Best Practices for Transition Visits

What is a transition visit?

- Transition visits optimally occur within 48 hours of SNF admission.
- Transition visits enable providers to identify errors that occur as a result of the transition, clarify unclear orders, ensure appropriate follow up care, and communicate with hospital caregivers and resident/family.

Why are transition visits important?

- Transitions of care are a time of high vulnerability for adverse events for patients admitting to PALTC.
- Up to 40% of patients transitioning to a skilled nursing facility (either for readmission or new admission) experience an adverse effect, many of which are preventable.

Steps for Best Practices Transition visit:

1. Obtain and review discharge summary. If unable to obtain a discharge summary, review provider progress notes from last few days of hospital stay.
   - Review key elements of hospitalization.
   - Note testing that was completed.
   - Note follow up testing recommended and order as necessary.
   - Note follow up visits and communicate dates and time to facility team so transportation can be arranged.
   - Consider if virtual visit or in-person visit is most appropriate.
   - Identify pending test results and determine plan for following up results.
2. Medication Reconciliation

- Be aware that hospital may not have started with an up to date medication list and could have inadvertently restarted medications the patient was no longer taking. If in doubt, reach out to discharging prescriber for clarification.
- Confirm allergies.
- Identify any medication at bedside that were brought from home.
- Assess new medications:
  - Were these intentional?
  - Is there ongoing need?
  - Proton pump inhibitors often not needed.
  - Is there a stop date for the antibiotic?
  - Assess the need for stop date or tapering plan for new antipsychotics.
- Consider duplicate medications which may be due to formulary interchanges.
- Medications stopped: Were these intentionally stopped?
- Dose changes to chronic medications: Were these intentional or a result of outdated medication list?
- Review medication list with resident and family.

3. Introduce advance care planning

- Review any notes regarding ACP discussions during hospitalization.
- Confirm current advance directives.
- Arrange time to further discuss advance directives if needed.

4. Provide resident and family education about hospitalization.

5. Identify any new areas of concern.

Sources: