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Short-Stay Nursing Home Rehabilitation Patients: Transitional Care Problems Pose Research Challenges

Charlene C. Quinn, RN, PhD[1], **Cynthia L. Port, PhD**[1], **Sheryl Zimmerman, PhD**[2], **Ann L. Gruber-Baldini, PhD**[1], **Judith D. Kasper, PhD**[3], **Irene Fleshner, RN, MHSA**[4], **Barbara Yody, MPA**[4], **John Loome, MD**[4], and **Jay Magaziner, PhD, MSHyg**[1]

[1]*Division of Gerontology, Department of Epidemiology and Preventive Medicine, School of Medicine, University of Maryland, Baltimore, Maryland* [2]*Cecil G. Sheps Center for Health Services Research and School of Social Work, The University of North Carolina at Chapel Hill, Chapel Hill, North Carolina* [3]*Department of Health Policy and Management, The Johns Hopkins University Bloomberg School of Public Health, Baltimore, Maryland* [4]*Genesis HealthCare, Kennett Square, Pennsylvania*

Abstract

We conducted a NIH-funded clinical intervention pilot study to improve depression care for short-stay nursing home Medicare-reimbursed rehabilitation patients. Despite a solid theoretical and clinical grounding and the support of a large nursing home company, we encountered several roadblocks to implementation, including 1) involving patients and families, 2) communication between providers, 3) involving community primary care physicians (PCP), 4) staff time constraints, and 5) conducting research with short-stay patients. While frustrating from a research standpoint, these roadblocks closely reflect problems identified by the American Geriatrics Society (AGS) as impeding the delivery of high quality transitional care in geriatrics. We describe these research roadblocks as we encountered them in the clinical setting and place each within the larger context of challenges associated with care transitions, especially for older persons with complex health needs receiving nursing home rehabilitation. Finally, we offer recommendations for researchers conducting much needed research within geriatric transitional care settings, including starting early in the care transition chain and assisting patients and families to provide continuity across care settings.

Keywords

Care transition; Nursing Home; Rehabilitation; Research

INTRODUCTION

Close to 1.5 million elderly receive rehabilitation in nursing homes (NHs) yearly, and the use of NHs for rehabilitation is increasing.[1] For these patients, successful rehabilitation often means the difference between remaining in the NH and discharge home. Given the negative impact of untreated depressive symptoms on rehabilitation outcomes, we evaluated a 90-day depression screening intervention to apply successful depression care management models (see Gilbody et al., 2003 review)[2] to persons receiving NH rehabilitation. At the end of data

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Corresponding Author: Charlene C. Quinn, RN, PhD Assistant Professor Division of Gerontology Department of Epidemiology and Preventive Medicine School of Medicine 660 W. Redwood Street Baltimore, MD 21201 410.706.2406 410.706.4433 cquinn@epi.umaryland.edu. Alternate Corresponding Author: Cynthia L. Port, PhD cport@epi.umaryland.edu.

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collection, data were limited and enrollees had not completed the intervention as envisioned. After careful review, we identified five roadblocks that impeded our ability to conduct the intervention, namely 1) involving patients and families in care management, 2) communicating with care providers at the next care site, 3) involving PCPs, 4) staff time constraints, and 5) enrollment of short-stay patients. While these issues were frustrating from a research standpoint, each also is symptomatic of difficulties in transitional care. Indeed, problems endemic to geriatric transitional care represented the major impediment to our research. Neither a highly experienced group of researchers, our clinical counterparts, or our reviewers anticipated how current transitional care practices would negatively impact our study. This suggested that there might be insufficient awareness of the extent of transitional care problems and their effect on patient care and research.

