Hospitalists Improving Transitions of Care Through Virtual Collaborative Rounding with Skilled Nursing Facilities – The HiToC SNF Study

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Introduction

- Many patients continue their post-acute care in settings such as a skilled nursing facility (SNF).
- One in four hospitalized Medicare patients are discharged to SNFs.
- These patients generally require more support than those discharged home, placing them at increased risk of clinical deterioration and rehospitalization.
- Moreover, 25% of patients discharged to SNFs were readmitted within 30 days costing Medicare $4.34 billion in 2006.

Objectives

- The aim of this intervention was to evaluate the impact of the program on improving the transition from the inpatient to the post-acute care setting and reducing readmissions from SNFs.
- We believed that the communication enabled by this program would augment the written discharge summary and in turn improve provider satisfaction on the safety of the transition and reduce medical errors.

Materials and Methods

- In our intervention, patients discharged from two academic hospitals to one of six partner SNFs were reviewed weekly in a multi-disciplinary post-discharge telephone or video encounter that included a hospitalist from the hospital and medical and nursing leadership from the discussant SNF.
- The discussion reviewed the clinical status, discharge medications, treatment plan, and follow-up care of the discharged patients and took place from July 2021 to December 2021.
- Hospitalists were asked to assess for clinically significant errors within the discharge summary based on the discussion and classified as errors of omission when important information was not included and errors of commission when there was incorrect or conflicting information.
- SNF providers (n=13) and hospitalists (n=10) were also asked to complete a survey to assess the importance of the intervention

Figure 1 – Examples of Errors

Errors	Examples
Medication Reconciliation	• Missing medication from discharge summary and med-list • Inappropriate or inaccurate end times placed in discharge summary medication list • Conflicting information in discharge summary and med list • Two medications of the same class included in the discharge medication list
Post-hospitalization follow-up appointment	• Important specialty care follow up appointment not scheduled or included in discharge summary
Post-hospitalization treatment plan	• Missing wound care recommendations
Baseline clinical status or labs	• Missing dry weight • Missing baseline Creatinine level • Missing baseline mental status in patient with delirium or dementia
Goals of Care	• Goals of care conversations not included in discharge summary

Results

Figure 2 – Demographics

	N (SD)	% Frequency
Total Discharges	545	
Gender		
Male	291	53.39%
Female	254	46.61%
Age	70.82 (13.01)	
Ethnicity		
Not Hispanic or Latino	533	97.79%
Hispanic or Latino	11	2.02%
Choose not to Disclose	1	0.18%
Race		
White or Caucasian	384	70.46%
Black or African American	138	25.32%
Asian	4	0.73%
American Indian	3	0.55%
Other/Choose Not to Disclose	16	2.94%
Insurance		
Medicare	336	61.65%
Medicare Advantage	90	16.51%
Medicaid	74	13.58%
Commercial	30	5.50%
Other	15	2.75%

Figure 4 - Errors

	N (SD)	% Frequency
Total Post Discussion Assessments Completed	510	
Total Errors Identified	127	24.90%
Errors of Omission	92	
Medication Reconciliation	4	4.35%
Post-hospitalization follow-up appointments	58	63.04%
Post-hospitalization treatment plan	21	22.83%
Baseline clinical status or labs	5	5.43%
Goals of Care Conversations or Advance Care Planning	4	4.35%
Errors of Commission	35	
Medication Reconciliation	27	77.14%
Post-hospitalization follow-up appointments	2	5.71%
Post-hospitalization treatment plan	4	11.43%
Baseline clinical status or labs	2	5.71%
Goals of Care Conversations or Advance Care Planning	0	0%

Survey Results

- Participating hospitalists (n=6) thought the intervention improved transitions of care (4.5, SD 0.6), although there was less certainty that it reduced readmissions (3.5, SD 0.8).
- This view was shared by medical and nursing SNF providers (n=8); 4.6 (SD 0.5) on improving transitions of care and 3.9 (SD 0.6) on reducing readmissions.

Conclusion

- Virtual collaborative rounding improves hospitalists knowledge of SNF clinical capabilities and thus can bridge the gaps during the transition of patients from the hospital to the post – acute care setting.
- Hospitalist-lead virtual collaborative rounding with SNFs improves transitions of care and identifies clinically significant errors in discharge summaries.
- Post-hospitalization follow-up plans, and medication reconciliation are the most common sources of errors identified in discharge summaries.

Clinical Implications

- This process improved the transition of care of patients from the inpatient to post-acute care setting.
- Open communication between the hospitalist and SNF providers allowed for gaps to be bridged and collaboration on ways to keep patients from being readmitted.