

**AMERICAN MEDICAL DIRECTORS ASSOCIATION
POLICY
RESOLUTION H 10**

SUBJECT: IMPROVING CARE TRANSITIONS BETWEEN THE NURSING FACILITY AND THE ACUTE-CARE HOSPITAL SETTINGS

INTRODUCED BY: PUBLIC POLICY COMMITTEE

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Summary

The primary focus of this white paper is

- to recognize and emphasize the importance of efficient processes for transferring patients from the acute-care hospital (ACH) to skilled nursing facility/nursing facility (SNF/NF) and from SNF/NF to ACH, including the emergency department (ED);
- to highlight key elements in the care transition process; and
- to specify key features of a successful care transition process.

AMDA recommends that the key elements to ensure a safe care transition process should be focused on the following:

- Patient-Centered Care
 - Transfer occurs with the patient's and/or family's input and understanding to the extent possible.
 - Transfers are consistent with goals of care and advance care documents of the patient and/or family.
 - Transfers include appropriate patient and caregiver education.
- Communication
 - Information about the patient, including medication and care plans, should be collected through the stay and be available well in advance of any transfer.
 - Those professionals involved in the care of long-term care patients and other frail, at-risk patients should actively work with other relevant professionals and each site of care to create and improve policies and procedures that assure timely and accurate communication.
 - When possible, communication about transfers should be communicated from professional to professional in different sites of care.
 - The sending and receiving professionals should have reliable contact information for each other (e.g., phone, pager, fax).
- Safety
 - Safe transfers rely on appropriate assessment of the patient prior to transfer. AMDA provides tools such as the *AMDA Acute Change of Condition in the Long-Term Care Setting Clinical Practice Guideline* to help with such assessment.
 - Safety requires accurate and timely transfer of key information including

- patient’s functional and cognitive status;
- plan of care and advance care directives;
- current problem list;
- current treatment regimen, including all necessary equipment needed;
- allergies;
- meal consistencies and preferences; and
- recent labs, consultations, and diagnostic testing results.

This goal of this white paper is to guide policies and procedures that enhance communication and support safe, patient-centered care as patients and families transition between sites of care. The paper expands upon the three main tenets of successful transfers and offers links to existing tools that help ensure a safe care transition process. The lists above are not exhaustive, but are offered as a guide to some of the most important elements in a successful care transition.

Introduction

The purpose of this white paper is to recognize and emphasize the importance of efficient patient-centered processes for transferring patients from the acute-care hospital (ACH) to skilled nursing facility/nursing facility (SNF/NF) and from SNF/NF to ACH, including the emergency department (ED). Rather than duplicate the practical material already available in AMDA’s recently published Clinical Practice Guidelines (CPG) *Transitions of Care in the Long-Term Care Continuum* and *Acute Change of Condition in the Long-Term Care Setting*, documents and tools from the National Transitions of Care Coalition (NTOCC), and others, this paper aims to highlight critical factors in the care transition process and to specify key features of a successful care transition process. We will refer to some specific documents and tools currently available, but these are by no means exhaustive, and the interested reader is directed to the additional resources found in the Summary of Available Tools section.

Transitions between silos of care like ACHs and SNF/NFs are well known as a frequent nidus for medical errors that cause harm to patients. Moreover, it is well established that transferring a patient from a familiar environment (e.g., the SNF/NF where s/he resides) to a new, unfamiliar, and potentially bewildering location like an emergency room can cause severe and sometimes permanent decompensation and lead to medical errors. So while we aim to discuss methods of optimizing transfers between these settings, another important goal should be to reduce the incidence of inappropriate transfers, particularly those resulting in unnecessary rehospitalizations—a topic of great concern in the current health care climate. While a detailed discussion of this topic is beyond the scope of this paper, it is mentioned both for its importance and its relevance to this paper—since more efficient, safer processes for initial ACH-to-SNF/NF transfers are likely to reduce the need for rehospitalization. Hence, *avoidance* of unnecessary transfers should be a primary goal, but when transfers *are* necessary, we support implementation of processes that optimize efficient and well-orchestrated patient transitions. We also encourage improved competencies of the entire interdisciplinary team in the SNF/NF setting, both as individuals and as a team, and more effective processes to ensure appropriate assessments are performed before the decision to transfer a patient to the hospital is made.

This white paper supplements AMDA's previous white paper C-09, *Improving Care Transitions from the Nursing Facility to a Community-Based Setting*, which addressed transitions between the SNF/NF and the community.^a AMDA supports care processes with a patient-centered focus emphasizing communication and appropriate documentation.

It is well established that there are significant deficits in the current system of care transitions, but there is limited evidence as to which interventions will most positively affect outcomes. We welcome additional data and new models of care that will help us create and evolve optimal processes for transitions between care settings. In the meantime, we propose some basic tenets that we believe, at least intuitively, will serve as underpinnings to enhance safe and efficient transitions:

- Consistent discussion and documentation of advance directives and end-of-life care preferences, with up-to-date POLST (Physician Orders for Life Sustaining Treatment)/POST (Physician Orders for Scope of Treatment)/MOLST (Medical Orders for Life Sustaining Treatment)/MOST (Medical Orders for Scope of Treatment) forms or, in states where these are not available, with other appropriately executed advance directive forms.*
- Education, communication, and engagement of patients and family as to the reason(s) for transfer, goals and next steps in care, the nature and severity of their conditions, appropriate health care provider contact information for problem solving, and optimization of the actual location of care to meet patient-specific needs.
- Prompt and consistent medication reconciliation at every transition point, as well as proper planning to ensure no discrepancies in administration of medication.
- Avoidance of harm to the patient and primary consideration of the patient's individual preferences.
- Retention of responsibility for the patient by the sending entity (ACH, SNF/NF, ED) until assumption of care by the receiving entity, and availability to respond to clinical inquiries from the receiving entity.

