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Improving Communication Between Community Care Settings and Primary Care

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IMPROVING COMMUNICATION BETWEEN COMMUNITY AND PRIMARY CARE

Abstract

Background

In older patients with more complex and chronic health concerns, consistency and continuity of care is essential. Patients often live in assisted living residences or independently with support from programs such as Support and Services at Home (SASH), so nurses are available to address concerns and assist with certain aspects of care. Effective inter-professional communication is essential, but communication of assessments and coordinating care with participants' primary care providers is complex.

Purpose

Improve efficiency and clarity of care-related communication for patient and care team by developing a system that standardizes and streamlines workflow and addresses current concerns.

Methods

At a small primary care office in New England, a standardized communication tool was developed based on concerns voiced by community nurses and primary care staff, to be used to relay pertinent information, and request appropriate follow-up. Primary care providers and support staff were surveyed about communication efficacy with residential care sites prior to implementation of the communication tool, and utilization and outcomes of the tool were measured quantitatively.

Results

Primary concerns at the outset were redundancy, communication by multiple methods, unclear expectation of office action, and lack of follow-up communication. During the 6 week implementation, the communication tool was utilized nine times for non-urgent issues, and resulted in reduction in back-and-forth communication and increased clarity.

IMPROVING COMMUNICATION BETWEEN COMMUNITY AND PRIMARY CARE

Conclusion

Tool was used appropriately for non-urgent concerns. Initial response indicates the tool improves communication, and that this office will continue to use this tool for future communication with community based care staff.

Keywords: Care coordination, communication, primary care, geriatrics

Table of Contents

IMPROVING COMMUNICATION BETWEEN COMMUNITY AND PRIMARY CARE

Introduction

Problem Description

The population in Vermont is aging and this has and will continue to cause an increase in the complexity of healthcare for Vermonters. For older patients with more complex and chronic health concerns, consistency and continuity of care is essential; effective inter-professional communication is integral to well-coordinated care. The Support and Services at Home (SASH) program and assisted living residences supports many older adults in Vermont, providing nursing and social services to their participants, assisting with managing wellness and monitoring health, and coordinating wellness care and long-term health management with primary care offices around the state. This is often complicated by challenges in communication, incompatible EHRs preventing directly sharing data, and patients' varying ability to relay information between organizations and care team members.

Available Knowledge

SASH program and Assisted Living

The SASH program in Vermont is a unique care model, which helps older adults continue to live in their own homes, provides programming and connects participants with community-based services based on specific population needs in each residence (www.sashvt.org). The program has been developing and expanding in Vermont since 2011. On entering the SASH program, a participant completes a wellness assessment with the RN and social worker assigned to their panel to gain an understanding of their health, wellness goals, social supports, cognitive function, mental health concerns, and medications. This information allows the SASH staff to coordinate with their participants' health care team, facilitate transitions of care after hospitalization or sub-acute rehabilitation, and provide continuity of care. Early evaluations show that participants who

had been with the program since its initial implementation showed lower rates of hospitalization, slower rates of growth for hospital and specialty physician costs, and slower growth of Medicare expenses, all while allowing older adults to continue living independently and promoting health and wellness (U.S. Department of Health and Human Services, 2017). A more recent study by Kandilov et al., (2018), compared SASH site-based and community participants to Medicare users living in non-SASH low-income housing, and also found that while participation does not directly decrease Medicare spending for individuals, it does significantly slow the increase in spending over time compared to individuals not participating in SASH in the Chittenden county area. The authors found that most of this reduction in this spending is surrounding acute care, emergency room visits, and hospitalizations.

An Assisted Living Residence (ALR) is defined as a facility or program that combines housing, health, and supportive services to support resident independence and aging in place. Ultimately, assisted living promotes resident independence and active participation in decision-making while emphasizing individuality, privacy, and dignity. Under VT state law, there are no specific regulations or restrictions on the level of care an ALR may provide. While an ALR may not admit an individual who has a serious, acute illness requiring the either skilled nursing care or specific medical equipment, they may retain a current resident who develops a terminal illness or who develops the need for complex care or equipment as long as the ALR can safely meet the resident's care needs and/or the resident's care needs are met by an appropriate licensed provider. At an ALR, there must be sufficient qualified personnel available at all times to provide necessary care, maintain a safe and healthy environment, and assure prompt, appropriate action in an emergency. ALR residents who have an identified acute or chronic medical problem are required to be under the continuing general supervision of a medical provider of their

IMPROVING COMMUNICATION BETWEEN COMMUNITY AND PRIMARY CARE

choosing, who need not be affiliated in any way with the ALR (Vermont Agency of Human

Services, 2020).

