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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Speaker Disclosures

Dr. Perry has no financial relationship(s).

Dr. Saiedi has no financial relationship(s).

Note: Disclosure must never include the use of a corporate logo, trade name or a product-group name of an ACCME-defined commercial interest.

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”

  Jenks, et al. NEJM, April 2009... from “Transitions of Care in the Long Term Care Continuum: AMDA Practice Guideline 2010.”

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 A Failure to Communicate” ALTC. Acute Care and Emergency Departments. 2010 (18) 4: 17-19.

A Case....

• 83 y/o male with:

  • vascular dementia with behavioral issues
  • PAD a/p R AKA
  • DM
  • HTN
  • MVR
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 his meds and I went to see him the next afternoon... a Friday!

The case continues
- Mr. FC is very lethargic and barely answering.
- 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

Where does the ED fit in transitions of care?
- PALTC patients access 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
- 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 evaluation of change in condition
  - SBARs
  - eINTERACT Change in Condition Evaluation
PALTC side of Transition

- Readmission rates in the United States have been 19.6% of Medicare beneficiaries were re-admitted to the hospital within 30 days of discharge, and 34.6% were readmitted within 90 days (1).
- Among Medicare beneficiaries discharged to a PAC facility in 2006, nearly 25% of patients were readmitted within 30 days at a cost of $4.34 billion (2).
- Readmission risk prediction tools
- Care bundles: CHF COPD etc.


What Happens When a PALTC Patient Arrives in the ED?

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

Ships Passing......at 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.
Diagnosis/Disposition and Risk Management

- ED patients over 65 have, on average, 20% greater LOS.
- A nursing home resident has a 60% chance of being transferred to an emergency department in a 1-year period.
- People 65 years and older have a 40.8% admission or transfer rate to a hospital from the emergency department.

Baseball Cards

- Speed/Productivity
- Many ED Docs are ICS/1000 - its matter
  - Actual
    - Act (95th perc)
    - Act (90th perc)
  - Multiple Incentives
    - (hospital, provider, patient, community)
    - align to emphasize SPEED
  - Hospital Employment-Contractor
    - may affect degree of involvement with QI processes

Metrics, incentives and things that matter

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<th>Description</th>
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<tr>
<td>PTEC</td>
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<td>Time to seen, decision, dispo</td>
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<td>Imaging Rate</td>
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<td>Core Measure Compliance- sepsis, trauma, CVA, AMI</td>
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<tr>
<td>Fall evaluation rate</td>
<td>Consultant/PCP communication</td>
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Market pressures are pushing us to collaborate

- ACO-affiliated hospitals reduced rehospitalizations from SNFs
- VBID - starting in fiscal year 2018
- Bundled 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
Guidelines Transform ED from “Front Door” to “Front Porch” of Hospital

**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%. (EEDA 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.”

Guideline Development Process

- 2011/12- Interdisciplinary group from ENA, SAEM, ACEP Geriatric Section, and AGS conducted teleconferences.
- 14 Coauthors divided into two working groups; clinical/operational and structural/staffing.
- Two working groups reviewed literature and provided best-evidence recommendations for geriatric emergency care.
- Oct, 2013 – Feb, 2104 – Guidelines approved by Boards of Directors of SAEM, ACEP, AGS, and ENA

Geriatric ED Guidelines

Key Content:
- Structure
- Process of care
  - Care coordination
  - Medication reconciliation
  - Screening
- Education
  - GENE
  - HPOG
- Community Connection

Geriatric Emergency Care Guidelines

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

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 SNF/NFs in a community."

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


"AMDA Policy Resolution H 10 "Improving Care Transitions Between The Nursing Facility And The Acute-Care Hospital Settings." March 2010."
Designing a QI approach to ED Transition

- Frame ED transfer at a Consult
- Design program around incentives shared between your PALTC site and receiving EDs.

What Works?

- 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
One Size Does Not Fit All

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 on deficiencies that occur with transfer form-only strategies."

Collaborate with the ED to build ID Team
- PALTC and ED:
  - Admin
  - Medical Directors, Attendings, APPs
  - Nursing Managers and Nurses
  - CNA
  - CM/SW
  - EMS - Medical Director (often based at ED) and Paramedics

Focus on Shared Challenges/Incentives
- ACO/APM
- Hospital (and SNF) Readmit penalties
- Re/Admit Rate
- Length of Stay/Productivity
- ED returns
- GED Guidelines and Accreditation

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 NEDs?"
- "Such an approach recognizes that NEDs 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.

- 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 interdisciplinary interfacility collaboration and consideration of shared incentives and capabilities.