**Hospital Discharge to SNF Admission:**

**Prompts to Guide Process Mapping**

**Overarching Themes to Consider:**

1. Timing/Shifts: Does this occur 24/7 or only on weekdays 9-5 pm? Are we relying on one person? Do we have contingency plans?
2. Ideal vs. Actual: Are we discussing the ideal process or what will likely happen?
3. Roadblocks/Dependent Tasks: Are there specific items (e.g. authorizations) that create roadblocks or barriers in the process, as they are dependent on other processes and can prevent things from moving forward?
4. Communication Mechanisms: What communication systems are being used (e.g. landline, pager, fax, secure email, special dedicated hotline, mobile phone)?

**Specific Questions:**

1. The decision to Discharge to an SNF: Once the decision to discharge takes place, what are the critical steps that take place?
2. Evaluations/Medical Clearance

* Is a rehabilitation consultation or PT evaluation needed? When does this occur? What other documentation and authorizations are required?
* Is psychiatric clearance required? Who conducts this?

1. Facility Identification and Selection

* What is the facility selection process? When does the conversation with patient, family/caregiver about facility selection occur?
* How do you ensure that the facility has the capabilities to meet the patient’s special needs?

1. PRI Process

* Who completes this? Does this person work certain shifts? Does this process occur 24/7?
* How does this work? What is the turnaround time?
* What other authorizations need to be obtained (e.g. insurance)?
* What are the barriers?
* How does this differ based on a patient’s insurance?
* What happens if no facilities accept the patient?

1. SNF Selection Confirmed, Finalizing the discharge and Transfer Process: Once the SNF selection is confirmed what are the next steps to finalize the discharge and transfer process?
2. Finalizing the Discharge Process

* Who is shepherding this process? Are they shift based, what happens on off hours?
* What other activities need to take place?
* Are there any barriers?

1. Transfer Process

* What is the process for transfer and identifying transport?
* Who prepares and bundles the patient’s information for transfer to the next care facility? Is it done all at once, it is it done in steps? It what formats is transmitted, e.g. fax, electronic, paper?
* What verbal communications that occur between the hospital and the facility before transport transferring the patient? How, when?

1. Arrival in the Nursing Home: Once a patient arrives at a nursing facility, what is the process?
2. What is the admission process?

* Who coordinates admission of the patient?
* What other aspects (e.g., medication reconciliation, medication order and receipt, physician orders, clinical evaluation) occur to ensure continuity of care?
* What process brings all information together and informs the care team? Who is/are involved?
* When is the hospital health record received (e.g., before patient’s arrival, with the patient, shortly after the patient’s arrival)?
* How is this documentation transmitted (e.g., fax, electronic, paper)?
* Who receives the hospital health record? How is that information organized and processed once the patient arrives? Who reviews the documentation sent from the hospital?

1. What is the process to acclimate the patient and the family/caregiver to the facility?

* What conversations (e.g., goals of care, patient/family/caregiver expectations, patient preferences, advanced directives) occur with the patient, family/caregiver? When do these conversations happen?
* In addition to face-to-face conversations, are there other means of communication (e.g., phone call to family/caregiver)? When do they happen?
* Does any communication occur with the patient’s hospital clinical team?
* What verbal communications occur between the hospital and the nursing home once a patient is admitted and arrives at the nursing home? This may include clarification of medication and justification for use, patient management in the hospital—what worked and did not work, advanced directives, goals of care and patient and family expectations, or any neurobehavioral issues. How and when does this occur? Do you normally call a specific person, landline, etc., when you have a question?

1. What are the barriers?

* Have payor or authorizations issues delayed access to care? If so, to what services (e.g. therapy, consultation with a specialist)?