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Bridging the Hospital-Skilled Nursing Facility Information Continuity Divide

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There is a communication chasm between most hospitals and skilled nursing facilities (SNFs), one that often remains invisible to many hospital-based clinicians and often negatively impacts patient experience, satisfaction, and health outcomes. Hospital settings provide the lions' share of clinician training in the US health care system, whereas SNF settings are rarely encountered in standard health professional training pathways. This lack of awareness, coupled with a number of other clinician, policy, and system factors, conspires to create our current reality in which hospital clinicians are regularly blind to the unique challenges of SNF environments. In a SNF, patient acuity approaches that of a hospital, medical clinicians and pharmacists are not regularly on site, and staff nurses face patient ratios much larger than those in hospital settings. Information quality and flow between hospitals and SNFs at the point of hospital discharge are notoriously poor and delayed. Solutions to information continuity have been slow in coming and often neglect the real-world practical constraints of the SNF setting. The SNF simply does not have the extra resources, time, or staffing to span the breadth of this communication chasm. Bridge building between these settings must proceed from both ends of the gulf.

Adler-Milstein and colleagues[1] provide an important contribution to this debate by presenting their findings from the first nationally representative survey of SNFs on this topic. Unfortunately and disappointingly, their survey demonstrated continued widespread inadequacies of information communication during transitions from hospitals to SNFs.[1] Despite broader adoption of electronic health records (EHRs) and gains in interoperability resultant from the Health Information Technology for Economic and Clinical Health Act over recent years, continued severe inadequacies in the flow and quality of essential information remain.[1] The study applied sound survey methods to address both medical and nonmedical communication domains essential to the needs of SNF patients, particularly those with cognitive and functional impairments. The gaps in information continuity were exceedingly common and multidimensional, reflecting omissions, delays, inconsistencies, redundancies, and poor usability, with nearly one-half of SNFs citing important information arriving well after the patient.[1] Because the study sampled well-established SNF-hospital pairs and surveyed directors of nursing who may have varied direct involvement in transitions, it is likely that the reported findings are underestimates, the proverbial tip of the iceberg.

We know from prior studies[2] that adverse patient outcomes, such as 30-day readmissions, are associated with poor quality information communication during hospital-to-SNF transitions. However, Adler-Milstein and colleagues[1] provide evidence of marked information gaps that likely are associated with both patient and SNF staff-specific outcomes. Prior studies[2] have found that nursing staff, the primary workforce in SNF environments, encounter significant added strain and burden as a result of poor hospital-to-SNF information continuity. The consequences of poor communication may also differentially impact highly vulnerable populations, such as the large number of SNF patients with cognitive impairment for whom poorly managed transitions may introduce considerable added stress for patients and family caregivers alike. Evaluation of patient-centered outcomes beyond satisfaction may better capture the impacts of poor information continuity on this population, particularly as findings from Adler-Milstein et al[1] indicate that social and behavioral status—which are essential to care planning for people with cognitive impairment—were the most frequently missing information categories.

With respect to policies targeting 30-day outcomes, the Hospital Readmissions Reduction Program has led to significant reductions in all-cause 30-day readmission rates for a range of targeted

and nontargeted conditions.[3] These improvements reflect important progress in intersetting care coordination, yet it remains unclear whether they have extended to the growing, vulnerable, and increasingly medically complex populations served by SNF settings.[4] In the years since the passage of the Patient Protection and Affordable Care Act, a number of initiatives and policies have been introduced that specifically target SNFs, including the Skilled Nursing Facility Value-Based Purchasing Program, which parallels hospital incentive programs by leveling payment rewards or disincentives for high readmission rates. In 2020, 77% of SNFs were penalized under the program.[5] Experts have cautioned that factors beyond the control of SNF settings, particularly suboptimal hospital discharge communication, underequip SNF clinicians in proactively meeting the needs of their patient population. Interestingly, studies have failed to demonstrate consistent associations between a range of SNF-specific quality indicators and 30-day patient outcomes, yet hospital discharge communication quality has consistently been associated with poorer posthospital outcomes.[6,7] Bridge building is best achieved via bidirectional effort. Policies or interventions that focus on one setting to the exclusion of the other may result in a forest of silos instead of a span of bridges.

The findings of Adler-Milstein and colleagues[1] renew the sense of urgency for expanded mandated hospital discharge summary components. Standards established decades ago (in the prehospitalist age) by the Joint Commission require discharging clinicians to provide a written discharge summary within 30 days that includes the following components: reason for hospitalization, significant findings, treatments and procedures, condition upon discharge, instructions, and clinician signature. Experts have belabored the inadequacy of these minimally required, yet frequently omitted, components.[8] Through the Improving Medicare Post-Acute Care Transformation Act of 2014 made actionable by a 2019 final rule, the Centers for Medicare & Medicaid Service (CMS) introduced new guidelines for the process of discharge planning, requiring hospitals to provide patients and families with information and choice on postacute care settings, promote interoperability and patient access to EHRs, and center patient care preferences and family involvement.[9] Effective March 2020, the Joint Commission responded with revisions to align their standards with CMS rules, requiring information on physical and psychosocial status, care plan goals and progress toward goals, community resources and referrals, and advance directives to be sent to receiving clinicians.[10] These changes represent a substantial update in global communication standards, yet they fall short of mandating the more comprehensive array of discharge communication components required by SNF clinicians for the development and implementation of a safe, comprehensive, individualized plan of care, a CMS requirement that SNFs struggle to meet. As such, even for the most empowered and clinically stable patient, the revised standards may still be inadequate.

Changes are needed. First, standards should be set for information continuity, including timeliness, completeness, and usability, and they should include the comprehensive array of information required by the SNF setting.[1] Second, communication beyond written and electronic format must be facilitated, particularly given the clear value of warm handoffs encouraged through a comprehensive discharge process. Finally, future research should endeavor to extend beyond evaluating information continuity at single transitions to consider the longitudinal nature of transitions across multiple settings (ie, home-to-hospital-to-SNF-to-home with home health). Such a shift can encourage comprehensive, patient-centered solutions for improving information continuity across time and highlight the necessity of research on tools like longitudinal care plans that extend beyond hospital and postacute care settings and evolve with the patient.

Despite increased adoption and sharing of EHRs, communication gaps between these settings clearly persist. The study by Adler-Milstein and colleagues[1] sheds light on the value and significance of engaging the SNF setting more fully in efforts to understand the communication, care, and outcome disparities that continue to befall highly vulnerable SNF populations and their regularly marginalized workforce. There is much more bridge building to be done.

ARTICLE INFORMATION

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