AMDA supports research, public policy, and best practices designed to improve the safety and efficiency of care transitions, and AMDA has recently published CPGs (e.g., *Acute Change of Condition in the Long-Term Care Setting*) to enhance care transitions specific to the long-term care setting. We hope that health care reform and future legislation will recognize and address the current deficits in care transitions and seek to reward seamless and reliable processes for transitions. This white paper focuses on specific issues of transfers between hospitals and SNF/NFs and vice versa, but we strongly support efforts to improve transitions across all care settings.

^a AMDA. *Improving Care Transitions From the Nursing Facility to a Community Based Setting*. http://www.amda.com/governance/whitepapers/transitions_of_care.cfm. March 2009.

* The Physician Orders for Life-Sustaining Treatment (POLST) Paradigm program is designed to improve the quality of care people receive at the end of life. More detailed information is available at <http://www.ohsu.edu/polst/>.

Key Elements of a Successful Care Transition

As each patient is unique in the needs and specifics of his/her acute disease process, so is each care transition; however, some general principles can be applied to define success in a transfer. The success of each transfer is quantified by the degree to which it meets the requirements of the patient through creating an individualized plan of care. It is imperative that goals of care and advance directives be addressed early on with the patient and family. Early identification of short- and long-term goals will help to determine the appropriate next level of care. Discussion of patient/family expectations and goals of care should facilitate determination of the next level of care for the patient at the completion of each health care institutional stay.

The transition plan must consider caregiver availability for the patient, as well as caregiving responsibilities by the patient him/herself. Advance directives are determined and respected. It may not be reasonable to assume that a declining, frail patient with multiple comorbidities would be best served in a rehabilitation (SNF) setting versus a hospice setting. Moreover, financial and insurance issues are important factors for some patients, and must be taken into account when deciding the appropriate level of care for an individual patient.

When the patient is transitioned to a SNF/NF, clinical information to seamlessly continue the plan of care is sent forward, and hospital clinicians should remain available to answer questions about transfer orders and to oversee patient care until SNF/NF clinicians have assumed clinical control. Necessary medications and equipment should be on site when the patient arrives whenever possible to prevent gaps in care. An area of particular concern is ensuring that the next level of care is one that will meet the needs of the patient.

The current health care climate ensures that many patients, often elderly, moving to SNF/NFs are vulnerable physically, mentally, or both. Transitioning from the ACH setting to the SNF/NF is often traumatic to the patient and family. Planning for the patient's discharge as early as possible in the acute care stay may lessen some of the anxiety. Early understanding of the needs of the patient, adequate time for patient and family input into the plan of care, and time for education of the patient/family about the SNF environment and reasonable expectations for it will mitigate the trauma of the transition.

The decision to transfer the patient to a SNF/NF will require input from the patient, family, and sending facility's interdisciplinary team (nursing, rehab, medicine). If the patient's goal is to return home, then it must be determined whether there is either a formal or informal caregiver available in case further care is needed. If not, can the patient then be directed into the SNF/NF to facilitate a future return to his or her previous level of function compatible with independent community living? If the patient previously lived in an assisted living facility, will a SNF/NF stay allow for sufficient return of function to enable the patient to return to the level of care offered by the assisted living facility? The need for a caregiver in the home may be of concern at the time of discharge from the SNF/NF to the community. This will be a part of the care continuum as planning for the discharge to the community begins at the time the patient enters

the SNF/NF, and the interested reader is directed to AMDA's white paper C-09 on the topic of transitions from SNF/NF to community.^b

Patient-Centered Care (Culture Change)

Safe and effective care transitions involve conforming each transition to the involved patient, not attempting to fit the patient into the existing transfer process. This is the heart of the concept of patient-centered care. Patient-centered care has two basic elements. The first is patient/family ownership and empowerment in the process; the second is that appropriate clinical and psychosocial information travels with the patient rather than remaining anchored at individual sites of care.

The concepts of ownership and empowerment respond to the historical perception that health care institutions foster dependence and acceptance. Patients are encouraged to remain in bed unless helped; they have food prepared for them and brought to them. Checking blood sugars and administering insulin, for example, is all done by hospital staff. Upon discharge, all these functions suddenly become the responsibility of the patient and family, as well as the assumption that they will recognize warning signs of problems with their medical conditions and drugs. Additionally, patients and family may be unprepared for changes imposed by clinicians as they move to the next setting. Diets and medications are abruptly modified, and decisions on tests and courses of therapy are made without consulting the patient or family on how those adjustments may conflict with personal beliefs, financial considerations, or the reality of daily life in the community.

Furthermore, patients may have difficulty determining which physician to call for questions and problems, especially in the current hospital environment where multiple consultants are often involved in the absence of the community primary care physician (PCP). This intensifies with the move to the SNF/NF, where a different set of physicians and caregivers assume care, also usually in the absence of the PCP. Discharge instructions, simple in the unique environment of the hospital, become formidable if not impossible when not inclusive of the realities of financial resources, transportation, and limitations of insurance plans. If specific medications are not on the health plan formulary, who adjusts the prescription? If an imaging study requires pre-authorization, who obtains this?

In a patient-centered process, the patient and/or family learns the reasons for hospitalization, is told whom to call for concerns at any point in time, is prepared for self-care to the degree possible, participates in significant decisions, is instructed in recognition of warning signs for the disease processes and medications, and is advised about next steps in care. Problematic areas such as pre-authorizations, transportation, and psychosocial concerns are acknowledged and addressed, even if not solvable. Put simply, patient-centered care means determining patient/family preferences and incorporating those preferences into the plan of care. It creates a new relationship for health care, with the patient embracing responsibility as an active partner to the extent possible.

^b AMDA white paper C-09: Improving Transitions of Care From the Nursing Facility to a Community-Based Setting. www.amda.com/governance/whitepapers/transitions_of_care.cfm. March 2009.

