APPENDIX

Supplementary Table S1 Frequency of reported care delivery approaches and barriers for surveyed SNFs

	Surveyed SNFs n = 377
	% or mean
Care Delivery Approaches	16.8
Condition-specific care pathways/protocols	63.8%
Data analytics to identify high-risk residents	75.1%
Huddles or team review of patient census	97.9%
Use of MD or NP focused on SNF care	82.5%
Education on shorter length of stay	84.5%
Medication reconciliation on discharge	97.2%
Use of discharge check list	95.7%
Post-discharge follow-up on clinical needs	74.7%
Post-discharge follow-up on PCP appointment	55.4%
Selective referral to HHAs based on quality	69.0%
Care pathways to reduce readmissions	77.2%
Formal screening for SDoH	70.5%
Formal processes to directly address SDoH	66.4%
Post-discharge referrals to community resources	89.5%
Staff training on patients with cognitive decline	87.0%
Dementia focused short stay unit	17.9%
Dementia occupational therapy	58.8%
Tracking of hospital readmissions during stay	93.8%
Tracking of hospital readmissions post-discharge	72.1%
Tracking of repeat ED visits during stay	90.7%
Tracking of repeat ED visits post-discharge	47.7%
Tracking of PCP follow-up post-discharge	44.7%
Patient experience surveys	76.7%
Barriers	5.0
Lack of access to non-emergent transport	34.2%
Inadequate availability of high-quality HHA	15.3%
Lack of patient social support	66.1%
Inadequate mental health services	65.1%
Inadequate substance abuse services	46.7%
Difficulty in forging affiliations with hospitals	15.0%
Difficulty in forging affiliations with HHAs	12.2%
Lack of staff buy in for changes	23.4%

Lack of funding for new programs	38.7%
Lack of data to assess facility quality	17.7%
Lack of personnel to support care adoptions	50.5%
Staff turnover and burnout	73.8%

Note: ED is emergency department. EHR is electronic health record. HHA is home health agency. MD is medical doctor. NP is nurse practitioner. PCP is primary care physician. SDoH is social determinants of health. SNF is skilled nursing facility.

Supplementary Table S2 Position of survey respondents

Respondent position	Freq.	Percent
SNF Administrator	254	67.37
Executive Director	59	15.65
missing	36	9.55
Director of Nursing	23	6.1
Admissions Nurse	1	0.27
Director of Safety	1	0.27
Interim Director of Nursing	1	0.27
Regional Director of Operations	1	0.27
Assistant Director of Nursing	1	0.27

Supplementary Table S3 Characteristics of SNF Survey Respondents and SNF Survey Non-Respondents (Table)

Variables	**Contacted SNFs**	**Respondents**	**Non-Respondents**	
	% or mean	**% or mean**	**% or mean**	**p-value**
N of SNFs	693	377	316	
Ownership status				
Not for profit	28.8%	27.0%	30.7%	0.46
Government	4.0%	4.6%	3.4%	0.51
For profit	67.2%	68.3%	66.0%	0.64
Urban				
large metro	41.6%	41.3%	41.9%	0.92
medium/small metro	32.7%	31.5%	34.1%	0.61
micropolitan/non-core	25.7%	27.2%	23.9%	0.47
Number of residents	100.4	96.3	104.9	0.42
Number of federally certified beds	111.4	109.2	113.9	0.57
SNF in chain	58.9%	54.8%	63.5%	0.10
SNF hospital based	5.9%	5.3%	6.6%	0.67
Region				
West	12.9%	16.0%	9.4%	0.04
Northeast	19.2%	19.0%	19.3%	0.94
Midwest	32.1%	33.3%	30.7%	0.59
South	35.9%	31.6%	40.6%	0.09
Overall quality rating	3.1	3.1	3.1	0.61

Note: Pearson chi-square tests performed for ownership status, urban location, chain membership, hospital-based, and region. *T*-tests performed for number of residents, number of federally certified beds, and overall quality rating.