Continuity of Care

Continuity in care, especially around transitions in care, is very difficult to coordinate and can

be hindered further by poor communication. A patient may have multiple specialists managing

different facets of their care, which can be overwhelming and raises the potential for conflicting

recommendations. The Transitional Care Model (TCM) is an evidence-based theoretical model

first proposed by Dr Mary Naylor, which has been adapted in the US for many purposes.

Hirschman et al. (2015) describe the TCM as a nurse-led intervention targeting older adults at

risk for poor outcomes as they move across healthcare settings and between clinicians. It is based

on 9 core components: screening, staffing, maintaining relationships, engaging patients and

caregivers, assessing and managing risks, promoting self-management, collaborating, promoting

continuity, and fostering coordination. Use of this model has been associated with increased

patient satisfaction with care, decreased costs, and improved outcomes.

Naylor et al. (2018) discuss adaptation of the TCM in various local healthcare settings, and

found that while organizations who adopt this model tended to keep the core components the

same, they did have to make contextual modifications. The original architects of this model

understand that the process cannot always be feasibly implemented as originally written, though

they posit that the closer an adapted implementation aligns with the original layout, the more

likely the program will achieve the desired results. Specifically, this study on adaptation found

that the most frequent adaptations were using RNs instead of APNs for management, use of

telephone follow-up or visits from skilled home-health nurses instead of at home provider

follow-up, and using different clinicians on the same health care team instead of one designated clinician for the whole process.

Barry (2017) implemented a different form of care coordination, which involved one primary care office setting up a regular half-day clinic at a senior residence, inspired in part by the SASH program. In this situation, the care team, consisting of a nurse, a social worker, and physician, used the EHR utilized by their home clinic to run ED and hospitalization reports, review charts, and conduct their clinic. The authors ultimately concluded that there were encouraging findings from the initial trial but further research would be needed to evaluate cost savings and overall benefits, as well as to develop the ideal way to provide routine care and social services to seniors.

At the core of the TCM is clear and efficient communication, and collaboration between clinic providers and the caregivers who see the patient on a regular basis. While many of the specific logistical ideas in the TCM are intended for transitions in care, they can also be applied to managing long term care, where changes the patient's health or functional abilities may necessitate adaptation from the care team to support them.

Rationale

The SASH model has provided significant benefits to many older adults who wish to continue living on their own, particularly in a senior housing setting. Assisted living is an increasingly popular intermediary between skilled nursing facilities and independent housing for older adults, but without the supervision of an on-site provider, all medical decision-making and changes to services provided is managed through the PCP. However, communication of assessments and coordinating care with participants' primary care providers is complex. The two parties can be duplicating time-consuming assessments and providing care and referrals that are either

redundant or contradictory, causing confusion for patients. Additionally, providing care based on incomplete or inaccurate information, can be problematic and potentially dangerous. Assisted living and SASH staff often expect the primary care provider to manage health concerns, whether new or chronic, based only on the information the caller reports, hence it is very important the information provided be complete. Communication of incomplete information also frequently results in additional calls or faxes back and forth, which is time-consuming and frustrating for staff in both settings, and delays care for the patient. It is vital to develop clear, accurate and concise means of communication between care team members

Specific Aims

Purpose of the Project

1. Improve efficiency of care-related communication for patient and team.

2. Develop a system that prioritizes action-oriented communication and addresses current concerns and needs of both SASH/ALR and the primary care office.

Methodology

Context

This project was implemented at a small primary care office with approximately 2,500 patients in a small city in New England, with seven PCPs, one RN, two reception/intake, two patient support specialists, and one practice supervisor. The community care sites involved were two SASH sites in close proximity to the office, and two local assisted living residences.

Previously, nurses from SASH and ALRs sent faxes, emails, or telephoned the office and left messages with reception staff or on the answering machine, which were then relayed to PCPs. The triage RN and PCPs reported that messages are not always clear about the desired action or whether follow up from the PCP was necessary. Messages were often redundant, as any change

IMPROVING COMMUNICATION BETWEEN COMMUNITY AND PRIMARY CARE

in services provided must have PCP's written and signed approval. Additionally, any

communication with patients or family members must be separately relayed to staff if any

changes are to be made. Patients do not always relay information from PCP visits completely,

clearly, or at all to their community nurses. These gaps in communication hinder coordinated,

inter-professional interagency care.

Intervention

Stakeholders from the primary care office as well as the SASH and ALR locations were

interviewed to establish needs, barriers, and desired improvements in communication.

Additionally, a survey was given to the staff of the primary care office to further assess pre-

intervention perception of communication with community care staff. This information was

utilized to develop a one-page communication tool to facilitate communication (see Appendix

A). The tool was distributed to the four participating community sites, and a six week trial of the

tool was implemented. When each encounter was completed, the forms were scanned into the

patient's electronic chart, then collected in a secure location at the primary care office for review

and data collection. PDSA cycles were done at one week intervals throughout the

implementation with feedback from stakeholders in the primary care office, and improvements

were made to the process as indicated.

Measures

In an initial survey, office staff were asked about ease of communication, clarity of

communication, promptness of action, and follow-up on communication. Results of the pre-

intervention survey, which was given using a four point Likert scale, were 1 = strongly disagree,

2 = disagree, 3 = agree, and 4 = strongly agree. Results of pre-intervention discussion and survey

IMPROVING COMMUNICATION BETWEEN COMMUNITY AND PRIMARY CARE

were consolidated, discussed further with stakeholders, and utilized to develop the

communication tool.

The frequency of tool utilization were measured, as well as reason for communication,

requested action, and outcome of each interaction to assess for efficacy. Results of pre-

intervention discussion and four point Likert scale survey of care team satisfaction and post-

intervention interviews were compared to assess effectiveness and ease of use.

Ethical Considerations

The primary ethical concern in this project is patient privacy and HIPPA compliance. The

intervention will be developed so that data will be shared directly between SASH clinical offices

and primary care offices by confidential means to protect patient protected health information.

Additionally, while in theory information can be disclosed between care team members, explicit

consent is preferred by both organizations. SASH includes permission for them to share

information with a participant's PCP in their general guidelines, but there is currently no set

process in place to obtain written consent for the PCP office to share information with SASH.

There is also a question of information patients may not desire PCP to share with SASH, or that

would cause dilemmas for SASH, as they play a dual role of health care team members and

landlords and property managers. Some information that can be important to know for health

care reasons, such as cannabis use, can result in a conflict from the housing perspective. Patients

will be given opportunity to request specific information not be shared, or to opt out of their PCP

office communicating directly with their residential facility's care staff.

There is no conflict of interest known to the author at this time.

Results

IMPROVING COMMUNICATION BETWEEN COMMUNITY AND PRIMARY CARE

There were five respondents to the pre-intervention survey. On a 4 point likert scale, the staff, on average, rated ease of communication 2.4/4.0, clarity of communication 2.6/4.0, promptness of action 3.0/4.0, and follow-up on communication 2.2/4.0 (see Appendix B)

When asked for specific concerns about communication, one respondent commented, "it is not always clear WHO the patient's contact is." Another commented, "community health staff are good about communicating patients' needs; follow-up is the one area I believe needs improvement." A third noted that, "they call several times all related to the same issues". In pre-intervention discussions with reception and care staff, the main concerns brought up were regarding clarifying requested action from the provider, allowing for easier communication of data and assessments without going through non-clinical staff, who may unintentionally miscommunicate assessments or data, and streamlining the process for communicating new orders and other signed documentation.

During the 6-week initial implementation, the communication tool was utilized nine times (see Chart C1). Reasons for communication included new problems (n=4), management of a known chronic problem (n=2), and provider updates that did not require follow-up (n=3). Requested actions were to set up an appointment (n=2), review and change medication or other orders (n=3), and care coordination(n=1), while some noted that no action was needed (n=3). The care outcomes were scheduling an appointment (n=3), returning new orders (n=2), care coordination(n=2), or no provider review (n=2). In one case, the request was for a medication change, but instead necessitated coordination between the PCP, patient, physical therapy, and a specialist. In one other case, provider review was requested, and the PCP followed up with the patient directly at a scheduled appointment (see Figure C1).

General post-intervention feedback was positive, particularly from reception staff and the triage RN, who reported a significant reduction in back-and-forth communication, and that communications from SASH and ALR staff using the form for non-urgent issues was now arriving nearly exclusively by fax. Triage nursing also reported that the tool allowed for more assessment data to be sent with the initial communication, reducing the need for further calls for more details.

Discussion

Creation of the tool was done by modifying a standard SBAR communication format to better address the specific concerns and needs of this situation, as established during pre-intervention interviews. As this is meant for non-urgent concerns from established patients, the background section of the SBAR format has been removed. More emphasis was placed on requested action from the PCP, and on means of communicating a resulting plan, change, or new orders, as pre-intervention surveys and interviews indicated that these were areas that staff felt were problematic.

Feedback from stakeholders in the primary care office was that the tool was effective in reducing redundant phone calls and requests, especially regarding order changes. They also indicate that they will continue to use the tool for communication with residential care facilities, and may expand its use to other facilities, or adapt it for other purposes.