The second element of patient-centered care, that of mobilizing the information essential to good care along with the patient, involves addressing the frequent misconceptions surrounding the Health Insurance Portability and Accountability Act (HIPAA) and reversing the inertia of current information flow practices. At present, clinical information is well preserved at the site of care, but timely transmission of data to other sites of care is less evolved. The advent of the electronic health record (EHR) is poised to alleviate much of this problem, but long-term care is lagging well behind the hospital and outpatient settings in its implementation. Individuals are increasingly becoming comfortable with electronic data storage, but few at this time have on-line, available data repositories or portable information devices for health care facilities to access. While support for appropriate electronic data transfer is strongly supported by AMDA, paper information flow remains the norm at this time.

While institution-to-institution information transfer is important to the patient-centered concept, a key component is to provide patients with their own clinical data. The extension of that is an expectation that patients will assume ownership of that information, update it, and provide it to individual care sites. It will supplement, not replace, current clinical data transferred from sites of care and allow quality assurance of that information. There are numerous sources for personal health records, medication records, and advance directive forms that patients/families can access, complete, and update. AMDA encourages health care personnel to honor these sources of information and assist in their completion and updates.

A simple way to achieve patient-centered care is to ask the patient about his/her “simple pleasures.” This can be done by having a liaison from the SNF/NF meet with the patient prior to or upon transfer from the ACH to discuss those things that would make his/her stay at the SNF/NF more comfortable. It may be as simple as having a cup of coffee each morning in his/her own mug or having his/her cat visit (or even live with him/her) while he/she is at the SNF/NF. Not all requests can be accommodated, but most can at least be considered, which helps create an environment where the patient feels valued and honored. This is also a good time for a facility liaison to discuss the patient’s expectation for the SNF/NF stay and an opportunity to answer questions about the facility and planned next steps. The patient’s wishes for advance directives and end-of-life care need to be reassessed, as well as the understanding of the patient and family regarding diagnosis, reason for hospitalization and SNF/NF stay, and prognosis.

Medication Reconciliation

November 1, 2009 marked a decade since the publication of the Institute Of Medicine’s famed monograph “To Err is Human: Building a Safer Health System,” which suggested that up to 98,000 avoidable deaths due to medical errors occur in the U.S. each year.¹ This publication galvanized a focus on patient safety from multiple sectors. From the standpoint of medical directors in SNF/NFs, a key focus to improve patient safety is to ensure a smooth transition of care from the ACH setting to a SNF/NF. As referenced in AMDA’s *Transitions of Care in the Long-Term Care Continuum* CPG, adverse events and avoidable complications can occur due to

“poor communication and coordination among caregivers, health care professionals, and the patient during such transitions.”^c

Another transitional patient safety concern is medication changes from hospital admission to hospital discharge. A prospective study by Coleman *et al* suggested that about half of regularly used home medications were discontinued, and over a third of those omissions were considered to have the potential to cause moderate or severe discomfort or clinical deterioration.² Likewise, articles appearing in the *Annals of Internal Medicine* in 2003³ and *Archives of Internal Medicine* in 2004⁴ noted that “adverse drug events attributable to medication changes occurred in 20% of transfers between nursing homes and acute care hospitals.” Recent literature has noted both inadequacies of hospital discharge summaries (e.g., not mentioning outstanding test results or necessary post-discharge testing)⁵ and failure to identify a PCP or receiving physician, with 11% of discharge letters and 25% of discharge summaries never reaching the PCP.⁶

Many excellent definitions of medicine reconciliation exist. Rather than recite a definition, this paper chooses to describe the actions involved in safe medication management. Medication reconciliation is not an event, but an enduring activity. Medication reconciliation has several components. First is the process of assembling the most current, complete and accurate list possible of patient medications, including prescription, non-prescription, and over-the-counter medications, borrowed medications, vitamins, complementary and alternative medications, and all ingested compounds. Equally important are the dose and frequency of true use. The next component is reconciling that actual use list against the current medication orders at each transition, resolving any discrepancies. Utilizing the family to bring in medications from home for review will allow the greatest accuracy. Once certainty (to the extent possible) has been reached on the medication regimen, each drug should be evaluated to ensure there is a solid reason for its use, and, indeed, a good reason not to discontinue it. The final component is clear communication of the drug regimen to those involved in the transition. The patient and family should understand which medications are to be taken, their therapeutic purpose, duration of use, and adverse effects requiring prompt contact with a clinician. That same information is transmitted to the SNF/NF. It is advisable to send the community PCP or medical home a copy of the reconciliation form both upon departure from the hospital and admission to the SNF/NF, as well as—more importantly—upon discharge from the SNF/NF as described in AMDA’s white paper C-09.

The reconciliation itself begins when the physician provides discharge or transfer orders from one level of care to the next. As always, other members of the health care team are critical partners for patient safety in the transfer. Oversight, review, and discussion of medications before and after transition can include the consultant pharmacist, the attending physician, nurse practitioner, physician assistant, hospital nurse, community PCP or pharmacist, SNF/NF nurse, and other health care team members as appropriate.

^c AMDA. Transitions of Care in the Long Term Care Continuum. Clinical Practice Guideline. 2010.

Information Transfer

The appropriate point for information transfer is *prior to* the patient's move to the SNF/NF. It is vital to have information regarding any specific equipment needs such as specialty beds, intravenous (IV) pumps, wound care supplies, or enteral feeding supplies. A recent survey of 241 directors of nursing in SNF/NFs gives additional information on real-world transfer of care between ACHs and SNF/NFs.⁷ It revealed that initial care information was shared between the hospital discharge planners (69.3% of cases) or social workers (31.2%) and the SNF/NF admissions coordinator (94%). The medical director was involved only 3.3% of the time. The individual with the greatest responsibility for transition of care information, especially regarding medications, was the admission nurse, followed by the SNF/NF attending physician. Medical administration records (MARs) and discharge/transfer sheets were usually present within one hour of a patient's arrival, but discharge summaries, notations of last medications, and communication between the ACH discharging nurse and the SNF/NF admitting nurse were markedly less frequent. More than half (57.6%) of attending physicians in the SNF/NF "rarely" or "never" discussed patients with the transferring physicians.

