing form: _____

Date Completed: _____ Date Reviewed: _____

Required Criteria for Participation	Current State	If No, plan and timeframe for alignment
High speed internet access?	☐ Y ☐ N	
Active email account for involved providers and staff?	☐ Y ☐ N	
Electronic Health Record? How does it interface with the hospital?	☐ Y ☐ N	
If No, plans to have an EHR by 12/31/18?	☐ Y ☐ N	
Ability to submit data electronically (Excel)?	☐ Y ☐ N	
Signed *OCV Collaborator* agreement in Medicare Next Generation?	☐ Y ☐ N	
Reviewed and willing to complete the OCV SNF Waiver education and training modules?	☐ Y ☐ N	
Use of Modified Barthel Index (MBI), INTERACT, or comparable care management tools?	☐ Y ☐ N	
Access to Care Navigator & willing to train users?	☐ Y ☐ N	
Access to OCV Secure Portal?	☐ Y ☐ N	
Use of Clinician's Order for Life Sustaining Treatment (COLST) or comparable tool?	☐ Y ☐ N	
Capability to admit 7 days/week, with after-hours option?	☐ Y ☐ N	
24 Hour RN Coverage?	☐ Y ☐ N	
CMS 5-Star overall rating of "3" or better?	☐ Y ☐ N	
30 day re-hospitalization from facility of 20% or less as confirmed by Nursing Home Compare?	☐ Y ☐ N	
Average length of stay, per admission, 30 days or less as confirmed by Nursing Home Compare?	☐ Y ☐ N	
Willing to participate in ongoing quality initiatives?	☐ Y ☐ N	
Formalized patient experience program?	☐ Y ☐ N	
Agree to self-report data that is not publically available around Quality, Utilization, and Patient Experience	☐ Y ☐ N	
Do you have a full-time SNF medical director? Who rounds on patients?	☐ Y ☐ N	
Number of subacute beds?	NA	
In the past year, the number of subacute patients admit- ted to your SNF who were discharged from inpatient after just three nights?	NA	

Appendix B: SNF Waiver Roles & Responsibilities

Hospital Personnel and Medical Providers

Hospitalist/Inpatient Covering Physician: A dedicated in-patient physician who may identify patients appropriate for the SNF waiver and work closely with the care coordination hospital staff to transfer patients to SNF.

ED Medical Doctor: Provider who will identify patients appropriate for the SNF waiver and work closely with the ED care coordination staff to transfer patients to SNF.

Hospital Care Coordinator: Nurse or Social Worker, employed by the hospital, responsible for coordinating discharges from the hospital. Works closely with SNF-based team to facilitate smooth transitions of care, confirms patient eligibility for waiver, reviews goals of care, plan of care, and appropriate utilization. Informs patient and family of the SNF waiver and their options.

Primary Care Provider: Patient's primary care provider and is typically responsible for coordinating all aspects of a patient's care while the patient moves along the care continuum.

PCP Care Coordinator / Community Health Team Member: The ambulatory care coordinator, typically embedded in the PCP, will be responsible for coordinating the patient's care in the ambulatory setting and facilitating transitions of care to/from SNF.

Specialist Provider: Physician who is treating the patient for a specific issue.

SNF Personnel (Note: not all SNFs employ each role outlined below)

SNF Administrator/Executive Director: Responsible for the operations of the SNF and for ensuring that all Federal, State, and local regulations are met. May lead the local benefit enhancement waiver implementation team.

SNF Medical Director/Attending Provider (Physician/ NP/PA): Assumes overall responsibility for a patient's medical care while at the SNF; is the team lead and is available to provide clinical consultation to other members of the care team. Ensures 24 hour call coverage is in place. The SNF attending provider performs the initial history and physical within 48 hours of admission to the SNF. Provides on-going care to the patient in the SNF and is integral in the planning for a timely and seamless SNF discharge; often responsible for orchestrating the medical aspects of discharge including updating medication list and writing prescriptions for discharge.

SNF Admissions and Discharge Coordinator: Nurse or Social Worker, responsible for coordinating admissions and discharges. Works closely with SNF-based team to

facilitate smooth transitions of care, confirms patient eligibility for waiver, reviews goals of care, plan of care, and appropriate utilization. Completes documentation on metrics to be shared with CMS on each waiver participant and sends the required documentation to OneCare.

SNF Director of Nursing: Registered Nurse who is responsible for the care that is provided by the SNF's RNs, LPNs and Certified Nursing Assistants (CNAs). Ensures that appropriate staffing levels are maintained.

SNF Case Manager: Nurse or Social Worker, who reviews the patient's progress, serves as a liaison with the patient and family and oversees all aspects of the discharge.

SNF Pharmacist: Licensed pharmacist who reviews the patient's medication list and makes recommendations to optimize the patient's medication regimen.

SNF Rehabilitation Director: Coordinates all aspects of a patient's rehabilitative care, including Physical Therapy, Occupational Therapy, Speech Therapy (includes swallowing).

OneCare Vermont Personnel

OneCare Chief Medical Officer/Medical Directors: Provides oversight and medical consultation, as needed, of the benefit enhancement waiver among network participants. Monitors cost, experience, and quality impacts of the waiver to the ACO.

OneCare Waiver Administrator: Leads, manages and coordinates OneCare's efforts in operationalizing the SNF Waiver in communities. Provides technical support and educational resources to SNFs, hospitals and medical providers as needed.

OneCare Clinical Consultant: Experienced clinician with process improvement expertise to assist in developing process workflows, support quality improvement initiatives, provide clinical technical assistance, and network support.

For a customizable **Team Member Template**, please contact the Medicare Waiver Administrator.

Please print and post

Emergency Department MD Decision Making Tool

Provided to ED MDs to assist in making decisions for appropriate level of care

Sample Conditions to Warrant a SNF Admission

- **Wound care** - extensive, where Home Health with family could not assist
- **IV Antibiotics** – multiple times a day where the infusion center or Home Health with family couldn't assist
- **Pelvic Fracture**
- **Compression Fracture**
- **Extremity fracture with limited weight-bearing**
- **Falls** – multiple, progressive
- **Fall(s) with Concussion**

CMS describes skilled care as, "Service so *inherently complex* that it can be safely and effectively performed *only by or under supervision of professional and technical personnel on a daily basis.*"

- Medical necessity for SNF level of care should be met
- Therapy and/or nursing documentation *must* support medical necessity

Appendix D: Suggested Process Workflows

Below are suggested process workflows for admitting patients under the SNF Waiver from short impatient and observation, ED, and PCP/Medical Provider and Patient's Home. An important step in this process is to detail who does what in each step. Feel free to modify these process work flows to reflect your community.

Originating Setting: Short Inpatient and Observation Status
Attending: Hospitalist or Inpatient Covering Physician

1) The referring hospital physician will contact either the PCP or their coverage to discuss SNF admission under the SNF waiver. If it is determined that the patient meets the criteria for admission to a preferred provider SNF under the waiver, then the hospital case manager will proceed with a bed search at the preferred provider SNFs.

2) OneCare believes strongly in the concept of shared-decision making, and the decision to proceed with a SNF admission utilizing the waiver will be undertaken in the context of a shared-decision making discussion. The referring hospital physician, hospital discharge planner, or hospital case manager will be responsible for informing eligible beneficiaries of the option of SNF admission under the waiver.

3) All of the options available to the patient will be reviewed and discussed. If the patient chooses to proceed with admission under the waiver, they will be asked to choose from a preferred provider SNF with an available bed. Patients will still have the option of being admitted to a non-partner SNF, although they will be provided a notice of non-coverage.

4) If patient (or health care proxy, if activated) agrees and there is bed availability at a preferred provider SNF, the SNF Case Manager will verify ONECARE patient attribution.

5) Care Coordinator may check to determine if patient is Very High or High Risk in CareNavigator. If yes, Care Coordinator may add documentation in shared care plan.

6) The referring hospital physician will speak directly with the admitting SNF physician to provide a warm handoff. The admitting SNF physician must be available in a timely fashion to speak with the referring clinician. The SNF should not accept the patient until the SNF physician discusses the patient with the referring hospital physician. The SNF admitting physician may decline the admission.

7) The patient arrives at the SNF, and will be seen within 24 hours of arrival for assessment and a care plan will be completed within 48 hours of admission.

It is expected that the attending SNF physician and/or the nurse care coordinator communicates with the PCP and/or the PCP care coordinator, upon admission, at discharge and if there is an unexpected change in the patient's condition at any point during the stay.

8) The PCP care coordinator provides an integral interface between the PCP (ambulatory team) and the SNF care management team. Ideally, the PCP care coordinator will attend the initial admission team meeting and share pertinent information (or follow up telephonically that day) with the team and participate in the development of the SNF plan of care. They will share the SNF care plan with the PCP and members of the patient's medical home team. Going forward, the PCP care coordinator will participate in the SNF's interdisciplinary team meeting and will communicate updates to the PCP.

9) Sharing conference completed. CareNavigator may be used for sharing a care plan for Very High and High Risk patients.

10) An interdisciplinary approach is expected with clear communication channels between the PCP and the SNF care management team. As the time of discharge approaches, the PCP care coordinator works closely with the SNF case manager to review the timing of the discharge as well as ensuring enhanced services (home care, hospice, DME, etc.) will be in place at the time of discharge. They will also ensure that the appropriate follow-up appointments are scheduled.

11) When discharged from the SNF to home, the PCP care coordinator will update the plan of care in the PCP EHR and CareNavigator.

Originating Setting: Emergency Department
Attending: ED Physician

1) The referring ED physician will contact either the PCP or their coverage to discuss SNF admission under the SNF waiver. If it is determined that the patient meets the criteria for admission to a preferred provider SNF under the waiver, then the hospital case manager will proceed with a bed search at the preferred provider SNFs.

2) OneCare believes strongly in the concept of shared-decision making, and the decision to proceed with a SNF admission utilizing the waiver will be undertaken in the context of a shared-decision making discussion. The referring ED physician, hospital discharge planner, or hospital case manager will be responsible for informing eligible beneficiaries of the option of SNF admission under the waiver.

3) All of the options available to the patient will be reviewed and discussed. If the patient chooses to proceed with admission under the waiver, they will be asked to choose from a preferred provider SNF with an available bed.

Patients will still have the option of being admitted to a non-partner SNF, although they will be provided a notice of non-coverage.

4) If patient (or health care proxy, if activated) agrees and there is bed availability at a preferred provider SNF, the SNF Case Manager will verify ONECARE patient attribution.

5) The referring ED physician will speak directly with the admitting SNF physician to provide a warm handoff. The admitting SNF physician must be available in a timely fashion to speak with the referring clinician. The SNF should not accept the patient until the SNF physician discusses the patient with the referring ED physician. The SNF admitting physician may decline the admission.

6) The patient arrives at the SNF, and will be seen within 24 hours of arrival for assessment and a care plan will be completed within 48 hours of admission. It is expected that the attending SNF physician and/or the nurse care coordinator communicates with the PCP and/or the PCP care coordinator, upon admission, at discharge and if there is an unexpected change in the patient's condition at any point during the stay.

7) The PCP care coordinator provides an integral interface between the PCP (ambulatory team) and the SNF care management team. Ideally, the PCP care coordinator will attend the initial admission team meeting and share pertinent information (or follow up telephonically that day) with the team and participate in the development of the SNF plan of care. They will share the SNF care plan with the PCP and members of the patient's medical home team. Going forward, the PCP care coordinator will participate in the SNF's interdisciplinary team meeting and will communicate updates to the PCP.

8) An interdisciplinary approach is expected with clear communication channels between the PCP and the SNF care management team. As the time of discharge approaches, the PCP care coordinator works closely with the SNF case manager to review the timing of the discharge as well as ensuring enhanced services (home care, hospice, DME, etc.) will be in place at the time of discharge. They will also ensure that the appropriate follow-up appointments are scheduled.

9) When discharged from the SNF to home, the PCP care coordinator will update the plan of care in the PCP EHR and CareNavigator.

For a **Sample Process Workflow Map** for patients referred from short inpatient, observation, or ED see **Appendix E.**

Originating Setting: Primary Care Office or Home
Attending: Primary Care Physician

1) The referring PCP will notify the PCP Care Coordinator that the patient is eligible for skilled nursing and the Care Coordinator will proceed with a bed search at the preferred provider SNFs.

2) OneCare believes strongly in the concept of shared-decision making, and the decision to proceed with a SNF admission utilizing the waiver will be undertaken in the context of a shared-decision making discussion. The referring PCP/Care Coordinator will be responsible for informing eligible beneficiaries of the option of SNF admission under the waiver.

3) All of the options available to the patient will be reviewed and discussed. If the patient chooses to proceed with admission under the waiver, they will be asked to choose from a preferred provider SNF with an available bed. Patients will still have the option of being admitted to a non-partner SNF, although they will be provided a notice of non-coverage.

4) If patient (or health care proxy, if activated) agrees and there is bed availability at a preferred provider SNF, the SNF Case Manager will verify ONECARE patient attribution.

5) The referring PCP will speak directly with the admitting SNF physician to provide a warm handoff. The admitting SNF physician must be available in a timely fashion to speak with the referring clinician. The SNF should not accept the patient until the SNF physician discusses the patient with the referring ED physician. The SNF admitting physician may decline the admission.

6) The patient arrives at the SNF, and will be seen within 24 hours of arrival for assessment and a care plan will be completed within 48 hours of admission. It is expected that the attending SNF physician and/or the nurse care coordinator communicates with the PCP and/or the PCP care coordinator, upon admission, at discharge and if there is an unexpected change in the patient's condition at any point during the stay.

7) The PCP care coordinator provides an integral interface between the PCP (ambulatory team) and the SNF care management team. Ideally, the PCP care coordinator will attend the initial admission team meeting and share pertinent information (or follow up telephonically that day) with the team and participate in the development of the SNF plan of care. They will share the SNF care plan with the PCP and members of the patient's medical home team. Going forward, the PCP care coordinator will participate in the SNF's interdisciplinary team meeting and will communicate updates to the PCP.

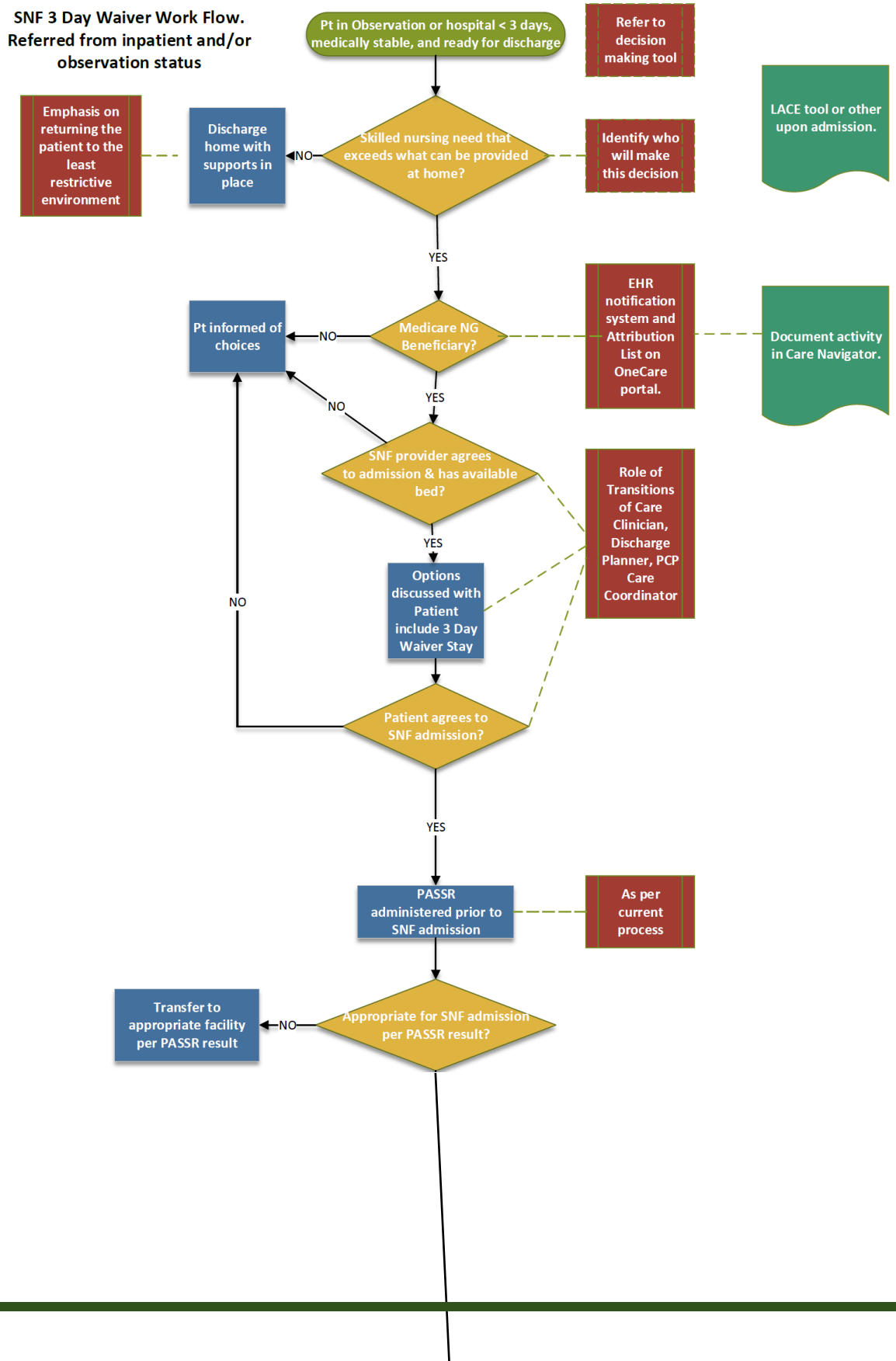
8) An interdisciplinary approach is expected with clear communication channels between the PCP and the SNF care management team. As the time of discharge approaches, the PCP care coordinator works closely with the SNF case manager to review the timing of the discharge as well as ensuring enhanced services (home care, hospice, DME, etc.) will be in place at the

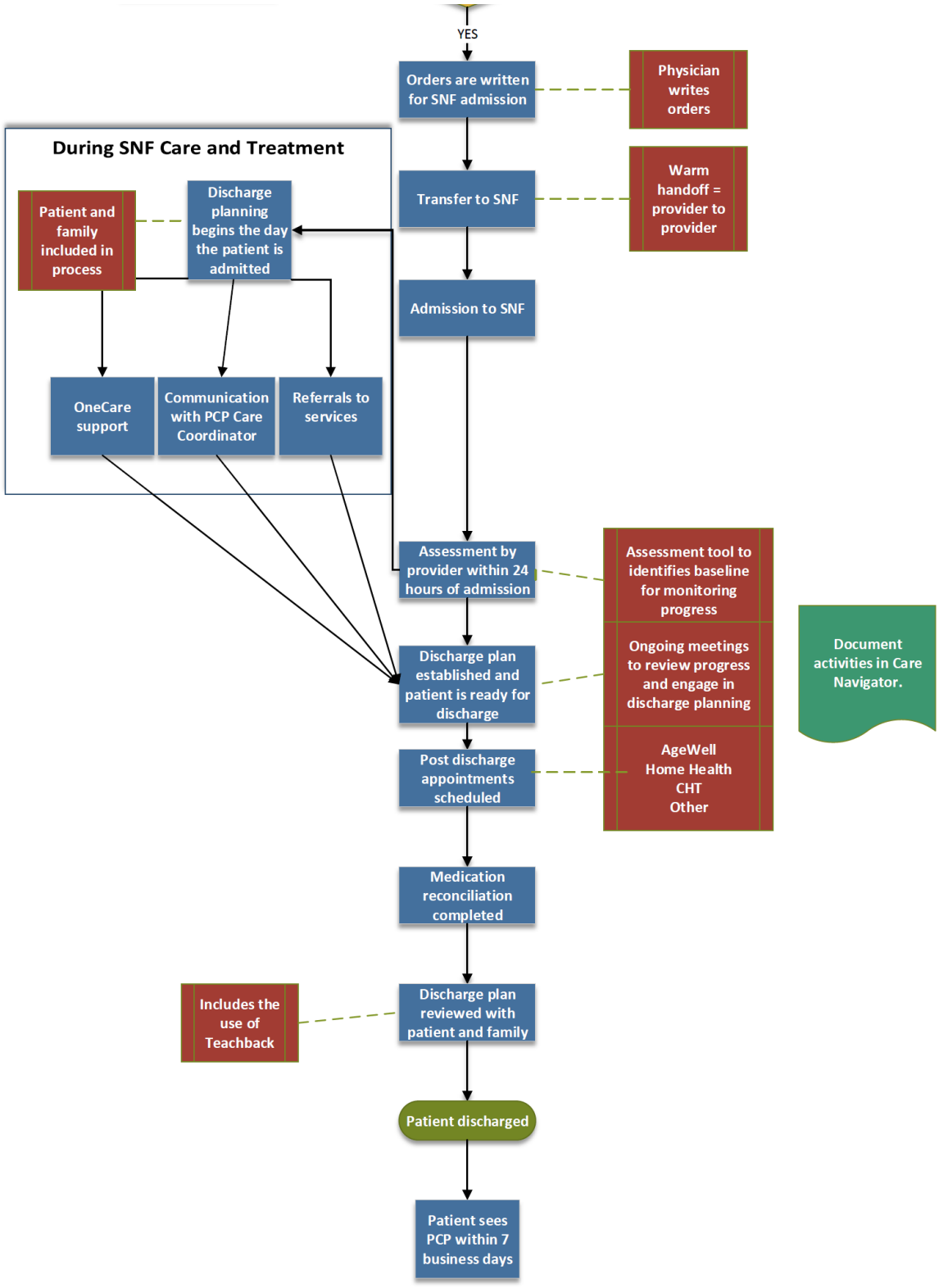
time of discharge. They will also ensure that the appropriate follow-up appointments are scheduled.

