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Strategies to Improve Care Transitions between Nursing Homes and Emergency Departments

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Abstract

OBJECTIVE—To identify testable solutions that may improve the quality and safety of care transitions between nursing homes (NHs) and emergency departments (EDs).

DESIGN—Structured focus group interviews.

SETTING—Group interviews took place in Indianapolis, Indiana.

PARTICIPANTS—NH administrators, nurses, and physicians; emergency medical services (EMS) directors, paramedics, and emergency medicine technicians (EMTs); ED nurses and physicians; and a representative from the Indiana State Department of Health.

MEASUREMENTS—Opinions, perceptions, and insights of participants.

RESULTS—18 participants were included. The central theme was the need for additional structure to support care transitions between NHs and EDs. Participants agreed that the structure afforded by hospital-to-hospital transfers would benefit patients and providers during transitions between NHs and EDs. Because transfer forms currently vary from NH to NH, participants recommended that the entire state use the same form. They recommended that the transfer form be useful in both directions by including a section for the ED provider to complete to support the ED-to-NH transition. Participants suggested that systems use a transfer checklist to help ensure that all processes occur as expected. They strongly recommended verbal communication across care settings to complement written communication and to improve on deficiencies that occur with transfer form-only strategies. Notably, participants suggested that the different care sites engage in

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relationship-building efforts to improve compliance with recommendations (e.g., form completion) and collaborative problem solving.

CONCLUSION—Participants advised additional structure to NH-ED care transitions, similar to hospital-to-hospital transfers, that includes a 2-way, statewide transfer form; a checklist; and verbal communication.

Keywords

Nursing Homes; Emergency Service, Hospital; Emergency Medical Services; Patient Transfer

Introduction

Emergency departments (EDs) are major health care providers for nursing home (NH) residents. Urgent on-site physician evaluation, radiology and laboratory testing, and intravenous therapy are not available in most NHs.[1–2] As a result, NH residents who suffer acute illnesses or injuries are generally transported to an ED for evaluation and management. Indeed, each year nearly 25% of NH residents are transferred at least once to an ED.[3]

Transitional care has been defined as "a set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location."[4] Regrettably, healthcare settings, such as NHs and EDs, operate independently of one another, often providing care without the benefit of information from the other site of care.[5–7]

To improve communication of vital information between sites of care, investigators have tested the use of standardized transfer forms. This research has shown that transfer forms significantly increase communication of important clinical information;[8–9] however, NH providers complete the forms for fewer than half of transfers.[8–9] Even when the forms are used, much of the requested information still is not recorded,[9–10] and the exact reason for the ED visit remains missing or unclear in most cases.[11] Although a better transfer form may be an important part of the solution, we must look beyond the simple introduction of a transfer form to increase the quality and safety of care transitions.

Because previous research has centered only on transfer forms, progress in transitional care is unlikely until investigators have a richer understanding of additional mechanisms to improve communication across care settings. The purpose of this study was to identify testable solutions through focus group interviews with a diverse group of stakeholders.

Methods

Study Design

Data were collected via focus group interviews, a qualitative group discussion format. The research was deemed exempt and approved by the Indiana University Institutional Review Board (IRB).

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Study Setting and Population

The two group interviews took place in Indianapolis, Indiana. We invited a diverse mix of individuals known to be particularly knowledgeable about the topic, including NH administrators, nurses, and physicians; emergency medical services (EMS) directors, paramedics, and emergency medicine technicians (EMTs); ED nurses and physicians; and representatives from the Indiana State Department of Health.

Focus Group Process

We included the most important questions to ask participants in a question guide. One week prior to the group interviews, the question guide was sent by email to participants. This provided participants an opportunity to consider and plan their initial responses to questions, while the focus group process permitted participants to react to the comments of others and to have a structured group discussion. During each focus group interview, the moderator (KMT) used well-accepted methodology,[12] along with the question guide, to lead the group interviews. All focus group discussions were audiotaped.

Measured Outcomes

The outcomes were the opinions, perceptions, and insights of the participants. The overarching focus of the discussions was to identify and develop ideas to improve the quality and safety of transitional care (in both directions) between NHs and EDs. The two major themes were (1) facilitators and characteristics of high quality transfers and (2) specific ideas to improve the current care transitions system. We decided on these themes *a priori* but were open to adding other pertinent topics if they were raised by participants.

Data Analysis

Audiotapes were transcribed verbatim. Each author (an emergency physician and a geriatrician) independently and systematically analyzed the transcripts. The transcripts were systematically coded and analyzed using conventional methodology.[13] Coding involved highlighting important quotations in each transcript and placing each highlighted section of text into a category. Each category was then placed into thematic areas.

Results

We conducted two focus group interviews. Table 1 lists the categories of subjects who participated in the interviews. The central theme that emerged from the group discussions was the need for additional structure to support care transitions between NHs and EDs. According to an emergency physician, “We should look at this more as [a hospital-to-hospital] transfer than a discharge [from the ED].” [During hospital-to-hospital transfers, providers are required to follow specific steps to communicate information from one hospital to the other;[14] see Discussion for some relevant specifics.] Participants agreed that the structure afforded by hospital-to-hospital transfers would benefit patients and providers during transitions between NHs and EDs. They advised that this structure include a two-way, statewide transfer form; a bidirectional checklist; accountability; and verbal communication across care settings.

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Transfer form

A common frustration voiced by ED and EMS providers was that NH-to-ED transfer forms vary from NH to NH. To help emergency providers receive and find information in transferred documents, an EMS provider recommended that all NHs in the state of Indiana adopt the same ED transfer form. An ED physician agreed and advocated for a statewide transfer form that is used for both NH-to-ED transfers and ED-to-NH care transitions. He commented, "…[W]e fill out forms for [hospital-to-hospital] transfers…so I don't think it would be that hard for us to fill that out for every patient that goes back to an extended care facility." An NH administrator agreed with the importance of receiving useful information when residents return from the ED. She mentioned, "If we get good information coming back to the facility, then we can resume that plan of care at a better level."

Although he agreed with the sentiments in the preceding paragraph, an NH physician cautioned, "We can implement as many forms as we want, and they don't get filled. That's the problem. We get an awesome form, they don't get filled out the right way, or there are errors." An NH administrator advised that the best way to overcome such issues is to develop relationships across care settings. He personally has "developed a relationship with…the head of the emergency room, met the discharge planners and several physicians." He stated that this relationship-building effort has helped them overcome many of the challenges of care transitions.

An NH administrator agreed with the idea of a bidirectional statewide transfer form and advised brevity, "I think it's important to think of what needs to be on that form, and also what does not need to be on that form. We just don't want to add on to the work. I've seen these universal transfer forms. They are tedious and long, and they also have a detailed therapy thing in there on how much they walked and all those things." Participants agreed that a new transfer form should include only information that would be useful to the receiving providers during the majority of transfers.

Transfer checklist

In addition to a more useful transfer form, an EMS provider advocated for "some type of basic protocol or policy [to follow]. If EMS has to come, here are your steps [to take]." After some discussion, the group advocated that providers use a transfer checklist to ensure that important processes are not overlooked during care transitions. An NH administrator mentioned that his facility has a checklist that they use for transfers to EDs. The checklist helps them send the appropriate documents and, in his experience, prevents calls from ED providers to request items that should always be transferred with residents, such as medication lists.

Accountability

When care transitions don't go as planned, providers often blame another group of providers. For example, when an ED physician doesn't receive transfer documents from the NH, the EMS providers may incorrectly receive blame for losing the paperwork. To help combat this, participants advocated for some mechanism to hold providers accountable for carrying out the processes for which they are responsible. According to one EMS provider, "[W]e

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need to look at something more standardized, say almost like evidence in a case. You know, they establish a chain, wherever [the transfer documents] go, somebody is responsible for [them].”

Verbal communication

The greatest amount of discussion in both group interviews centered on the importance of verbal communication during transfers of care. An NH provider mentioned, “[A]ny kind of transfer that takes place in the hospital, if it's from the ED even to an acute floor bed or to a monitor bed or to ICU, what happens is somebody calls somebody.” Participants agreed that care transitions between NHs and EDs are particularly vulnerable to breakdown without verbal communication across care settings.

An NH physician shared an example of how a call from an ED physician prevented a return visit to the ED. “I got a page around 2:30 in the morning…about a patient of mine who had a skin tear and was sent to the emergency room, and the ED physician who was there called me… [He planned to] send the patient back without any sutures… [We] would have sent him right back [for sutures]. …[T]he ED physician picked the phone up, called me, and a lot of hassle was avoided.”

An ED physician stated that she would also appreciate “a call from [the NH physician]. [Alternatively,] it would be helpful to have the nurse who is sending the patient call me… If I don't [personally] see the patient in the ED, I can give that information to [another ED physician] and say, `Hey, we are going to get this person, this is what [the NH providers] are concerned about, here's the pager number, [and the NH physician] would like to be called back.'”

