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Getting Past The “Black Box” – Opportunities for Hospitalists to Improve Post-Acute Care Transitions

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For many hospitalists, the care provided after hospital discharge in skilled nursing facilities (SNF) and home health care (HHC)—collectively termed post-acute care (PAC)—represents a “black box.” Hospitalists often lack clarity about the resources available, processes of care, and outcomes for patients discharged to PAC. This is important because approximately 1/3 of adult inpatients are referred to PAC after hospital discharge, and this proportion is increasing as the population ages. Further, patients transitioning from the hospital to PAC have higher readmission rates than patients discharged home, and evidence suggests suboptimal care transitions play a significant role in these cases (1–3). In this article, we outline three key problems with PAC transitions, and offer potential solutions.

Problem 1: Hospitalists often lack sufficient understanding of PAC settings and outcomes to effectively coordinate care during the transition.

When asked, many hospitalists recognize deficiencies in their knowledge about SNF care practices and patient outcomes (1). It is easy to see how this could lead to unsafe transitions of care. For example, hospital clinicians may not be aware that SNF physicians are allowed up to 30 days to complete an initial patient evaluation, and that SNFs are only required to have a registered nurse available for 8 hours per day. Thus, hospitalists may have unrealistic expectations about the degree of monitoring and management provided in these settings. Similarly, HHC nurses often find that patients discharged from the hospital have unrealistic expectations about what HHC can provide, leading to patient dissatisfaction (2).

How can we achieve the goal of improved understanding of PAC for hospitalists and trainees? A valuable first step would be for trainee education to include some experience in both SNF and HHC settings. Clinical encounters with patients in PAC settings could provide trainees with experiential knowledge about the care provided and the outcomes achieved in these settings. A second important step would be to ask hospitalists to take on a larger leadership role in PAC decision-making. In many cases, hospitalists defer decisions about PAC to physical therapists (do they have rehab needs?) or social workers (are they eligible?). However, we believe that it is the responsibility of the hospitalist to lead the multidisciplinary team and create the optimal post discharge care plan. To do this well,

hospitalists will have to learn about important aspects of PAC (e.g., how patients qualify, which PAC setting are appropriate for specific needs, etc.).

Problem 2: PAC clinicians often do not receive all of the information they need to provide optimal care for patients

Clinicians in PAC settings frequently encounter problems due to lack of communication from the hospital, and struggle to reach a hospitalist with questions (2, 3). Structured communication of critical information from hospital to PAC clinicians should be completed before discharge and should include information that is of particular interest to PAC clinicians (but may not always be a part of traditional discharge summaries). For example, PAC clinicians need to know the indications and expected durations for lines and catheters; the goals of care, including code status or physician's orders for life saving treatment (POLST); contact precautions; current cognitive and functional status; and hospitalist contact information. Depending on local SNF practices, patients may also need paper copies of prescriptions for controlled substances, including opioids, to avoid delays in providing these medications at the SNF.

New models of communication may also address transitional care gaps. The Extension for Community Healthcare Outcomes-Care Transitions (ECHO-CT) model uses a weekly videoconference to connect an interdisciplinary hospital-based team—including hospitalists—with SNF clinicians (4). Patients discharged over the prior week are discussed, including an update of the patient condition, and a medication review, which provides the opportunity to address medication discrepancies or omissions. Each review also includes reflection on areas for improvement in care transition processes. ECHO-CT has been associated with lower 30-day readmissions, healthcare costs, and shorter SNF length of stay (4).

Problem 3: Hospitalists receive little feedback about outcomes of patients discharged to PAC, which limits their ability to improve the care transition.

Most hospitalists are not aware of what happens to patients after they are discharged to PAC. Yet, 30-day readmissions from PAC exceed those of patients discharged home, and readmissions are associated with adverse long-term patient outcomes. Most PAC patients are readmitted to the same hospital as their index admission, allowing opportunities to review and iteratively improve care transitions. Hospitalists and trainees could lead joint hospital-PAC reviews of readmitted patients, with the goal of identifying gaps in transitional care that might have contributed to the readmissions (5). For example, the ECHO-CT model discussed above could provide an opportunity for hospital and PAC clinicians to review readmissions together, determine preventability, and identify opportunities to improve care processes.

Conclusion

As hospitalists, we believe that providing optimal transitional care for our patients is ultimately our responsibility. Improving hospitalists' knowledge of PAC, improving

communication after hospital discharge, and creating mechanisms for feedback to hospitalists are all possible ways of getting past the PAC “black box.”

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