**Hospital/Nursing Home Assessment**

The hospital/nursing home assessment is designed for hospitals and nursing homes to assess current transition practices implemented during transitions in care.

**How to Use the Assessment:**

These assessment instruments were designed for each organization to complete independently and review collaboratively. The gaps identified in the current practices of hospitals and nursing homes can be used to inform priority areas for improvement, setting goals, and developing work plans. Hospitals and nursing homes can modify these tools to meet their needs and goals. The assessments can also be used as a baseline to determine progress over time.

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**Hospital Information:**

Please enter the name of your hospital:

**Please enter the name and email address of the person completing the assessment:**

Name:

Email Address:

**Please enter the name of the nursing home that you are working with:**

Name:

**GOAL 1: Build and strengthen relationships across care settings**

Approximately how often does your facility's team meet with your partner nursing home (in person and/or over the phone)?

* Once a week or more
* Every other week
* Once a month
* Every other month
* Once a quarter or less
* Do not meet

Has your hospital implemented a review of data or cases to identify root causes of readmissions with your partner nursing home?

* Yes
* No

On average, how many case reviews does your hospital conduct each month with your partner nursing home?

Approximately how often does your hospital meet with your partner nursing home to perform or discuss case reviews (in person and/or over the phone)?

* Once a week or more
* Every other week
* Once a month
* Once a quarter or less
* Teams do not meet to perform or discuss case reviews

**GOAL 2: Develop standardized processes for communication and information transfer between facilities**

Which of the following have you implemented with your partner nursing home? *Select all that apply.*

* Maintaining hospital and nursing home contact lists
* A communication/information sharing process for hospital discharge to nursing home admission
* A communication/information sharing process for nursing home transfer to hospital emergency department (ED)/unit
* “Warm” handoffs/proactive outreach post-discharge and post-transfer
* Ongoing review of patient information and forms shared between facilities to ensure essential, actionable information is included
* Medication reconciliation process between facilities at hospital discharge
* Medication reconciliation process between facilities at nursing home transfer
* A process to address differences in medication formularies
* Usage of a standardized transfer tool (e.g., INTERACT) to communicate between facilities

Describe which of these standardized processes you have found to be particularly useful in improving communication and information transfer with your partner nursing home, and why?

Please select the top three priority areas that require further improvement with your partner nursing home. *Select up to three items from the list below.*

* Maintaining hospital and nursing home contact lists
* A communication/information sharing process for hospital discharge to nursing home admission
* A communication/information sharing process for nursing home transfer to hospital emergency department (ED)/unit
* “Warm” handoffs/proactive outreach post-discharge and post-transfer
* Ongoing review of patient information and forms shared between facilities to ensure essential, actionable information is included
* Medication reconciliation process between facilities at hospital discharge
* Medication reconciliation process between facilities at nursing home transfer
* A process to address differences in medication formularies
* Usage of a standardized transfer tool (e.g., INTERACT) to communicate between facilities

Which of the following elements are routinely communicated as part of a “warm” handoff between your hospital and the nursing home at patient discharge from the hospital? *Please select all that apply.*

* Overview of patient’s hospital course
* Vital Signs
* Medication list (date/time last does was given; date/time next dose is due; high risk medications; medication allergies)
* Advance directive(s) and Goals of Care, (i.e., Full Code, DNR, DNI, Do Not Hospitalize, MOLST)
* Treatment plans
* High risk conditions
* Relevant lab and diagnostic testing results (completed, pending, and outstanding tests)
* Communications between patient, family members and caregivers
* Behavioral Issues
* Follow up appointments that have been made or need to be made
* Special care needs (e.g. wound care, diet, catheters, infection control issues, skin integrity, fall risk, special equipment)
* Hospital follow up contact information (e.g., PCP or hospitalist name and phone number; specialist name and phone number)
* Other, please specify:

Which of the following statements best describes your approach for determining which patients receive a “warm” handoff at discharge from the hospital? *Please select only one response.*

* All patients should receive a “warm” handoff
* Only certain types of patients should receive a “warm” handoff
* No formal process in place for determining which patients receive a “warm” handoff
* Other, please specify:

Among patients that always require a provider-to-provider “warm” handoff, how often does a “warm” handoff occur when a patient is discharged from your hospital to your partner nursing home?

* Never
* Rarely
* Sometimes
* Often
* Always

Does your hospital have the following medication information sharing processes in place with your partner nursing home? *Please select all that apply.*

* Communication of critical medication information **prior** to a patient's discharge to the nursing home (e.g. prescriptions that may need to be ordered)
* Communication of critical medication information **following** a patient’s discharge to the nursing home (e.g. potential medication discrepancies, time next dose due, important medication administration)

Does your hospital provide education to staff from your partner nursing home on how to interpret medication information received from your facility?

* Yes
* No

**GOAL 3: Incorporate patient, family members, and caregivers**

How often do each of the following activities take place with patients, family members, and caregivers in your facility?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Never | Rarely | Sometimes | Often | Always |
| Discussion of patient’s goals of care |  |  |  |  |  |
| Discussion of patient’s anticipated outcomes upon admission and transfer  |  |  |  |  |  |
| Discussion of advance care planning needs of patients upon admission and transfer |  |  |  |  |  |
| Continually inform and include patients, family, and caregivers in discussions about their care |  |  |  |  |  |
| Collection of information from patients, family members, and caregivers on reasons why a patient was transferred and/or readmitted to better understand reasons for readmission |  |  |  |  |  |

Describe any specific activities your facility has used to incorporate patients, family members, and caregivers that you found to be particularly useful in improving the care coordination process, and why?

Please select the top three priority areas that require further improvement in your facility. *Select up to three items from the list below.*

* Discussion of patient’s goals of care
* Discussion of patient’s anticipated outcomes upon admission and transfer
* Discussion of advance care planning needs of patients upon admission and transfer
* Continually informing and including patients, family and caregivers in discussions about their care
* Collection of information from patients, family members, and caregivers on reasons why a patient was transferred and/or readmitted to better understand reasons for readmission

**Tools Adopted**

Has your hospital adopted a tool or tools to aid with any of the following processes? *Please select all that apply.*

* Discharge planning
* Medication reconciliation
* Patient transfer
* “Warm” handoff between hospital and nursing home clinical staff
* Case reviews
* Advance care planning
* Communication between non-clinical staff and nurses within your facility
* Communication between nurses and physicians within your facility

For the processes selected in the previous question, please list the specific tools that your hospital has adopted:

Discharge planning:

Medication reconciliation:

Patient transfer:

 “Warm” handoff between hospital and nursing home clinical staff:

Case reviews:

Advance care planning:

Communication between non-clinical staff and nurses within your facility:

Communication between nurses and physicians within your facility:

**Process Measures**

Does your hospital currently collect process measures on care transition interventions?

* Yes
* No

[If answered “Yes” in previous question]

On which of the following topics does your hospital currently collect processes measures? *Please select all that apply.*

* “Warm” handoffs
* Medication reconciliation
* Identification of a family member/caregiver
* Advance care planning
* Other, please specify: