SONE HEALTH

Workflow Process for SNF 3-Day Waiver Utilization

Beneficiary has been evaluated in ER, Obs, or Inpatient < 3 Days, believed to be candidate for SNF 3-Day Waiver

→ CM follows process to confirm patient eligibility with THofNE ACO; if confirmed, communicates this with provider

Weekday →

CM emails Patient name, DOB, MRN and approving provider to SNFWaiver@sfhcp.org for Waiver Eligibility; a return email will confirm eligibility and provide list of affiliated SNFs

Weekend →

CM logs into Patient Ping and searches patient; Patient will be listed as participating with "SFHCP Waiver Eligible" or "VALLEY HEALTH ALLILANCE WAIVER ELIGIBLE"

→ ACO Provider and Case Manager make determination that patient meets clinical criteria for SNF-level of care.

Criteria for Patient to use SNF 3-Day Waiver:

1. **Does not reside in a SNF or Long-Term Care setting or require Long-Term Care**
2. **Is medically stable**
3. **Does not require further inpatient hospital evaluation or treatment**
4. **Has confirmed diagnosis**
5. **Has an identified skilled nursing or rehabilitation need that cannot be received in an outpatient setting or at home**
6. **Has not been in bundle in last 90 Days**

****NOTE: PT Eval not required if need medical admission or**

→ CM explains 3-Day Waiver to patient and reviews the list of affiliated SNFs with patient/family to choose preferred facility

→ CM places referral in system and communicates to hospitalist/provider

→ CM contacts the SNF point of contact (intake/admissions) to check bed availability and review patient transfer; SNF intake reconfirms patient eligibility through

→ Provider writes D/C order to transfer to SNF; documents that clinical criteria is met, patient is eligible, and approval of ACO provider was obtained (if applicable)

→ CM notifies patient/family of SNF acceptance and arrange ambulance transfer to SNF

→ Hand off to SNF Care Team

→ CM notifies ACO via SNF Waiver email confirming the patient transfer and SNF information

→ ACO will send Waiver Notification form to the receiving SNF via email

→ SNF admits patient, reaffirms reason for admission and develops individualized care plan. Patient is followed by ACO PACCS