

## Leveraging the Care Team to Optimize Disposition Planning

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Is this patient a good candidate? In medicine, we subconsciously answer this question for every clinical decision we make. Occasionally, though, a clinical scenario is so complex that it cannot or should not be answered by a single individual. One example is the decision on whether a patient should receive an organ transplant. In this situation, a multidisciplinary committee weighs the complex ethical, clinical, and financial implications of the decision before coming to a verdict. Together, team members discuss the risks and benefits of each patient's candidacy and, in a united fashion, decide the best course of care. For hospitalists, a far more common question occurs every day and is similarly fraught with multifaceted implications: *Is my patient a good candidate for a skilled nursing facility (SNF)?* We often rely on a single individual to make the final call, but should we instead be leveraging the expertise of other care team members to assist with this decision?

In this issue, Boyle et al<sup>1</sup> describe the implementation of a multidisciplinary team consisting of physicians, case managers, social workers, physical and occupational therapists, and home-health representatives that reviewed all patients with an expected discharge to a SNF. Case managers or social workers began the process by referring eligible patients to the committee for review. If deemed appropriate, the committee discussed each case and reached a consensus recommendation as to whether a SNF was an appropriate discharge destination. The investigators used a matched, preintervention sample as a comparison group, with a primary outcome of total discharges to SNFs, and secondary outcomes consisting of readmissions, time to readmission, and median length of stay. The authors observed a 49.7% relative reduction in total SNF discharges (25.5% of preintervention patients discharged to a SNF vs 12.8% postintervention), as well as a 66.9% relative reduction in new SNF discharges. Despite the significant reduction in SNF utilization, no differences were noted in readmissions, time to readmission, or readmission length of stay.

While this study was performed during the COVID-19 pandemic, several characteristics make its findings applicable beyond this period. First, the structure and workflow of the

team are extensively detailed and make the intervention easily generalizable to most hospitals. Second, while not specifically examined, the outcome of SNF reduction likely corresponds to an increase in the patient's time at home—an important patient-centered target for most posthospitalization plans.<sup>2</sup> Finally, the intervention used existing infrastructure and individuals, and did not require new resources to improve patient care, which increases the feasibility of implementation at other institutions.

These findings also reveal potential overutilization of SNFs in the discharge process. On average, a typical SNF stay costs the health system more than \$11,000.<sup>3</sup> A simple intervention could lead to substantial savings for individuals and the health-care system. With a nearly 50% reduction in SNF use, understanding why patients who were eligible to go home were ultimately discharged to a SNF will be a crucial question to answer. Are there barriers to patient or family education? Is there a perceived safety difference between a SNF and home for nonskilled nursing needs? Additionally, care should be taken to ensure that decreases in SNF utilization do not disproportionately affect certain populations. Further work should assess the performance of similar models in a non-COVID era and among multiple institutions to verify potential scalability and generalizability.

Like organ transplant committees, Boyle et al's multidisciplinary approach to reduce SNF discharges had to include thoughtful and intentional decisions. Perhaps it is time we use this same model to transplant patients back into their homes as safely and efficiently as possible.

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