Transitional Care Following a Skilled Nursing Facility Stay

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Transitional Care services provided by a Nurse Practitioner (NP) can have a positive impact on hospital readmissions in high risk older adults who discharge from a skilled nursing facility (SNF).

Why worry about hospital readmissions following a SNF stay?

- About 22% of SNF discharges will be readmitted within 30 days
- Over 25% of these readmissions could have been prevented
- Cost of readmissons: Average $9000 per patient; over 17.4 billion to Medicare
- Hospitals now face monetary penalties for high readmission rates

(Bixby & Naylor, 2009; Kripalani, et al., 2014; Smith, Pan, and Novelli, 2016; Toles, et al., 2016; Toles, Anderson, Massing, Naylor, Peacock-Hinton, and Colon-Emeric, 2014)

Transitional Care

- A care transition occurs when patients transfer from one care setting to another.
- Utilization of NPs for transitional care services, particularly in the home, shows promise

Project : Transitional care visit performed by a NP within 72 hours of SNF discharge in older adults considered high risk from 2/1/2020-7/31/2020

-High risk = LACE score ≥ 10 and/or an electronic health record frailty index (eFI) > 0.21 (or Rockwood Clinical Frailty Scale >5 if unable to calculate eFI in EHR)

-Other inclusion criteria: Age > 65, reside within 20 miles of index hospital, discharge to home from index SNF

-Visit was offered prior to SNF discharge

-Goal: Reduce 30-day hospital readmissions by 20%.

Benefits of transitional care visit:

-Improve quality

-Improve outcomes

-Reduce costs

-Improve patient satisfaction

-Reduce readmission risk

-Identify gaps in care

(Smith, Pan and Novelli, 2016; Kripalani, et al., 2014; Naylor, 2006)

Elements of the Transitional Care Visit included

- Medication reconciliation
- Physical exam
- Home assessment for fall hazards
- Disease self management education
- Additional community referrals if needed
- Confirmation of follow up appointments
- Confirmation that therapy was initiated
- Confirmation durable medical equipment in place
- Communication with Primary Care Provider (PCP)

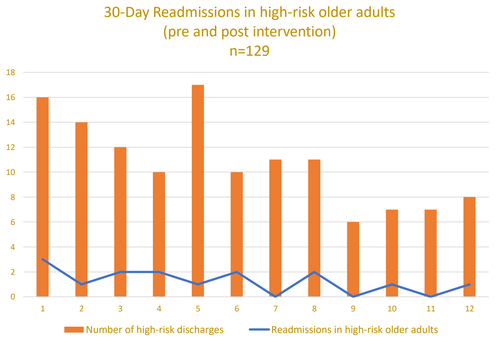
Evaluation:

1. Survey of patients and PCPs following the TSC intervention assessing satisfaction with care provided, social needs, and follow up care.

2. Pre- and post-intervention hospitalization rates in cohort and comparison group over the span of six months.

Outcomes:

- 81.25% of patients who received Transitional Care visit had medication discrepancies
- 37.5% reported delays in start of home health
- 81.25% of patients seen had one or more impairments in ADLs or IADLs
- 6.25% had difficulty paying bills or worried about running out of food
- 68.75% needed transportation assistance
- Approximately 25% of high-risk patients followed up with their PCP within 7 days

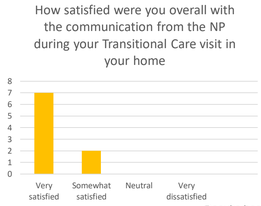


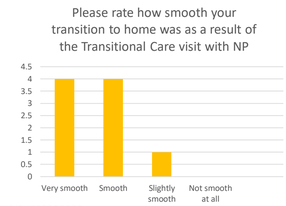
30-Day Post-Hospital Discharge Readmissions	
High risk pre-intervention 11/1/19-1/31/20	11 (n=79, 13.92%)
High risk no transitional visit 2/1/20-7/31/20	4 (n=34, 11.76%)
High risk received transitional visit 2/1/20-7/31/20	0 (n=16, 0%)

Survey themes:

-80% of PCPs surveyed felt the Transitional Care visit was of value to their patients

-100% of PCPs surveyed felt the Transitional Care Progress note sent by the NP was beneficial to them when patient was seen in follow up





Results based on 9 survey responses

Lessons learned:

This group of high-risk older adults were found to be well resourced and despite this there were still a lot of potential hazards post-hospitalization.

The value of Transitional Care visits is evident as none of the patients seen by the NP were readmitted!!

Next Steps:

Deep dive into the discharge process at facility

Tapering of narcotics prior to discharge

Discontinuing sliding scale insulin

Expand transitional care services

Improve follow up with PCP

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