# Full Disclosure= Better Outcomes

## *SNF to ED Transitions*

Anita Chopra MD FACP
Chair, Dept. Of Geriatrics and Gerontology
Director, NJ Institute for Successful Aging
Rowan SOM

# Learning Objectives

- Identify potential challenges associated with transfer of an older adult from a skilled nursing facility (SNF) to the emergency department (ED)
- Discuss opportunities to improve patient care and safety

# Case Study

Mrs. Smith, 87 years old, is a resident of nursing home for 2 years. She has moderate dementia secondary to Alzheimer's disease. One morning, the nursing staff notices she hasn't eaten her breakfast, she's more confused than usual, and she has a temperature of 99.4°F. The nurse decides that she will continue to monitor the patient and there is no specific reason to call the physician at this time since the doctor is scheduled to come to the nursing home the following day.

Mrs. Smith eats very little at lunch or dinner ,and her confusion and mental status progressively worsens. At 9PM the night nurse notes she has a temperature 100.6°F. At this time, the nurse calls the answering service and gets the on call physician who does not know the patient. The on call physician recommends that patient be sent to the emergency department (ED) at the local hospital for evaluation. The nurse calls the ED and informs the unit clerk that the patient is being transferred to ED.

In the ED, Mrs. Smith is unable to provide any information. She has decreased responsiveness and a temperature of 101°F, Work up done in the ED reveals slightly elevated WBC count, and a urinalysis with many WBCs and bacteria. CT scan of head is negative. The ED physician feels that she has a urinary tract infection. However, due to the time of night, and the fact that the ED physician doesn't feel comfortable that the patient will be followed up closely, he recommends she be admitted to the hospital for IV fluids and antibiotics.

Patient is sent to the floor around 3 AM. On the floor the nurse finds the patient confused, anxious and agitated trying to pull her IV line. She calls the resident doctor on call to get an order for Ativan to calm the patient down. Early morning patient is drowsy, tries to get out of bed, falls and sustains a hip fracture.

# Overview of the Problem

- Twenty-three percent of patients discharged from a hospital to an SNF will be readmitted to the hospital within 30 days
- Reducing unnecessary hospital transfers from nursing facilities is a national priority stated by CMS
- Quality and safety of care transitions are hindered by poor communication, competing priorities, and a lack of understanding about different health care settings
- Improvement efforts designed to reduce unplanned admissions from SNFs call for a multidimensional approach that considers organizational culture, financial risk, along with patient clinical acuity.

# Potential Challenges in SNF to ED transition

# Patient related Factors

- Many complex and possibly interacting co-morbid illnesses
- Multiple medications
- Patient difficulty in providing information and history due to dementia or acute illness
- Uncertainty of patient goals of care and identification of any surrogate decision-makers

# External Factors

- Inadequate preparation of patient care and history documents prior to emergent transfer
  - Reason for patient transfer, acuity verses chronicity, what interventions have already been tried, and a lack of information regarding the patient's baseline health, cognition and functional status.
- Information loss due to multiple points of information transfer (e.g. from SNF to EMS to ED intake to ED care team)
- No contact numbers for a physician or nurse sent from SNF
- Inadequate knowledge of capability of the referring SNF

# Opportunities for Improvement during ED to SNF transitions

# Systems-based Practice Improvements

- Frame the ED transfer as an "ED consultation" with specific questions asked to clarify goals and purpose of care
- Design a process for "warm handoff" verbal communication: Consider phone conversations between the SNF provider and the ED provider prior to, or just after patient arrival in the ED, and again just prior to return transfer to the SNF at ED discharge. Include Emergency Medical System (EMS) providers in communication and care
- Create a standard transition document and process for transfer to and from ED
- Educate ED staff and providers about types of long-term care facilities and diagnostic and treatment capabilities available at the referring facilities

# Individual Practice level Improvements

- Ensure that the patient is comfortable as much as possible during this vulnerable situation
- Check with the patient about their chief complaint as they may be able to accurately provide information
- Review:
  - SNF transfer form, looking for the specific reason for the transfer as well as what care was provided prior to the transfer
  - Advance directives and goals of care with the patient, family and the power of attorney for health care, as appropriate.
  - Baseline cognitive and functional status, as well as recent changes from baseline.
  - Co-morbid illnesses
  - New diagnoses and any recent hospital discharges
  - Medication list, including “as needed” medications and supplements as well as any recent changes in medications or dosages.

