Lost Transitions

Dear Dr. Jeff:

The major referral hospital for our skilled nursing facility is a highly rated academic medical center. Nonetheless, they repeatedly transfer to us medically complex patients who may be unstable, typically with minimal, inaccurate, or incomplete information. Sometimes they also have suggested care regimens that are inappropriate or unfeasible for a post-acute setting, from sources who are clearly not the attending physician. These transfers usually occur during the evening hours when only nursing staff are still present in the facility, placing a giant burden on evening staff to obtain needed orders to initiate care and unable to find anyone at the hospital to provide additional information. Newly admitted residents, and their families, are bewildered that we seem so uninformed regarding their needs. Our Admissions office is certain that we need to accept these transfers to maintain census. Several attempts to meet with hospital administrators and discharge planners have been unproductive. I am certain that this contributes to hospital readmissions, which are a financial penalty for them as well as for us, but the costs don’t seem to motivate them to change. Do you have any suggestions?

Dr. Jeff responds:

In a fragmented medical world, the needs of different players may be poorly aligned. As patients transition from outpatient care to hospital care to post-acute care to home care and back to community care, each site functions according to its own internal needs and those of insurance companies, which may or may not overlap with the needs of the sick. As infuriating as long-term care facilities find the discharge practices of most hospitals, we should acknowledge that they are driven by hospital needs and priorities. We should also acknowledge that skilled nursing facilities have been enablers of poor care by admitting patients who are not accompanied by the information needed to provide quality care or stepping up to provide care for unstable patients who might have been safer in the hospital setting for another day or days. Still, there is much that can be done to decrease miscommunication and improve patient care.

Market Pressures

In the era before diagnosis related group (DRG) reimbursement for hospitals, acute care facilities were reimbursed a daily rate by insurance companies, so they had no incentive to discharge a patient any earlier than absolutely necessary. When I was an intern, I took care of a patient with an infected diabetic foot ulcer who stayed in the hospital 27 extra days because his insurance only covered orthopedic shoes if they were provided in a hospital. This was, obviously, a bad policy for his insurer, but the hospital was not unhappy, and the patient got the shoes he needed.

Later, I was the medical director for an excellent, large SNF with a waiting list, which typically accepted half of admissions directly from home. Most admissions were for long-term care, and the newly admitted residents for rehabilitation were usually our own residents returning after strokes or fractures. The facility had a strict policy that admissions were only accepted between 9:30 a.m. and noon. Every new admission had a comprehensive evaluation by every discipline — including, of course, medicine — on the day of admission. An ambulance arriving at 1:00 p.m. would be turned back to the hospital, so hospitals rarely attempted a “late” transfer twice.

The SNF could afford to do this because, of course, the bed would be filled the next day anyway, and we were very concerned that every new admission be fully welcomed and introduced into his or her new home. At that time, the Medicare reimbursement rates were much lower than our private pay rate and no higher than our state Medicaid rate, so the facility had no incentive to oblige acute care referrals. New York State actually passed a bill requiring nursing homes to bill Medicare and receive a denial before billing Medicaid because many facilities did not even bother to bill for Medicare extended care stays.

In the 21st century, post-acute care is the tail that wags the dog. Even facilities with relatively small post-acute programs are typically dependent on the dramatically enhanced reimbursements for these admissions to achieve financial viability, particularly since state Medicaid rates nationally are significantly below average daily costs. Skilled nursing facilities are in competition for these valuable admissions, regardless of the problems involved in providing care for them. Because nursing home reimbursement is based on the “head in the bed at midnight” principle — that is, every resident admitted by midnight is counted as a reimbursable day — the ambulance arriving at 11:45 p.m. will have its gravy rushed to the elevator to get the patient into bed, rather than turning anyone away.

Your discharges director is probably correct that sick patients with planned evening transfers will simply go elsewhere. The Patient Driven Payment Model (PDPM) reimbursement system recently introduced by the Centers for Medicare & Medicaid Services only enhances the incentive to accept medically needy admissions for post-acute stays.

At the same time, the DRG system placed great financial pressure on hospitals to shorten a patient’s length of stay. Private physicians were replaced by hospitalists largely because studies showed that they delivered a shorter length of stay and lower hospital costs compared with physicians who had known the patients before admission. Discharge planning services were greatly enhanced to speed the entire process, prioritizing professionals skilled in working the system over those with clinical sophistication about postdischarge needs. Many hospitals have frequent turnover of discharge planners because they burn out under the pressure. Meanwhile, the much-vaunted readmission financial penalties for hospitals have proven to be quite small; many hospitals essentially accept them as a cost of doing business, and elaborate programs to discourage readmissions have rarely proven cost effective.

After 20 years of discharges to “rehab,” your local hospital’s indifference to effective communication remains sadly typical, and current practices are ingrained and traditional.

These market pressures are important to understand because collaborating with the hospital and designing communication strategies must be aligned with the hospital’s incentives and needs (or at least perceived needs). These are unlikely to involve delays transferring, but they could involve at least some communication strategies that have proven successful in many facilities.

Handoff Collaborations

The handoff is a nursing practice with a long, honored tradition in the profession. Whenever a patient is transferred from the emergency department (ED) to a nursing unit, or from nursing unit to unit, there is an expectation that a professional, usually a nurse, on the sending unit will speak directly to a colleague on the receiving unit. The nurse will outline the patient’s condition and any needs that might require attention by the receiving unit.

This handoff procedure is actually a requirement of the Joint Commission for hospitals, which has recommended a structured format for these communications, although there is little evidence to support any particular structure. Many articles in the literature refer to a “warm handoff,” which technically involves communication with the patient or family present and thus able to provide supplemental or corrective information. Although an argument could certainly be made for a physician or nurse practitioner handoff to the receiving clinician, these have proven problematic in many settings because the hospitalist on duty at night may have little familiarity with the patient and not be physically at bedside when the transfer occurs. The receiving practitioner is typically not in the facility at the time of admission, particularly for these problematic transfers.

Implementation of these handoffs should not be a major time commitment, training task, or expense for the hospital, and performing them would demonstrate compliance with a Joint Commission expectation. The nurse at the hospital end could make the call at the time of discharge, along with the provision of discharge documents and instructions to the patient. Perhaps a director of nursing and vice president for nursing meeting could be the initiating step.

It is vital that exactly which individual at the SNF should be called is made clear — whether it’s the floor nurse, the receiving unit, or the discharging unit. There is no normal process that is best for all patients, but the receiving unit should be made aware of the patient and notified with documentation and instructions.

Resources

AMDA — The Society for Post-Acute and Long-Term Care Medicine has developed several resources on transitions of care. These are available for purchase online:


• Conference Session: Are We Doing Enough? A Need for New Approaches to Address Transitions of Care for the Older Adults Across Continuum of Care, http://bit.ly/2tUL7VY

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or specialty admissions nurse, or evening nursing supervisor, depending on the facility’s structure and needs. Exact telephone numbers should be posted at the hospital’s nursing stations. And, of course, the nursing staff at the SNF must be poised to receive these calls and to maximize each call’s value with appropriate questions such as the indication for a Foley catheter or needed details about wounds and wound care.

Implementation of the handoff practice should be two way. The nursing home should provide this same service to the ED whenever a resident is transferred, in addition to whatever standard paperwork is sent. This could be an ideal quality assurance performance improvement (QAPI) project. These calls should be documented as received or performed, allowing for the collection of statistics about performance rates that can be shared with the hospital.

Record Access

A second intervention with high potential for success would be to obtain access for one or more clinicians at the SNF to the hospital’s Electronic Health Record, at least on a read-only basis. Most hospitals have mechanisms to provide access to affiliated physicians in their offices, so the extension of this to appropriately qualified professionals in the facility is not a stretch. Obviously, there is no HIPAA issue involved because these are patients for whom you are providing care.

Although these connections might, theoretically, also be achieved through a Regional Health Information Organization (RHIO), the consent mechanisms for many of these have proven slow and unwieldy. With a single major referral hospital, direct access would be much simpler. Among the major clinical benefits that such access provides is the ability to review culture and sensitivity reports, biopsy and other pathology reports, and other complex radiology procedure reports that are often still pending at the time of discharge.

Ironically, PDPM provides an opening to initiate this discussion. Our billing now requires more sophisticated information regarding details of the hospital stay, such as the exact surgical procedure performed and detailed ICD-10 codes for diagnoses. Without these, our Minimum Data Set and finance staffs will be bound to the hospital medical records department for information. Direct computer access would save hospital time and decrease aggravation. Although hospital administrators may see the clinical needs as somewhat theoretical, everyone understands the stark reality of federal billing requirements.

Common Goals

Effective communication requires two interested parties. Although some hospitals are highly motivated to be good partners in care, unfortunately this is a low priority for many acute care facilities facing multiple challenges. Small rural hospitals are closing, major tertiary care centers are in brutal competition for better-paying patients with attractive diagnoses, national and state so-called leaders are hacking away at insurance coverage, overworked and short-staffed nurses are threatening to walk off the job as we have already seen in other countries, and high-paying private insurance plans are disappearing. Meanwhile, an aging population leads to sicker geriatric patients in the hospital with the same expected length of stay. We need to offer communication solutions that are easy and quick.

As clinicians, our goal is to provide the best possible quality in a health care system driven almost exclusively by the bottom line. The faults in transfer communications processes are not those of indifferent discharge planners, ignorant hospitalists, or thoughtless administrators. Within the constraints of this system, we need to find innovative ways to provide the informed, quality, person-centered care that our residents deserve.

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“somewhat concerned.” Further, some patients have expressed worries that data from their health records will be used to deny them health benefits, insurance, or job opportunities.

Dr. Swenson said that, to date, he “can’t think of one patient or family member [in post-acute and long-term care] who has asked me about the security of information.” However, he added, “I think we will see our operators, patients, and families start asking about things such as how we protect patient information and how we communicate and share data.” He suggested that practitioners should start to prepare for such conversations. For instance, he brings his tablet to meetings with new facilities and team leaders and shows them how his practice’s EHR works. He said, “Immediately, they relax and feel more comfortable that we are doing everything we can to protect data and prevent breaches.”

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