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Catherine M. Glew BM, BS, CMD
Lehigh Valley Health Network, Catherine.Glew@lvhn.org

Anne M. Yawman MD
Lehigh Valley Health Network, Anne_M.Yawman@lvhn.org

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Improving the Quality of Information sent to Primary Care Physicians for Patients Discharged from Nursing Facilities

Catherine M Glew BM, BS, CMD; Anne M Yawman MD

Lehigh Valley Health Network, Allentown, Pennsylvania

Abstract:

As part of an assessment on documentation in transitions of care, we identified that none of the nursing facilities (NF) where our group is on staff had a formal process for a discharge communication (DC) to the primary care provider (PCP).

The six providers in our geriatric group developed a standardized single page summary to be sent to the PCP at discharge. This form included Patient name and Date of birth, NF where the patient received care and discharge destination, functional and cognitive status, Home Health Agency and contact numbers, details of admission diagnoses and course in the NF, other medical diagnoses, medication list, any follow up laboratory or radiology testing and follow up appointments. Approval had to be given by each NF to allow the DC form to be used and placed on the NF chart.

The form was completed by the discharging provider and faxed to the PCP and our office for tracking. PCP office is called by staff to ascertain if form was received, and if not, form is re-faxed. Comments made by PCP office were also logged.

During the initial pilot period of 8 weeks, 75 DC forms were faxed to PCP office. Of these, 30/75 (40%) needed to be re-faxed. 3/75 (4%) PCP offices never responded back as to whether DC form was received despite multiple calls. Multiple process issues were identified. Many PCPs were incorrectly identified in our provider registry and phone and fax numbers were also wrong. Many PCP offices asked for the DC to be re-faxed, mostly as they were not sure if they had received it or not.

As a measure of provider compliance, we compared billing codes for discharged patients with forms sent. 77% of patients with a 315/316 code on a bill had a DC form. 10 additional DC forms were sent for whom no bill with a discharge code was made out. One NF was slow to give approval for the form, and so the physician at that NF could not use the form for 6 weeks out of the 8 week pilot period.

Providers found some difficulties with the process; obtaining information about the Home Health Agency and accurate functional status and contact numbers for the PCP office were the most troublesome. One provider photocopied prescriptions given to the patient instead of listing the medications, and these were illegible when received by the PCP. In some cases the handwriting on the DC form was hard to read.

Four revisions were made to the form during the pilot period- the space for narrative for the NF stay was enlarged and space for addition of cognitive testing scores was added. We found numbered spaces for diagnoses and medication to be too short to write some data and so this was changed to free text space. We also plan to include code status and allergies on a next updated version.

One NF adopted the DC form for all short term discharges, though it will be completed by a case manager and nurse rather than providers.

To evaluate the usefulness of the content of the DC form, we plan to survey PCP offices.

Background:

Lehigh Valley Health Network (LVHN) began an initiative to improve the transfer of information when patients transition between sites of health care. Physicians from the Division of Geriatrics care for patients in multiple skilled nursing facilities (SNF), and we determined that there was no discharge form to transfer information to the Primary Care Provider (PCP) when the patient leaves the SNF to return home. All of the providers attempt to send information, but the process is not standardized and is inefficient. Our goal was to develop a single page discharge form that would update the PCP about the nursing facility stay, the patient's condition at discharge and any follow up required.

Methods:

Development of the Form and Utilization

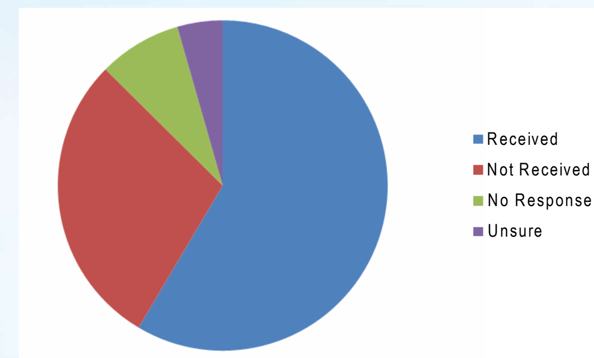
The providers in our group met to determine what information should be included on the form. The first draft of our form is shown in Figure 1. The providers are able to fax any additional documentation they wish. We began using this form on August 8 2010.The form is completed before discharge by the discharging provider (Physician or CRNP). All forms are faxed by the provider to the PCP office and our office. Follow up calls are made by a nurse in our office to ensure that the form has been received; if the form has not been received by the primary care office, it is re-faxed. We also ask if any further information is needed, and any comments made by the PCP office were recorded.

Figure 1. Initial Discharge Form

Results:

For the five month period from mid August to the end of December 2010, there were 135 copies of a DC form received in our office. Follow up calls showed that 79 (58.5%) were identified as "received" by the PCP office, 39 (28.8%) were identified as "not received" by the PCP, 6 (4%) were unsure if they were received and 11 (8%) of PCP offices never responded to the inquiry. 44 (32.5%) had to be re-faxed by our office.

Figure 2. Receipt of Discharge Form by Primary Care Provider Office



Discharging Provider Compliance with Use of the Form:

We did not have the resources to visit the NFs and perform a chart audit to assess for compliance. We thus attempted to measure provider compliance with use of the form by looking at number of DC forms completed, and comparing to the number of patients in whom a 99315 or 99316 billing code was billed. From August 8 2010 to December 31 2010, there were 177 discharge codes billed, for which only 135 DC forms (76%) were received in the office. The individual provider compliance was 32% to 85 % and is shown in Table 1. This is only a measure of how many copies of the DC form were received in our office; it may be that forms were completed and faxed to the PCP, but not to our office. Also the form was not in use at two NFs for the first two months of this project due to delay in NH approval.

Provider	99315/ 99316 Billed	DC Form Found for Patient in Office	Compliance (%)
1	26	18	69
2	37	12	32
3	85	69	81
4	14	12	85
5	14	8	57

Process Issues:

Providers

The main provider process issues are shown below. Although it was recognized as an essential component of a safe transition back to the primary care provider, completion of the form was considerable extra work for the discharging provider.

Provider buy in: "yet another form"
Major disagreement about what is "essential information"
Determining who is primary care provider
Obtaining information on phone and fax numbers for primary care provider
Obtaining name and contact numbers for Home Health Agency
Obtaining accurate functional status at discharge
"Not enough space"

Nursing Facility

The NF process issues are as shown:

Approval for the form to go on the facility chart
Approval for the form to fill the facility physician discharge summary requirements
Staff education about the form

Primary Care Provider

PCP process issues are shown below. The main issue was the inability to locate the form in their office. We did not inform the PCP offices about our project before starting to send discharge forms. Thus many of them were unfamiliar with the form which may have contributed to their evaluation that the forms had not been received.

Unfamiliarity with form
Inefficient office process /filing
New EMR
Legibility

Geriatric Division Office

The implementation of this new discharge form had implications on our office staff as shown below:

Multiple calls to primary provider to assess receipt of form
Long wait time on telephone
Time looking up primary provider information in network database
Time to re-fax or mail forms when not received
Network database incomplete and incorrect leading to repeating of work

Post Utilization Review

The providers in our group met again to identify issues related to the layout and content of the form. Most were finding the form adequate for the purpose. The form was updated and is shown in Figure 3. We plan to survey PCP offices to assess their satisfaction with the form in the future.

Figure 3. Revised Discharge Form

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