Caring Transitions

What You Don’t Know Can Hurt Mattie

Connect the dots during care transitions to complete the picture of quality outcomes.

The Case

Matilda (Mattie) is a 78-year-old woman who was hospitalized with a repeat episode of congestive heart failure. She developed atrial fibrillation that, with addition of amiodarone to the generic digoxin she had been taking, converted to a normal rhythm during her inpatient stay. Her hospitalist wisely wished to check Mattie’s digoxin level before her discharge, but her Medicare managed care plan pushed for an immediate discharge. The finding of an elevated digoxin level didn’t return to the hospital until the day after her discharge.

She was transferred to the skilled nursing facility, and at 3 p.m., the admitting SNFist group’s pharmacy technician at the dispensing pharmacy called the on-call physician to question a new digoxin order. After being told that pharmacy technicians should not question a physician’s order, she decided to dispense the drug. She planned to notify her supervisor the next day of the digitals-order, little knowing she would be at home then tending to a sick child. The additional digitals order went forward unchallenged.

By day 3 after admission, the admitting physician saw Mattie face to face for the first time and noted that she seemed “a little down.” She had slowed in her eating, but everyone thought that was due to her reaction to being in the facility. By day 5 Mattie was nauseated and had stopped eating. Her performance in therapy was declining. Concerned about the nausea, a nurse notified a nurse practitioner, who ordered promethazine.

By day 8, Mattie had lost 9 pounds since admission. The SNFist group’s pharmacy technician at the dispensing pharmacy had written the order for promethazine. The admitting physician saw Mattie face to face for the first time and noted that she seemed poor but was very alert with clear eyes. The admitting physician asked her if she was stopping eating. Her reply: “My medications are making me sick.”

The charge nurse persuaded her to take a few bites of food, saying, “I don’t feel good. I think my medications are making me sick.”

A hospitalist did a medication reconciliation and was shocked that it showed Mattie on both Lanoxin and generic digoxin in addition to amiodarone, which can elevate digoxin in the blood. A review of the chart from the patient’s last hospital admission showed that the digoxin-level test indeed had been done on Mattie’s final day of hospitalization but had come back after her discharge. It showed an elevated level of 3.2 ng/mL. Since Mattie was already gone, the unit clerk decided that the report should be sent to medical records, where it sat awaiting dictation of the discharge summary.

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On day 12, Mattie became acutely short of breath. Florid heart failure was indicated by chest congestion, distressed breathing, and a pulse oximetry reading of 78%. She was immediately transferred to the hospital emergency department. There, lab work revealed a sky-high digoxin level of 6.0 ng/mL, and an electrocardiogram showed a heart rate of 32 with complete heart block.

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In a further review of the case, the hospital’s quality committee asked for the SNF’s records to see what went wrong in what appeared to be a very avoidable readmission—the kind that as of October is costing cost the hospital a 1% penalty for excessive Medicare readmissions. The committee noted a cascade of iatrogenic errors in Mattie’s care.

It started with the missed lab finding of digoxin toxicity at the time of discharge. It worsened when the admitting physician at the SNF and the covering physician did not communicate regarding the Lanoxin and digoxin orders.

Mattie’s poor appetite, weight loss, nausea, and lack of progress in therapy were then treated with a cascade of unnecessary medications instead of her medication error being addressed, even when she tried to tell a nurse of her problem. Her digitals toxicity cost Mattie her skilled benefit, and the improper addition of megestrol was a probable factor in the exacerbation of her heart failure. The hospital decided to avoid further discharges to this particular SNF; the chief executive officer stating, “We cannot afford to do business with this SNF.”

Lessons Learned

As the nursing facility found out, hospitals are closely following 30-day readmission rates because of their impact on Medicare reimbursements as of this past October. Losing referrals from its main referring hospital because the administration there fears readmissions, the nursing facility in this scenario faces a threat to its financial survival.

Mattie’s unfortunate cascade of events began when her digoxin-level test was still pending at discharge. A 2005 study found that 11% of patients have abnormal test results that become known only after hospital discharge (Ann. Intern. Med. 2005;143:121-8).

The best method of addressing this potential pitfall is to acknowledge its possibility. Engage your hospitals in conversations on how your SNF can be alerted to lab tests, radiologic studies, and other results that return after a patient has been discharged to your facility. What method does your facility or do local hospitals have to identify late-arriving information?

Mattie’s care undermined all four pillars of Dr. Eric Coleman’s Care Transitions Intervention program. First, her attempt at medication self-management went unheeded. One of the potential, unintended consequences of enforcement of medication regimens in nursing facilities can be adverse drug reactions. In the community setting, patients will stop or reduce medications they feel are causing problems and reach a medication-regimen equilibrium where they feel good, a phenomenon that could be called “therapeutic noncompliance.” In this scenario Mattie was convinced to take a drug she felt was making her ill.

Second, the health record here was anything but patient-centered. Such a record would have included hospital test results, even those completed after the patient had transitioned to a new site of care.

Third, there was no structured follow-up with a primary care physician. The clinical carousel for Mattie had at least three clinicians writing orders, resulting in a duplication of the Lanoxin with digoxin and medications prescribed for symptoms instead of etiology. A regularly available primary care provider would have reviewed and understood Mattie’s medication irregularities, symptoms, and declining therapy performance.

Fourth, Mattie wasn’t allowed to red flags signaling to her caregivers her impending health decline, so she couldn’t contribute to her care plan. Mattie recognized at some level that her medications were the real issue in her decline, but without acknowledgement that she was correct in that assessment, she didn’t persist in declining her medication or requesting that a physician be notified of her suspicion.

Finally, Mattie wasn’t provided a transition coach—the central player in the Care Transitions Intervention program. This person typically is an advanced nurse who oversees a patient’s care across sites and who prompts families and patients to take active roles in the person’s care. Such a coach probably would have supported Mattie’s conviction that her meds were making her ill and then discovered the high digoxin level. Mattie then would have been coached to demand that her decline be investigated instead of symptomatically treated.

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What’s Your Opinion?

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