It is also important to have information about any specific medication needs, including antibiotics, analgesics (especially Schedule II controlled substances), inhaled/nebulized medications, antiarrhythmics, and other important drugs to ensure timely availability at the time of transfer. The availability of this advance information will allow the receiving facility to have these items present at the time of admission or shortly thereafter, promoting good patient care and helping to alleviate patient/family anxiety about the transfer. It is important to communicate infection control issues that may require isolation or cohorting to allow the receiving SNF/NF to plan for this, or to notify the ACH that this arrangement is not available at their facility.

Other essential information should come with the patient at the time of transfer. A formal, dictated discharge summary from the sending facility is the ideal, but transcription issues and local practices make this the exception rather than the rule. A brief medical care summary can be of enormous value. Tools such as the AMDA Universal Transfer Form can also transmit crucial clinical information. There needs to be a list of medications and the times when the patient last received them. This may be best accomplished by having a copy of the MAR accompany the patient. Recent vital signs, baseline mental status, fall risk, pulse oximetry, and any other nursing concerns (e.g., time of last bowel movement) are important. There needs to be communication regarding outstanding laboratory or diagnostic studies, such as cultures and sensitivities, biopsy results, or imaging studies. It is essential that there be a mechanism for obtaining the results of these outstanding studies. Other considerations are for pending studies or consultations that will need to be done on- or off-site. The receiving facility needs to assure that the patient will make necessary appointments along with facility-arranged or family-provided transportation.

Communication is enhanced when patient information exchange occurs between professionals at both sites of care. Nurse-to-nurse report is traditionally done, but any clinician interaction by dietitians, therapists, and others augments patient safety in transfers. In addition, physician-to-physician contact is to be encouraged whenever possible, especially when there are complex or nuanced clinical or psychosocial issues. It is helpful to have contact numbers available for the

facility attending and the acute-care clinician/hospitalist, which can be shared prior to the transfer of the patient into the SNF/NF. Another important exchange is between the SNF/NF attending physician and the patient's community PCP. Having the information and contact numbers for the various providers is essential to assuring that information can be readily exchanged before, during, and after the SNF/NF stay.

Transportation to the facility depends on the needs of the patient. When transportation personnel are involved, the hand-off should be clear. "Here are records, orders, and patient," should be a personal communication from the transport staff to the facility staff upon admission, followed by facility staff acknowledging receipt with "I have the records, orders and patient." Similar closed-loop hand-offs should occur with each patient transition. If the family is involved in transporting the patient, they should be queried about any accompanying paperwork. If none was sent, then the receiving facility should notify the sending facility immediately to expedite this transfer of crucial information.

The ability of receiving SNF/NFs and their attending physicians to provide safe and comprehensive care for new residents is dependent on their receiving timely and accurate information from the referring source as noted. Once received, the SNF/NF must provide the ordered necessary services while completing its own patient-specific assessments and subsequent care plans. The receiving physician ideally should screen this information on the admission day, and then complete and document his/her initial evaluation within 1-3 working days in accordance with state and facility standards and the clinical needs of the patient. The initial care plan should also document the patient's goals of care and advanced illness management plans, such as advance directives or POLST/POST/MOLST/MOST forms. Patient health literacy and educational needs should be assessed and integrated promptly into the patient's plan of care.

Medical Director Oversight

One of the essential functions of the SNF/NF medical director is his/her involvement in the implementation of resident care policies. While one does not expect the medical director to write the policies or be there to meet each patient on admission, s/he should be involved in assisting the SNF/NF with the development of these transition policies. The medical director is instrumental in assisting the facility to determine what constitutes essential information to help ensure smooth transfers.

The second essential function of the medical director is the coordination of medical care. The medical director can assist with education of transferring facilities and attending physicians as to the need for pertinent information to facilitate appropriate transitions and well-coordinated care. The medical director should globally review admissions and discharges to assure that transitions are occurring appropriately. This can be done either as part of a Medical Care Committee or in the SNF/NF's Quality Assessment and Assurance Committee. Some medical directors have had success in meeting with hospital staff or hospitalist groups to engage them in collaborative methods to improve transitions, and this is to be encouraged, especially in situations where problems are commonplace.

Within the SNF/NF, the medical director can develop internal indicators of appropriate transitions. This can be accomplished by working with the SNF/NF interdisciplinary team and/or the attending physicians. Some indicators may include frequency of readmissions to acute care within 24 to 48 hours of admission to the facility, the availability of transfer information at the time of the patient's admission to the facility, and the availability of key durable medical equipment (e.g., beds, medication pumps). However it is done, the involvement of the medical director is the key to creating a culture of safe and efficient facility transitions. It is an intimate part of the role of the medical director in the SNF/NF.

Another way SNF/NF medical directors can assist in ensuring appropriate transfers is by educating hospital physicians (e.g., hospitalists, emergency physicians, surgeons, residents) and other hospital personnel on the specific services and levels of care available in their SNF/NF. Many hospital physicians seem to have only a marginal idea of what kind of care is given in SNF/NFs, and helping them to understand the abilities and limitations of these facilities will improve placement decisions and patient care.

Improving ACH to SNF/NF Transfers

The focus of this section is to identify some barriers and explore opportunities to improve the transitions of care process in the hope of decreasing medical errors and adverse events; increasing patient, family, and/or caregiver participation and satisfaction; and potentially decreasing avoidable hospital readmissions, which may be particularly relevant in light of the proposal by the Center for Medicare & Medicaid Services (CMS) to reduce costs by bundling payment for acute hospital care and discharge services (home health, SNF/NF) for a given time period, such as 30 days post-discharge, under Medicare Part A.

The key to a successful transfer of care is communication. Ideally, this would be physician-to-physician; however, several barriers have been identified here. In the best of all possible worlds, the patient has a primary care physician (PCP) in the community (medical point of contact) who is the attending in the acute care hospital (ACH), who at discharge continues as the attending in the SNF/NF, and who upon return to the community continues to serve as his/her PCP. This concept of following patients across care settings, using continuity to improve care and reduce errors, is being popularized by models such as 'medical home' and PACE (Program for All-inclusive Care for the Elderly) programs. In the current environment, fewer physicians are able to follow the patients throughout the continuum themselves. The patient may not have a community-based PCP or medical home. For many patients who do have a PCP, the patient meets the ACH hospitalist at the time of hospitalization, and upon discharge to the SNF/NF, s/he meets yet another new physician (SNF/NF attending physician), also usually not the PCP who will ultimately be responsible for care after discharge from SNF/NF. The PCP may not even be aware of the hospitalization and rehabilitative stay until the patient is seen at a follow-up office visit.

Some barriers and problems that are common in the ACH to SNF/NF transfer are as follows: ACH patients may be kept in bed until the day of discharge, often with a Foley catheter in place for unknown reasons. The lack of ambulation in the acute-care setting can result in significant

setbacks with respect to rehabilitation and endurance for the patient, in addition to increased risk of infections, depression, and other complications. The medical indication for an indwelling catheter, if not specified, may result in inappropriate discontinuation and difficulty replacing the catheter. Transportation costs (for ambulance, wheelchair transport, etc.) are often not considered when there is a need for additional studies or consultations that could have been accomplished in the ACH setting. Patients with dysphagia are sometimes transferred with a temporary nasogastric (NG) feeding tube without documentation of any substantive discussion of advance directives, creating significant issues for SNF/NF personnel and attending physicians. Intravenous access may be an issue, and when the need for prolonged access or difficult peripheral line placement is anticipated, placement of a peripherally inserted central catheter (PICC) or similar line while the patient is still in the hospital is advisable.

Transfer of Information from the ACH to the SNF/NF

The inter-facility transfer form is the most commonly used method for transferring information between ACHs and SNF/NFs. These forms are not standardized, although universal transfer forms are available. AMDA provides a sample Universal Transfer Form on its Clinical Corner website located at www.amda.com/tools/index.cfm.

Many problems exist with respect to information transfer between ACH and SNF/NF. Information on baseline cognitive and functional status prior to hospitalization may not be provided. Special needs or problems such as intravenous fluids/access, catheters or drains, feeding tubes, and pressure ulcers or other skin conditions may not be accurately or completely recorded. Transfer forms frequently are not filled out by physicians, may have incorrect information, may be filled out incompletely, may have additional errors and omissions if patient discharge is delayed, and may not be legible, especially if faxed. Final culture reports, pending biopsy reports, or other pending labs and diagnostic test results may not be available. Information on items such as vaccination status, necessary consultations and follow-up visits, and advance directives may also be lacking.

There is often no ACH contact person or floor call-back number documented to allow the SNF/NF admitting nurse to call when information is missing or unclear. Even when the contact number is present, hospital staff may have changed shifts and/or records may be unavailable when the SNF/NF calls. As good a job as many ACH case managers/social workers/discharge planners and SNF/NF admission coordinators do, this is still an area of significant problems. Often, identifying and notifying the receiving physician in a timely fashion, as well as identifying the transferring physician and conducting physician-to-physician discussion when necessary, remains highly problematic. An accurate pre-hospitalization medical regimen may also be unavailable.

A potentially important piece of information is the ACH discharge or transfer summary. Since the attending physician in the SNF/NF rarely has direct communication with the transferring physician, and since patients or their advocates frequently aren't clear on what transpired in the ACH, the adequacy of the discharge summary is extremely relevant to continuity of care. The

Society of Hospital Medicine and the American College of Physicians in their hospitalist section have recently published standards for essential components of a discharge summary.⁸⁻¹⁰ The information of most help to the SNF/NF attending would include the reason for SNF/NF referral and whether a return to the community is the intent; recommendations of specialty consultants; pending laboratory or other diagnostic study results; and recommended follow-up and management plans, particularly if someone other than the attending physician will be monitoring some aspect of care (e.g., infectious disease clinic monitoring intravenous antibiotics, orthopedist monitoring DVT prophylaxis). Additional helpful information would be documentation of cognitive and functional status, both at pre-hospital baseline and at hospital discharge; decision-making capacity, and whether there is an advance directive or resuscitation preference; and the name of the PCP.

A solution in some hospitals is providing the cell phone number of the discharging hospitalist for the receiving physician to allow a call back; however, this does not always resolve weekend and holiday call coverage issues. Developing an initiative for standardization of transfer forms might help call attention to the problem. Staff education in the hospital regarding transfer form completion needs to be provided and emphasized on an ongoing basis. Attention should be focused on what information is most critical for the SNF/NF to know. Evolving technology may improve flow of and access to hospital information, but has its own specific issues (see next section).

Electronic Health Records and HIPAA

HIPAA and other security issues are of great importance in the hospital setting. The ACH may be unwilling to provide access to its electronic health records (EHRs) to the SNF/NF. The SNF/NF may have its own EHR system that is unable to interface with the ACH's system. The SNF/NF may not even have adequate computer access for staff and/or physicians, and may not have internet or intranet access. Moreover, HIPAA should never serve as an impediment to transfer of necessary information between health care providers caring for the same patient. Nonetheless, some misinformed health information technology (medical records) and other involved personnel sometimes still invoke HIPAA as a reason for refusing to share vital information.