# Full Disclosure = Better Outcomes: The Universal Transfer Form

Jennifer Levy, LNHA, LSW, MSW
VP of Strategic Initiatives and Business Development
Spring Hills Senior Communities
jlevy@spring-hills.net

# Learning Objectives

- Identify communication process between SNF and ED to assure efficient communication resulting in Patient being treated at correct level of care
- Ability to effectively complete and utilize the UTF and SNF to ED consultation form

# Purpose

To improve communication between the SNF and ED and provide the most clinically relevant information on transferring the patient

- **Process** - 5 South Jersey stakeholder organizations collaborated to develop a single-page form to supplement the Universal Transfer Form (UTF)
  - Rowan University School of Osteopathic Medicine – NJ Institute for Successful Aging
  - Our Lady of Lourdes
  - Cooper Health System
  - Jefferson Health New Jersey
  - Virtua Health Systems

# How Did We Get Here?

- Focus by hospital systems to decrease hospital readmissions
- South Jersey hospitals agreed to come together in collaboration to develop one form to be used by the 5 hospital systems and their SNF preferred providers
- Consultation form focuses on information not always provided on UTF

- <u>4 Focus areas:</u>
- Detailed Reason for Transfer
- Code Status
- MD to MD communication
- SNF capabilities within 24 hours of return and will a physician be able to see the patient

# SNF to ED Consultation Form

**SNF to ED Consultation**

***Completed form must accompany patient to ED.***

****SNF staff must complete Sections A through E.**

**A**

**Patient Name:** _____ **DOB:** _____

**Most recent hospitalization dates:** _____ **Hospital:** _____

**Nursing Facility:** _____ **Nurse Contact #:** _____

**Attending Physician:** _____ **Physician Contact #:** _____

**DNR Status:** ☐ Full Resuscitation ☐ DNR ☐ DNI ☐ POLST

**B**

**REASON FOR TRANSFER/CONSULTATION:**

**Vital Signs: BP** _____ **Pulse** _____ **Respirations** _____ **Temp** _____

***Attach: Universal Transfer Form, Facility Capability List, current medications, lab work, diagnostics, etc.)***

**Comments:**

**C**

**RECENT LABS/DIAGNOSTICS:** ***(e.g., CBC, electrolytes, BUN/Creatinine, PT/INR, FBS, etc.)***

**D**

**MENTAL AND FUNCTIONAL STATUS:**

**Baseline mental status:** ☐ Oriented ☐ Alert ☐ Confused ☐ Withdrawn ☐ Non-verbal

**Has this patient's mental status changed from usual at the time of transfer?** ☐ Yes ☐ No

**Comments:**

**Functional Status:** ☐ Ambulatory ☐ Wheelchair ☐ Bedridden ☐ Other *(Specify)* _____

**E**

**NURSING FACILITY CAPABILITIES IN THE NEXT 24 HOURS:**

☐ Facility can temporarily manage a peripheral IV.

☐ Facility can temporarily manage a nasogastric tube for tube feeding.

☐ Lovenox ☐ IV Diuretics ☐ IV antibiotics ☐ IV hydration ☐ Please transfer back with IV access if placed.

☐ Other: _____

**Will a physician/NP be able to see patient in the facility TOMORROW?** ☐ Yes ☐ Uncertain

**Nurse completing form at SNF:** _____ ***(Please print)***

****ED completes Section F**

**F**

**Please provide the following if the patient is transported back to the facility:**

**ED Diagnosis:**

**Treatment Plan:** ☐ IV Fluids ☐ IV Antibiotics ☐ Laboratory Testing Tomorrow

**Specify:**

**ED to SNF Transfer Checklist:** *(Please check items completed)*

☐ Discharge instructions ☐ Lab results obtained in ED

☐ ED Nurse-to-SNF Nurse report ☐ Imaging results obtained in ED

☐ ED Physician to SNF Physician report

**ED Physician:** _____ **Date:** _____

**Contact number:** _____

# Assumptions of Consultation Form

- SNF to ED Consult Form **to be used by Preferred Provider Network SNF facilities** of each of the participating hospital systems
- paper- currently looking to keep the form "white"
- SNF to ED Consult Form to be **completed by SNF prior to transfer** of resident/patient to hospital ED
- SNF to ED form **supplements the UTF** form (It does not replace the UTF!)
- Orientation and follow-up
  - Stakeholders must orient staff at facilities and emergency departments to the form, its purpose, and how to complete it correctly
  - Form usage should be monitored as part of an ongoing quality improvement process

# SNF to ED Tracking Form

- Tracking tool rolled out via preferred provider relationships
  - Goal is for each facility to track usage and forward to their hospital preferred provider on a monthly basis.
  - Looking to determine if this form truly impacts ER readmissions

| SNF NAME: | | SNF to ED Tracking Form | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2018 | Hospitals | Cooper | OLOL - Camden | OLOL - Burlington | Inspira | Jefferson - Stratford | Jefferson - Cherry Hill | Jefferson - Wash. Twp. | Virtua - Voorhees | Virtua - Marlton | Virtua Memorial | TOTAL BY MONTH |
| January | Number of Acute Discharges | | | | | | | | | | | 0 |
| | Consult Form Sent to ER | | | | | | | | | | | 0 |
| | Number of ER Visits (not admitted) | | | | | | | | | | | 0 |
| | Consult Form Returned from ER to SNF | | | | | | | | | | | 0 |
| February | Number of Acutes | | | | | | | | | | | 0 |
| | Consult Form Sent to ER | | | | | | | | | | | 0 |
| | Number of ER Visits (not admitted) | | | | | | | | | | | 0 |
| | Consult Form Returned from ER to SNF | | | | | | | | | | | 0 |
| March | Number of Acutes | | | | | | | | | | | 0 |
| | Consult Form Sent to ER | | | | | | | | | | | 0 |
| | Number of ER Visits (not admitted) | | | | | | | | | | | 0 |
| | Consult Form Returned from ER to SNF | | | | | | | | | | | 0 |
| April | Number of Acutes | | | | | | | | | | | 0 |
| | Consult Form Sent to ER | | | | | | | | | | | 0 |
| | Number of ER Visits (not admitted) | | | | | | | | | | | 0 |
| | Consult Form Returned from ER to SNF | | | | | | | | | | | 0 |
| May | Number of Acutes | | | | | | | | | | | 0 |
| | Consult Form Sent to ER | | | | | | | | | | | 0 |
| | Number of ER Visits (not admitted) | | | | | | | | | | | 0 |
| | Consult Form Returned from ER to SNF | | | | | | | | | | | 0 |
| June | Number of Acutes | | | | | | | | | | | 0 |
| | Consult Form Sent to ER | | | | | | | | | | | 0 |
| | Number of ER Visits (not admitted) | | | | | | | | | | | 0 |
| | Consult Form Returned from ER to SNF | | | | | | | | | | | 0 |
| July | Number of Acutes | | | | | | | | | | | 0 |
| | Consult Form Sent to ER | | | | | | | | | | | 0 |
| | Number of ER Visits (not admitted) | | | | | | | | | | | 0 |
| | Consult Form Returned from ER to SNF | | | | | | | | | | | 0 |
| August | Number of Acutes | | | | | | | | | | | 0 |
| | Consult Form Sent to ER | | | | | | | | | | | 0 |
| | Number of ER Visits (not admitted) | | | | | | | | | | | 0 |
| | Consult Form Returned from ER to SNF | | | | | | | | | | | 0 |
| September | Number of Acutes | | | | | | | | | | | 0 |
| | Consult Form Sent to ER | | | | | | | | | | | 0 |
| | Number of ER Visits (not admitted) | | | | | | | | | | | 0 |
| | Consult Form Returned from ER to SNF | | | | | | | | | | | 0 |
| October | Number of Acutes | | | | | | | | | | | 0 |
| | Consult Form Sent to ER | | | | | | | | | | | 0 |
| | Number of ER Visits (not admitted) | | | | | | | | | | | 0 |
| | Consult Form Returned from ER to SNF | | | | | | | | | | | 0 |
| November | Number of Acutes | | | | | | | | | | | 0 |
| | Consult Form Sent to ER | | | | | | | | | | | 0 |
| | Number of ER Visits (not admitted) | | | | | | | | | | | 0 |
| | Consult Form Returned from ER to SNF | | | | | | | | | | | 0 |
| December | Number of Acutes | | | | | | | | | | | 0 |
| | Consult Form Sent to ER | | | | | | | | | | | 0 |
| | Number of ER Visits (not admitted) | | | | | | | | | | | 0 |
| | Consult Form Returned from ER to SNF | | | | | | | | | | | 0 |
| TOTALS BY FACILITY | Number of Acute Discharges | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Consult Forms sent to ER | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Number of ER Visits (not admitted) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 |
| | Consult Form Returned from ER to SNF | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

# Where do we go from here?

On 4/13/18 the New Jersey Hospital Association, Health Care Association of New Jersey, HQSI, and the DOH met to present the supplemental form

The goal is for the SNF to ED Consultation to be embedded within the UTF with a pilot program through the DOH slated to begin in June 2019- lasting 3 months

Pilot program to be held in both North Jersey and South Jersey

Based on the outcome of the pilot program, the goal is for the revised UTF to become regulation coupled with bi-annual education requirements