Supplementary Table S4 Regression estimates of the association between facility-level characteristics and the number of barriers and care delivery approaches reported by SNF survey respondents

	(1) care delivery approaches		**(2) barriers**	
BPCI/ACO status (ref: both)				
BPCI only	1.025	(0.6646)	0.996	(0.9784)
Neither	0.975	(0.4127)	0.829	(0.0206)
Assisted Living Facility	1.030	(0.4979)	0.924	(0.5713)
Ownership (ref: Non-Profit)				
Government	1.103	(0.2999)	0.867	(0.4068)
For Profit	1.114	(0.0099)	0.994	(0.9569)
Chain Membership (ref: No)				
Yes	1.045	(0.2582)	0.790	(0.0142)
Number of Certified Beds	1.021	(0.0543)	0.975	(0.5265)
Average Number of Residents per Day	1.034	(0.1127)	0.967	(0.5158)
Continuing Care Retirement Community (ref: no)	1.007	(0.9203)	1.139	(0.4404)
Quality (ref: 1-2 Star)				
3 Star	1.039	(0.4062)	0.758	(0.0161)
4-5 Star	1.067	(0.0713)	0.821	(0.0530)
Percent Minority	0.949	(0.0198)	0.913	(0.0306)
Reported Total Nurse Staffing Hours per Resident per Day	0.938	(0.0009)	0.936	(0.2172)
Percent Medicaid	1.024	(0.3700)	1.105	(0.0783)
Urban (ref: micropolitan/non-core)				
large metro	1.084	(0.0712)	0.932	(0.5244)
small/medium metro	1.071	(0.1236)	0.996	(0.9717)

Note: Results are from a Poisson model with estimated coefficients expressed as a factor change in the expected count for a 1 unit increase in X. Continuous variables are standardized as the factor change in the expected count for a 1 standard deviation increase in X. N = 301. P-values in parenthesis. BPCI is bundled payments for care improvement. ACO is accountable care organization.

Supplementary Table S5 Pooled egression estimates from 10 multiply imputed datasets of the association between facility-level characteristics and the number of care delivery approaches and barriers reported by SNF survey respondents

	(1) care delivery approaches		(2) barriers	
BPCI/ACO status (ref: both)				
BPCI only	1.005	(0.9226)	0.908	(0.5597)
Neither	0.964	(0.1946)	0.808	(0.0073)
Assisted Living Facility	1.017	(0.6900)	0.932	(0.6060)
Ownership (ref: Non-Profit)				
Government	1.052	(0.5698)	0.911	(0.5536)
For Profit	1.073	(0.1174)	0.985	(0.8892)
Chain Membership (ref: No)				
Yes	1.040	(0.2784)	0.773	(0.0056)
Number of Certified Beds	1.020	(0.0364)	0.967	(0.3457)
Average Number of Residents per Day	1.038	(0.0453)	0.968	(0.4985)
Continuing Care Retirement Community	1.023	(0.6990)	1.144	(0.3910)
Quality (ref: 1-2 Star)				
3 Star	1.031	(0.4698)	0.772	(0.0275)
4-5 Star	1.054	(0.1297)	0.823	(0.0427)
Percent Minority	0.956	(0.0399)	0.899	(0.0258)
Reported Total Nurse Staffing Hours per Resident per Day	0.940	(0.0005)	0.930	(0.1421)
Percent Medicaid	1.027	(0.2489)	1.057	(0.3015)
Urban (ref: micropolitan/non-core)				
large metro	1.076	(0.0799)	0.975	(0.8184)
small/medium metro	1.044	(0.3031)	1.086	(0.4514)

Note: Pooled regression results from ten multiply imputed datasets. Poisson model with estimated coefficients expressed as a factor change in the expected count for a 1 unit increase in X. Continuous variables are standardized as the factor change in the expected count for a 1 standard deviation increase in X. P-values in parenthesis. BPCI is bundled payments for care improvement. ACO is accountable care organization.

Supplementary Table S6 Frequency of reported care delivery approaches and barriers by BPCI participation

	BPCI Participation n = 377		
	BPCI n = 179 % = 47.5	**Non-BPCI** n = 198 % = 55.52	**p-value**
	% or mean	**% or mean**	
Care Delivery Approaches	18.2	16.7	
Condition-specific care pathways/protocols	79.0%	62.6%	0.00
Data analytics to identify high-risk residents	78.7%	74.9%	0.41
Huddles or team review of patient census	98.2%	97.9%	0.81
Use of MD or NP focused on SNF care	94.1%	81.6%	0.00
Education on shorter length of stay	86.8%	84.4%	0.53
Medication reconciliation on discharge	98.4%	97.1%	0.40
Use of discharge check list	96.8%	95.6%	0.57
Post-discharge follow-up on clinical needs	84.7%	74.0%	0.02
Post-discharge follow-up on PCP appointment	67.1%	54.5%	0.02
Selective referral to HHAs based on quality	71.6%	68.8%	0.58
Care pathways to reduce readmissions	90.8%	76.2%	0.00
Formal screening for SDoH	75.8%	70.1%	0.26
Formal processes to directly address SDoH	75.0%	65.7%	0.07
Post-discharge referrals to community resources	87.7%	89.6%	0.54
Staff training on patients with cognitive decline	83.8%	87.2%	0.35
Dementia focused short stay unit	20.5%	17.7%	0.53
Dementia occupational therapy	62.3%	58.5%	0.50
Tracking of hospital readmissions during stay	98.4%	93.4%	0.02
Tracking of hospital readmissions post-discharge	81.3%	71.4%	0.03
Tracking of repeat ED visits during stay	97.7%	90.2%	0.00
Tracking of repeat ED visits post-discharge	61.1%	46.6%	0.01
Tracking of PCP follow-up post-discharge	51.7%	44.2%	0.18
Patient experience surveys	85.8%	76.0%	0.03
Barriers	5.5	4.9	
Lack of access to non-emergent transport	47.0%	33.2%	0.01
Inadequate availability of high-quality HHA	18.9%	15.1%	0.37
Lack of patient social support	74.4%	65.4%	0.09
Inadequate mental health services	56.6%	65.8%	0.09

Inadequate substance abuse services	50.9%	46.4%	0.42
Difficulty in forging affiliations with hospitals	16.6%	14.9%	0.67
Difficulty in forging affiliations with HHAs	12.3%	12.2%	0.98
Lack of staff buy in for changes	35.2%	22.5%	0.01
Lack of funding for new programs	45.6%	38.2%	0.17
Lack of data to assess facility quality	16.9%	17.7%	0.83
Lack of personnel to support care adoptions	54.3%	50.2%	0.47
Staff turnover and burnout	76.5%	73.6%	0.57

Note: Pearson Chi-square tests performed. ED is emergency department. EHR is electronic health record. HHA is home health agency. MD is medical doctor. NP is nurse practitioner. PCP is primary care physician. SDoH is social determinants of health. SNF is skilled nursing facility.

Supplementary Table S7 Frequency of reported care delivery approaches and barriers by ownership type

	Ownership n = 375			**Chain Membership** n=368		
	For-Profit n = 289 % = 77.1	**Government/ Non-Profit** n = 86 % = 22.9	**p-value**	**No** n = 139 % = 37.8	**Yes** n = 229 % = 62.2	**p-value**
	% or mean	**% or mean**		**% or mean**	**% or mean**	
Care Delivery Approaches	17.4	15.5		16.1	17.2	
Condition-specific care pathways/protocols	72.1%	44.8%	0.00	63.6%	63.3%	0.96
Data analytics to identify high-risk residents	80.7%	62.5%	0.01	72.8%	75.8%	0.62
Huddles or team review of patient census	97.6%	98.7%	0.56	98.3%	97.5%	0.63
Use of MD or NP focused on SNF care	83.8%	79.2%	0.43	78.7%	84.7%	0.30
Education on shorter length of stay	87.1%	78.6%	0.10	77.6%	90.1%	0.01
Medication reconciliation on discharge	97.5%	96.5%	0.68	97.3%	97.1%	0.92
Use of discharge check list	94.4%	98.4%	0.11	96.4%	94.9%	0.56
Post-discharge follow-up on clinical needs	77.8%	69.4%	0.20	68.4%	79.5%	0.09
Post-discharge follow-up on PCP appointment	61.2%	43.9%	0.03	51.8%	57.3%	0.44
Selective referral to HHAs based on quality	71.5%	62.9%	0.23	67.0%	70.0%	0.65
Care pathways to reduce readmissions	78.6%	73.7%	0.43	69.3%	83.4%	0.03
Formal screening for SDoH	72.5%	65.7%	0.36	71.0%	69.9%	0.88
Formal processes to directly address SDoH	70.0%	57.8%	0.11	67.5%	65.0%	0.72
Post-discharge referrals to community resources	90.5%	87.0%	0.41	87.6%	90.5%	0.47
Staff training on patients with cognitive decline	87.9%	84.6%	0.50	88.6%	86.0%	0.56
Dementia focused short stay unit	20.4%	12.7%	0.17	15.7%	20.5%	0.36
Dementia occupational therapy	61.6%	53.7%	0.30	51.8%	64.4%	0.07

Tracking of hospital readmissions during stay	92.8%	95.9%	0.35	94.8%	92.7%	0.54
Tracking of hospital readmissions post-discharge	75.0%	67.5%	0.25	66.9%	76.3%	0.13
Tracking of repeat ED visits during stay	90.5%	90.9%	0.94	90.2%	90.7%	0.90
Tracking of repeat ED visits post-discharge	48.3%	47.3%	0.90	45.4%	48.1%	0.70
Tracking of PCP follow-up post-discharge	50.2%	33.7%	0.03	40.8%	48.1%	0.30
Patient experience surveys	78.3%	74.8%	0.63	75.7%	77.4%	0.79
Barriers	5.1	4.8		5.5	4.5	
Lack of access to non-emergent transport	38.0%	26.6%	0.15	34.5%	34.3%	0.98
Inadequate availability of high-quality HHA	15.6%	14.9%	0.91	17.1%	14.1%	0.58
Lack of patient social support	65.1%	69.3%	0.55	63.1%	68.0%	0.47
Inadequate mental health services	66.9%	60.6%	0.38	66.3%	62.5%	0.58
Inadequate substance abuse services	48.7%	41.4%	0.34	42.2%	49.5%	0.30
Difficulty in forging affiliations with hospitals	17.1%	10.8%	0.22	15.2%	14.3%	0.85
Difficulty in forging affiliations with HHAs	14.3%	8.1%	0.17	13.8%	10.7%	0.48
Lack of staff buy in for changes	28.5%	13.0%	0.01	28.6%	19.5%	0.12
Lack of funding for new programs	35.7%	45.8%	0.17	50.0%	29.5%	0.00
Lack of data to assess facility quality	15.7%	20.5%	0.37	27.6%	8.6%	0.00
Lack of personnel to support care adoptions	51.3%	47.8%	0.64	59.5%	42.6%	0.02
Staff turnover and burnout	73.5%	74.1%	0.92	78.0%	70.9%	0.26

Note: Pearson Chi-square tests performed. ED is emergency department. EHR is electronic health record. HHA is home health agency. MD is medical doctor. NP is nurse practitioner. PCP is primary care physician. SDoH is social determinants of health. SNF is skilled nursing facility.

Supplementary Table S8 Frequency of reported care delivery approaches and barriers by quality rating and minority quartiles

	Overall Quality Rating n=374				**Minority** n=377			
	1-2 Stars n = 134 %= 35.8	**3 Stars** n = 71 % = 19	**4-5 Stars** n = 169 % = 45.2	**p-value**	**Lowest Quartile** n = 98 % = 26.0	**2-3 Quartiles** n = 185 % = 49.1	**Highest Quartile** n = 94 % = 24.9	**p-value**
	% or mean	**% or mean**	**% or mean**		**% or mean**	**% or mean**	**% or mean**	
Care Delivery Approaches	16.9	17.1	16.5		16.8	17.3	15.6	
Condition-specific care pathways/protocols	61.0%	77.5%	60.5%	0.18	60.2%	71.0%	53.9%	0.13
Data analytics to identify high-risk residents	75.8%	62.3%	79.1%	0.13	80.7%	75.2%	67.6%	0.28
Huddles or team review of patient census	96.7%	99.7%	98.2%	0.28	97.3%	99.9%	94.9%	0.03
Use of MD or NP focused on SNF care	84.4%	93.0%	76.9%	0.08	78.0%	88.5%	76.4%	0.15
Education on shorter length of stay	84.3%	90.0%	82.6%	0.54	83.3%	83.8%	87.6%	0.78
Medication reconciliation on discharge	97.7%	95.0%	97.7%	0.65	98.1%	96.9%	96.7%	0.87
Use of discharge check list	96.5%	89.8%	97.3%	0.10	97.3%	93.4%	98.4%	0.20
Post-discharge follow-up on clinical needs	82.3%	71.3%	71.1%	0.20	73.6%	78.1%	69.6%	0.54
Post-discharge follow-up on PCP appointment	65.0%	54.4%	49.2%	0.12	56.8%	58.7%	47.3%	0.43
Selective referral to HHAs based on quality	66.9%	61.8%	72.8%	0.44	76.9%	74.3%	48.0%	0.00
Care pathways to reduce readmissions	75.6%	83.5%	75.9%	0.59	77.9%	82.2%	66.5%	0.12
Formal screening for SDoH	67.4%	77.9%	69.8%	0.55	70.7%	69.6%	72.1%	0.96
Formal processes to directly address SDoH	63.8%	76.5%	64.2%	0.39	66.9%	67.9%	62.7%	0.84
Post-discharge referrals to community resources	89.0%	90.1%	89.5%	0.98	90.7%	86.8%	93.2%	0.41

Staff training on patients with cognitive decline	88.1%	88.2%	85.5%	0.83	89.6%	83.8%	89.9%	0.41
Dementia focused short stay unit	20.0%	19.8%	15.8%	0.73	17.8%	20.1%	13.9%	0.64
Dementia occupational therapy	63.9%	56.6%	56.4%	0.58	53.8%	66.8%	49.6%	0.10
Tracking of hospital readmissions during stay	93.8%	92.5%	94.1%	0.94	95.1%	92.8%	94.0%	0.84
Tracking of hospital readmissions post-discharge	77.1%	73.4%	68.7%	0.46	67.9%	79.1%	63.3%	0.09
Tracking of repeat ED visits during stay	94.1%	84.4%	90.3%	0.33	95.2%	91.8%	82.5%	0.07
Tracking of repeat ED visits post-discharge	47.1%	43.5%	50.2%	0.78	46.5%	56.1%	32.3%	0.03
Tracking of PCP follow-up post-discharge	43.5%	57.0%	41.8%	0.29	49.4%	46.7%	34.6%	0.26
Patient experience surveys	71.9%	80.4%	80.0%	0.45	79.9%	77.6%	70.8%	0.57
Barriers	5.8	4.4	4.5		5.8	4.7	4.5	
Lack of access to non-emergent transport	40.7%	39.0%	27.9%	0.18	40.9%	34.2%	25.3%	0.23
Inadequate availability of high-quality HHA	19.3%	6.7%	15.6%	0.22	22.1%	13.9%	9.2%	0.16
Lack of patient social support	75.7%	61.4%	61.3%	0.11	65.7%	68.3%	62.0%	0.77
Inadequate mental health services	78.3%	53.2%	58.9%	0.01	76.0%	60.5%	59.7%	0.10
Inadequate substance abuse services	57.9%	35.2%	41.7%	0.04	42.3%	47.6%	50.7%	0.67
Difficulty in forging affiliations with hospitals	18.8%	16.3%	11.9%	0.41	16.3%	12.0%	19.3%	0.46
Difficulty in forging affiliations with HHAs	17.8%	13.0%	7.8%	0.11	15.3%	6.9%	18.8%	0.06
Lack of staff buy in for changes	33.1%	16.4%	18.8%	0.04	33.1%	15.9%	25.5%	0.03
Lack of funding for new programs	42.8%	34.6%	37.6%	0.66	49.2%	35.0%	32.2%	0.11
Lack of data to assess facility quality	22.8%	10.7%	15.2%	0.19	24.5%	15.2%	13.5%	0.21
Lack of personnel to support care adoptions	54.1%	52.1%	46.4%	0.59	61.1%	45.9%	45.6%	0.14
Staff turnover and burnout	78.9%	64.1%	73.2%	0.28	81.2%	75.6%	60.6%	0.06

Note: Pearson Chi-square tests performed. ED is emergency department. EHR is electronic health record. HHA is home health agency. MD is medical doctor. NP is nurse practitioner. PCP is primary care physician. SDoH is social determinants of health. SNF is skilled nursing facility.

Supplementary Table S9 Average shares of residents with cognitive impairment in facilities with and without each of the dementia-focused care delivery approaches

Dementia-focused delivery approach	**Cognitive deficiency training**		**Dementia Focused Short Stay Unit**		**Dementia Occupational Therapy**	
	YES	**NO**	**YES**	**NO**	**YES**	**NO**
Low CFS	47.00%	49.12%	44.19%	48.07%	47.47%	47.17%
Moderate CFS	0.03%	0.07%	0.01%	0.04%	0.03%	0.04%
Severe CFS	4.04%	3.60%	4.29%	3.90%	4.09%	3.80%

Note: CFS is cognitive function scale.

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HARVARD T.H. CHAN
SCHOOL OF PUBLIC HEALTH

Thank you for participating in the **Survey of U.S. Skilled Nursing Facilities**. COVID-19 has created numerous challenges for nursing homes caring for long- and short stay patients and facilities have seen a falloff in revenue on the short stay side. Thus, payment issues for short stay nursing home patients continue to be critically important for SNFs financial success. With support from the National Institute of Aging, researchers at the Harvard T.H. Chan School of Public Health and Washington University in Saint Louis are fielding this survey to understand skilled nursing facilities' priorities, strategies, and challenges **for short-stay residents** around new payment systems. This survey has been endorsed by the American Health Care Association (AHCA) and LeadingAge. The survey will take about 15 minutes to complete. We have enclosed a $100 check to thank you for your valuable time.

Your participation is critical to inform these findings, but this survey is voluntary. Please have this survey filled out by the SNF administrator, the Executive Director or the person in your skilled nursing facility that is most knowledgeable about clinical strategies. All responses are **private and confidential**. Results will be analyzed only in the aggregate and no individual responses will be reported. Please respond to the following questions.

SURVEY INFORMATION

- For each question, please check the box or boxes next to the most appropriate answer or answers.
- Please answer all questions unless directed otherwise.
- When you have completed the survey, please return it in the enclosed postage-paid envelope.

SURVEY OF U.S. SKILLED NURSING FACILITIES

SECTION 1: RESPONDENT AND CARE SETTINGS

1. What is your position at: [INSERT SNF FACILITY NAME AND ADDRESS FROM SAMPLE]?
   Please select all that apply.

   ❑ SNF Administrator
   ❑ Executive Director
   ❑ Other Administrator (PLEASE SPECIFY: _____)

2. What types of services are offered at your facility? **Please record a response for each item below.**

Types of Facility Services	Yes	No	Don't Know
Short stay rehab care	❑	❑	❑
Long term care	❑	❑	❑
Assisted/independent living	❑	❑	❑
Dementia care unit for short stay residents	❑	❑	❑
Dementia care unit for long stay residents	❑	❑	❑

SECTION 2: PARTICIPATION IN ALTERNATIVE PAYMENT METHODS

This section concerns **"alternative payment models,"** or payment models besides the standard Medicare Part A RUG model or the new patient-driven payment model. Examples of alternative payment models include episode-based payment (also known as "bundled payments"), accountable care organizations and other value-based payment models.

3. Do you participate in any alternative payment models, such as episode-based payment ("bundled" payments), accountable care organization contracts or other value-based purchasing? "Participation" means that your facility has financial exposure to the alternative payment model of meaningful importance for your facility.

❑ Yes → **Continue to Question 4**

❑ No
❑ Don't Know → **Skip to Question 5**

4. Please indicate which of the following payment models you have participated in over the past 2 years and with which payer. **Please check all that apply for each item below**.

Payment Models	Fee for Service (Standard) Medicare	Medicaid	Medicare Advantage (Part C)	None	Don't Know
Episode-based or bundled payment	❑	❑	❑	❑	❑
Accountable care organization	❑	❑	❑	❑	❑
Other pay-for-performance program	❑	❑	❑	❑	❑

SECTION 3: CARE REDESIGN

5. Below is a list of care redesign initiatives that SNFs might pursue. Please indicate whether each tool or strategy is currently used by your SNF for **short-stay residents. Please record a response for each item below.**

	Currently Use		
I. Short-Stay Care Redesign	**Yes**	**No**	**Don't Know**
Condition-specific care pathways or protocols for SNF care	❑	❑	❑
EHR or other data-based analytics to identify high-risk short-stay residents	❑	❑	❑
Huddles or regular review of patient census as a team	❑	❑	❑
Use of physician or nurse practitioner focused on SNF care (i.e. "SNFist")	❑	❑	❑
Educating short-stay residents/families to anticipate a shorter length of stay	❑	❑	❑
Medication reconciliation on discharge	❑	❑	❑
Use of discharge check list	❑	❑	❑
Post-discharge follow up to check in on clinical needs and prevent rehospitalization	❑	❑	❑
Post-discharge follow-up to confirm appointment completed with primary care physician	❑	❑	❑
Selective referral to HHAs based on quality	❑	❑	❑
Care pathways to reduce re-hospitalization of current short-stay residents (e.g. INTERACT model)	❑	❑	❑

6. Below is a list of initiatives focused on social determinants that SNFs might pursue. Please indicate whether each tool or strategy is currently used by your SNF for **short-stay residents. Please record a response for each item below**.

