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

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

Abstract:
Adverse events and errors are due in part to a lack of communication in transitions of care, we identified that none of the nursing facilities (NFs) where our group is on staff had a formal discharge form. The six providers in our geriatric group developed a standardized page summary to be included on 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 address, phone number, details of admission diagnosis and course in the NF, other medical diagnoses, medication list, any follow up plan or referrals, xray and lab 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 is notified by email to obtain it if was not faxed to them. The form was sent to nursing facilities before patients were discharged.

During the initial pilot period of 5 weeks, 75 DC forms were used in PCP office. Of these, 50/75 (66%) needed to be re-fixed, 7/5 (4%) PCP offices never responded back as to whether the DC form was received despite multiple calls. Multiple process issues were identified. Many PCPs were incorrectly identified in our provider registry and phone and fax numbers were also an issue. Many PCPs asked for the DC to be re-fixed, many as 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 31591 code on a bill had a DC form. 10 additional PCPs were sent a letter for whom no bill with a discharge was received. The PCP office is notified by email to obtain it if was not faxed to them. Providers found some difficulties with the process; obtaining information about the home health agency, address, telephone number 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 and the space for the home address were increased. We also deemed it too short to write some data and so this was changed to fit more text space. We also plan to include code status and allergies on a next updated version. One NF accepted the DC form for all short term discharges, though it still be completed by another provider. We plan to survey PCP offices.

Methods:
Development of the Form and Utilization

The providers in our group met 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 wish. We plan using this form on August 8 2010. The form was completed before patients were discharged.

Discharging Provider Compliance with Use of the Form:

We did not have the resources to visit the NFs and perform a chart audit to assess for compliance. We thus chart reviewed the progress notes, and measure provider compliance with use of the form by looking at number of DC forms completed, and comparing to the number of patients in whom a 93315 or 93316 billing code was billed. From August 8 2010 to December 31 2010, there were 177 discharge codes billed, for which only 135 DC forms (76%) were received in the office. The individual provider compliance was 32% to 85 % and is shown in Table 1. This is only a measure of how many copies of the DC form were received in our office; 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:

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 and they used it every time. 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

Results:

For the five month period from mid August to the end of December 2010, there were 135 copies of a DC form reached in our office. Follow up calls showed that 79 (58.5%) were identified as “received” by the PCP office, 36 (26.8%) were identified as “not received” by the PCP office. 7 (6%) were unsure if they were received and 1 (1%) were PCP offices never responded to the inquiry. 44 (32.5%) had to be re- faxed by our office.

Process Issues:

Providers

The main process provider issues are shown below. Although it was determined on a separate transmission back to the primary care provider, completion of the form was considerable extra work for the discharging provider.

Multiple calls to primary provider to assure receipt of form
Long wait time on telephone
Unable to obtain important information in network database
Time to no show or small errors when cost reduced
Providers not able to locate form or fax return to improving of work process

Figure 3. Revised Discharge Form

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