Emergency Department Transitions with Nursing Homes:
Improving and standardizing communication

Change AGEnts Initiative

The John A. Hartford Foundation's Change AGEnts Initiative was a three-year effort dedicated to improving the health of older Americans, their families, and their communities through practice change. Managed by The Gerontological Society of America, the initiative harnessed the collective strengths, resources, and expertise of the foundation's interprofessional community of scholars, clinicians, and health system leaders.

The 34 projects funded through the Action Awards grants program showcased the improvements that interprofessional teams can bring to light by implementing evidence-based programs into targeted care settings in local environments.

A recent article on transfers to the emergency department (ED) by Hwang et al. in Health Affairs (2013;32:2116–2121) resonated only too well with staff at MaineHealth Elder Care Services in Portland: "Nursing home patients are a particularly challenging population because essential information is often lacking," it reported.

Sharon Foerster, LCSW, MSW, program manager for Elder Care Services at MaineHealth, was hearing the frustration in messages from staff throughout the Portland-based system of hospitals and nursing facilities. Despite sometimes voluminous documents sent by the facilities with each resident, ED staff reported often being unsure of the reason for the transfer. Facility staff expressed concerns that—despite using standard-of-care procedures—things were going wrong too often. Staff members reported the information they sent was not used, that they were not called by the ED nurse for clarification, or that the patient might return having undergone testing or interventions that did not address the original reason for transfer. All parts of the care continuum wanted to go beyond the standard of care by ensuring better and safer care of MaineHealth nursing home residents who were being transferred and resolving system communication issues at the time of ED transfer.

Today the situation is much improved. A standardized, streamlined set of information goes with residents so that ED staff members have the information they need the most about the patient, including a clear description of the reason for transfer. ED staff members can quickly and easily find the reason the facility sent the patient to the ED. The average length of stay in the ED has been reduced, facility staff members have the information they need from the test or procedure, and the resident is returned more quickly to the familiar nursing home surroundings.

What changed? Foerster worked with a cross-continuum team, including nursing facility, ED, and emergency medical service (EMS) personnel, to build a new process that improves and streamlines written and oral communication. Once the new process was piloted and found successful, MaineHealth decided to make it a standard process with other health system EDs. Foerster used a John A. Hartford Foundation Change AGEnts Initiative Action Award to support her role as a facilitator and Change AGEnt to disseminate the new process to other hospital EDs. The results have been remarkable.

Managed by The Gerontological Society of America, the John A. Hartford Foundation Change AGEnts Initiative accelerated sustained practice change to improve the health of older Americans, their families, and communities. It did so by harnessing the collective strengths, resources, and expertise of the John A. Hartford Foundation's interprofessional community of scholars, clinicians, and health system leaders to learn from and support one another while they adopted, evaluated, and sustained changes in practice and service delivery. The Change AGEnts Action Awards grants program was designed to support Change AGEnts in implementing promising ideas in practice change.

The Status Quo

Sending nursing home residents to the ED was one of the great frustrations of nursing staff, said Gail Hauser, RN, corporate clinical director for Continuum Health Services. A lot of effort went into the transfer—making telephone calls to ED staff, compiling copious notes for the EMS personnel to give to the ED, notifying family members, and talking with residents (many of them with dementia) about what would happen and why the transfer was necessary.

Once the resident was at the ED and the reason for the transfer was not obvious, staff often couldn't get a person with information specifically relevant to the patient's need on the phone at the nursing facility. The copious notes were usually but not always delivered by the EMS staff (they sometimes kept some of the patient's information for their own records). The notes were so detailed that busy ED staff frequently couldn't quickly spot the reason for the transfer. When they asked the patient, she might say, "My foot hurts," when in fact the facility staff had sent her for a neck scan or another diagnostic procedure that couldn't be performed at their facility. Following the patient's incorrect cue, ED staff might take an X-ray film of the foot or perform a head-to-toe examination to ensure they did not miss an issue. A urinalysis was standard practice, and this often resulted in prescribing unnecessary antibiotics.

