

Transitions to and From Nursing Facilities

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Many nursing home transition barriers are manmade and avoidable. PPACA is encouraging improvement and reduced unnecessary hospitalizations through incentives and penalties. Providers are responding through a variety of internal and collaborative models. The resulting communication, technology, education, and emphasis can improve the quality of life for the people served.

Nursing facilities of 2011 are completely different from the old folk's homes of the 1960s. Modern nursing facilities have evolved into complex community health care providers. They care for "40-something" clients with 24-hour post-op double knee replacements, PICC lines, and porta-caths, and they use electronic medical records. People are calling in advance to schedule hip replacement rehabilitation. Memory or Alzheimer's-secure neighborhoods that didn't exist in the 60s are now commonplace.

Some changes have been person-centered and customer-driven, but many have been driven by regulatory and risk management requirements. That trend will continue with the Patient Protection and Affordable Care Act (PPACA). The PPACA encourages improving health care quality while reducing cost. Hospitals will be penalized for unnecessary readmissions. The PPACA is encouraging providers to cooperate and collaborate with the resulting savings being shared between the provider and government. We must make this challenge person-centered by using this opportunity to improve transitions.

Nursing facilities often stand at the crossroads between other health care providers such as hospitals and home health agencies, and are an essential component in the effort to reduce cost across all settings. Hospitals discharge a large number of people to nursing facilities, and because of the high acuity, complexity, and instability of those individual's conditions, many are readmitted from the nursing facility to the hospital. The impending PPACA penalties to hospitals strongly encourages collaboration to reduce unnecessary rehospitalizations and, more importantly, to improve care and safety for each person. Transition planning would improve services, reduce unnecessary hospitalizations, and assist nursing facilities in their multiple challenges related to admissions, transfers, and discharges.

Challenges

Communications seems to top every list of health care delivery concerns, and health care transitions are no exceptions. Often times, providers in different segments of health care do not communicate with each other effectively. American health care is siloed, resulting in providers not effectively sharing information. Regulations and risk management concerns have hardened these silos.

Hospitals and nursing facilities transfer people back and forth accompanied by doctor's orders, medication records, medical histories, discharge summaries, advanced directives, and general information. That ever-increasing volume of documentation is sent with the person, which means receiving staff must wade through the information to assess and care for the person. Missing, inaccurate, and conflicting information can directly affect the quality and effectiveness of the care received. A prime example is the reconciliation of medication records during transitions, or the lack thereof. The Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill houses the Medication Error Quality Initiative to improve medication safety in North Carolina's nursing homes. In its latest annual report (2010), 1,549 errors or 10.2% of all errors, occurred in the transition from hospital to nursing facility [1].

Nursing facilities now receive the majority of their admissions from hospitals. For example, in one nursing facility reviewed over a 6-month period, 52 people were admitted from the hospital and 15 were admitted from other settings including home. There are many areas for improvements to be made in these transfers. Hospitals often don't have a choice but to discharge late in the day. This is not an uncommon event on late Friday afternoons as the weekend approaches. The accompanying paperwork is often conflicting and sometimes incomplete. Beneath all of that paperwork is a person waiting for quality care in the face of end of the week pressures on staff.

Late afternoon and off-hour admissions pose other challenges for the person and the nursing facility. These unusual

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admission times often mean a lengthy, sometimes uncomfortable wait for transportation services provided by local emergency management services, a transport company, or the nursing facility. Pharmacy is another major challenge with late and off-hour admissions, as late admissions miss institutional pharmacy deadlines. Every nursing facility has emergency medication boxes, Pyxis-type automated drug delivery machines, and back up pharmacy providers, but extra paperwork, availability, and quick delivery remain challenging.

Nursing facilities are not immune from creating some of the same issues when transporting to the hospital. However, hospitals are better equipped to handle incoming transfers. People are generally transported to the hospital emergency room for assessment and treatment, or to triage toward admission to the hospital. Incomplete or inaccurate paperwork from the nursing facility is a burden to the processes of assessment and treatment.

Nursing facility discharges to home health, hospice, or assisted living can usually be scheduled in advance with time for planning and implementation. Nursing facilities discharge people to other settings with physician's orders, paperwork, non-narcotic medications, and referrals to other providers as needed. Areas for improvement include accurate documentation and improved communication upon discharge.

Considering the silos, the admission, discharge, and transfer process works fairly well. In the case of the hospital to nursing facility transfer, the physician makes the decision to discharge the patient from the acute setting. The hospital discharge planner seeks nursing facility placement and the person is moved. The process works, but not well enough to satisfy our customers or providers of care, or to foster efficiencies.

Strategies for Improvement

Communication and education. Just as communication is the primary problem, improved communication is the primary solution. Providers and the public need ever-improving communication and education. Every North Carolinian needs to better understand the health care system. Providers need to break down the silos to improve care and services through communication. Person-centered care eliminates the silos. Organizations and providers are still separate and independent, but all serving the person. For example, in a siloed system, a patient might be transferred after a hospital stay to a nursing home that they did not choose because of bed availability. In a person-centered culture, the resident and family would collaborate with an advocate to determine what is best for the person, which might be rehabilitation in a skilled nursing facility, further strengthening in that nursing facility or in assisted living, and then home with services set up and planned in advance.

As long-term care has changed, staff must change as well. Higher acuity demands higher education and com-

munication standards for nursing staff. Lutheran Services for the Aging (LSA) and similar organizations have adopted INTERACT (Interventions to Reduce Acute Care Transfers), developed through Florida Atlantic University as a CMS (Centers for Medicare and Medicaid Services) innovation project. INTERACT is "a quality improvement program designed to improve the early identification, assessment, documentation, and communication about changes in the status of residents in skilled nursing facilities. The goal of INTERACT is to improve care and reduce the frequency of potentially avoidable transfers to the acute hospital. Such transfers can result in numerous complications of hospitalization, and billions of dollars in unnecessary health care expenditures." [2]

INTERACT supports continuing education for nurses, raising standards, improving care, and reducing unnecessary transfers. LSA has also implemented the Just Culture model to further improve communications, investigate incidents, and improve performance. Just Culture encourages organizations to "console the mistake, counsel at-risk behavior, and punish the reckless." Most problems are process-related, and Just Culture encourages improvement of the process instead of irrational, subjective reaction.

The federal government's desire for electronic health records would be the ultimate solution for improved communications. The best outcome scenario for individualized care would be one in which providers upload all medical records from all sources into the person's electronic health record in a standard format, then that record is protected but available to all providers who serve that person. Privacy rights activists and economics render that a solution for the future. At this point nursing facilities are not included in federal incentives for developing health information technology and exchange, which means a major health care component is being ignored.

Reduce unnecessary hospital readmissions. Reducing avoidable transfers from nursing home to hospital eliminates a source of trauma for the resident (especially of the cognitively impaired), reduces costs, and meets PPACA mandates. Physician services are vital to the success of a strategy to reduce transfers from nursing facility to hospital. Nursing facilities do not have a physician on premises 24 hours a day. The attending physician for each person is on call 24/7. The attending physician is faced with a significant challenge when the nursing facility calls with a serious change in condition. Without the benefit of direct patient contact and with the fear of legal liability, the physician may feel inclined to order transfer to the hospital without considering other interventions. They simply cannot stop what they are doing to make an in-person visit.

Physician's extenders, such as nurse practitioners, have proven helpful in reducing transfers. A 2007 study in three Georgia nursing homes reduced hospitalizations by 50%. A key factor was the utilization of nurse practitioners [3]. They are often in the nursing facility for more extended periods

of time and often know the residents better. They are more likely to be present and, if not present, to be at least well-versed in the resident's condition if they are called by telephone. Nursing facilities have long advocated for the right to directly employ physician's extenders. Under current state law, insurers are not required to reimburse for services of nurse practitioners if they are employed by a nursing facility [4]. Further, reimbursement for physician assistants can only be made to the physician, clinic, agency, or institution employing the physician assistant. Regulations and reimbursement surrounding the utilization of physician extenders in nursing facilities is complex. Clarity around regulations and reimbursement would encourage the utilization of nursing facility employed physician extenders.

The Geisinger Health System in Pennsylvania created a skilled nursing facility staffing model called "SNFist", similar to a hospitalist model. The SNFist was to be in the nursing facility daily and improve communications with the patients, families, staff, and other care partners. When the program began, the nursing facility was readmitting one in three residents to the hospital, residents averaged 2-4 readmissions to the hospital annually, there were opportunities for improvement, and end of life care was poorly managed. In a skilled nursing facility pilot in 3 nursing facilities, the readmission rate was reduced in all 3 facilities, and reduced by over 50% in 2 of the 3 [5]. A physician extender could well fill that role with training and physician support. The public would be well served, both from a quality and cost standpoint, by a regulatory change to allow physician's extenders to be employed directly by nursing facilities.

Community Care of North Carolina (CCNC), after participating in the successful nursing facility nurse practitioner pilot, has proposed statewide improvements including the use of nurse practitioners tied to CCNC networks in nursing facilities to reduce unnecessary hospitalizations [6].

The federal government is supporting a number of innovative programs that apply to transitions and nursing facilities. Stanly Regional Medical Center received a Beacon grant to improve care transitions. Stanly has a physician leading the project and has utilized grant funds to hire a physician's extender to follow patients after discharge [7]. In addition, the Centers for Medicare and Medicaid Services has created a demonstration program, the Community Based Care Transitions Program (CTTP) to test models to improve care transitions for high risk Medicare beneficiaries. CCTP goals are: to reduce hospital readmissions, test sustainable funding streams for care transition services, maintain or improve quality of care, and document measureable savings to the Medicare program. The program will utilize case managers to work with hospital patients to ensure the most effective transitions after the patient leaves the hospital [8]. (Other innovation projects are available at <http://innovations.cms.gov/>.)

Regulatory reform. Regulatory reform can certainly improve care and transitions. One example of a needed

regulatory change involves dispensing narcotics. Narcotics prescriptions require the pharmacy to receive the original physician's signature prior to dispensing. Electronic prescribing and safety and security have progressed but regulatory reform has not kept pace, and often times the patient suffers.

Opinions vary on every regulation between public protection and ineffective governmental interference. Regardless, regulatory requirements and related legal liability concerns add significant cost to the price of health care in the US.

The CMS-required MDS (Minimum Data Set) form requires a highly trained registered nurse to assess a person and complete the 14-page form, a 3.5-hour process. The form is of nominal value to the nursing facility, and is a costly way for CMS to collect data and determine level of payment.

One positive regulatory change could be the adoption of a universal transfer form to be used by all providers. North Carolina providers and regulators have debated this for many years with no resolution. The state of New Jersey adopted a universal transfer form effective October 30, 2011. Positively, the form creates a standard. Negatively, the form duplicates much information, many attachments are required, and the form would take a great deal of staff time to complete when the patient needs the attention. The transfer form issue should be debated at least as an interim step until the adoption of a true electronic health record.

Barriers to improved and person-centered transfers and discharges exist, many being manmade and avoidable. Government is encouraging providers to improve using incentives and penalties. Providers are responding through a variety of internal and collaborative models. The resulting communication, technology, education, and emphasis can improve the quality of life for the people served. NCMJ

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Odds of a child becoming a professional athlete: 1 in 16,000

Odds of a child being diagnosed with autism: 1 in 110

Some signs to look for:

No big smiles or other joyful expressions by 6 months.	No babbling by 12 months.	No words by 16 months.
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To learn more of the signs of autism, visit autismspeaks.org

 

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