TMF Health Quality Institute

QI Snapshot

Brief #11

Skilled Nursing Facility Transitionalist Program

A Patient-Centered Initiative to Reduce Unnecessary Hospital Readmissions from a Post-Acute Care Skilled Nursing Facility

Project Overview

The TMF Quality Innovation Network Quality Improvement Organization (QIN-QIO), under contract with the Centers for Medicare & Medicaid Services (CMS), recruited providers in the community of Norman, Oklahoma, to participate in a care coordination coalition to decrease unnecessary readmissions and provide better outcomes for Medicare Fee-for-Service beneficiaries. Medical Park West Rehabilitation and Skilled Care (MPW), led by Senthil Raju, MD, piloted the Transitionalist Program with Norman Regional Hospital. Dr. Raju, a hospitalist and medical director, found there was a disconnect in communication between the hospital discharging patients and the skilled nursing facility (SNF) receiving them, and also identified a need to provide more comprehensive services at the SNF to address the growing complex needs of the patients. The Transitionalist Program was piloted by MPW, in a coordinated effort to reduce preventable readmissions for patients between the two organizations. A 22 percent relative reduction in readmissions was seen 16 months after the implementation of the Transitionalist Program.

Intervention Methodology

The purpose of the Transitionalist Program is to provide improved communication and comprehensive care for patients transitioning from the acute to the skilled setting. A critical element of the program is establishing a direct line of communication between MPW (SNF) and Norman Regional Hospital (acute facility) from the patient's initial transition throughout the patient's stay. Establishing a relationship with the acute care facility improves communication during patient transitions, but also establishes a mutual confidence between the acute care setting and SNF. This direct line of communication between MPW and Norman Regional Hospital also extends to the hospital's emergency department. In some cases, patient care requires a clinical test or medical equipment that the SNF does not have access to in-house. In this model, the SNF contacts the emergency department with the patient's medical history and current status to prevent an unnecessary admission and potentially unnecessary tests.

From admission throughout the patient's stay, the multidisciplinary care team works cohesively across all tasks, facilitating improved communication between members and across care settings and standardizing the assessment and care of patients, minimizing duplication of tasks. The multidisciplinary care team initially included the medical director and a nurse practitioner, and was later expanded to include a nurse liaison (LPN) and specialty physicians. The nurse practitioner visits the patient within 24 hours after admission, and daily thereafter, in order to evaluate the patient's condition, determine his/her acuity level and provide medication reconciliation. Many physicians or medical directors in SNFs are also hospitalists or treating physicians in hospitals, and being responsible for patients in both roles can mean patients are not seen quickly after admission to the SNF or as frequently during their stay as needed. The nurse practitioner also provides education to the other nurses caring for the SNF residents in the program and is responsible for communication with the residents' families. In addition to the daily rounds made by the nurse

practitioner, the transitionalist physician and other identified specialty physicians visit the patients on a routine basis. The transitionalist sees patients at least one time per week, depending on acuity and emergent needs. Specialists, like nephrologists and infectious disease physicians, round with the team weekly for specified patients. During these rounds, each team member is provided the opportunity to focus on their core function because they are supported by the other team members. For example, the nephrologist focuses on the patient's specific kidney disease-related needs, and the nurse practitioner shares appropriate updates and information on the patient's condition from daily rounds and provides direct care to the patient. The nurse liaison serves as a scribe to ensure accurate documentation of the visit. The main focus of the team is to care for skilled nursing residents in the first 30 days post-hospital discharge to avoid preventable readmissions.

In the Transitionalist Program model, the care team is the core of what makes the model effective. However, just having staff in place is not enough to maintain consistent and improved reductions in hospital readmissions. For MPW, it was imperative to include ongoing education and training for the nursing staff at the SNF. By providing mandatory training, the SNF can ensure that their nursing staff, who work with the Transitionalist Program care team's higher-level providers, are knowledgeable about timely and relevant issues for their patients. In addition, the staff education also covers training on how to effectively and confidently communicate patient care needs with higher-level practitioners.

Monitoring and evaluation identifies other areas for change or process improvement for the Transitionalist Program. For example, MPW found that non-emergent issues during nights and weekends often led to hospital readmissions. To reduce these cases, a log book for non-emergent issues was created for overnight and weekend staff nurses to log patient issues and address them with the physician or nurse practitioner during the next day's rounds. The MPW team also identified the need to have an onsite emergency kit with stocked medications (rather than waiting for a pharmacy to deliver) that are required to be administered in a timely manner post-hospital discharge to avoid a re-hospitalization. The Transitionalist Program has exceeded the project aims, with strong outcomes and relationships developed with the local acute care hospital. Expansion to other facilities and rural areas is planned.

Outcomes

For this project, readmissions were tracked through the electronic medical record, and patient records were reviewed to determine program success. In addition, the TMF QIN-QIO used internal (CMS) claims data to verify accuracy of the data by trending 30-day readmission rates for the facility's Medicare beneficiaries.

The Transitionalist Program was implemented on Nov. 1, 2016. Examining readmissions from Oct. 31, 2016, to Feb. 28, 2018, the readmission rate fell from 19.1 percent to 14.9 percent (see Figures 1 and 2). This reflects a relative improvement of 22 percent in 16 months post-implementation.

Figure 1: Medical Park West Pre-Intervention Data

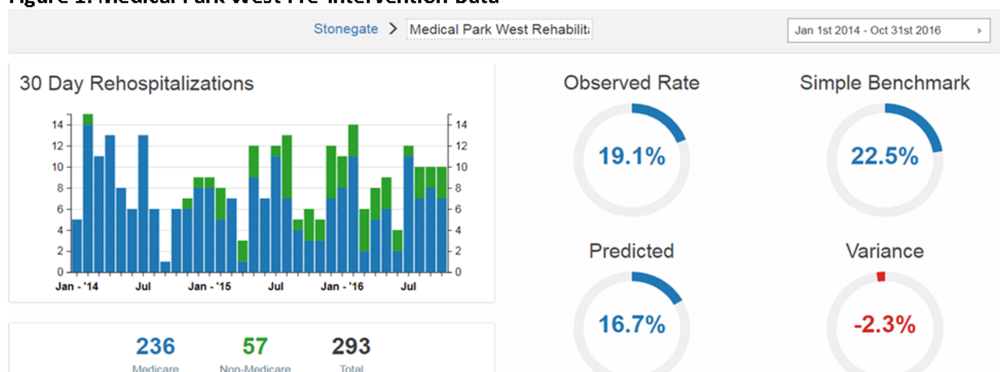
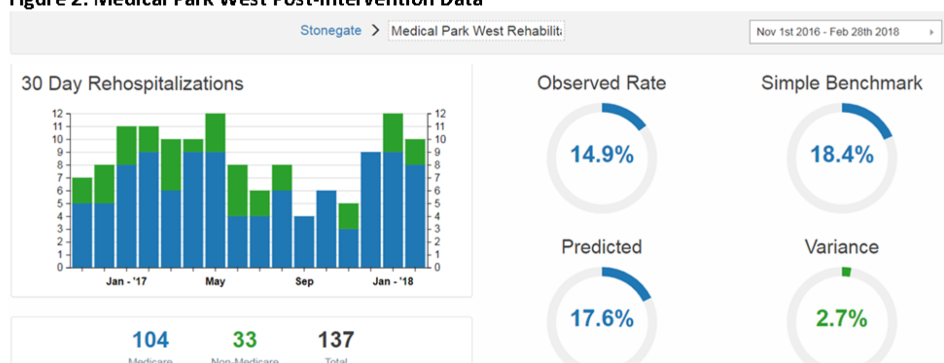


Figure 2: Medical Park West Post-Intervention Data



Discussion

A key factor in stablishing the Transitionalist Program included determining staffing needs. The facility also evaluated its resident census and the residents' acuity level to determine levels and type of care the residents required. The facility then analyzed their current staffing levels to identify staffing gaps for the Transitionalist Program team. MPW identified that additional staff was needed to successfully implement the program, and after reviewing the return on investment, the team decided to staff the nurse practitioners as independent contractors and also contract with the specialists.

A key finding during this intervention was the importance of a multidisciplinary team to care for high-risk and high-acuity patients. In addition, strong communication during transitions of care ensures appropriate care post-discharge and prevents unnecessary admissions. The outcomes from the implementation of the Transitionalist Program show a reduction in readmissions after the program was implemented. The program has also shown continued reductions the longer the program has been in place. Ongoing internal evaluation has also allowed the Transitionalist Program model to evolve as additional data and information is available. For example, routine rounding by specialist physicians for patients with complex or high-need conditions was implemented after the care team identified it as a need for improved patient care.

The Transitionalist Program can have a positive impact on the health care system. Hospitals have been working to reduce preventable readmissions in order to avoid financial penalties, and SNFs will soon be facing the same challenge. The Transitionalist Program provides a model of care that can improve coordination and communication between the hospital and SNF setting that can reduce preventable readmissions and decrease the risk of facing penalties for both facilities.

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