Limitations

This project was limited by use of the tool in the 6-week trial period, and to use in communications with two SASH sites and two assisted living residences. The project was done at a small primary care office, which limited the number of staff that could be surveyed and interviewed for their input. The intervention itself is limited in scope to assisting with non-urgent

communication between care team members for established mutual patients, and is relevant only

to the specific subset of patients who are living independently, but for whom it is easier, safer, or

more effective for the nurse at their residence to communicate with their primary care office for

them.

Conclusions

Implementation of this communication tool was successful in that primary care staff found the

tool to improve communication and would continue to use the tool for future communication

with SASH sites and assisted living residences. Overall, the tool was effective for non-urgent

communications, reduced the need for additional calls, and was especially ideal for concerns that

involve changing orders.

References

About SASH. (2023). Retrieved from https://sashvt.org/

Barry, T. T. (2017). Health care merged with senior housing: description and evaluation of a

successful program. *Gerontology and Geriatric Medicine*, *3*, https://doi-

org.ezproxy.uvm.edu/10.1177/2333721417713096

Hirschman, K. B., Shaid, E., McCauley, K., Pauly, M. V., & Naylor, M. D. (2015). Continuity of

Care: The Transitional Care Model. *Online Journal of Issues in Nursing*, *20*(3), 1.

https://doi-org.ezproxy.uvm.edu/10.3912/OJIN.Vol20No03Man01

Kandilov, A., Keyes, V., Van Hasselt, M., Sanders, A., Siegfried, N., Stone, R., ... Brophy, J.

(2018). The Impact of the Vermont Support and Services at Home Program on

Healthcare Expenditures. *Cityscape, 20*(2), 7-18. Retrieved April 23, 2020, from

www.jstor.org/stable/26472164

Vermont Agency of Human Services. (2020, January). *Comparing Nursing Homes, Assisted*

Living Residences, and Residential Care Homes in Vermont. Department of Disabilities,

Aging, and Independent Living. Retrieved from

https://dail.vermont.gov/sites/dail/files/documents/1-2-

20_Consumer_Guide_Comparing_NHs_ALRs_RCHs.pdf

Naylor, M. D., Hirschman, K. B., Toles, M. P., Jarrín, O. F., Shaid, E., & Pauly, M. V. (2018).

Adaptations of the evidence-based Transitional Care Model in the US. *Social Science &*

Medicine, *213*, 28-36.

U.S. Department of Health and Human Services Assistant Secretary for Planning and Evaluation

Office of Disability, Aging and Long-Term Care Policy. (2017). *Support and Services at*

IMPROVING COMMUNICATION BETWEEN COMMUNITY AND PRIMARY CARE

Home (SASH) Evaluation: Evaluation Of The First Four Years. Retrieved from

https://aspe.hhs.gov/system/files/pdf/257936/SASH4.pdf

IMPROVING COMMUNICATION BETWEEN COMMUNITY AND PRIMARY CARE

Appendix A

Appletree Bay Communication Tool

Patient name: Residence:

Date of Birth: PCP: _____

_____

Reason for Communication: Recipient notes:

    ○ New problem   ○ FYI

    ○ Management of chronic   ○ Other _____
       condition

Current problem:

Requested Action:

    ○ Advice or Education

    ○ Appointment   ○ Care coordination

    ○ Medication change   ○ Other

*Appointments required for new referrals (including PT), SSTA or other paperwork, and imaging