The paperwork that came back with the nursing home resident contained sometimes nothing more than the standard preventive medicine admonitions—"Don't smoke and wear your seatbelt"—of the type that every ED patient receives. In short, the cross-continuum communication was ineffective and inefficient. The MaineHealth system, which supports quality improvement, recognized the problem, and a team from across the continuum of care began seeking solutions.

The Remedy

Working within an accountable care organization (ACO) environment, staff understood the importance of ensuring seamless transitions and individualized patient care. The first step was to convene a meeting with staff from long-term care, emergency medical services, and ED. The

group reviewed tools from the INTERACT program, or Interventions to Reduce Acute Care Transfers, a quality improvements program for improving communication within health systems and for reducing unnecessary transfers.

"Sitting around that table, something happened," Foerster said. "We were just discussing the current process, but doing so in an open, transparent, honest, humorous, and understanding way. We began to better understand," she said. "Right before our eyes, we began to see the integration of the health care system."

After such "Aha!" moments, the group participated in a flow, or process, mapping exercise that detailed what everyone in the room did during the current transfer process. The patient traveled along the ACO continuum of care, they realized. Though staff members do not know one another, it is essential to work in concert because they are essentially the patient's cross-continuum team during transfer.

For the team to work together, understanding the other parts of the system/continuum was crucial. Each team explained its role. The nursing facility staff members were able to explain the limits on the services and procedures that could be provided in the various types of long-term care settings in their facilities. EMS staff talked about the urgent care and assessment provided during transport and the need to make sure the patient is stabilized before transport in nonemergent situations. EMS team members are not transportation alone. Finally, ED staff talked about the vital pieces of information needed for intake and patient-centered care.

The team designed a one-page resident transfer form listing the most vital pieces of information. Details needed by ED staff included baseline mental status, the direct telephone number of a nursing home staff member who could answer further questions, the name and number of the patient's family or responsible party, and the name of the referring provider. The ED staff needed to know the reason the person was being transferred. To meet this need, the group chose to use a one-page SBAR (Situation, Background, Assessment, and Request/Recommendation) form.

Under the procedure developed by the group, these documents and other necessary information are placed in a packet. A checklist of contents is attached, based on INTERACT principles, to the front of the packet to serve as a reminder to the nursing facility staff.

Two copies of the packet are sent with each resident—one for EMS personnel and one for ED staff. With the information organized and easily accessible, everyone in the continuum of care can reliably and easily find the information needed. It was acknowledged that, ideally, all information could be electronic, but not all facilities have an electronic health record system or share one with the hospital. This new process, though not electronic, works in a practical manner.

How the Change AGEnts Action Award improved outcomes

The Change AGEnts Action Award supported Foerster in expanding the scope of the transfer project to more facilities and hospital EDs in the MaineHealth system. During the dissemination process, the issue of sustainability was of utmost importance. Wanting to ensure that sustaining

the process was top of the cross-continuum team's minds as well, the Action Award also supported a one-day workshop to teach nursing home staff and others about Kotter's eight stages of change. Rob Schreiber, MD, a Change AGEnts mentor, gave the keynote at the workshop and shared his extensive Change AGEnt expertise in the Kotter model. An eight-minute video was also created as a result of the award to support the scale-up of the procedure throughout the MaineHealth system.

The result of this project has been better, safer care for residents and less frustration for nursing facility staff when ED transfers are needed. While a change in process is never easy, most staff quickly understood the overall benefits and realized they would actually be compiling less paperwork for each resident transfer.

In the one-year span of the award with three hospitals, 35 nursing home residents, on average, have been transferred to these MaineHealth EDs each month. Assuming a total of approximately 400 patients transferred in a 12-month period, an estimated 120 ED staff, 80 EMS personnel, and 175 health professionals at long-term care facilities have benefited from the new system—775 patients and health professionals overall.

"The group noticed a problem and wanted to fix it," Foerster said. Within the ACO environment, different parts of the system were able to work together for overall better, safer patient care. "As a result of better communication among members of a dedicated team of professionals and enhanced support made possible through this Action Award, we are making changes that really are improving our health system," said Foerster.