SA16- The Emergency Department Joins the Interdisciplinary Team: Strategies to Improve Acute Care Transitions and Reduce ED Capture

Saturday, March 24
2:30 PM- 3:30 PM

Session Description

This session will explain how PA/LTC nurses, providers, and administrators can partner with receiving emergency departments (EDs) to improve the transitions between their sites, enhance resident safety in the ED, and reduce potentially avoidable hospitalizations.

Learning Objectives

- Design a program to enhance collaboration with the emergency department.
- Evaluate their site's PA/LTC to ED transition process and identify areas of improvement.
- Explain the unique challenges of treating PA/LTC residents in the emergency department.
- Discuss the Geriatric ED Guidelines as they relate to the PA/LTC to ED transition.

Presenter(s): Adam Perry, MD; Firas Saidi, MD, CMD

Presenter(s) Disclosures: All speakers have reported they have no relevant financial relationships to disclose.
The Emergency Department Joins the Interdisciplinary Team: Strategies to Improve Acute Care Transitions and Reduce ED Capture

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The Geriatric Emergency Department Collaborative
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We Are....

Learning Objectives

• By the end of the session, participants will be able to:
  • Evaluate their site’s PALTC to ED transition process and identify areas of improvement.
  • Explain the unique challenges of treating PALTC residents in the ED.
  • Discuss the Geriatric ED Guidelines as they relate to the PALTC to ED transition.
  • Design a program to enhance collaboration with the ED.

Welcome

• “From a system perspective, a safe transition from the hospital to the community or a nursing home requires care that centers on the patient and transcends organizational boundaries”


A Persistently Difficult Transition

• Transfer paperwork averages 24 pages.

• Stack contains 5 of 9 elements deemed important to ED care.

  • Hustey, F. “Care Transitions Between Nursing Homes and Emergency Departments: A Failure to Communicate.” ALTC. April 2010 (18) 4: 17-19.
A Case

- Nurse notifies me of sleepiness and lethargy. Stable vitals, no focal symptoms or signs.
- There was a questionable fall 2 days prior.
- He is on quetiapine, lorazepam and trazadone.
- Also on warfarin.
- I held the psychotropics, ordered labs and I went to see him the next afternoon…a Friday!

The case continues

- Fred is somnolent but answering simple questions.
- I reviewed the plan with daughter at bedside: further evaluation at the ED of Lankenau Medical Center.
- I spoke to the ED physician.
- I went home!
- Logged into EMR at 11pm, CT head negative, patient responsive…… DC back to facility?

What happened next?

- Mr. FC is admitted… diagnosis?
  - Subtherapeutic INR
  - He is on a heparin drip
- As the psychotropics wash out of his system, he starts kicking and pulling out IVs, and is discharged after 7 days on Enoxaparin

How do PALCT patients get tangled in ED?

- PALTC patients are referred to ED from
  - The nursing facility
  - A specialist’s office
  - Another facility e.g. dialysis
  - By family

Focusing on the facility- ED interface
PALTC side of Transition - What Matters?

• SNF utilization is one of the bigger expenses of the US health system
• Rehospitalizations
• Length of stay
• ED visits correlate highly with readmission
• Rates vary by providers and ED
• Timely & accurate eval of change in condition
• SBARs
• eINTERACT Change in Condition Evaluation

Variation in Readmission Rates by Emergency Department Providers Caring for Patients After Discharge
Siddhartha Singh, MD, MS,1,2,* Yu-Li Lin, MS,3 Ann B. Nattinger, MD, MPH,1,2 Yong-Fang Kuo, PhD,3 and James S. Goodwin, MD

What Happens When a PALTC Patient Arrives in the ED?

Baseball Cards

• Speed/Productivity
  • Many ED Docs
  • are ICs/1099 - #s matter

Multiple incentives

• (hospital, provider, patient, community)
• align to emphasize SPEED

Employed-v-Contractor

• may affect degree of
• involvement with QI processes

More Metrics – Admits, Imaging, and BounceBacks

• In Addition to Time Variables, EDs also track:
  • Admission Rate
  • ED returns ("Bouncebacks")
  • Imaging (CT and MRI) rate
SNF to ED transition

1. CNA to SNF RN
2. SNF RN to SNF Provider
3. SNF RN to EMS
4. EMS to Receiving ED RN
5. Receiving ED RN to Primary RN
6. Primary RN to ED Provider
7. Shift changing ED Nurse
8. Shift changing ED Provider

Two Ships in the Night

- ED Providers work 8-12 hour shifts.
- Multiple Providers (Docs, APPs) working in different areas.
- Nursing and Provider shifts overlap - patients often have multiple providers and nurses.
- Off hours - ED provider is going home in the morning when the PALTC provider is going to work.

How to Partner with the ED – Offer Speed

- Help them “move” your patient
- Efficiently communicate the information needed to quickly evaluate the change in condition.

How to Partner with the ED – Assist with Disposition

The ED provider, and patient, will benefit greatly appreciate your assistance with disposition.

- Pt information
- Family information
- Facility Capabilities

How to Partner with the ED – Risk Mitigation

- Share the Risk
- Timely follow up
- Patient safety
- Facility and Provider comfort with dispo.

Consulting an ED Provider - Talking Points

- Acute change and baseline.
- What’s been done at SNF/recent hospitalization.
- Why the patient needs the ED.
- How you (or partner) may be reached to discuss disposition and risk sharing.
- Do you anticipate admission or return?
### Metrics, Incentives and Things That Matter

<table>
<thead>
<tr>
<th>PA/LTC Records/ hand-off</th>
<th>ED Records/ hand-off</th>
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<tbody>
<tr>
<td>ED utilization rate</td>
<td>Admission rate</td>
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<tr>
<td>Readmissions</td>
<td>Bounce Back Rate- ED readmit</td>
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<tr>
<td>Risk mitigation</td>
<td>Risk mitigation</td>
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<td>ED consult vs admission</td>
<td>Assistance with disposition</td>
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<tr>
<td>Productivity- facility &amp; Providers</td>
<td>Provider Productivity (RVU)</td>
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<tr>
<td>Patient/Family Pressure</td>
<td>Patient/Family Pressure</td>
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<tr>
<td>Best practices</td>
<td>Core Measure -sepsis, trauma, CVA, AMI</td>
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### Market Pressures are Pushing us to Collaborate

- ACO-affiliated hospitals reduced rehospitalizations from SNFs
- VBP- starting in fiscal year 2019
- Bundle payment programs
- AND re-hospitalizations are now part of your facility QM

### Recent Developments in EM

- **Geriatric ED Guidelines**
  - 2013 – AGS, ENA, ACEP, SAEM

- **Geriatric ED Accreditation**
  - 2018 - ACEP

### Geriatric ED Guidelines

**Front Door**: ED as site of rapid diagnosis, initial treatment, and disposition.
- 68% of admits/obs are processed through the ED.
- Smaller EDs are managing over 80% admits. (EDBA 2015)
- Older adults represent 43% of hospital admissions, and 48% of ICU admits.

**Front Porch**: ED as site for diagnosis, initial treatment, and Care Coordination

- “A goal of the geriatric ED is to recognize those patients who will benefit from inpatient care, and to effectively implement outpatient care to those who do not require inpatient resources.”
Improving Transitions – It’s in the Guidelines

“The Geriatric ED will have protocols that facilitate the communication of clinically relevant information (with) patient/family and outpatient providers, including nursing homes.”

Emergency Nurses Association Topic Brief

- “Because readmissions can be related to gaps in the transition of care and/or education, there is the potential to team with the skilled nursing facility in tracking readmissions.”
- “Staff from skilled nursing facilities, emergency medical services, and the emergency department can work together to build or choose transitions of care tools that best provide the communications appropriate for their patients.”

“ENA Topic Brief: Collaborative Care of the Older Adult.” Dec. 2014

Take Home- Geriatric Emergency Care Guidelines

“The Geriatric ED will maintain relationships and resources in the community…to facilitate care.”

Including relationships with CCRCs, AL, SNFs, home health,…

AMDA Policy: Improving Care Transitions

- The ED Consult- “Whenever there may be ambiguity as to the reason for the transfer, it is a good practice for the sending clinician to place a call to the ED to clarify specific concerns and goals.”
- “Improving transitions between the SNF/NF and ACH (ED) may be facilitated by the development of partnerships between the ACHs and the SNFs/NFs in a community.”

Coming Soon – Geriatric ED Accreditation

“RESERVED FOR SENIORS
An ER with Seniors in Mind
1st Place General
St. Petersburg General Hospital”

ACDP Accredits Geriatric Emergency Care for Emergency Departments

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<th>CARE</th>
<th>POLICY</th>
<th>GOALS</th>
<th>MEASURES</th>
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<td>1</td>
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Keywords: geriatric, emergency, care, accreditation, ED, seniors, consultation, communication, continuity.
Designing a QI Approach to ED Transition

Design program around incentives shared between your PALTC site and receiving EDs.

ED Readily Incorporates New Processes

- ED employs a growing number of “trigger and bundle” protocols.
- Sepsis, CVA, STEMI, Trauma
- ED providers expect to incorporate new protocols, and receive feedback on compliance.

For Example….What Works Where?

- HIT-based transition Pilot Project.
- HIT shared between 5 LTCs and single receiving ED,
- Industry EMR support.
- Decreased readmission and return ED visits.


Winchester Hospital SNF-ED Transition Model

- ACO with 8 “preferred” Post acute SNFs
- Supportive Admin, private ED group.
- Dedicated “Warm Handoff” SNF provider phone line.
- SNF provider must call dedicated line.
- ED doc must answer and assume responsibility for incoming SNF patient, including sign out to another provider, as for any patient already in ED.

INTERACT

- Certain EHRs use the eINTERACT Transfer Form
- Autopopulate fields
- Printed or electronically transferred via Direct Messaging

INTERACT Transfer Form
Main Line Health SNF-ED consultation form

Designing a Program - One Size Does Not Fit All

- Focus on a simple program that offers:
  - Speed
  - Disposition Assistance
  - Risk Sharing
- And works for the PALTC and ED Day and Night

Collaborate with the Hospital and ED to build TransDisciplinary Team

- PALTC and ED:
  - Administration
  - Medical Directors, Attendings, APPs
  - Nursing Managers and Nurses
  - CNAs
  - CM/SW
  - EMS - Medical Director (often based at ED) and Paramedics

What’s In It for Me? Focus on Shared Incentives

- Improved transitions help the ED “move” PALTC patients.
- Assistance with Disposition.
- Risk Sharing.
- ACO/APM.
- Re/Admit Rate.
- Hospital (and SNF) Readmit penalties.
- Guideline-driven Care.
- Geriatric ED Accreditation.

Redundancy – EMS as the “missing link”

- EMS participates in most SNF-ED and hospital-hospital transfers.
- Focus groups w/ EMS suggest SNF-ED transfer should be structured like hospital-hospital transfers, to include:
  - Standardized, 2-way transfer form- from SNF-ED and ED-SNF
  - Checklist completed by EMS with sending facility/ED/SNF

- “Strongly recommend verbal communication across care settings to complement written communication and to improve deficiencies that occur with transfer form-only strategies.”


In Support of Warm Handoffs

- “Rather than mandated on-site examinations…(m)ight a ‘bigger bang for the buck’ be had by requiring improved communication between hospitals and NHs?”

- “Such an approach recognizes that NHs do not operate in isolation and are significantly dependent on the adequacy of the information provided by their acute care hospital partners.”

- “Likewise, ED staff who have to make rapid decisions about the need for admission must have adequate clinical data in a usable format to make these decisions.”

Take Home

- The PALTC-ED transition involves multiple information transfer steps.

- The Time Is Now: Recent payment, guideline, and accreditation innovations enhance opportunity for collaboration between PALTC and the ED.

- One Size Does Not Fit All: Designing a durable transition QI process involves multidisciplinary interfacility collaboration and consideration of shared incentives and capabilities.