



Transitions of Care: SNF – Emergency Department - SNF

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Objectives

At the end of this session the participant should be able to:

- Understand the barriers to appropriate information exchange between the SNF and ED
- Describe key elements of information to be included in transitions of care
- Define process steps required for successful implementation of a SNF-ED transitional care program



SNF-ED-SNF Transfers “Too much of not a good thing”

- Of all transitions, least is know about SNF-ED-SNF. There is little documentation about frequency, reason or outcome
- Recognized as a frequent occurrence, often not linked with hospital admission. Est. up to 25% of SNF residents are transferred to ED yearly

ED transfers are typically driven by:

- Need for assessment and rapid diagnostic testing
- Need for symptom management (including EOL care)
- Family and/or resident expectation
- Assumed access to service needed but not available in SNF (eg: PIC placement, PEG tube placement)
- Fear (liability, family anger, missed diagnosis, lack up clinical support or direction for staff)



View of the Problem: From the ED Side

- “Too much or not enough”. What information they get is poorly organized and of little value
- “No contact info re: facility, direct care giver or family/decision-makers”
- No history of present illness – “What is the problem?” which needs to include list of meds, recent labs, allergies, etc
- Advance directives





View of the Problem: From the SNF Side

- “Emergency Room notes are cryptic and illegible”
- “No knowledge of the work-up.” Results and even diagnosis are often not provided
- Mis-application of HIPAA rules; “We cant share anything with you”
- Treatments ordered without stop dates
- Assumptions about intensity of care and services available in SNF (eg: *RT to provide respiratory treatments q 2 hours until seen by M.D.*)

Each side believes **THEY** provide needed info...but the gap remains



If only the solution was to just “fix” the transport system!



Real Tools for Real Solutions

- Communication and engagement (there needs to be a voice and a Champion)
- Create a *process* to allow the desired outcome to occur (and continue to occur)
- Define a measurement and feedback cycle
- Provide the tools (forms, procedures, policies, etc...) to make all this happen



Improving Transitional Care SNF-ED-SNF

- Forms by themselves, don't change process (pilot in Hamilton, Ontario = 60% of forms never came back)
- Examples of models of change
 - Indiana Univ. Center for Aging Research, K Terrell, D.O. and D. Miller, M.D.
 - Missouri DHSS, Missouri Am College of Emergency Physicians, Missouri Medical Directors Association
 - Univ of Texas, Galveston, M Davis, et al
 - Cleveland Clinic, E Hustey, R Palmer



Annals of Long Term Care
Nov, 2005

A One-Page Nursing Home to Emergency Room Transfer Form: What a Difference It Can Make During an Emergency!

M. Nelia Davis, MSN, APRN, BCCS, Valerie C. Brumfield,
RN, MSN, CCRN,
Sarah Toombs Smith, PhD, Susan Tyler, APRN, BC, GNP,
MSN, and
Jennifer Nitschman, RN, MSN, CNA

Lessons Learned continued

- Define **specific process** for needed info gathering on SNF side
- Review **ED transfers** for adherence to process
- Provide **feedback to ED** from SNF and back to SNF from ED: “what’s working, what’s not, what needs to be changed”
- Start with **1-2 facilities** – grow as you learn



Additional Forms and Tools

A template for an "ED hand-off Communication Form". It features a vertical column of ten checkboxes on the left side, each with a small icon. At the bottom right, there are two empty rectangular boxes for initials or a signature.

Most Important to Remember...

The transfer is about the PATIENT, not the facility!

- What does the patient/family understand about the transfer?
 - Where am I going?
 - Why am I going?
 - What should I expect?
 - What do I need to know or to tell the next facility?
 - What changes in my care are planned?



Resources and References

1. Davis M, et al. A One-Page Nursing Home to Emergency Room Transfer Form: What a difference it Can Make, *Annals of LTC*, 13 (11), Nov 2005
2. Fernandez C. Geriatric Care in the ED, *Acad Emerg Med*, 12 (2), Feb 2005
3. Gaddis G. Elder Care Transfer Forms, *Acad Emerg Med*, 12 (2), Feb 2005
4. Missouri State Dept of Health and Senior Services
5. Terrell K, Miller, D. Challenges in Transitional Care between Nursing Homes and Emergency Departments, *JAMDA*, Oct 2006
6. Terrell K, Miller, D. Critical Review of Transitional Care Between Nursing Home and Emergency Departments, *Annals of LTC*, 15 (2), Feb 2007