THE NURSING HOME CO-MORBID DEPRESSION CARE MANAGEMENT INTERVENTION

The goals of the intervention were to improve communication, assessment and planning in the NH related to depression care, and bridge the transition to the next care site by involving family and the patient's primary care physician (PCP) in care decisions. We enrolled Medicare rehabilitation patients and a family member upon admission. The research team provided a masters-level care manager who conducted initial and repeat patient evaluations for 90 days (days 5, 14, 30, 60 and 90). Results were communicated by the care manager to a care team consisting of facility staff (medical director, attending physician, director of nursing, social worker and others), the resident (when able), family, and the community PCP to whom care would transfer upon discharge. If discharge occurred prior to 90 days, the care manager would continue repeat evaluations and provided feedback to the patient, family member and PCP. The study was conducted within several facilities of a large NH company with which we had a strong collaborative relationship. Frontline staff and senior clinical management were part of an expert panel to finalize the study design, and the latter participated in bimonthly research meetings.

TRANSITIONAL CARE IN GERIATRIC SETTINGS

The American Geriatrics Society defines transitional care as a set of actions designed to ensure coordination and continuity of healthcare as patients transfer between different locations or different care levels within the same location.[3] Locations can include hospitals, subacute/postacute facilities, patients' homes, primary and specialty care offices, and long-term care (LTC) facilities.[3] Quantitative studies show that during transitions, patients are at risk for delay in follow-up, inappropriate or conflicting care recommendations, medication errors, and patient/caregiver distress.[4-7] Qualitative studies document that patients are not sufficiently involved in care planning and lack the tools to manage their care as they move between settings.[8-9] Collectively, these issues lead to higher readmission rates (ranging from 15-25% among older Medicare recipients) and health care utilization.[7,10, 11] A population-based study found that 22% of elderly persons discharged from the hospital have a subsequent adverse health event, such as an emergency room visit or hospital readmission within 30 days.[12]

Patients receiving NH rehabilitation epitomize the need for good transitional care due to their complex health status, multiple transitions, short stays, and goal of returning to the community. Hospital stays have shortened, resulting in medically fragile acute care discharges, many to NHs. For example, between 1993-2003, the mean hip fracture hospital length of stay fell approximately 35%.[13] The average NH stay per Medicare admission is 25.9 days, and 83.6% are discharged prior to day 40.[14] With such little time to acclimate to a facility and prepare for the next setting, these patients are receiving transitional care from the moment of hospital admission, and not merely in the days immediately preceding NH discharge.

The American Geriatrics Society Health Care Systems Committee (AGSHCSC) recently offered five position statements, each describing an important goal for improving geriatric transitional care.[3] They recommend (1) actively involving patients and caregivers in decisions and preparing them for care in the next setting, (2) insuring good bidirectional communication between sending and receiving clinicians , (3) developing policies that promote high quality transitional care, including reimbursement rule changes, (4) providing education to all professionals involved in patient transfer, and (5) conducting research to improve transitional care processes, focusing on patient/family involvement and training healthcare professionals. In this paper we discuss the five research roadblocks encountered in our study of new NH Medicare rehabilitation admissions, placing each within the larger context of transitional care and the AGSHCSC recommendations.[3]

RESEARCH ROADBLOCKS AND THE AGS TRANSITIONAL CARE RECOMMENDATIONS

Research Roadblocks Related to Involving Patients and Families in Decisions and Preparing Them for Transitions

Arguably the most important component of good transitional care is family involvement. Families may be the only source of continuity throughout a patient's care transitions,[3,6] and family involvement in NH care is related to care quality.[15] In clear recognition of the importance of families, the first AGSHCSC position statement on transitional care asserts that facilities must actively involve patients and families in decisions and help them prepare for care in the next setting.

Involving families was an integral component of our patient-focused care management intervention strategy. We sought to enroll a resident and a family member in pairs and maintain contact with family through mailings and family/staff meeting(s). Due to NH staff time constraints, we were unable to convene a new family/staff meeting dedicated to depression care. While an admissions meeting took place early in the patient's stay, it included a large number of staff and covered several patients, precluding convenient family scheduling or sufficient time for family involvement. A second possible opportunity was the care plan conference mandated to occur no later than day 21 and intended for further patient evaluation and to educate patients and families about current and future treatment needs. Using the care plan conference as a venue for promoting family involvement in care was recommended by the study NHs, and has been highlighted by NH consumer groups as an important way for families to affect care.[16] Of the residents we enrolled, however, only half had a care plan conference. For the remainder, no meeting occurred prior to discharge due to cancellations, early discharge, death or unknown reasons. Since the average NH stay per Medicare admission is 25.9 days[14] and care plan conferences are mandated to occur by day 21, the completion rate we observed is not surprising. Thus, an all too common casualty of short stays appears to be the care plan conference, and along with it a prime opportunity to involve and educate families.

Research Roadblocks Related to Communication Between Clinical Professionals

The second AGSHCSC position statement advocates for strong bidirectional communication between the ‘sending’ and ‘receiving’ ends of transitions. In particular, the AGSHCSC emphasizes uniformity and accessibility of information, electronic or other systems of communication, and opportunities to involve a ‘coordinating’ health professional with high level skills such as an advanced practice nurse (APN).

The discharge summary is the primary means through which NHs communicate with the next site of care. Since most short-stay residents are discharged home, the discharge summary is intended primarily for the patient's PCP and home care providers. While little or no research has specifically examined NH discharge summaries, studies of hospital summaries indicate such forms often omit critical care issues, including pending test results, follow-up tests needed, and specialist referrals.[17] Our study did not evaluate NH discharge summaries, but we noted the absence of information relating to the residents' mental health (other than cognition), such as depression and anxiety, both of which are common within this population[18] and critical to rehabilitation outcomes.[19]

Furthermore, the only means employed by the NHs for transmitting the discharge summary to the PCP was giving it to the resident or family with instructions to share it with the PCP. A meta-study of hospital discharge summaries found that this method increased the average speed at which doctors received the information.[20] This method may be less effective for frail or cognitively compromised patients, who may have difficulty getting to PCP appointments or bringing their summary with them. Overall rates of hospital discharge summary availability at post-discharge physician visits are only 12-34%, and we see no reason to expect higher rates from NH discharges.[7, 20] Heightening our concern was the fact that a fifth of our study enrollees indicated having no PCP and another fifth provided an unusable name (e.g., not found in any directory or license was expired).

Research Roadblocks Related to the Need for Policies to Promote High-Quality Transitional Care

The third AGSHCSC position statement asserts that care providers need to be involved in and accountable for the success of a patient's transition. Unfortunately, a survey of over 20,000 community-based physicians found that 77% spent no measurable time caring for NH patients, and those with a NH practice spent less than two hours a week with NH patients.[21] Payment policies undergird the problem in that PCP NH visits are reimbursable only if consulting on a specific medical issue, and not for purposes of promoting transitional care. Physicians therefore lack the accountability and incentives for greater involvement in the transitional care of patients receiving NH rehabilitation.

Our intervention sought to increase PCP awareness of patients' depression symptoms and treatment during the NH stay in order to improve continuity of depression care upon discharge. We planned to include the PCP in baseline patient assessment and care conferences, and maintain involvement through repeated patient updates mailed or faxed over the 90-day intervention. While we had low expectations of PCP attendance at care conferences, neither our research group (which included NH administrators) nor the NIH reviewers who favorably reviewed our pilot project voiced major concerns over the feasibility of the PCP component of the study. Nevertheless, we were not able to make connections with outside physicians for various reasons: no usable name from the medical record or patient, the patient was readmitted to the hospital or died, or we received minimal or no response to multiple attempts to contact PCPs via phone, fax, and mail.

Research Roadblocks Related to Educating Professionals Involved in Transferring Patients Across Settings

The AGSHCSC's fourth position is to provide education to all professionals involved in transferring patients across settings. From our research standpoint, NH staff time constraints presented a major roadblock to success in this area. Even with high-level administrative support and a focus on minimizing NH staff time use, we adjusted our protocols several times to make them feasible within the tight time constraints under which staff worked. The future trial for which we were conducting this pilot would have included staff education via the creation of a staff-based care manager who would educate families and staff about the depression care needs of identified patients. For real world settings, providing transition care coordination for short-stay patients would require additional staff resources that are unlikely without funding targeted to this purpose.

Research Roadblocks Related to Conducting Research to Improve the Process of Transitional Care, with a Focus on Patient and Family Involvement and the Training of Healthcare Professionals

The AGSCHCSC recognizes that research is vital to improving transitional care outcomes. For NH rehabilitation patients, better transitional care translates to higher patient quality of life and reduced costs through lower rates of long-stay conversion and hospital or NH readmissions. Given high clinical needs, frequent moves, and short stays, this patient population may represent a prime research target for improving transitional care systems generally. However, basic issues of enrollment and data collection present challenges for researchers in this setting. Procedures for identifying eligible short-stay patients were problematic. ICD-9 codes were not a viable source of admission diagnoses, and admission and discharge forms tended to describe symptoms rather than diagnoses as a reason for admission (e.g., “weakness” was indicated rather than ‘complications following hip fracture’). We therefore had to broaden our potential patient population and conduct time-consuming chart reviews to obtain basic eligibility criteria. With regard to enrollment, despite a research team with a longstanding successful track record of recruitment in LTC, short-stay NH Medicare patients were challenging to recruit due to their frail and fluctuating health status, pain levels, and therapy schedules. Our enrollees stayed an average of 21 days and recruitment took an average of 8 days. This left under two weeks to conduct baseline evaluations and interviews, compile feedback, and complete a care plan conference. Similar logistical issues within this population have been described previously.[22] These difficulties likely help to explain the lack of research directed specifically toward short-stay NH residents.

CONCLUSIONS

Our research team has experience in a wide range of LTC settings and patient groups, and anticipated many if not all of the roadblocks we encountered. We also worked closely in the planning and execution of the study with our clinical colleagues to insure that it would be feasible within a ‘real world’ setting. Nevertheless, we were unsuccessful in our attempt to apply depression care management models to persons receiving NH rehabilitation. Recruiting earlier in the care transition chain (i.e., hospital or physician's office), might have afforded more time for baseline data collection and for the intervention to affect outcomes, including outcomes across multiple settings. Networking with PCP offices to identify patients as they were admitted to the hospital might also have yielded greater PCP participation, something we were unable to achieve post admission. In an effort to make our intervention more affordable and therefore more translatable to real world settings, RN-level skills were not required to fulfill the duties of the depression care manager. However, the lack of a nurse in this position might have limited the development of relationships with family and healthcare professionals. Controlled studies show that transitional care improves when there is an identified individual, such as an APN, managing the transition who is skilled in the complex care needs of the elderly.[23, 24]

While these approaches might have improved our results, the main difficulty we faced was the poor quality of transitional care that is provided to these patients before and after NH stays. The US medical care system is described as having ‘silos’ or ‘islands’ of care in which patients work with unique teams of health professionals at each setting who know little about the patient's prior or subsequent care, and where there is no clearly responsible party for insuring that good transitions occur.[20, 25] Ironically, the rapidly growing short-stay rehabilitation NH cohort may be both the least prepared to utilize such a disjointed system and also the most vulnerable in terms of the sheer number of transitions they experience and the speed with which they move through the system. In recent years the demise of the family physician has necessitated that patients and their families take a greater role in care management. While this may be less problematic for younger and healthier patients, it is undoubtedly more difficult for older adults with complex health care needs to navigate the complex world of the US health care system with its multiplicity of insurers and plans, independent care providers, and unreliable information transfer systems, all the while monitoring their own medication regimens, specialist treatment options, and future care alternatives. If the trends toward hospitalist models of care and ever-shorter stays for these and other patients continue, there must be an equally strong commitment to improving transitional care.

RECOMMENDATIONS FOR FURTHER RESEARCH

For researchers interested in NH rehabilitation or other transitional care settings, the exigency of the current transitional care system must weigh heavily in hypothesis development and study design. As such, we see two potentially fruitful avenues of investigation: system-based and family-based descriptive studies and interventions. These, along with the AGS position statements and our research roadblocks, are presented in Table 1. First, research can focus on the transitional care system itself by examining existing systems and testing new approaches. An evaluation of communication pathways is clearly needed, including the content and quality of discharge summaries and their availability and utility for downstream care providers.[26] Electronic medical record sharing systems could also be explored, including ‘smart cards’ that carry vital medical information and can be updated at each point of care.[20,25] Models should also be evaluated that promote the importance of transitional care by a) making critical components of that care (e.g., patient care coordination) reimbursable Medicare benefits, b) providing a transition care manager to eligible patients and c) instituting standardized transitional care performance indicators. In all of these efforts, demonstrating cost effectiveness, and not just better patient care outcomes, will be key to large-scale adoption.