	Currently Use		
II. Social Determinants / Vulnerable Populations	**Yes**	**No**	**Don't Know**
Formal screening for problems with transportation, food, or housing	❑	❑	❑
Formal processes for directly addressing social determinants such as transportation, food or housing	❑	❑	❑
Post-discharge patient referrals to community resources to address social determinants of health	❑	❑	❑

7. Below is a list of initiatives focused on patients with cognitive impairment or dementia that SNFs might pursue. Please indicate whether each tool or strategy is currently used by your SNF **for short-stay residents** . **Please record a response for each item below**.

	Currently Use		
III. Cognitive Impairment	**Yes**	**No**	**Don't Know**
Special training for staff caring for patients with cognitive decline	❑	❑	❑
Specific physical unit for short stay patients with dementia	❑	❑	❑
Enhanced occupational therapy for patients with dementia (e.g. kitchen simulation environment)	❑	❑	❑

SECTION 4: BARRIERS AND CONTEXT

8. Please indicate whether the following factors posed a barrier to reducing spending or improving care **for your short-stay residents**, regardless of payment type. **Please record a response for each item below**.

Does this pose a barrier to reducing spending or improving care?	**Yes, this poses a barrier**	**No, this does not pose a barrier**	**Don't Know**
Care During SNF Stay			
Inadequate availability or accessibility of non-emergent transportation services for appointment while at facility	❑	❑	❑
Post Discharge Care			
Inadequate availability of high-quality HHA in the area	❑	❑	❑
Difficulty with patients' lack of social support (e.g. living alone)	❑	❑	❑
Inadequate availability or accessibility of mental health services	❑	❑	❑
Inadequate availability or accessibility of substance use treatment services	❑	❑	❑
Facility Resources and Staff			
Difficulty in forging effective affiliations with hospitals	❑	❑	❑
Difficulty in forging effective affiliations with HHAs	❑	❑	❑
Difficulty getting buy-in from facility staff to implement changes	❑	❑	❑
Inadequate financial resources to implement new programs	❑	❑	❑
Insufficient availability of analytics and data to assess your facility's quality and cost performance	❑	❑	❑
Lack of personnel to support care innovations	❑	❑	❑
Staff turnover and/or burnout	❑	❑	❑

SECTION 5: QUALITY

9. Do you collect data and monitor performance over time for the following performance indicators **for your short-stay residents**?
Please record a response for each item below.

	Currently collect data and monitor performance		
	Yes	**No**	**Don't Know**
Readmission to acute care hospital during SNF stay	❑	❑	❑
Readmission to acute care hospital after SNF discharge	❑	❑	❑
Repeat emergency room visits during SNF stay	❑	❑	❑
Repeat emergency room visits after SNF discharge	❑	❑	❑
Post-SNF discharge ambulatory follow-up with PCP or other physicians	❑	❑	❑
Patient experience surveys	❑	❑	❑

SECTION 6: RELATIONSHIPS WITH OTHER INSTITUTIONS

10. Below is a list of the types of relationships you might have with various institutions. Please indicate whether these relationships exist. **Please record a response for each item below.**

	Does this type of relationship currently exist?		
Relationships with Hospitals	**Yes**	**No**	**Don't Know**
Preferred Network for Hospital Discharges to Your Facility	❑	❑	❑
Financial Integration	❑	❑	❑
EHR integration or data sharing	❑	❑	❑
Relationships with Home Health Agencies			
Preferred Network for Your Facility's Discharges	❑	❑	❑
EHR integration or data sharing	❑	❑	❑

11. Did alternative payment models substantially influence the formations of these relationships?

	Formation of relationship influenced by an alternative payment model			
Relationships with Hospitals	**Yes**	**No**	**Don't Know**	**Not Applicable**
Preferred Network for Hospital Discharges to Your Facility	❑	❑	❑	❑
Financial Integration	❑	❑	❑	❑
EHR integration or data sharing	❑	❑	❑	❑
Relationships with Home Health Agencies				
Preferred Network for Your Facility's Discharges	❑	❑	❑	❑
EHR integration or data sharing	❑	❑	❑	❑

SECTION 7: ADAPTING TO THE PATIENT DRIVEN PAYMENT MODEL (PDPM)

12. Overall, how difficult has it been for your facility to adapt to the "Patient Driven Payment Model,"(PDPM), Medicare's new billing system for skilled nursing facilities?

- ❑ Not Difficult
- ❑ Slightly Difficult
- ❑ Moderately Difficult
- ❑ Very Difficult
- ❑ Don't Know

13. How difficult has it been for your facility to conduct the following tasks relating to the Patient Driven Payment Model (PDPM)? **Please record a response for each item below**.

	Not Difficult	Slightly Difficult	Moderately Difficult	Very Difficult	Don't Know
Identifying medical comorbidities necessary for billing	❑	❑	❑	❑	❑
Measuring functional score necessary for billing	❑	❑	❑	❑	❑
Understanding financial changes for your facility	❑	❑	❑	❑	❑
Training billing staff	❑	❑	❑	❑	❑
Training clinical staff	❑	❑	❑	❑	❑

14. Has the Patient Driven Payment Model changed the following aspects of care delivery in your SNF, either more, less, or no change, compared to the prior 2 years? **Please record a response for each item below**.

	More	Less	No Change	Don't Know
Amount of physical therapy	❑	❑	❑	❑
Amount of occupational therapy	❑	❑	❑	❑
Amount of speech and swallow therapy	❑	❑	❑	❑
Length of stay	❑	❑	❑	❑
Admissions of complex/high-cost patients	❑	❑	❑	❑
Clinical documentation	❑	❑	❑	❑

15. Has the Patient Driven Payment Model led to a change in the number of staff or total full-time equivalents of these types in your SNF, either more, less, or no change compared to the prior 2 years? **Please record a response for each item below**.

	More	Less	No Change	Don't Know
Physical therapists	❑	❑	❑	❑
Occupational therapists	❑	❑	❑	❑
Speech and swallow therapists	❑	❑	❑	❑
Nurses (RNs or LPNs)	❑	❑	❑	❑
Therapy aides	❑	❑	❑	❑
Nursing aides	❑	❑	❑	❑
Nurse practitioners or physician assistants	❑	❑	❑	❑
Physicians	❑	❑	❑	❑
Administrative/billing staff	❑	❑	❑	❑
Medication technicians or aides	❑	❑	❑	❑

16. Do any of the following issues pose a challenge for your success with the Patient Driven Payment Model? **Please record a response for each item below**.

	Not Challenging	Slightly Challenging	Moderately Challenging	Very Challenging	Don't know
Getting accurate, timely DRG diagnoses from hospital	❑	❑	❑	❑	❑
Obtaining financial resources	❑	❑	❑	❑	❑
Hiring new staff	❑	❑	❑	❑	❑
Staff turnover and/or burnout	❑	❑	❑	❑	❑
Engaging current staff to implement changes	❑	❑	❑	❑	❑
Procuring and using analytics and data to assess performance	❑	❑	❑	❑	❑
Patient/family expectations for length of stay or therapy	❑	❑	❑	❑	❑
Managing multiple different payment models	❑	❑	❑	❑	❑

17. In the next 2 years, how will the Patient Driven Payment Model affect the following aspects of care delivery at **your** skilled nursing facility? **Please record a response for each item below**.

	Much Worse	Somewhat Worse	No Change	Somewhat Better	Much Better	Don't know
Quality of care	❑	❑	❑	❑	❑	❑
Financial performance	❑	❑	❑	❑	❑	❑
Retention of staff	❑	❑	❑	❑	❑	❑
Patient experience	❑	❑	❑	❑	❑	❑

CONCLUSION

If you have any anything you would like to add, please give us your thoughts here. Often these thoughts turn out to be the most important part of the survey.

Thank you very much for your response and participation in this survey. If you would like us to send you the results of the research once it is complete, please provide your email address here. We will not share this address or use it for any other purpose.

Email Address: _____

❑ I do not wish to receive a copy of the findings.

That completes the survey. To ensure that your survey reaches us, please return it in the enclosed postage-paid envelope to: