Improving the Quality of Information sent to Primary Care Physicians for Patients Discharged from Nursing Facilities

Catherine M. Glew BM, BS, CMD  
*Lehigh Valley Health Network*, Catherine.Glew@lvhn.org

Anne M. Yawman MD  
*Lehigh Valley Health Network*, Anne_M.Yawman@lvhn.org

Follow this and additional works at: [https://scholarlyworks.lvhn.org/medicine](https://scholarlyworks.lvhn.org/medicine)

*Part of the* Geriatric Nursing Commons, Geriatrics Commons, Medical Sciences Commons, and the Primary Care Commons

*Let us know how access to this document benefits you*

**Published In/Presented At**

Improving the Quality of Information sent to Primary Care Physicians for Patients Discharged from Nursing Facilities

Catherine M Giew BM, BS, CMD; Anne M Yawman MD
Lehigh Valley Health Network, Allentown, Pennsylvania

Abstract:
A successful improvement in documentation in transitions of care, we identified that none of the nursing facilities (NF) where our group is on staff had a formal process for completing the forms. The six providers in our genetic group developed a standardized single page summary to include in the discharge form. This included Patient name and Date of birth, NF where the patient received care and discharge destination, functional and cognitive status, home/most recent address, phone number, details of admission diagnosis and course in the NF, other medical diagnoses, medication list, any follow up instructions or radiology testing and follow up appointments. Approval had to be given by each NF to allow the DC form to be used and placed on the NF chart.

The form was completed by the discharging provider and faxed to the PCP and our office for tracking. PCP office was called to inform them if was received and if not to verify whether forms was needed. These forms were stored in the office of those NPs that were not able to complete the form.

During the initial pilot period of 3 weeks, 75 DC forms were used to PCP office. Of these, 50/75 (66%) needed to be re-faxed. 5/7 (6%) PCP office never responded back to us as to whether the form was received despite multiple calls. Multiple process issues were identified. Many PCPs were incorrectly identified in our provider registry and phone numbers were hard to contact. Many PCPs asked for the DC to be re-faxed, mostly because they were not sure if they had received it or not. As a measure of provider compliance, we compared billing codes for discharged patients with forms sent. 77% of patients with a 31536 codes on a bill had a DC form. 10% additional DC forms were sent for whom no bill with a discharge code was sent. These forms were returned with a note from the medical provider that at that time could not use the form.

Providers found some difficulties with the process; obtaining information about the Home Health Agency (HHA) functional status and contact numbers for the PCP office were the most troublesome. One provider photocopied prescriptions given to the patient instead of listing the medications, and these were illegible when received by the PCP in some cases the handwriting on the DC form was hard to read.

Four revisions were made to the form during the pilot period- the space for narrative for the NF stay was enlarged and space for addition of cognitive testing increased. It was agreed that the form was too short to be used in all situations and so this was changed to fit new text space. We also plan to include code status and allergies on a next updated version. One NF adopted the DC form for all short term discharges, though it will be completed by a computer.

To evaluate the usefulness of the content of the DC form, we plan to survey PCP offices.

Methods:
Development of the Form and Utilization
The providers in our group meet to determine what information should be included on the form. The first draft of our form is shown in Figure 1. The providers are able to fax any additional information that they think is needed to allow for continuity of care. We are currently using this form on August 8 2010. The form is completed before the patient leaves the facility. We are planning to send the form to primary care physician the first two months of this project due to delay in NH approval.

Background:
Lehigh Valley Health Network (LVHN) began an initiative to improve the transfer of information when patients transition between sites of health care. Physicians from the Division of Geriatrics care for patients in multiple skilled nursing facilities (SNF), and we determined that there was no discharge form to transfer information to the Primary Care Provider (PCP) when the patient leaves the SNF to return home. All of the providers attempt to send information, but the process is not standardized and is inefficient. Our goal was to develop a single page discharge form that would update the PCP about the nursing facility stay, the patient’s condition at discharge and any follow up required.

Discharging Provider Compliance with Use of the Form:
We did not have the resources to visit the NPs and perform a chart audit to assess for compliance. We thus charted our procedures and developed a survey sent to all NPs (Table 1). This is a tool to be used for the next two months of this project. It may be that forms were completed and faxed to PCP but not to our office. Also the form was not in use at two NFs for the first two months of this project due to delay in NH approval.

Primary Care Provider
PCP process issues are shown below. The main issue was the inability to locate the form in their office. We did not inform the PCP offices about our project before sending discharge forms. Thus many of them were unfamiliar with the form which may have contributed to their evaluation that the forms had not been received.

Geriatric Division Office
The implementation of this new discharge form had implications on our office staff as shown below:

Results:
For the five month period from mid August to the end of December 2010, there were 135 copies of a DC form received in our office. Follow up calls showed that 79 (58%) were identified as “received” by the PCP office, 29 (20%) were identified as “not received” by the PCP office, 6 (4%) were unsure if they were received and 11 (8%) PCP offices never responded to the inquiry. 44 (32%) had to be re- faxed by our office.

Post Utilization Review
The providers in our group met again to identify issues related to the layout and content of the form. Most were finding the form adequate, but a few were still not using it. The form was updated and is shown in Figure 3. We plan to survey PCP offices to assess their satisfaction with the form in the future.

Nursing Facility
The NF process issues are as shown:

Figure 1: Initial Discharge Form

Figure 2: Receipt of Discharge Form by Primary Care Provider Office

Figure 3: Revised Discharge Form

This Quality Improvement project was supported by the Lehigh Valley Physicians Health Organization (LVPHO) as a recognition of the physician champion of this project.

Improving the Quality of Information sent to Primary Care Physicians for Patients Discharged from Nursing Facilities

Catherine M Giew BM, BS, CMD; Anne M Yawman MD
Lehigh Valley Health Network, Allentown, Pennsylvania

Abstract:
A successful improvement in documentation in transitions of care, we identified that none of the nursing facilities (NF) where our group is on staff had a formal process for completing the forms. The six providers in our genetic group developed a standardized single page summary to include in the discharge form. This included Patient name and Date of birth, NF where the patient received care and discharge destination, functional and cognitive status, home/most recent address, phone number, details of admission diagnosis and course in the NF, other medical diagnoses, medication list, any follow up instructions or radiology testing and follow up appointments. Approval had to be given by each NF to allow the DC form to be used and placed on the NF chart.

The form was completed by the discharging provider and faxed to the PCP and our office for tracking. PCP office was called to inform them if was received and if not to verify whether forms was needed. These forms were stored in the office of those NPs that were not able to complete the form.

During the initial pilot period of 3 weeks, 75 DC forms were used to PCP office. Of these, 50/75 (66%) needed to be re-faxed. 5/7 (6%) PCP office never responded back to us as to whether the form was received despite multiple calls. Multiple process issues were identified. Many PCPs were incorrectly identified in our provider registry and phone numbers were hard to contact. Many PCPs asked for the DC to be re-faxed, mostly because they were not sure if they had received it or not. As a measure of provider compliance, we compared billing codes for discharged patients with forms sent. 77% of patients with a 31536 codes on a bill had a DC form. 10% additional DC forms were sent for whom no bill with a discharge code was sent. These forms were returned with a note from the medical provider that at that time could not use the form.

Providers found some difficulties with the process; obtaining information about the Home Health Agency (HHA) functional status and contact numbers for the PCP office were the most troublesome. One provider photocopied prescriptions given to the patient instead of listing the medications, and these were illegible when received by the PCP in some cases the handwriting on the DC form was hard to read.

Four revisions were made to the form during the pilot period- the space for narrative for the NF stay was enlarged and space for addition of cognitive testing increased. It was agreed that the form was too short to be used in all situations and so this was changed to fit new text space. We also plan to include code status and allergies on a next updated version. One NF adopted the DC form for all short term discharges, though it will be completed by a computer.

To evaluate the usefulness of the content of the DC form, we plan to survey PCP offices.

Methods:
Development of the Form and Utilization
The providers in our group meet to determine what information should be included on the form. The first draft of our form is shown in Figure 1. The providers are able to fax any additional information that they think is needed to allow for continuity of care. We are currently using this form on August 8 2010. The form is completed before the patient leaves the facility. We are planning to send the form to primary care physician the first two months of this project due to delay in NH approval.

Background:
Lehigh Valley Health Network (LVHN) began an initiative to improve the transfer of information when patients transition between sites of health care. Physicians from the Division of Geriatrics care for patients in multiple skilled nursing facilities (SNF), and we determined that there was no discharge form to transfer information to the Primary Care Provider (PCP) when the patient leaves the SNF to return home. All of the providers attempt to send information, but the process is not standardized and is inefficient. Our goal was to develop a single page discharge form that would update the PCP about the nursing facility stay, the patient’s condition at discharge and any follow up required.

Discharging Provider Compliance with Use of the Form:
We did not have the resources to visit the NPs and perform a chart audit to assess for compliance. We thus charted our procedures and developed a survey sent to all NPs (Table 1). This is a tool to be used for the next two months of this project. It may be that forms were completed and faxed to PCP but not to our office. Also the form was not in use at two NFs for the first two months of this project due to delay in NH approval.

Primary Care Provider
PCP process issues are shown below. The main issue was the inability to locate the form in their office. We did not inform the PCP offices about our project before sending discharge forms. Thus many of them were unfamiliar with the form which may have contributed to their evaluation that the forms had not been received.

Geriatric Division Office
The implementation of this new discharge form had implications on our office staff as shown below:

Results:
For the five month period from mid August to the end of December 2010, there were 135 copies of a DC form received in our office. Follow up calls showed that 79 (58%) were identified as “received” by the PCP office, 29 (20%) were identified as “not received” by the PCP office, 6 (4%) were unsure if they were received and 11 (8%) PCP offices never responded to the inquiry. 44 (32%) had to be re-faxed by our office.

Post Utilization Review
The providers in our group met again to identify issues related to the layout and content of the form. Most were finding the form adequate, but a few were still not using it. The form was updated and is shown in Figure 3. We plan to survey PCP offices to assess their satisfaction with the form in the future.

Nursing Facility
The NF process issues are as shown:

Figure 1: Initial Discharge Form

Figure 2: Receipt of Discharge Form by Primary Care Provider Office

Figure 3: Revised Discharge Form

This Quality Improvement project was supported by the Lehigh Valley Physicians Health Organization (LVPHO) as a recognition of the physician champion of this project.