The second research avenue we see is improving transitional care within the existing system by focusing on the primary source of continuity available to patients – themselves and their family members. A family-focused intervention approach strives to give patients and families the skills and tools needed to manage the patient's care transitions themselves, including training in effective communication with interdisciplinary providers and maintaining a personal patient medical record.[6,23] A family-focused intervention also minimizes many of the roadblocks resulting from our care manager model, such as tight facility schedules and unresponsive PCPs. We recognize that most family caregivers in LTC are working and many have additional dependents, yet families are willing to be involved in the care of elderly family members in LTC.[27-29] In our study, family participated in the large majority of care plan conferences that did take place. Nevertheless, not all patients have available or able family, and short-stay NH patients may have less family involvement than those receiving home-based rehabilitation.[30] For patients who lack family and are unable to manage their own care transitions, there is no ready solution short of a more responsive health care system.

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Table 1

Recommendations for Research to Improve Transitional Care for Nursing HomeRehabilitation Patients

AGSHCSC Position Statement on Transitional Care[3]	Research Roadblock in the NH Rehabilitation Setting	Recommendations for Health Care System-Based Research	Recommendations for Family-based Research
1. Involve patient and caregivers in decisions and prepare them for the next setting.	Difficulty in convening meetings between families and NH staff to discuss clinical status and treatment options and to prepare for care in the next setting.	Recruit families earlier in the care transition chain. Consider telephone conference, email or other alternative means of communication. When possible, create internal staff-based initiatives that prioritize family meetings.	Train family to better utilize existing opportunities to communicate with staff and empower them to initiate communication when needed for proper patient care.
2. Insure good bidirectional communication between clinicians at the sending and receiving ends of care.	Discharge summaries may not be communicated to the next site of care and may omit critical information such as mental health issues that require follow-up.	Create a discharge summary supplement that addresses mental health issues such as depression. Recruit prospectively at PCP offices to help ensure that patients can accurately identify their PCP. Include a process for ensuring that discharge summaries are communicated to the PCP as part of the research protocol and intervention. Explore alternative communication methods such as electronic medical record sharing and electronic 'smart cards.'	Help families create and maintain a personal patient medical record that includes facility discharge summaries and is tailored to the specific health and mental health needs of the patient.
3. Develop policies that promote high quality transitional care, including changes to reimbursement rules.	Poor response from PCPs; also, patients are often unable to identify their PCP, or they indicate that they do not have one.	Recruit patients prospectively through PCP practices to ensure that patients and research staff can identify PCPs and that PCPs are involved in the research study. Identify and work with the hospitals that discharge patients for rehabilitation care to targeted NHs to promote earlier patient identification.	Teach patients and their families to communicate better with the patient's PCP.
4. Provide education to all professionals involved in transferring patients across settings.	Staff time constraints restrict opportunities for staff training and staff-based care manager approaches.	Utilize existing NPs as case managers.	Focus on educating patients and families to work with care providers.
5. Conduct research to improve transitional care processes, with a focus on patient and family involvement and training healthcare professionals.	Patient frailty, pain, therapy schedules and short stays severely impact recruitment, data collection, and intervention protocol schedules. Poor quality admission information makes eligibility determination slow and costly.	Start earlier in the transition chain, including recruiting prospectively at the PCP practice or hospital. Current NH trends to utilize electronic record systems using ICD-9 codes may simplify eligibility determinations.	Sensitize patients and families to the challenges in transitional care and to their role in promoting research to improve care.

Note: Primary Care Physician (PCP); Nursing Home (NH)