POST-ACUTE AND LONG-TERM CARE MEDICAL ASSOCIATION
WHITE PAPER
RESOLUTION C09

SUBJECT: IMPROVING CARE TRANSITIONS FROM THE NURSING FACILITY TO A COMMUNITY-BASED SETTING

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Introduction

Issues related to transitioning patients across sites of care increasingly have been in the national spotlight. There is evidence that poor transitions may result in adverse outcomes such as an avoidable re-hospitalization or medication errors.[1] Problematic transitions often involve inadequate participation by a primary care provider (PCP). Nationally, the extent to which physicians follow their patients throughout the continuum of care varies considerably. It is hoped that programs such as the patient-centered medical home, now being evaluated by the Centers for Medicare & Medicaid Services (CMS), will encourage greater PCP involvement during the care transitions of their practice participants.

While much has been written about transitions between the acute and long-term care settings, there is minimal literature on transitions between the nursing home and the community-based setting. This paper focuses on the importance of patient-centered care in improving transitions from nursing facility to home- and community-based settings and proposes several solutions to addressing these issues. However, it is important to note that effective transitions out of the nursing facility begin with appropriate transitions into the nursing facility and good care during the stay. Otherwise, problems related to the patient and the information accompanying the patient can accumulate and adversely affect a successful transition elsewhere.

Need for Better Care Transitions

Promoting better care transitions in and out of nursing facilities promotes continuity of care throughout the healthcare continuum, which can help improve the quality of care for these individuals; for example, by reducing rehospitalization and adverse outcomes from medication errors.[1] Furthermore, improved care transitions may improve a nursing facility's satisfaction and performance ratings and the public's perception of facilities. Nursing homes have a financial interest in getting patients to return to that particular facility if they subsequently need inpatient care. A problematic transition to the community may discourage individuals from choosing to return to that facility for subsequent skilled care.

Increasingly, the reimbursement system is moving toward pay-for-performance programs, such as the CMS' Physician Quality Reporting Initiative (PQRI). These programs, still voluntary at present, are intended to address gaps in care such as those related to transitions-of-care issues. In addition, nursing home performance is being rated through the Five Star Rating System based on survey data, staffing

ratios and quality measures. Enhanced processes and practices related to better care transitions will help improve the nursing home's performance on quality measures that affect a facility's rating. Facilities should consider the role of these programs and the possibility that pay-for-performance measures will address transitions of care in the near future.

Barriers to Effective Transitions

The current health care system presents barriers to effective transitions. These barriers include problems identifying and communicating with a patient's primary care physician, working with patients who do not have a primary care physician upon discharge; and inadequate reimbursement incentives to support adequate care transitions. Additional barriers include the lack of accurate, pertinent, and timely information about the patient sent to the receiving facility, provider, or community-based care setting; inadequate instructions for follow-up care, including monitoring the patient and identifying and managing risk factors; an absence of appropriate measures to determine good care; and the extent of patient and family understanding of condition, prognosis, and treatment.

Identifying and Communicating with the Primary Care Physician (PCP)

It appears that PCPs are often left out of the transitions process, leaving them unaware of their patient status throughout the acute and long-term care continuum. As a result, PCPs may not know what happened to their patients during their inpatient stay, or even that they were admitted to a long-term care facility. In adequate information upon transfer, may impede a physician's ability to give the best possible care for a patient at the receiving facility.

One challenge is to identify who is in charge of the patient in each setting. Some patients lack a community-based PCP or they may not have seen their PCP for some time. The physician who cared for them in the acute care facility or the nursing home may not follow them in the next setting. Many patients have various consultants managing aspects of their care in the nursing facility and in the community. Different consultants who are not familiar with the patient may assume care after discharge from a facility.

Health care settings and providers may not obtain or send other kinds of patient-related information, such as the past history or recent course in the facility, to the receiving facility. Often, the patient or family serves as the primary source of such information for the receiving provider and the facility. Nursing facilities may not assign responsibility for identifying a patient's PCP or for determining what type of information to send to, or obtain from, that PCP and other community- based providers such as home care, DME, hospice, etc.

In addition, the patient and/or facility may not know which physician to contact for follow-up visits after patients are discharged from the nursing facility. The facility may not have sent the PCP a copy of the discharge information that the facility received when the patient was admitted, or they may not send it when they discharge the patient elsewhere.

Sometimes, a PCP may not be notified of either the resident's admission or discharge. There may be delays in the patient receiving follow-up medical care after discharge. Some PCPs decline to prescribe medications, especially controlled substances, without first seeing the patient.

When a nursing facility knows the identity of the PCP, it must determine whether and how often to update the practitioner regarding the patient's course while still at the nursing facility (assuming that the practitioner is not following the patient during their stay). Who would be responsible for doing so, and by what means? Do physicians value periodic updates, or would they prefer to receive a more informative and comprehensive discharge summary?

These and other issues can upset families, result in inadequate care, increase the potential for patient harm and increase provider and practitioner liability.

Dealing with Residents who do not have a Primary Care Physician
Little information is available on how to work with patients who lack a community-based PCP. Some nursing facilities may not actively try to identify an individual's community-based PCP unless that physician is providing care during the patient's stay. Yet early identification of patients without a community-based PCP is important to the plan to discharge these individuals to the community. The nursing facility can begin to help such individuals identify a PCP within the community prior to discharge, to facilitate appropriate transitions.

Patient Follow-up After a Transition
Currently, there is little standardization of approaches to patient follow-up after transition into a community-based setting. Nursing facilities may not clarify who is responsible for follow-up, the appropriate approach to follow-up, or for how long after the transition the patient should be followed.

As in the hospital, the discharge process for the nursing facility begins at the time of admission. Identifying the environment into which the patient is to be discharged should influence the care plan and the essential care objectives required for a successful discharge. Essential information includes, but is not limited to:

- Whether there is a primary care physician, medical home, or clinic that will assume care;
- The identity of the receiving entity, and the contact person to receive information;
- The best way to communicate information to the receiving facility;
- The identity of family or other individuals acting on the patient's behalf;
- Whether the discharged patient can afford discharge medications, and whether the patient has a means (e.g., transportation, delivery, family) to obtain medications;
- Whether there are caregivers to appropriately support the patient after discharge;
- Whether the patient has responsibilities to care for someone else upon returning home; and
- Other significant risks for discharge issues, such as non-English-speaking, low-income, social isolation, multiple chronic conditions, and cognitive impairment.[2,3]

The responsibility for the patient does not end when the patient leaves the facility until a patient's community-based provider has been contacted, appropriate information is transmitted, and the receiving provider/clinic assumes responsibility for clinical care. Nursing facility staff, or the clinician caring for a patient within the nursing facility, should attempt to communicate with the receiving caregiver at or around the time of each discharge, to alert them to the transfer of care responsibility. When the receiving physician and/or facility cannot be reached to accept responsibility for care, the facility and/or current provider should be prepared to respond to the extent possible to patient requests for help or information.

If the facility cannot reach a receiving physician and/or facility, a post-discharge call to the patient/family within 24 to 48 hours after discharge from the nursing facility can be valuable. The nursing facility can reinforce that the patient/family needs to follow up with their health care practitioner and can tell them if the nursing facility was able to reach the receiving provider. Furthermore, this approach notifies the patient that the nursing facility will respond to requests for information- but in general cannot provide active medical care or follow up.

The individual whom the nursing facility designates for post-discharge follow-up should document these post-discharge contacts and attempted contacts with patients, families, and outside practitioners, along with results of those communications.

Medication Management

Currently, there is no universally employed approach to address medications that are prescribed upon patient discharge. Some patients are given "bubble packs" of medications from the nursing facility, while others may be given prescriptions from the discharging physician. The approach taken may depend in part on the patient's insurance coverage at the time of discharge. If the patient is leaving the nursing facility while still covered by Part A/Skilled Care or Managed Care, the nursing facility must pay for any medications sent home with the patient. Some nursing facilities may be unwilling to incur that cost and may insist that the attending physician write new prescriptions for all medications to be taken after discharge. The nursing facility can then return unused medications for a refund. Other facilities may absorb that cost and give the patient a 3- to 5-day supply of medications, except controlled substances. Some facilities also will accommodate the transition by directly transmitting prescription information to the pharmacy of patient/family choice.

If the patient's medications are covered by Medicare Part D, the prescription drug plan (PDP) will have been billed for whatever medications the patient has not used prior to discharge, and may not permit a refill of those medications until the predicted time when they would be exhausted after the patient returns home. A warning such as "Refill too soon" may show on the local pharmacy's query if the patient brings in prescriptions for medications that still should have a quantity remaining, and the patient will have to pay out-of-pocket. Thus, the nursing facility generally should send unused Part D-covered medications home with discharging patients, with instructions for administration and refills.

Ideally, the discharging nursing facility and the attending physician at the nursing facility should give the community-based PCP a relevant discharge summary and medication reconciliation. Upon transfer from a nursing facility, discharge medications rarely are reconciled with the medications the resident had been taking at home. Communication with the resident's PCP can help to alleviate this situation by including a review of current and past medications. Absence of medication reconciliation can be problematic if the patient decides to resume his/her previous medications and also takes the medications given by the facility, especially if there are potentially significant medication interactions.

An alternative approach is to use the patient's community pharmacy to help reconcile medications. Most pharmacies have computerized histories of previous medication regimens and can help ensure that ongoing medications are appropriate. The receiving community pharmacy can be asked to contact the patient's community PCP to clarify any conflicting or confounding orders. While not ideal, this is an alternative way to reach the community PCP. As with the nursing facility attending physician, the

community PCP can piece together the possible rationale for any changes in regimen. This also may give the community PCP an incentive to call the nursing home physician with any questions or needed clarification. If the PCP insists that the patient visit prior to any attempted clarification, then the PCP should facilitate such an appointment, especially if the situation is urgent.

Timing of communication is also an issue. The facility person responsible for transmitting information about the discharge medication regimen should identify that information as soon as possible during the discharge process. It is better to identify early if the potential receiving PCP is unwilling to care for the patient or disagrees with the discharge medication regimen. Medication changes immediately before discharge also can be problematic if they are not incorporated into the discharge information. One way to address this is to recommend that the receiving physician and/or facility make the change, instead of doing so before discharge. This assumes that the community-based PCP will comply with the recommendation to monitor and modify the medication regimen.

Barriers Created By the Current Reimbursement System

In 2006, the American Medical Association's (AMA) Current Procedural Terminology (CPT) committee recognized the value of a nursing facility physician's work in coordinating the discharge day process. The CPT committee identified and assigned a fair relative value for two code levels: 99315 (less than 30 minutes) and 99316 (30 minutes or more). It also recognized that—unlike in the hospital—the nursing facility physician was not necessarily present on the day of service but provided that complex service over several days. Subsequently, some intermediaries may resist paying for this service. More recently, new interpretations from CMS have required a patient visit on the day of service as a prerequisite to any use of the codes. Physicians may become less inclined to provide such services because they are unlikely to be reimbursed adequately for the service. The AMA CPT committee has perpetuated this misinterpretation. The issue should be addressed again in the future, since discharge from a nursing facility differs substantially from a hospital discharge.

Recommendations

The following section recommends approaches to addressing the issues identified in this paper.

Identifying Responsibility

In order to improve communication with the resident's PCP, the nursing facility should designate someone to coordinate care transitions. This coordinator would be responsible for at least the following tasks:

- Identify and/or confirm the resident's community-based as well as facility-based (if different) PCP upon resident's admission.
- Ensure that contact information for both the nursing facility attending physician and the community-based PCP is available in the facility's record and for the patient.
- Ensure the patient/family understands the next step in follow up care.
- Ensure that the facility's discharge information regarding medications is correct and complete. This information should be based in part on the patient's current medication regimen, and should reconcile that regimen with the one prior to the current episode of illness.
- Act as a liaison between the nursing facility and the resident's PCP. This includes providing the PCP with a summary (created by the interdisciplinary team) of relevant

physical, functional, and psychosocial information about the resident within five days of discharge from the nursing facility.
- Provide the patient/family with a list of PCPs in the area on admission to the nursing facility, if none were identified for that patient on admission.

The nursing facility should develop policies and procedures that promote active communication between the nursing facility and the PCP. The communication plan may need to be flexible to accommodate the PCP's preferred method and frequency of receiving information (i.e., phone calls, e-mails, faxes on a daily/weekly/as needed monthly basis). It also should consider keeping a list of community PCPs that includes their contact information as well as their preferred communication approaches. PCPs could obtain additional information about the patient if they are informed about key contacts in the nursing facility.

The care transition process can benefit from involvement of the patient's community-based PCP. Approaches that could help to identify and involve the patient's PCP include the following:

- List the PCP on the nursing facility's admission record.
- Have the hospital list the community PCP (not just the physician who provided care in the hospital) on the transfer sheet.
- Instruct the admissions director to inquire about the PCP prior to or upon admission.
- Educate all staff about the role of the PCP.
- Ask the patient and/or the patient's family for the name of the PCP.
- Check with the patient's outpatient pharmacy about who prescribes their medications, if the PCP is unknown.
- Develop a discharge process in the nursing facility to help improve care transitions.

Improve Information Provision at Transition

What kinds of information, and how much, should be sent to physicians who are receiving a patient? Typically, a nursing facility discharge summary is completed by nurses, often with the input of other disciplines. Such summaries may contain considerable data about the patient, but not necessarily much of a story about his or her stay. Discharging physicians may provide only a cursory summary. Thus, receiving physicians and facilities may not receive much narrative information about a patient's course (clinical and otherwise) in a nursing facility.

It is important to identify whether optimal information is being sent to help PCPs continue to manage their patients. Transfer information should give the receiving physicians and/or facilities the "story" of what happened to the patients during their stay. This is important because clinical events happen in a sequence, depending on the link among causes (e.g., medical and psychiatric illnesses) and between causes and consequences (symptoms and risks such as falls and weight loss). Several studies suggest that physicians value the patient history much more than the physical exam or labs in helping them diagnose their patients.[4, 5] In addition, PCPs need such information to help them understand the rationale for treatments, including medications, in order to determine whether and how to modify them.

The physician who cares for the patient during the nursing facility stay should help the nursing facility provide adequate, timely information on discharge. The medical director of the nursing facility should

actively encourage such involvement. This key information could be assembled and organized gradually during the patient's stay so that it is available at discharge.

It can be helpful if transfer information indicates what has been, and what still needs to be, discussed or decided with the patient and/or substitute decision-maker; for example, how medical instability, multiple active acute and chronic conditions, recurrence of symptoms despite treatment, severity of complications, and risks associated with treatment affect a patient's prognosis. Transfer information also should identify any known priorities to be addressed by the PCP; i.e., issues that need to be taken care of before other problems or complications can be resolved effectively. For example, it may be necessary to treat anemia or further resolve delirium before function and behavior can improve.

Nursing facilities should strive for more efficient and effective ways to provide essential transfer information. For example, weekly (for short-stay patients) or quarterly (for long-term residents) summaries of a patient's stay can be aggregated upon transfer to provide key details of the course. Once patient information is computerized, it can potentially be organized in various ways to generate reports in a useful format for receiving facilities and practitioners.

Medication Reconciliation

Nursing facility policies should promote medication reconciliation upon a patient's admission and discharge, as well as communication with an outside pharmacy/pharmacist of choice to review and discuss discharge medications. The discharge summary should include information on why medications were changed during the patient's stay and should clearly document the rationale for continuing medications after discharge.

Communication with the patient's PCP can facilitate a review of current and past medications. For example, the nursing facility might ask families to bring in all current medication prescriptions from the home for review prior to discharge. The practitioner (e.g., physician, nurse practitioner, physician assistant) should review and compare these medications to current medical orders. Patient and/or family education about medications is important both while the patient is in the facility and at discharge. The nursing facility might consider involving a home health agency and /or, if available, a community-based transitions coach.

Patient Centered-Approach

Nursing facilities should consider the advantages of minimizing opportunities for failure and maximizing the potential for successful transitions. A patient-centered approach to care is an emerging principle related to safe care transitions. It engages the patients/families in the process of transfers, values that input, and facilitates their decisions. An engaged, knowledgeable, activated patient and/or family can be an effective partner in care with the physicians and the nursing facility.

Institutions can foster dependency during the treatment course. Upon discharge, a patient and/or the family may be unprepared to continue appropriate care on their own.

Managing expectations and preventing excess disabilities facilitate successful transfers. Appropriate support can help patients achieve realistic goals, limit frustration, and minimize further decline.

Nursing facilities should promote policies to give patients and families necessary medical information and to educate them about their plan of care. The goal is to provide enough information and support to minimize gaps in care. Such information includes the disclosure that transitions carry risks and that the patient could potentially stabilize, improve, or decline after discharge.

Often, therapists or social workers make home visits prior to a discharge. A patient-centered approach focuses on the patient's needs and goals, from their perspective, and anticipates potential limitations. Using the patient-centered approach, appropriate modifications can be recommended and problems can be identified and solved promptly.

In many ways, the discharge process should mirror the admissions process. Nursing facilities should designate someone to oversee admissions: to arrange information flow, complete admission paperwork and be responsible for the patient's entry into the nursing facility. Likewise, a specific position or person should bear responsibility for the transition back into the community. Each nursing facility must decide whom to designate for this role. There should be a standardized method of discharge planning and post-discharge patient tracking. An example of a discharge program is one being promoted by the California Quality Improvement Organization[1].

Use of instructions and checklists, can provide a template for handling discharges that may reduce the likelihood of missing key steps. A structured discharge process includes identification of local community resources available to the patient and family. It involves patients and families in the transition and the preparation for discharge home. Patient follow-up is facilitated when everyone agrees on expectations and the patient/family is ready to assume care and other next steps.

Starting at admission, nursing facility inquiries can identify key contacts and optimal approaches to conveying information to subsequent care providers. Furthermore, nursing facilities should give patients and PCPs key information such as the following:

- A reconciled medication list;
- Discharge instructions from the facility;
- Specific next steps in care (e.g., which provider to see next, why, and when);
- Specific follow-up tests to be performed, why and when;
- Who at the facility (or a specific provider) to call if questions arise, and how to reach them;
- Pertinent laboratory and x-ray test results;
- Pertinent consultations, emergency room and other encounters for continuing care; and
- Advance directives.

Another suggested step is for the facility to make a post-discharge call to the patient and/or family 1 to 2 days after discharge, to demonstrate the facility's caring and competence. This call might include the following:

- Inquiries about whether a home health visit is scheduled, or was made as scheduled;
- Reinforcement of medication adherence until the community-based PCP can be seen;
- Reinforcement of the need to follow up on physician visits and diagnostic tests;

- Review of whether supplemental resources have started (e.g., Meals on Wheels); and
- Checking whether the patient understands the next steps in care.

Available Tools

Tools are available to support efforts to improve transitions. Examples include information about advance care planning and advance directives such as the Physician Orders for Life-Sustaining Treatment (POLST) that has been adopted by several states (http://www.ohsu.edu/ethics/polst/), the "Intervention Activities Checklist" by Dr. Eric Coleman (www.caretransitions.org), and the CMS discharge form "Planning for Your Discharge." (http://www.medicare.gov/Publications/Pubs/pdf/11376.pdf).

Recent literature offers several additional tools to help facilities try to improve transitions across care sites. Examples of some of those tools include:

National Transitions of Care Coalition (NTOCC): Improving on Transitions of Care: How To Implement and Evaluate a Plan http://www.ntocc.org/Home/HealthCareProfessionals/WWS_HCP_Tools.aspx

- Suggested Common/Essential Data Elements for Medication Reconciliation (p. 64)
- My Medicine List (p. 64)
- Elements of Excellence in Transitions of Care Checklist (pgs. 65-66)

Improving the Quality of Transitional Care for Persons with Complex Care Needs: American Geriatrics Society Position Statement http://caretransitions.org/documents/Improving%20the%20quality%20-%20JAGS.pdf

An Interdisciplinary Team Approach To Improving Transitions Across Site of Geriatric Care http://www.caretransitions.org/documents/manual.pdf

- Structure of the Care Transitions Interventions (pg. 8).
- Care Transitions Intervention Activities by Pillar and Stage Intervention (pg. 9).
- Roles and Functions of Transitions Coach (pg. 12).

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Results: Passed.