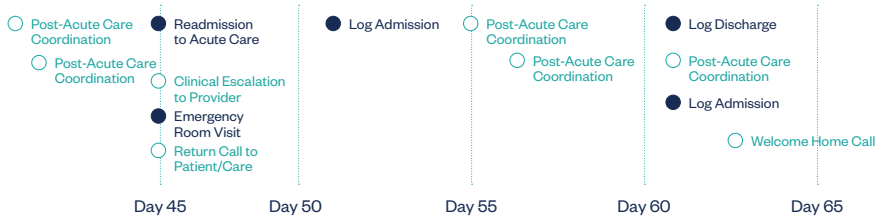
Monitoring Condition Changes in a SNF Prevents Unnecessary Readmission

CASE STUDY

Patient Profile

Female patient with a history of mild dementia and bi-polar disorder was admitted to hospital for sepsis. Patient's living situation created concern as she was living on a sailboat with her spouse.

Touchpoint Timeline



Customized Approach to Care

ICS Initial Assessment

Patient was admitted to a skilled nursing facility (SNF) for follow up care due to deteriorated condition upon discharge. Over the course of her first week in the SNF the patient's condition rapidly declined to include hallucinations, confusion and lethargy. SNF attributed this to her mental health history. Patient's home environment, which involved living with her spouse on a sailboat requiring ladders for access, was determined to be unfit for accommodating the patient's needs.

Action Plan

Determine Cause of Deterioration
ICS formed a multidisciplinary team to fully assess the patient's condition and determine the source of her deterioration as the severity raised questions about the SNF's diagnosis. After raising concerns with the facility's Director of Nursing, the SNF agreed to run labs, urinalysis, cat scan, and a chest x-ray.

Determine Appropriate Treatment Plan
Additional testing revealed the patient was suffering from a urinary tract infection, pneumonia, and pleural effusion. Patient was placed on an IV antibiotic, and recuperated while waiting for her metabolic encephalopathy to clear before beginning therapy.

Identify Safe Living Conditions
ICS met with the patient's spouse to discuss a safe, long-term living situation. The spouse, initially reluctant to make arrangements other than the patient returning to live on their sailboat, agreed to re-evaluate. It was decided that the patient would either stay in the SNF privately on Medicare Part B or for a month in an assisted living facility, at which point the spouse would re-evaluate appropriate living arrangements.

Key ICS Interventions

- Helped ensure appropriate discharge disposition post-hospitalization
- Worked with post-acute medical team to ensure correct diagnosis for patient conditions
- Ensured appropriate treatment plan was implemented
- Coordinated with spouse to make alternative living arrangements to keep patient safe

Key Takeaway

Hospital readmission was prevented by addressing deteriorating health conditions with the SNF. Length-of-stay in the SNF was kept to 40 days while rehabbing and determining a safe discharge location. Ensured patient safety by working with spouse to make alternate living arrangements.