9) When discharged from the SNF to home, the PCP care coordinator will update the plan of care in the PCP EHR and CareNavigator.

Appendix E: Sample Process Workflow Map from Short Inpatient, Observation, or ED

For optimum viewing, increase magnification of your screen to 150%.




YES
Orders are written for SNF admission
Physician writes orders
During SNF Care and Treatment
Patient and family included in process
Discharge planning begins the day the patient is admitted
Transfer to SNF
Warm handoff = provider to provider
Admission to SNF
OneCare support
Communication with PCP Care Coordinator
Referrals to services
Assessment by provider within 24 hours of admission
Assessment tool to identifies baseline for monitoring progress
Discharge plan established and patient is ready for discharge
Ongoing meetings to review progress and engage in discharge planning
Document activities in Care Navigator.
Post discharge appointments scheduled
AgeWell
Home Health
CHT
Other
Medication reconciliation completed
Includes the use of Teachback
Discharge plan reviewed with patient and family
Patient discharged
Patient sees PCP within 7 business days

Appendix F: SNF Discharge Plan Checklist

Patient Name or Identifier: _____

- ☐ Presenting problem that precipitated hospitalization identified and shared with patient/family/caregiver
- ☐ Patient/family/caregiver educated on primary and secondary diagnosis
- ☐ Patient/family/caregiver given a written schedule of discharge medications and verbal and written instructions on purpose and cautions
- ☐ Preadmission and discharge medications reconciled and patient/family/caregiver are aware of new medications, change in dose or frequency and medications that should be discontinued
- ☐ Patient/family/caregiver educated on anticipated problems and appropriate interventions for disease management
- ☐ Patient/family/caregiver have been educated on diet and activity and provided with resources, as appropriate
- ☐ Patient discharged with a follow-up appointment with PCP, within one week of discharge, if physician concurs
- ☐ Patient/family/caregiver can identify primary care physician and consultants; knows about signs and symptoms that may develop, and when to call the physician or seek emergency medical care by calling 911
- ☐ Teachback used: Patient/family/caregiver can give a brief summary of discharge instructions when asked

RN Signature: _____

Print Name: _____ Date: _____