Where feasible, patient-specific access to the EHR for specifically designated SNF/NF personnel (e.g., medical director, attending physician, director of nursing (DON), medical records clerk) for a defined period of time (e.g., from 3 days to 2 weeks) would provide a way for those currently providing direct care to the patient (HIPAA compliant and in the interest of continuity of care) to obtain records not available at the time of patient transfer such as pending test results, final x-ray reports, and even discharge summaries. This would be particularly beneficial to SNF/NF attending physicians who may not see the patient until several days after admission to the facility and depend on hospital records as the most accurate record of the patient's hospital care. Where SNF/NF attending physicians are on the credentialed staff of the transferring ACH, this access to their EHR system should be available, but where this isn't the case, facilities may encourage their attending physicians and medical directors to become credentialed. Some hospitals have

courtesy privileges that do not require extensive time commitments or actual care of ACH inpatients, and these avenues may be explored when appropriate.

Medications

As mentioned previously, medication reconciliation is one of the most difficult issues of care transitions and is one of the areas of greatest concern for patient safety. As a minimum, the medications the patient is currently taking at discharge should be clearly listed. Optimally, the MAR showing what medications have already been given on the day/time of discharge and what medications still need to be given should be provided to the receiving facility. Nursing administration in the hospital should be notified if transfer forms are incorrectly completed (e.g., if medications are not written on the transfer form and the phrase “see med sheet” is used). On late afternoon or weekend discharges, those medications that still need to be given should be sent as unit doses with the patient as many facilities do not have rapid pharmacy access, a well-stocked emergency kit, or a Pyxis type system. ACHs should also be encouraged to give a dose of appropriate and available medications just prior to transfer whenever possible to help avoid problems of delayed access in the SNF/NF.

The ACH should also provide a list of home medications the patient was taking prior to hospital admission, including dose and frequency (available in the admission history and physical); and provide an explanation if any of those medications were stopped during the hospital stay because of intolerance, allergic reaction, drug interaction, or other adverse event, or whether their discontinuation was temporary (e.g., because of a surgical procedure with resumption anticipated, or formulary issues). SNF/NFs need to be aware that medication changes are frequently because of ACH formulary mandates. Monitoring needs for high-risk medications such as international normalized ratios (INRs) for warfarin, glucose checks for insulin and other hypoglycemics, electrolytes and renal function tests for diuretics, hemoglobins for erythropoietin-stimulating agents, or therapeutic drug levels for selective medications (e.g., antibiotics like vancomycin, or antiepileptics) should be included in transfer orders. Likewise, stop dates for antibiotics, anticoagulants, or analgesics where appropriate should be designated in the transfer orders; if not, the SNF/NF should have a process upon admission to ensure proper monitoring. For example, many ACH patients are on routine fingerstick blood sugar monitoring and sliding scale insulin coverage four times daily, or on frequent nebulizer treatments. The SNF/NF provides a different level of care where less intensive measures may be appropriate. Hence, there should be a process in place to determine with the SNF/NF attending physician how long, if at all, these measures should be continued, as well as schedules and routes of other medications.

Continuity of pain medications is extremely important for patient quality of life and dignity. The ACH and SNF/NF must work on communication protocols that ensure adherence to federal regulations allowing patients to receive opioids and other controlled substances without delays.

SNF/NF Readmissions Versus New Admissions

Much of the information above—ideal communication practices, correct transfer forms, access to information, and medication issues—applies to all SNF/NF admissions. Nonetheless, there are differences between new patients and those being readmitted. In the former instance, the facility needs to pay special attention to the patient’s pre-hospital status, health care providers, and medication regimen. The community PCP, outpatient pharmacy, and especially the family are important resources. For the latter, the SNF/NF should carefully compare new medication lists with the medications from before hospitalization. Questions to ask are what medications are being given now that weren’t before, and what medications are not being given now that were before. Changes may be because of hospital formularies or medication Kardex transcription errors, and medications felt to be of lower importance while the patient was hospitalized (e.g., Vitamin B-12, osteoporosis treatments, dementia medications, or even antidepressants) are frequently not included on the transfer sheet. Because advance directives such as pre-hospital DNR/DNAR forms, or related physicians’ orders (such as POLSTs), are often sent to the ACH with the patient, it is important to ensure that the hospital return such forms with the patient upon transfer back to the SNF/NF. In some states, photocopies of these documents are considered valid, and SNF/NFs should definitely make a photocopy for the patient’s record before sending the original document with the patient.

SNF/NFs should also re-examine monthly order sheets when patients are readmitted. Items such as routine labs and wound care orders may have been changed. If changed orders are included, the patient is put at risk for unnecessary labs, or the facility may be at risk for survey deficiencies. In addition, most SNF/NFs do not currently have a policy for ensuring that important information from previous stays at their facility is placed in the current (new) chart. This creates situations where lab work, discussion of advance directives, previous diagnoses, or reasons for hospitalization are not available to those reviewing the current chart. Medical directors and other SNF/NF administrative personnel should consider instituting policies and procedures that define the documents that should be copied and transferred from the previous chart into the new chart upon readmission. These documents might include history and physical examination, progress notes, lab and radiographic reports, advance directives, MARs or order recaps, consultant reports, previous hospital notes, etc.

Improving Communication Between the ACH and SNF/NF

Regular meetings between selected representatives of ACHs and SNF/NFs may be an avenue to provide an open forum for discussion of transition of care issues and should include administrative representatives such as administrators and DONs or their designees; case managers, social workers, and other discharge planners or admission coordinators; other nursing staff representatives; pharmacists; medical directors; hospitalists; emergency room physicians; medical records staff; and interested attending physicians. These meetings can also serve as educational exchanges on the differences between acute and chronic care, differences in regulatory requirements necessitating specific information at transfer (e.g., the indication for a medication), and concerns about appropriate medications in select patient groups (Beers criteria).

In addition holding regular meetings of a joint committee or task force, it is important for SNF/NF physicians and medical directors to use ‘problem cases’ as a tool for process improvement. Often, the best time to contact a hospital Chief of Staff, Director of Nursing Services, or Quality Improvement Committee Chair is immediately after a problematic transfer has occurred—even if the outcome was not a bad one. Specific, physician-to-physician communication with respect to a poor hand-off can be very useful in identifying growth areas, and may serve as the beginning of an ongoing communication process.

From the SNF/NF side, it is important to have systems in place that provide protocols to monitor glucose levels in diabetics or INRs in anticoagulated patients as prompts in case a transfer order or order verification by an attending physician’s coverage fails to initiate safe monitoring for high-risk medications. It is also important that admission medication orders be verified with a physician or nurse practitioner/physician assistant within a timely fashion. While the nursing staff “sometimes” or “always” identifies medications that are not required by the patient’s condition or are outside the range of safe prescribing in the DON survey previously cited, physicians “sometimes” or “always” identify this 72.9% of the time, so this is a vital check and balance.

Patient/Family Education and Involvement

Upon transition from the ACH to the SNF/NF, patients and their families may have unrealistic expectations of what the SNF/NF stay will provide. Transition to another care setting is a time of great anxiety for patients and caregivers. They may not be involved in or aware of diagnoses, test results, prognoses, or follow-up plans. Many believe the SNF/NF setting is the same as the hospital and expect a daily visit from a physician and the same level of nursing intensity. Many don’t know who their attending physician is. Information should be provided to families in all settings and not just at the moment of ACH discharge. SNF/NFs should develop information packages or at least discuss on admission the differences between their care role and that of ACHs. Patients and families should be educated and empowered as much as possible to be active participants in their own care. This helps families to have more realistic expectations and may be a useful risk management technique. One way to assist patients and families is to honor their right to choose the physician caring for the patient in the SNF/NF setting. One best practice is for the hospital liaison from the SNF/NF to offer the patient or family a list of providers who practice in the SNF/NF being considered. Depending on insurance constraints, the patient or family may choose from this list and has an early opportunity to contact the provider to discuss expectations for care or other issues. Other models such as the transitions intervention model utilizing “transitions coaches” as per Eric Coleman have been explored to help patients and their families to optimize the transition process and minimize errors and omissions in care. Information about these models is available at www.caretransitions.org.

Improving SNF/NF to ACH Transfers (Including Emergency Department)

The first step in optimizing SNF/NF to ACH transfers is to *avoid* unnecessary transfers. Ouslander *et al* recently reported up to a 50% rate of avoidable hospitalizations with the use of some simple assessment tools and increased clinician presence in the facilities studied.¹¹ Interventions that seem to reduce unnecessary transfers include improved advance care planning, improved early recognition and treatment of early change of condition, improved ability of the SNF/NF to manage intercurrent illnesses, and improved communication with on-call providers at the time a change in condition is recognized.

In some areas, models of care exist that lend themselves to reducing the need to send SNF/NF residents to the ACH in response to a change in condition. Many of these models reduce financial disincentives for SNF/NFs to treat within the facility, and they also tend to feature increased presence of on-site providers and availability of providers for evaluation of patients with changes of condition. As a successfully studied example, the Evercare Institutional Special Needs Plan (iSNP) model of care includes each of the components mentioned above. Nurse practitioners provide extensive advance care planning and monitor residents closely in coordination with attending physicians. With the Evercare iSNP, traditional Medicare Part A “qualifying stay” incentives that encourage hospitalization with skilled nursing and rehabilitation payment only after hospitalization are removed. The Evercare SNF/NF contracts, like some other Medicare+ HMO plans and at-risk primary medical groups or independent practice associations, allow additional “skilled nursing” payments without qualifying hospital stays and typically include a special payment for very high acuity days, even for a resident who is on long-term custodial status. Additionally, contracts typically allow direct reimbursement for lab, radiology and medication costs. Evercare programs also partner with the SNF/NFs to implement improved clinical capabilities. While this is a proprietary program with a somewhat self-selecting population (patients or families who have chosen this method of coverage), the overall reduction in hospitalization demonstrated by the Evercare program is 50%.¹² Additional programs that systematically enhance SNF capabilities, incentives, and communication processes are encouraged. Such programs should address the key aspects of optimal SNF/NF transfer as follows:

Early SNF/NF recognition and intervention for a “Change of Condition” (COC) may reduce the necessity for transfers back to the ACH. Facilities can support early recognition by consistent staff assignments (“neighborhood” staffing), and by facilitating the development of caring relationships for the patients, staff, and the patient’s family. Licensed nursing should have access to and training with tools that support COC recognition, assessment and management. Standardized tools are available such as AMDA’s CPGs *Protocols for Practitioner Notification* and *Acute Change of Condition*, as well as the new INTERACT-II (Interventions to Reduce Acute Care Transfers) tool recently highlighted in Dr. Ouslander’s article in the Journal of the American Medical Directors Association (JAMDA).¹¹ Tools like Situation-Background-Assessment-Recommendation (SBAR) found on the INTERACT Web site <http://interact.geri.u.org> should be considered to improve efficiency of comprehensive nursing-to-physician communication. Managing a COC may be complex and labor intensive, requiring rapid recruitment of multiple members of the facilities staff. The effectiveness of this approach in the ACH has already been documented for the use of “Rapid Response” teams. A similar process may be helpful in the SNF/NF setting for the more serious and labor-intensive COCs.

The medical director and SNF/NF administration should work together to develop and implement policies and procedures that facilitate patient-centered care. This should translate into patient-centered transfers. For example, direct readmission to the ACH rather than via the ED are advisable, if feasible, since this avoids the chaos and long stays common in EDs. This type of transfer, while currently uncommon in most areas, could be systematically supported by hospital and SNF/NF management. A good working relationship between SNF/NF medical directors/attending physicians and hospitalists will facilitate such direct admissions when feasible. Critical information specific to this type of transfer should be identified and standardized.

The information transferred with patients in elective and emergent transfers between SNF/NF and ACH should be standardized. While the details of the specific information each community wishes to use may differ, the important thing is that each facility and its ACH have tools (checklist or documents) to ensure appropriate information is routinely transferred. AMDA's *Transitions of Care in the Long-Term Care Continuum* CPG has identified the usual vital information and tools necessary for safe, efficient, and effective transfers. As previously noted, an AMDA-developed Universal Transfer Form is available for use by sending SNF/NFs, EMS, and EDs/ACHs. Other transfer forms and tools are available through the National Transition of Care Coalition (NTOCC) at www.ntocc.org. Compliance with completion of these forms is crucial and requires competency development by all participants. Whenever time permits (i.e., in a non-life-threatening situation), assessments should be documented that include the patient's baseline status, wounds, mobility, continence, cognitive impairment, and fall risk.

When a patient is transferred between the SNF/NF and ACH, a series of communication concerns should be acknowledged. If the attending SNF/NF physician is not available, the facility should not assume that the on-call physician or ED physician will notify the attending about what happened. When the patient is sent out and when the patient returns, the attending physician should be notified by the facility about the COC, each change of location, and new or pending lab results, diagnoses, orders, or unresolved issues. In most facilities, this will occur via a fax or phone notification process, but this may change as EHRs, e-mail, and more sophisticated voice mail systems develop. EDs often are unclear on the reason for the transfer and may assume that the SNF/NF attending physician wants the patient admitted to the hospital, when in fact there are other reasons for the transfer (family pressure, need for more expedient testing, etc.) Whenever there may be ambiguity as to the reason for transfer, it is a good practice for the sending clinician to place a call to the ED to clarify specific concerns and goals.

Improving transitions between SNF/NF and ACH may be facilitated by the development of partnerships between the ACHs and the SNF/NFs in a community. These regular meetings may provide a learning forum with opportunities for community-based problem identification and sustainable solutions supported by the partnership. This type of partnership lends itself to measuring the quality of care transitions between the ACH and the SNF/NF perspective. Quality measures have been published by Terrell *et al*¹³ and are also present in the AMDA CPG. These measurements may provide the evidence for partnerships, SNF/NFs, and ACHs to further improve outcomes associated with care transitions over time.

Summary of Available Tools

This paper mentioned a few tools that are available to improve care transitions. The following is a summary of the tools mentioned.

- AMDA Acute Change of Condition Clinical Practice Guideline – www.amda.com/tools/cpg/acoc.cfm.
- AMDA Transitions of Care in the Long-Term Care Continuum Guideline (to be announced).
- AMDA Universal Transfer Form - www.amda.com/tools/universal_transfer_form.pdf.
- AMDA white paper C-09: Improving Transitions of Care From the Nursing Facility to a Community-Based Setting - www.amda.com/governance/whitepapers/transitions_of_care.cfm.
- INTERACT-II Project - <http://interact.geri.u.org>.
- National Transitions of Care Coalition – www.ntocc.org

References

1. Institute of Medicine. To Err is Human: Building a Safer Health System. 1999. Kohn LT, Corrigan JM, Donaldson MS, eds. Washington, DC: National Academy Press.
2. Coleman EA, Smith JD, Raha D, Min SJ. Posthospital medication discrepancies: Prevalence and contributing factors. *Arch Intern Med* 2005; 165(16): 1842-1847.
3. Forster AJ, Murff HJ, Peterson JF, et al. The incidence and severity of adverse events affecting patients after discharge from the hospital. *Ann Intern Med* 2003; 138(3): 161-167.
4. Boockvar K, Fishman E, Kyriacou CK, et al. Adverse events due to discontinuations in drug use and dose changes in patients transferred between acute and long-term care facilities. *Arch Intern Med* 2004; 164(5): 545-550.
5. Were MC, Li X, Kesterson J, et al. Adequacy of hospital discharge summaries in documenting tests with pending results and outpatient follow-up providers. *J Gen Intern Med* 2009; 24(9): 1002-1006.

6. Kripalani S, LeFevre F, Phillips CO, et al. Deficits in communication and information transfer between hospital-based and primary care physicians: Implications for patient safety and continuity of care. *JAMA* 2007; 297(8): 831-841.
7. Lester P, Stefanacci RG, Chen DG. Nursing home procedures on transitions of care. *J Am Med Dir Assoc* 2009; 10(9): 634-638.
8. Louden K. Creating a better discharge summary: Is standardization the answer? *ACP Hospitalist*. Published online March 2009. Available at: <http://www.acphospitalist.org/archives/2009/03/discharge.htm>. Accessed 02/23/10.
9. Snow V, Beck D, Budnitz T, et al. Transitions of care consensus policy statement: American College of Physicians, Society of General Internal Medicine, Society of Hospital Medicine, American Geriatrics Society, American College of Emergency Physicians, and Society for Academic Emergency Medicine. *J Hosp Med* 2009; 4: 364-370.
10. Halasyamani L, Kripalani S, Coleman EA, et al. Transition of care for hospitalized elderly patients--Development of a discharge checklist for hospitalists. *J Hosp Med* 2006; 1: 354-360.
11. Ouslander JG, Perloe M, Givens JH, et al. Reducing potentially avoidable hospitalizations of nursing home residents: Results of a pilot quality improvement project. *J Am Med Dir Assoc* 2009; 10(9): 644-652.
12. Kane RL, Keckhafer G, Flood S, et al. The effect of Evercare on hospital use. *J Am Geriatr Soc* 2003; 51(10): 1427-1434.
13. Terrell KM, Hustey FM, Hwang U, et al. Quality indicators for geriatric emergency care. *Acad Emerg Med* 2009; 16(5): 441-449.