Transitions of Care

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Session Description

Transitions of care in a skilled nursing facility (SNF) involve coordination, communication, and ensuring continuity of care focusing on the patient's needs and outcomes as patients move been different locations, including emergency department, hospital, SNFs, LTACHS, and home.

Learning Objectives:

- How to overcome challenges
- Strategies for improved transitions
- Resources and support

Key Points of Transitions of Care in SNFs

Definition

Transitions of care embraces a range of services and settings between different care organizations or levels.

Importance

These transitions are crucial for individuals with complex care needs, ensuring continuity and avoiding preventable negative outcomes.

Focus

Transitional care focuses on the communication, coordination, and continuity of care among the healthcare team members, as well as patient and family education.

Examples of Transitions

- Hospital to SNF
- SNF to Home
- SNF to Home with Home Health Care
- SNF to Assisted Living/Personal Care
- SNF to Another SNF

Challenges

Disorganizations in care and lack of or poor communication amongst the health care team members can be significant challenges during transitions.

Effective Communication

- Be clear and concise
- Actively listen
- Provide timely updates
- Follow up

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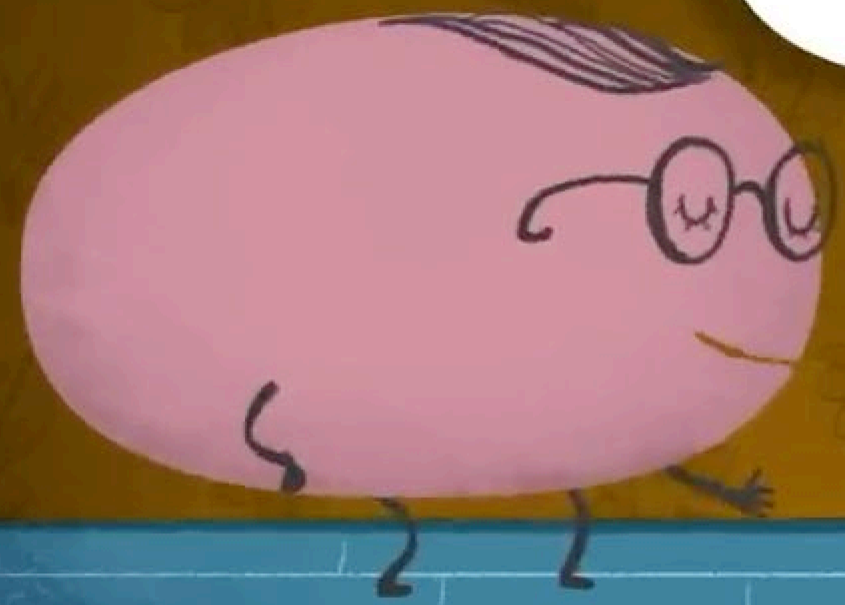

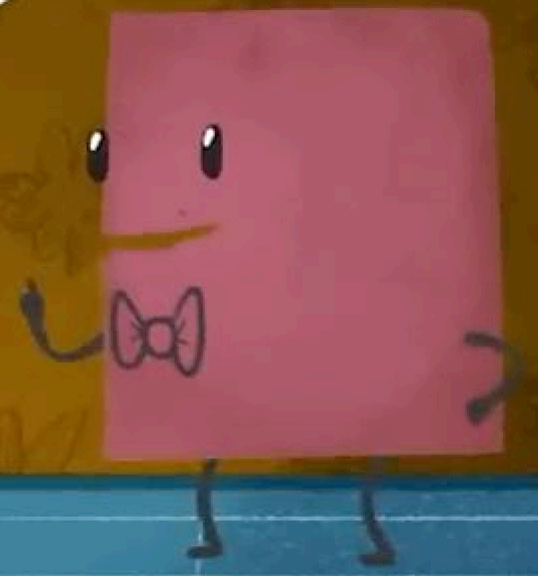

Strategies for Better Transitions

- Comprehensive Plan of Care
- Effective Communication
- Patient and Family Education
- Coordination of Care

Safe Transition Planning

The Playbook

- Initial safe transition meeting within 24-48 hours of admission
- Customer satisfaction
- Choosing the right location
- Determining the right length of stay
- Care plan – individualized
- Avoiding rehospitalization
- Prevention of leaving early

What can we do better?

- Earlier communication
- Setting a safe transition date
- Length of stay
- Barriers to education
- All interdisciplinary team members participate
- Providing our ‘expert’ option to achieving goal
- Get downstream partners engaged earlier

WHO SHOULD ATTEND:

- Social Services/Case Manager/Transitions Coordinator
- Unit/Nurse Manager
- MDS/RNAC
- Frontline staff (nurse and/or CNA)
- Recreation (Activities)
- Therapy
- Dining Services
- Administrator
- Down stream partner/s

Safe Transition – BECOMES A HABIT

- Hold meeting in resident room
- Utilize a speaker phone for family / NOK to participate (if unable to join in person)
- Body language, body language, body language
- Accountability

Safe Transition – COMMUNICATION of DATE and DESTINATION

- How do you communication and reinforce the safe transition date to the resident and family ongoing?
- What happens if we need to change it?
- How do your front line staff know of the safe transition date?
- How are the resident providers kept informed of the safe transition date so that they can support the plan and not transition too early or too late?

Work Collaboratively

- Maximize efficiency of care delivery
- Repetition accelerates learning. Nursing must reinforce therapy goals and vice versa.
- Think like Managed Care

Case Study – Every IDT Member Plays a Vital Role!