An ED nurse agreed that “there is no substitute for verbal communication, [but] one of the challenges that we see is that it's hard to get somebody who knows the patient.” An ED physician agreed and, as a potential solution, stated, “If there were a transfer form like we talked about that is standard with [the NH doctor's or nurse's] contact information, then that would help us.”

Discussion

The focus of this research was to identify promising next steps to improve the quality and safety of care transitions between NHs and EDs. Prior qualitative research has focused on (1) describing the challenges of providing high quality care to NH residents who receive ED care,[5] (2) identifying factors that influence decisions to transfer residents to an ED,[15] and (3) the identifying information that is exchanged between sites of care during transitions in both directions between NHs and EDs.[16] This study extends existing knowledge by (1) making clear that a primary need of NH-ED transfers is additional structure; (2) identifying the specific components of this added structure; and (3) suggesting that a statewide effort to standardize processes during care transitions is desirable. All of this information was generated from the perspectives of key stakeholders engaged in NH-ED care transitions.

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To our knowledge, this was the first research to suggest that care transitions between NHs and EDs be managed similar to hospital-to-hospital transfers. The requirements during hospital-to-hospital transfers that are pertinent to NH-ED care transitions are (1) the receiving hospital must be contacted, (2) the patient must be accompanied by copies of appropriate transfer documentation, and (3) the transferring hospital must complete paperwork to document that the appropriate actions occurred prior to and during the transfer.[14] This third item is generally accomplished using a checklist. This was also the first research to suggest that a proven system be spread across an entire state. Although a few states (e.g., Rhode Island, New Jersey) have implemented universal transfer forms for transfers from any institutional setting,[17] the impact of these initiatives on quality and safety has not been evaluated to our knowledge.

With the goal of eventually spreading the system across Indiana, we assembled the Indiana NH, EMS, and ED Transfers of Care Task Force. At present, 15 Indiana organizations (e.g., Indiana Medical Directors Association) contribute members to the Task Force. The Task Force is currently initiating a pilot project that was developed based on the results of the present study and other research. The intervention has three central components. First, the *new transfer documents* include a recently developed bidirectional transfer form and a new transfer checklist. EMS providers will sign the checklist prior to transporting residents to the ED and before transporting residents from the ED back to the NH. Second, to supplement written communication, providers will *communicate verbally across care sites*. After the NH resident is evaluated in the ED, the ED physician will contact the NH physician or nurse. If the NH resident will be discharged directly back to the NH, the ED nurse will call report to the NH nurse. Because previous research has questioned the usefulness of NH providers' calling the ED before sending residents to the ED,[5] that telephone communication is not part of the intervention, although it is not discouraged. Third, to *implement the intervention*, we will identify and partner with a champion at each NH, EMS, and ED study site. The site champion will be a nurse or physician leader at the care site. To help build relationships across care sites and to improve the intervention, the site champions will meet regularly to discuss how to make it more effective.

Limitations

This study has the usual limitations of focus group research. The selection of subjects was not random, because random sampling generally isn't appropriate in focus group research.[13] Instead, researchers commonly use purposeful sampling, which involves selecting participants based on the purpose of the study. A second potential limitation is that the ideas that were generated were largely speculative. However, qualitative research generally is done to facilitate the development of hypotheses that will be tested in future studies. A third potential limitation is that the moderator was an emergency physician, which is both an asset and a liability. Because the moderator knew about the topic and participants, he was better able to make comparisons, understand interrelationships, and derive meaning from comments. On the other hand, a moderator's expertise in the area of research can lead to assumptions and inexact interpretations. Mitigating the risk of these possibilities, the moderator previously received formal focus group training. More importantly, both authors

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(an emergency physician and a geriatrician) independently analyzed the transcripts to ensure that the results reflect more than one perspective.

Conclusions

This qualitative research advises that the system of care transitions between NHs and EDs must have more structure and a well-designed implementation process. The additional structure includes better processes for written and verbal communication across care settings as well as accountability for ensuring that documents are shared as expected. These processes should be empirically tested, modified as necessary, and when successful, expanded across entire states.

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Table 1

Subjects included in focus group interviews.

Nursing home	2 physicians 2 nurses 2 administrators
Emergency medical services	2 emergency medicine technicians (EMTs) 3 paramedics 2 directors
Emergency department	2 physicians 2 nurses
State Department of Health	1 nursing home surveyor