I-MPACT
INTEGRATED MICHIGAN PATIENT-CENTERED ALLIANCE IN CARE TRANSITIONS

Reduce readmissions with three simple items when discharging to a SNF

Inadequate or poor transitions of care may increase a patient's risk for negative outcomes and hospital readmissions.[1]

1 in 4 Medicare patients treated in the hospital are discharged to a SNF, of which 23% are readmitted within 30 days.[2]

I-MPACT data has shown that comprehensive and timely documentation of transition of care (TOC) items in a patient's discharge summary is associated with reduced readmissions.

These 3 TOC items could reduce 60-day readmissions

1 **Provide a Phone Number** for the patient to call with questions post-hospital discharge

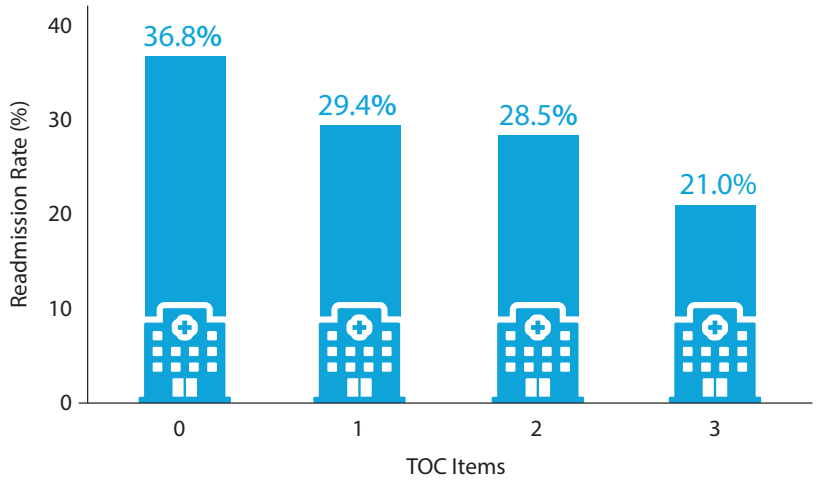
2 **Complete Discharge Summary** on the day of discharge

3 **Identify Primary Care Provider (PCP)** in the discharge summary

Each additional item could reduce readmissions:

- 1 item is associated with **20% lower risk of readmission** (P=0.032)
- 2 items are associated with **23% lower risk of readmission** (P=0.023)
- 3 items are associated with **43% lower risk of readmission** (P=0.001)

Association Between TOC Items and 60-Day Readmission (Adjusted)
(N=2,271)



Other Methods to Improve Transitions of Care:

Direct communication between hospital (acute care) providers and post-acute care providers is uncommon. There is no universal standard for how direct communication should be performed and inaccuracies or missing pertinent information (e.g., incorrect discharge medications, missing test results, follow-up plans, etc.) are commonly found within discharge documents.[3]

In a qualitative study about care transitions with hospital and SNF providers, it is suggested that "future interventions should focus on enhancing communication between clinicians, promoting provider understanding of post-acute care, and developing strategic opportunities to align facilities.[2]

Pertinent information for hospitals to include in SNF discharge documentation based on recommendations from the literature review[1-7] and I-MPACT findings:

- Functional status on discharge
- Equipment/supplies
- Advance care planning/code status
- Demographics
- Social determinants of health (SDOH) screening
- Readmission risk assessment
- Primary care provider identification
- Health history/diagnosis
- Test results
- Reconciled medication list (new, changed, continued, stopped categories).

According to I-MPACT data:

1 in every 2
readmissions (within 60 days of hospital discharge) occur while the patient is in the SNF or within the first 10 days of SNF discharge.

72.7%
of after visit summaries are missing a name or number for the patient to call with questions or concerns.

77.6%
of discharge summaries do not include a patient's code status.

81.7%
of discharge summaries do not include a risk assessment.

18%
of discharge summaries were NOT completed prior to or on the day of discharge.

References

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