Patient Background

- Admitted to Facility ABC on 03/12/2025
- Patient is 62 years old with S/P right hip replacement, poorly controlled Type 2 diabetes, and COPD. She is PA Dutch and eats many of the dough and homemade ethnic dishes that are high in carbohydrates daily. She has had no known education related to managing her diabetes or COPD. She was started on insulin during hospitalization and her oxygen was increased from 2 L to 4 L.
- Prior to admission, patient lived alone in a 2-story home with 10 steps to her bedroom. Only bathroom on 2nd level.
- Her son lives 15 miles away and her daughter lives in South Carolina. The son works full-time and overtime most days and is only able to assist his mother on weekend.
- Discharge plan is to be home alone within 2 weeks with home health and a home set up with a downstairs bedroom and partial bathroom.
- Health insurance is ABC Managed Care and requires a prior auth for SNF stay. Patient has been approved for 7 days with a review scheduled for day 6 of stay.

Day of Admission

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2 Days Post Admission

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4 Days Post Admission

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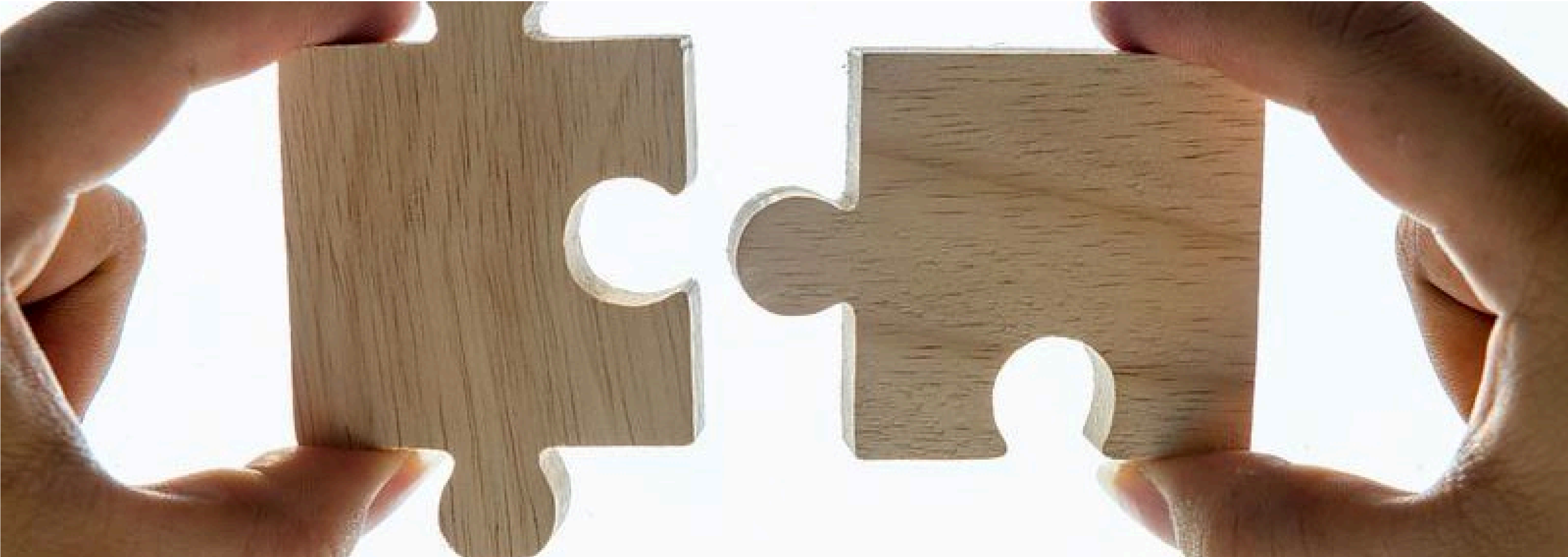
6 Days Post Admission – Review Date



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Hospital to Post-Acute Transition

- Discharge plan from hospital case management to Post-Acute admissions.
- Patient's son involved in choosing Post-Acute care facility.
- Discharge packet included:
  - R Hip precautions
  - Wound care
  - DME equipment needed to return home
  - Patient and family education (diabetes and COPD)

Therapy Plan / Progress

- OT and PT evaluated with treatment goals focusing on:

Dietary Intervention

- Meal planning
- Post discharge follow up with dietician
- American Diabetic Association educational information on meal planning
- Insulin administration

Diabetic Education

- Day one –
- Diabetic Certified Educator and Registered Dietician visited with patient -
- Nursing set up __________________ classes for patient post anticipated discharge home
- Patient was instructed on how to complete own __ ____ every am, prior to meals and HS.

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Discharge Planning

- When does this begin?
- Who and when are the goals shared with?
- Who attended the initial discharge planning meeting?
- What did the discussion include?

Safe Transition to Home

- Home visit completed when?
- Social Services completed?
- Nursing Services completed?
- Celebrated Patient success – how?

Day of Discharge

- Our Shared Success provided to patient to take to MD appointment
- Staff celebrated patient success
- Important phone number provided
- Patient belongings placed in take-home bag

24-48 Hours Post Discharge

What Went Well?

- All orders from hospital were followed
- Home visit completed prior to discharge
- DME equipment set up and ready for patient when she went home
- Home Health started care within 24 hours
- Educational materials provided
- Patient and son satisfied with care at facility

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What Could Have We Done Better?

Ensured that patient had resources (food, prescriptions, maybe portable O2 tank)

More diabetic teaching prior to discharge

What else?

The Power of TEAM

- Conduct root cause analysis on failed safe transitions
- Participate in educational session(s) on avoidable re-hospitalizations
- Utilize PCC, Pointright or other systems to identify high-risk patients
- Include pharmacy in discharge planning meeting
- Ensure documentation of patient education, fears, life-style
- And the list could go on . . . .

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Questions?

Thank you!

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