Gaps in Hospital and Skilled Nursing Facility Responsibilities During Transitions of Care: a Comparison of Hospital and SNF Clinicians' Perspectives

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BACKGROUND: Adverse outcomes are common in transitions from hospital to skilled nursing facilities (SNFs). Gaps in transitional care processes contribute to these outcomes, but it is unclear whether hospital and SNF clinicians have the same perception about who is responsible for filling these gaps in care transitions.

OBJECTIVE: We sought to understand the perspectives of hospital and SNF clinicians on their roles and responsibilities in transitional care processes, to identify areas of congruence and gaps that could be addressed to improve transitions.

DESIGN: Semi-structured interviews with interdisciplinary hospital and SNF providers.

PARTICIPANTS: Forty-one clinicians across 3 hospitals and 3 SNFs including nurses (8), social workers (7), physicians (8), physical and occupational therapists (12), and other staff (6).

APPROACH: Using team-based approach to deductive analysis, we mapped responses to the 10 domains of the Ideal Transitions of Care Framework (ITCF) to identify areas of agreement and gaps between hospitals and SNFs.

KEY RESULTS: Although both clinician groups had similar conceptions of an ideal transitions of care, their perspectives included significant gaps in responsibilities in 8 of the 10 domains of ITCF, including Discharge Planning; Complete Communication of Information; Availability, Timeliness, Clarity and Organization of Information; Medication Safety; Educating Patients to Promote Self-Management; Enlisting Help of Social and Community Supports; Coordinating Care Among Team Members; and Managing Symptoms After Discharge.

CONCLUSIONS: As hospitals and SNFs increasingly are held jointly responsible for the outcomes of patients transitioning between them, clarity in roles and responsibilities between hospital and SNF staff are needed. Improving transitions of care may require site-level efforts, joint hospital-SNF initiatives, and national financial, regulatory, and technological fixes. In the meantime, building effective hospital-SNF partnerships is increasingly important to delivering high-quality care to a vulnerable older adult population.

KEY WORDS: care transitions; care coordination; healthcare quality.
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INTRODUCTION

One in four hospitalized Medicare beneficiaries makes the complicated transition to skilled nursing facilities (SNFs) for post-acute care, and these transitions are becoming more common.[1] Nearly 25% of these patients will be readmitted to the hospital, and just over half will return to the community by 100 days following hospital discharge. There is growing recognition of the need to address care transitions to improve outcomes. For example, 30-day readmission rates are publicly reported for all Medicare-certified SNFs, and the SNF Value-Based Purchasing program has set financial incentives and penalties for SNF performance based on 30-day readmission rates.[1–5]

Improving coordination during care transitions requires collaboration between the discharging and receiving facilities.[6] Clear roles and responsibilities during a care transition are needed to reduce errors and adverse events. However, the division of responsibility between provider teams across hospital and SNF settings is not well understood. Previous research suggests the lack of clarity about these respective roles and responsibilities may contribute to adverse outcomes in care transitions.[7,8] Hospital and SNF providers often disagree about causes of preventable readmissions from SNFs.[7] Hospitals and SNFs each focus on activities that enable them to meet their own performance and financial goals, which may not be aligned, leading to gaps and duplications.[8]

We sought to identify congruence and gaps in transitional care activities between hospital and SNF staff, using the Ideal Transition of Care Framework (ITCF) to structure our inquiry. This

conceptual framework posits 10 domains essential for high-quality transitions and has been used to assess gaps in transitions and make inferences about their relative preventability.[9–12] The ITCF was the guiding framework for this analysis due to the evidence showing that a reduction in readmission rates is associated with more implemented domains.[13] In order to improve care transition processes and patient outcomes, we sought to understand how hospital and SNF providers perceive their respective roles and responsibilities in care transitions according to the 10 domains of the ITCF.

