Reducing Unnecessary SNF Utilization Through Coordination with Community Resources

CASE STUDY

Patient Profile

Female patient was hospitalized for a double amputation. Limited family support, and home environment unable to accommodate wheelchair entry. Patient was discharged as part of a COPD bundle under ICS's management.

Customized Approach to Care

ICS Initial Assessment

Upon discharge, the patient was transferred to a SNF with limited skill needed aside from pain management support while ICS worked to solve for wheelchair accessibility in the patient's home.

Action Plan

Secure Appropriate Care Setting
ICS collaborated with a cross-continuum care team including the SNF discharge planner, rehab director, and home health aide to identify the most clinically appropriate care setting for the patient.

Solve Wheelchair Accessibility
With coordinated support from the community, ICS was able to secure a grant to fund the installation of a wheelchair ramp at the patient's home.

Identify Home Health Provider
Patient had been under the care of a home health agency (HHA) prior to hospitalization. When contacted, the HHA indicated they would not be able to perform a home evaluation following discharge. ICS was able to identify an HHA that was able and willing to perform the home evaluation and provide necessary rehabilitative care.

Key ICS Interventions

- Identified replacement home health agency
- Collaborated with SNF to work toward a clinically-appropriate length of stay
- Coordinated community funding and support for constructing a wheelchair ramp so patient could return safely home, avoiding extended SNF stay

Key Takeaway

Without ICS interventions, the patient would have used all 100 days post discharge in a nursing home and started an application for Medicaid. Better post-acute care coordination led to this patient being discharged home safely in 24 days.