

Legal Issues



By William C. Wilson, Esq.

The Role of the ‘SNFologist’ in Today’s Transitional Care

The long-term care model has morphed over the years in an effort to provide efficient, high-quality medical care to increasingly higher acuity skilled nursing facility residents, while minimizing gaps in post-acute care and readmissions to acute facilities. A new primary care specialty, the nursing home specialist, sometimes referred to as an “SNFologist” or “SNFist,” transitionalist, or post-acute care specialist, has emerged to address these concerns. The SNFologist provides continuity of care after a hospital admission by seeing residents of SNFs at least weekly, if not several times a week. This oversight can result in fewer medications being administered, fewer patient and family complaints, and improved patient outcomes, especially when these clinicians have experience and training in the principles of geriatric medicine.

A successful SNFologist program also can help an SNF comply with federal regulations.

One example of a full-time SNFologist program is based on the hospitalist program in acute care: an SNF has on-site physicians and care managers who make rounds as a group every day. Twice a week, the rounds include other disciplines, such as the rehabilitation therapy team and a dietician. Ideally, the SNFologist model is a “high service” model of care that involves not only a high degree of physician or nonphysician practitioner involvement but also a high degree of communication among these clinicians. Because the skilled SNF resident generally stays in the facility much longer than in a typical acute care facility, the SNFologists and their teams get to know their patients and their families on a much more intimate basis.

Theoretically, this relationship can potentially decrease the number of claims against a facility because there should be fewer negative outcomes with patient and family satisfaction rate increases. This arrangement also allows for ample time and multiple occasions to explore goals of care and provide meaningful and informed advance care planning. It’s unclear whether or not having a practitioner’s very frequent presence in the facility improves readmission rates, but it makes intuitive sense that such an arrangement would allow the practitioner to promptly evaluate, diagnose, and

treat their patients’ changes of condition on-site.

Benefits of the SNFologist

One full-time, long-term acute care facility in Harrisburg, PA, saw its patient satisfaction scores rise significantly in just the first 9 months of implementing their program. They also saw a steady rise in performance and quality benchmarks and, by maintaining a full census and keeping utilization costs down, they made up for the cost of adding SNFologists to the facility. The SNFologists also played a key part in cost savings by regularly meeting with facility leadership to set up quality initiatives.

Another SNF program in southern California set up in the early 2000s by HealthCare Partners saw the benefits of such a program almost immediately. The SNFologists rounded every day and met with interdisciplinary team leaders at least twice a week. When handing off patients to the primary care physician, the SNFologists dictated discharge summaries (the “warm handoff”), and sent a medication reconciliation form. They also placed follow-up calls to high-risk patients. Their efforts drove down the acute care facility readmission rate to 17%.

The potential benefits of using hospitalists in the SNF setting are that they also have hospital privileges, they can access the same electronic health records, and they can review discharge summaries, labs, and other reports that may not always be available to other nursing home attending physicians. This perk conforms with the Affordable Care Act and the recent announcement from Centers for Medicare & Medicaid Services regarding proposed changes to Medicare and Medicaid requirements, which include strongly encouraging facilities to participate in health information exchange through the use of EHRs.

A successful SNFologist program also can help an SNF comply with federal regulations. With more time available to meet with the residents and their families, there is a better opportunity to ensure that all important information is shared. Communication with the residents and their families not only is good practice but also is required by F tags 151, 152, and 154. The SNFologist program dovetails nicely with the federal requirements to keep the lines of communication open when crafting a care plan for any resident.

An SNFologist program also will help facilities comply with proposed changes to 42 Code of Federal Regulations §483.30. The changes stipulate that the referring provider personally approves

in writing a recommendation that an individual be admitted to a facility, and that the resident receives an in-person evaluation by a physician or nonphysician practitioner before transferring the resident to a hospital, except in an emergency. It is obviously much easier to be in compliance with these potential requirements if there are SNFologists working in the facility full-time.

Case Study

Mr. W was an 88-year-old man who suffered mainly from end-stage renal disease, hypertension, and diabetes. He had been ambulatory until he suffered four successive falls at home over the course of a week. His daughter lived with him and was his full-time caregiver. Mr. W became virtually bedbound after his third fall, in which he had sustained a 50% compression fracture of his T11 vertebra. Mr. W began to develop altered mentation and was taken to the local hospital by his daughter. At the hospital, the clinicians discovered three serious pressure sores (stage III and stage IV), one of which contained maggots. Mr. W was also severely malnourished, evidenced by critically low albumin and prealbumin levels. After being stabilized at the hospital, Mr. W was transferred to an SNF for continued wound care and skilled nursing services.

The SNF had a quasi-SNFologist program in place, whereby a physician and nurse practitioner, who worked for a staff-model HMO group, shared an office at the SNF and rounded their residents at least once a week. The physician and nurse practitioner were highly involved in Mr. W’s care daily, and were immediately available to respond to changes of condition or abnormal labs, of which there were several. Mr. W’s condition improved dramatically during his residency to the point where the physician no longer believed him to be a hospice candidate.

Mr. W was a resident at the SNF for 5 months. After his 100 days of Medicare Part A were exhausted, Mr. W switched to private-payer status and became an LTC resident, still receiving care for wounds that were almost healed. One day, Mr. W suffered a sudden desaturation event and was transferred emergently back to the hospital. He never fully recovered and eventually died 3 months later. Mr. W’s daughter sued the SNF for elder neglect.

Mr. W’s children alleged that the switch in payer status led to a decline in care, as evidenced by the decline in weekly physician and nurse practitioner progress notes. The nurse practitioner

testified that it was her team’s policy not to round as frequently after the 100 days were exhausted, but that she still rounded every 60 days or upon change of condition. However, she said that because her office was in the facility, she saw her patients informally and could keep an eye on everyone. Both clinicians testified in their depositions that they were in the facility to such a degree that they could keep close tabs on all their patients and could respond to their patients’ medical issues much faster than if they were simply on-call. Once Mr. W became an LTC resident, they were still keeping tabs on his progress, but they were not making chart notes for every single encounter.

At the outset of the litigation, the plaintiffs took the position that the care provided to Mr. W during the entire residency was below the standard of care. The interesting part of this case came when the plaintiffs’ experts conceded that the care provided during the first 100 days met the standard of care. In other words, skilled nursing care provided pursuant to an SNFologist-type model can be very instrumental in successfully defending against professional negligence and elder neglect claims.

Conclusion

In Mr. W’s case, it is reasonable to conclude that if the clinicians had followed the SNFologist model throughout his entire residency, the plaintiff’s experts would have been forced to concede that all care met the standard of care for the entire residency. Unfortunately, if something is not in the chart, then there is the presumption that it did not happen. The lack of progress notes in Mr. W’s last 2 months of his stay left the facility open to claims of elder abuse.

Although an SNFologist program may not always prevent a readmission within 30 days or avert litigation, it is reasonable to conclude that when the entire care team is more involved with a resident and family members, it is less likely that the resident will be readmitted or that issues with care will cause the family to sue the facility. 

This column is not to be substituted for legal advice. WILLIAM C. WILSON is a partner in the law firm Wilson Getty LLP, which represents all types of long-term care facilities against civil claims. He also represents facilities in administrative hearings and advises long-term care clients on risk management and corporate compliance. Read this and other columns at www.caringfortheages.com under “Columns.”