METHODS

Conceptual Framework

The ten domains of the ITCF include as follows: Discharge Planning; Complete Communication of Information; Availability, Timeliness, Clarity and Organization of Information; Medication Safety; Educating Patients to Promote Self-Management; Enlisting Help of Social and Community Supports; Advance Care Planning; Coordinating Care Among Team Members; Monitoring and Managing Symptoms After Discharge; and Outpatient Follow up After Discharge (Fig. 1) (see accompanying definitions for each domain in Appendix 1).

Design, Setting, and Participants

This research study was a component of a larger investigation exploring how clinical decisions are made related to discharge placement at SNFs.[14–16] We used purposive sampling to maximize diversity of hospitals and SNFs, and clinicians in clinical units within these hospitals. Participants were recruited from a Veterans Affairs (VA) hospital, a university teaching hospital, and a safety-net community hospital. SNFs are nursing homes, where at least part of the facility is dedicated to the post-hospital care of adults. SNFs are certified by Medicare and are appropriate for patients with a daily nursing or therapy need prior to moving to home or long-term nursing care after a qualifying hospital stay. SNFs provide nursing, physical, occupational, and speech therapy and vary significantly in the types of services they provide beyond these "core" services.[17] Our three SNFs included a VA-affiliated SNF and two community SNFs, one of which provided only short-term rehabilitative care. Clinicians who participate in care transitions were sampled based on their relative years of experience and familiarity with hospital or post-acute care settings. We interviewed at least one clinician of each type within each of the six facilities. Participants provided verbal consent to participate. The study was approved by the Colorado Multiple Institutional Review Board.

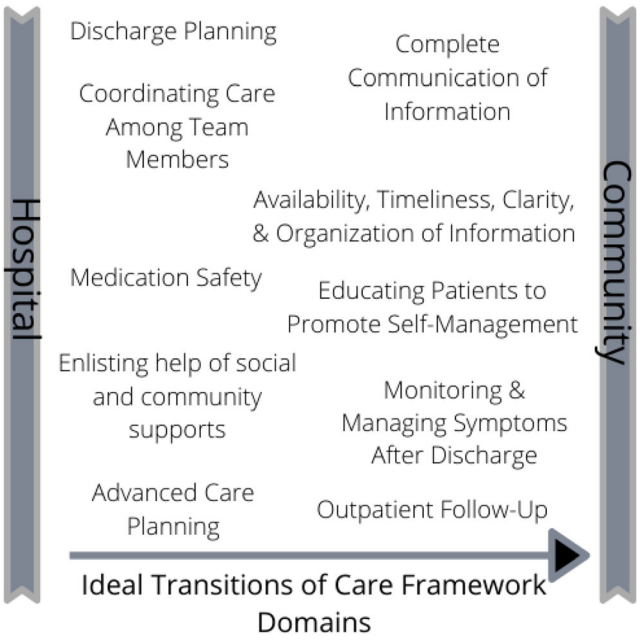

Figure 1 Transitions of Care Framework (modified from Burke RE, Kripalani S, Vasilevskis EE, Schnipper JL. Moving beyond readmission penalties: creating an ideal process to improve transitional care. *J Hosp Med.* 2013;8(2):102–109. doi:10.1002/jhm.1990).

Data Collection and Analysis

Between February and September 2016, qualitative analysts (RA, CL, EL, AL) conducted in-depth interviews lasting 20–60 min. We used a semi-structured interview guide (Appendices 2 and 3) informed by prior research related to care transitions and the ITCF.[18–21] Topics in the interview included evaluating the need for post-acute care; selecting post-acute care options; and post-discharge follow-up. Interviews were audio-recorded, professionally transcribed, validated, and analyzed in Atlas Ti (v7.5.11; Scientific Software Development, Berlin, Germany).

We used a team-based approach to framework analysis[22] and a deductive approach to identify key domains of the ITCF in the interview data as previously described[23–25]. Qualitative researchers (RA, CL) coded all transcripts, coding consistency checks were made throughout the coding phase, and discrepancies were resolved by team discussion. Summary of coded data was shared and discussed with the larger research team to increase reliability of results[26], including clinicians (BB, EC, RA). All coded quotes from each set of documents were reviewed for content on perceptions of responsibilities of either the hospital or SNF clinicians, as well as the performance of these responsibilities as perceived by staff at the other facility type. Congruence was identified when statements assign responsibility to the same clinical site or roles within those sites. A gap was determined when quotes suggested lack of responsibility for each site assuming the other was responsible.

RESULTS

We conducted interviews with 41 interdisciplinary clinicians across the six facilities (Table 1). Although there was considerable agreement between the hospital and SNF clinicians in respective roles, the implementation or actions related to the responsibility were lacking (Table 2). We focus on these gaps

Table 1 Description of Key Informant Interview Participants

Characteristic	Hospital *N* = 23 (%)	SNF *N* = 18 (%)
Race/ethnicity		
White/Caucasian	15 (65)	14 (78)
Black/African American	0	1 (6)
Latino	2 (9)	0
Native American	0	1 (6)
Asian	0	2 (11)
Other/mixed race/ethnicity	3 (13)	0
Missing	3 (13)	0
Clinician role		
MD/medical director	5 (22)	3 (17)
Nurse	4 (17)	4 (22)
Physical therapy	4 (17)	3 (17)
Occupational therapy	3 (13)	2 (11)
Social worker	5 (22)	2 (11)
Administration	0	2 (11)
Case manager/care Coordinator	2 (9)	0
Patient liaison	0	1 (6)
Registered dietician	0	1 (6)
Education		
Post graduate	17 (74)	13 (72)
College graduate	4 (17)	2 (11)
Some college	0	2 (11)
High school/GED	0	1 (6)
Missing	2 (9)	0
Women, *n* (%)	16 (70)	15 (83)
Veteran, *n* (%)	1 (4)	2 (11)

**Rounding may result in values > 100%*

in 8 of the 10 ITCF domains for two reasons. First, only SNF clinicians discussed Advanced Care Planning with little mention by hospital clinicians. Second, respondents did not identify a gap in responsibility for the domain Outpatient Follow up After Discharge. The results are presented by the ICTF domain, first describing areas of agreement, followed by gaps.

Discharge Planning

The stated primary responsibility of hospital staff is to place the patient in the most medically appropriate and safe setting. Hospital staff is aware of the need for timely discharge of patients to the SNF to reduce pressure at the hospital and maximize adequate care at the SNF. Despite the hospital medically "clearing" the patient prior to placement, SNFs identify unattended medical problems once admitted to the SNF, and viewed this as a major cause of re-hospitalizations.

> …hospitals are sending people out so quickly … they're leaving the hospital before I feel they should… because they're so sick. They haven't taken care of all the issues. They're not stable enough to be out of the hospital to come here and then we have to send them back. (SNF Nurse)

While hospital staff described trying to transition patients at appropriate times, the discharge may happen at inopportune times and disallow adequate adjustment of the care plan. Although SNFs decide on the appropriateness of admission, they desire more suitable hospital discharge timing.

> She [patient] was pretty upset because when she left the hospital, nobody told her she wasn't … getting that machine to her knee that night and of course, it looked like we were the bad guys, that we didn't provide something… [she said] well, nobody told me that at the hospital. I wouldn't have wanted to leave at 7:00 at night if I would've known. (SNF Director of Rehabilitation)

Complete Communication of Information

Both hospital and SNF staff understand and accept their role in facilitating communication to ensure safe transitions. The hospital must provide accurate and comprehensive information to the SNF for care continuity, while the SNF must address inadequate documentation. In one hospital, the adjacent location of the sub-acute center greatly facilitated communication between clinical teams and access to documentation within the same electronic health record (EHR). The main challenge was assignment of responsibility to communicate the required information at the time of transition, and who should be on the two ends of the communication.

> A five-minute phone call would save them [SNF clinicians] a lot more time than the length of the conversation…I don't know why it doesn't happen. I don't know if the docs and the clinicians there are just so overwhelmed by the amount of work that they have to do that they don't have time for it or they feel like they've gotten by with almost no information for so long.... (Hospital Physician)

Coordinating Care Among Team Members

When cross-facility communication is available, it is often funneled through gatekeepers such as the nurses, case managers, and patient liaisons, and may not include the larger care team who require direct communication with their colleagues at the receiving/sending facility.

> We work with a lot of [SNF] liaisons who are in-house, which helps with the communication because you can have a one-on-one conversation with the liaison, give them specific information and just detailed dispo [disposition] plan, what's really going on with this patient. (Hospital Case Manager)

Availability, Timeliness, Clarity and Organization of Information

Although ensuring complete information between sites is the responsibility of hospital staff, other aspects of information transfer demonstrate system problems beyond the control of

Table 2 Key Gaps in Ideal Transitions of Care Framework Domains

ITCF domain	Responsibilities	Key gaps
Discharge Planning	• Hospital to ensure medical readiness of patient for SNF placement • Both match patient to appropriate SNF • Assure safe discharge process	• Medical readiness of patient to discharge to SNF • Hospital discharge timing due to SNF admission process, medication reconciliation, and work with pharmacy
Complete Communication of Information	• Communication between hospital and SNF for safe transfer	• Closed loop communication after patient admitted to SNF • Hospital staff unclear what information is shared with SNF
Coordinating Care Among Team Members	• High coordination among multidisciplinary team within each setting	• Cross facility coordination directed through gatekeeper staff
Availability, Timeliness, Clarity and Organization of Information	• Hospital transfers timely and comprehensive information to SNF	• Discharge summary completed after patient admitted to SNF • Variability in quality and completeness of records transferred • Missing rehabilitation documentation • Incomplete discharge documents from SNF to hospital
Medication Safety	• Hospital provides accurate medication list	• SNFs require diagnosis information for medication review
Educating Patients to Promote Self-Management	• Both prepare patient and caregivers for transition and stepped down care	• Adequate hospital patient and family education on SNF service • Prepare patients for changes in pain medication administration prior to SNF admission
Enlisting Help of Social and Community Supports	• Both work toward the appropriate placement of patients with social challenges	• Initiate social work assistance for socially complex patients at hospital
Monitoring and Managing Symptoms After Discharge	• SNF ability to monitor and manage symptoms appropriate for the level of care	• Hospital staff unclear of SNF capabilities and staffing
Advance Care Planning	• Goal planning begins at hospital and continues through SNF	• Unknown status of medical directives prior to SNF admission
Outpatient Follow up After Discharge	• SNF communicates with primary care provider • SNF able to accommodate outpatient appointments	

the individual. Yet, hospital staff described the ideal manner of transferring information, even while being unable to do so. Hospital staff noted that rehabilitation information is infrequently provided but did not embrace responsibility for providing it to SNFs.

> They [SNF] hopefully get some of our notes printed out, but you know they might be kind of blind, I'm not sure, and then they're doing their own evaluation, which they can do, but it probably obviously would be nicer if we exchanged info. (Hospital Occupational Therapist)

SNFs perceived that hospital clinicians do not take responsibility for ensuring that information is high-quality and timely while hospital providers clearly acknowledge this issue.

> [for] the majority of the patients, the discharge summaries are in later that day … then writing it doesn't mean that it got sent, getting sent doesn't mean that it was received…there is no rule governing when this information needs to be sent or when or if there needs to be any check for it to be received or any of those things. This is all internally motivated and even what goes in the discharge summary. (Hospital Physician)

SNF clinicians spend considerable effort to obtain missing or unclear information even after receiving documents from the hospital.

> You're trying to piece this puzzle together, every single patient can take you up all the way from half an hour to two hours to get all the stuff straightened out, … and delay in care at times trying to extract information from all these sources. (SNF Physician)

SNF clinicians reported that patients perceive this gap in communication of information as the fault of the SNF, rather than the hospital, creating further frustration.

> I mean, a lot of folks are…gonna trust the acute care hospital cause it's more official… so if there's a breakdown initially they point the finger at us…eventually we might get the answer to the question…but then we're managing down somebody who has already become upset at a lack of continuity in the transition. (SNF Physical Therapist)

An additional gap is the transfer of needed documentation of rehabilitation goals and therapy received in the hospital to the SNF.

> I personally cannot get my hands on that information [hospital assessment of function], …That's a hole. Major hole. (SNF Physical Therapist)

Conversely, when the patient is readmitted to the hospital, records from the SNF may be lacking and funneled

through gatekeepers, limiting the clinical providers' access to complete information.

> From the case manager's call to the SNF? Well, some of it will be clinical information, but more than that… its will they take them back and if not, then what are we going to need to look for, for other options. (Hospital Occupational Therapist)

Medication Safety

The process of reducing medication errors during the transition period is dependent on the transfer of accurate medication information. Hospital staff provides medication information in the discharge materials and may be unaware of specific SNF requirements for additional details. SNF staff clearly stated their need to reconcile each medication prior to administration. The main challenge was assignment of responsibility to ensure that every medication was associated with a diagnosis, which was described by SNF staff as a key requirement but was not usual hospital practice nor supported by electronic health records in the hospital.

> It's missing …so you've got this medication but you don't know what they're taking it for. We do not receive stuff more often than not … diagnoses, proper medication, proper dosage. (SNF Nurse)

Educating Patients to Promote Self-Management

Hospital staff recounted numerous lengthy conversations to educate the patients and caregivers on the need for a SNF admission by the entire hospital care team. The most common gap identified was framing the role of SNF to patients making the transition. SNF clinicians want stronger patient education in the hospital in order to manage patient and family expectations of goals of care, insurance coverage, and SNF capacity.

> … they're [patients are] so…frustrated and discombobulated with the rush of getting out of the hospital that when they get to us [SNF], they're already upset with the whole transition process, so a lot of times our first day is spent explaining things that weren't able to be explained to them at the hospitals. (SNF Director of Rehabilitation)

Additionally, the inadequate in-hospital patient education can result in patients unprepared for the change in pain medication management at the SNF. If they could be told there [in the hospital] … from here on out, all of your pain medications are being changed to PRN, as needed, you can have them, they're all still on the list, but you're gonna need to ask. And then they get here and then we can say it, too. (SNF Physical Therapist)

Enlisting the Help of Social and Community Supports

Both hospital and SNF staff report challenges faced when discharging socially complex patients. Some hospital social workers address social challenges during the hospital stay, with concern for reducing the impact on SNFs; however, early intervention is inconsistent. SNF staff described housing the patient longer at the SNF even though they might be ready for discharge to home, solely due to social needs.

> We have to do a lot of work trying to figure out where this patient is gonna go…because our population does include folks that are homeless or have poor social support or poor financial backgrounds… or have substance abuse issues…[we see] a little bit of lack of communication on, … so our unit ends up having this person and keeping this person for longer than rehab. Sometimes we end up housing the person because they have such a complicated discharge issue. (SNF Physical Therapist)

Monitoring and Managing Symptoms After Discharge

Both the hospital and SNF attempt to match the needs of the patient to the care level available at the SNF, including monitoring and managing symptoms. Hospital and SNF clinicians described ambiguity in what the SNF can and should provide for post-hospital care. In some cases, SNF clinicians felt they were not given adequate time or information to make an assessment of whether SNF care was appropriate.

> Sometimes we get information ahead of time and we can review it and say oh yeah, we can definitely provide this care, [or] no we can't. (SNF Director of Rehabilitation)

In other cases, hospital staff described not knowing what SNFs could provide in terms of monitoring or managing care:

> I don't know how well staffed SNFs are…I've never worked in a SNF, I only worked in the hospital and home health. (Hospital Occupational Therapist)

One contributor to this ambiguity is the different capacity of SNFs, and the lack of awareness of these differences among hospital clinicians. One SNF patient liaison described the clinical capabilities of the SNF, "we can really take a fairly complex patient, minus somebody having a trach," while another SNF physician stated, "we don't monitor things as closely either because we shouldn't have to in this [SNF] environment. That's the whole point of them coming here is that they don't need as close monitoring with labs every day and vital signs six times a day and a doctor visit every day of the week."

DISCUSSION

Our study found several areas that should be improved for safer care transitions from the hospital to post-acute care. The gaps include the perceived medical appropriateness of the patient. Additionally, participants requested improved bi-directional communication; comprehensive and timely discharge documentation; optimal timing of discharge; improved in-patient education on SNFs; increased understanding of SNF capacity and staffing by clinicians; and improved support of socially complex patient earlier in the care continuum.

Using the ITCF to map hospital and SNF-based clinicians' perspectives of their responsibilities, we found areas of agreement but also considerable implementation gaps. This is a unique contribution, in that most prior studies were not guided by a comprehensive framework tied to quality of care, have focused on one aspect of transitions to SNF, the perspective of a single provider type or site of care, excluded rehabilitation staff from the analysis, or tried to assess degree of disagreement regarding preventability of readmissions.[27–31] In contrast, this study evaluated care transitions across domains, care settings, and multidisciplinary staff, and reframes preventable readmissions as those resulting from gaps in carrying out stated responsibilities within each domain of the ITCF—a position that has empiric support.[32]

Our study provides further support of care transition issues found previously. Britton et al. interviewed 41 hospital and SNF providers and also identified the increasingly complex nature of discharged patients problematic for SNFs, and systematic gaps in communication and document transfer between facilities.[33] Davidson et al. reported the results of a Delphi process among collaborative members that prioritized discharge communication as the top issue followed by medication reconciliation, patient social and resource barriers needs, patient education, closed loop communication from the SNF to the hospital, and use of gatekeepers for transfer of information and communication.[34] Unlike our study, follow-up with providers and outpatient provider communication were major concerns. We also found that physical therapy notes are not consistently shared between settings providing further support for integrating physical therapists into the transition process and reduce hospital readmissions[35,36].

Based on our findings, targeted improvements could efficiently address gaps in the ITCF domains. Figure 2 describes recommendations by level of difficulty in implementation and potential impact on improving care transitions. How could more shared responsibility be created across hospital and SNF settings for transitions? Our study did not ask this question to participants; however, a review of national- and state-specific efforts provides insight into what may produce shared accountability. Quality reporting, financial incentives, and value-based purchasing should prompt more consideration of these relationships to address gaps and would provide the enticement for sustained efforts.[37]

In addition to financial drivers, regulatory changes and technological innovations can push further improvements in the discharge process. Washington State has regulated transfer information requirements when discharging from hospital to long-term care which could be extended to SNFs. The National Quality Forum measures "timely transmission of transition record" to report how often a hospital sends a transition record to the physician (PCP) within 24 h of discharge[38] which could be expanded to address discharge to SNFs creating a performance feedback loop that was found to be lacking in our study. Further, a 2010 policy of the American Medical Directors Association delineates the optimal components of a care transition process which should be integrated into quality metrics, and payor requirements (i.e., Centers for Medicare and Medicaid).[39] A recent study of care transition models among primary care provider groups in accountable care organizations showed an association between EHR capability and adoption of care transition model processes further demonstrating the role of payors in driving improvements.[40,41] Facility-level efforts such as improved bi-directional communication, records sharing, and root-cause analyses[42,43] could help systematically address gaps over time. Finally, site-specific activities with more local impact and less implementation challenges include ensuring medication lists that include diagnosis codes, training opportunities for improved understanding of SNF clinical care services, special attention to discharge timing, and improved patient education on what to expect at the SNF including changes to medication.

Although this study included interdisciplinary clinical perspectives across six diverse hospital or SNF settings, several aspects may limit its generalizability. First, all the hospitals and SNFs are located in a single urban area. Second, this analysis focuses on the views of healthcare providers. While we also completed interviews with patients and caregivers,[44] we did not explicitly ask them to comment on these care transition domains. Third, while we sought to achieve thematic saturation in our interviews, these findings may not be representative of all hospital and SNF identification of responsibilities. Fourth, the ITCF is one of several conceptual models for transitions of care and other models may have valuable insights. Fifth, due to a lack of random sampling, purposive sampling of research participants is sometimes open to selection bias. However, we attempted to gather a diversity of perspectives and there was consensus among participants in what was discussed, providing evidence of concordance within each site. A strength of the study was including more than 40 participants from SNFs and hospitals, capturing a wide array of perspectives about roles and responsibilities in SNF placement decision-making. Additionally, we had an experienced multidisciplinary research team that conducted, analyzed, and interpreted these research results.

CONCLUSION

As hospitals and SNFs increasingly are held jointly responsible for the outcomes of patients transitioning between them,

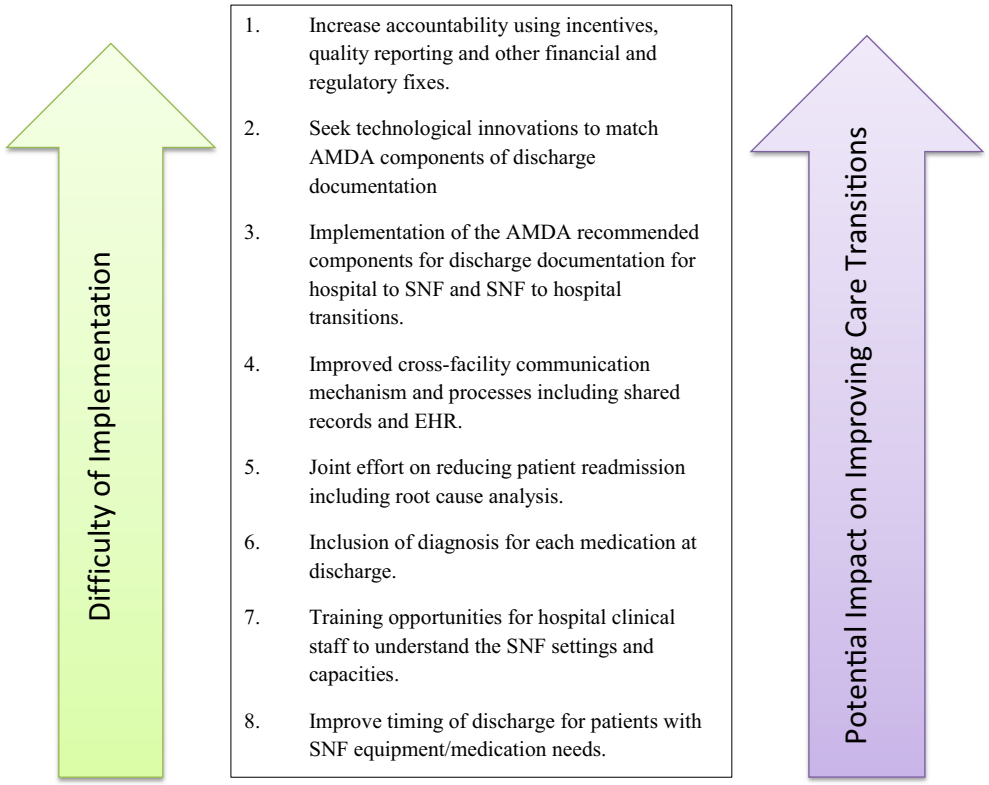

Figure 2 Recommendations to improve transitions of care from interdisciplinary hospital and SNF clinical staff.

explicit conversations and alignment in processes to address all domains for high-quality transitions are needed. In addition, future studies should explore the impact of these discordances between the two settings in patient outcomes and clinician's work processes. Building effective partnerships is increasingly essential to delivering high-quality care to all patients.

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Compliance with Ethical Standards:

Conflict of Interest: *The authors declare that they do not have a conflict of interest.*

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