    ○ Contact patient for _____

    ○ Contact care team member

      • Contact _____ by phone / fax : _____
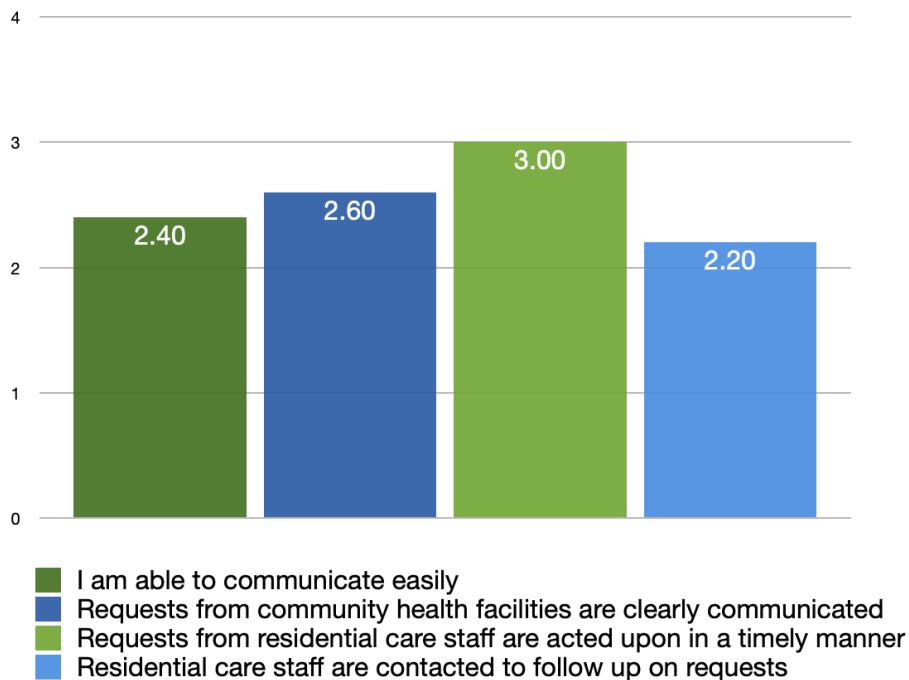
      • Good times to reach me:

Communication tool utilized for intervention

Appendix A. Form used for intervention

IMPROVING COMMUNICATION BETWEEN COMMUNITY AND PRIMARY CARE

Appendix B

Results of pre-intervention survey

Appendix B. Response to pre-intervention survey (*n*=5)

IMPROVING COMMUNICATION BETWEEN COMMUNITY AND PRIMARY CARE

Appendix C

Results of tool utilization

Uses of Communication Tool

Reason for Communication	Requested Action	Outcome	Notes
New Problem	Med Review/Change	Care Coordination	Sender did not complete response section and typed directly into form document. Form was first received in an email stating fax did not work, then came as a fax the next day
New Problem	Appointment	Patient attended appointment	Appointments were made, and faxes sent to request SASH assistance with facilitating patient attendance.
New Problem	Appointment	Patient attended appointments	Appointments were made, and faxes sent to request SASH assistance with facilitating patient attendance.
Management of chronic condition	Medication Change	New order sent	Medication change for increased pain, changing from PRN to scheduled. Order written on form and signed to be faxed back.
New Problem	Other	New order sent	Gave assessment of new wound, requested signed order for wound care be returned.
FYI	Care Coordination	Care coordination	Returned from hospital with discharge instructions to change meds. Requested PCP sign attached order if in agreement.
FYI	Provider review	FYI	Patient found sitting on ground, no injuries, VS WNL (recorded on form)
FYI	Provider review	FYI	Patient found sitting on ground, no injuries, VS WNL (recorded on form)
Management of chronic condition	Provider review	FYI, addressed with patient at appointment	Update on DM monitoring and SOB (both known issues)

Chart C1. Utilization of communication form during the 6-week trial
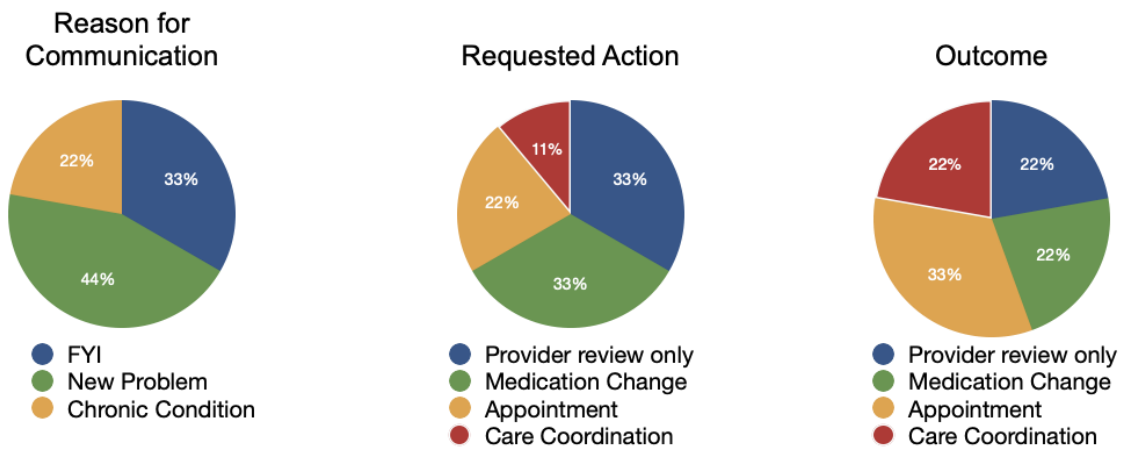
Figure C1. Use of form by reason for communication, requested action, and outcome (*n*=9)