Transitional Care Following a Skilled Nursing Facility Stay

Tiffany Rose, NP-C, Wake Forest Baptist Health, Section on Gerontology and Geriatric Medicine; Rachel Zimmer, DNP, NP-C, Wake Forest Baptist Health, Section on Gerontology and Geriatric Medicine; Karen H. Frith, PhD, RN, NEA-BC, CNE, The University of Alabama in Huntsville, College of Nursing, Associate Dean for Graduate Programs

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 readmissions: Average $9000 per patient; over $17.4 billion to Medicare
- Hospitals now face monetary penalties for high readmission rates

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 provided 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 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 discharge, home discharge 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

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

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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

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Survey themes:
- How satisfied were you overall with the communication from the NP during your Transitional Care visit?
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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
- Tapering of narcotics prior to discharge

References: