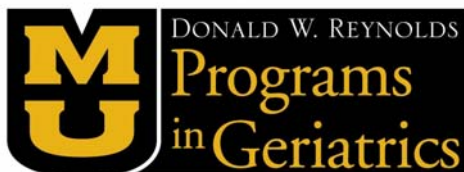


Published by  
the  
Missouri  
Association  
of  
Long-Term  
Care  
Physicians  
and the



# Long-Term Links

## TRANSITION PLANNING: Tips for a Thoughtful and Thorough Discharge

♦Steven C. Zweig, MD, MSPH  
Department of Family & Community Medicine  
University of Missouri-Columbia

### INSIDE:

- · Report on AMDA  
House of Delegates  
Page 4
- Medical Director F Tag  
501  
Page 5
- News & Notes  
Page 6
- Measurement of  
Quality of Care in LTC  
Settings  
Page 7
- Planned Presentations  
at the 15th annual  
*Caring for the Frail  
Elderly* conference  
Page 8

Vol. 15 No. 2  
Summer 2005

We often call it *discharge planning*, but that is only half the story. Instead, *transition* is a more accurate term for care on a continuous basis: we must change our focus from the facility or agency to the patient.

Transition planning often parallels changes in health status with new diagnoses or changes that affect ability for self-care, and frail elders are at special risk. Poorly executed transitions can result in inefficiencies, medical errors, duplication of tests and services that increase costs, readmissions, lack of reimbursement, patient complaints, and even litigation.

Three steps important to transition planning are: assessment (identifying patient needs and resources), creation of a care plan addressing those needs, and implementing the plan for the transition.

**Assessment.** To identify the patient's needs and resources, we must assess his functional and cognitive status. Also, we must

address patient/family preferences for goals and settings of care, and identify the resources of the patient – home assistance, social support, and financial resources.

### Measures of Functional Status

Instrumental Activities of Daily Living (IADLs):

- ♦ preparing meals
- ♦ shopping
- ♦ managing money
- ♦ using telephone
- ♦ doing housework
- ♦ taking medications

Activities of Daily Living (ADLs):

- ♦ bathing
- ♦ dressing
- ♦ eating
- ♦ toileting
- ♦ mobility
- ♦ transfer ability

### Creating the care plan.

What medical interventions must be carried out in the next phase of care? What is the most appropriate setting for this patient's needs and resources? Who needs to be involved in developing and implementing the plan? Special planning needs often arise in caring for

**Continued:  
Transition Planning  
Steven Zweig, MD**

## **Long-Term Links**

Published quarterly by the Missouri Association of Long-Term Care Physicians and MU's Donald W. Reynolds Foundation Programs in Geriatrics  
Columbia MO 65212  
Phone (573) 882-1758  
Fax (573) 882-9096

**Editor:**

Steven Zweig, MD

**Editorial Board:**

David Mehr, MD  
Charles Crecelius, MD, CMD  
Michael Hosokawa, EdD  
Marilyn Rantz, RN, PhD  
Larry Lawhorne, MD, CMD  
(*emeritus*)

**Managing Editor:**

Susan Kauffman

*Missouri Association of Long-Term Care Physicians*

**President:**

Jeff Kerr, DO, CMD, Rolla

**Treasurer:**

Randy Huss MD, CMD, Rolla

**Board of Directors:**

David Brunworth MD, CMD, Washington  
Carl Bynum DO, Columbia  
David Cravens MD, Columbia  
Leonard Hock DO, CMD, Kansas City  
David Mehr MD, Columbia  
Steven Zweig MD, Columbia

Official state chapter



older patients. Those living alone may not be able to return home after an acute episode. Delirium and underlying dementia may be undetected before discharge. Finally, in older patients with multiple chronic illnesses, attention to a dominant problem may complicate or hide others.

Each of these issues illustrates the value of multidisciplinary teams working throughout any hospital stay. Physicians should be responsible for determining medical needs and cognitive function. Nurses often know most about activities of daily living and capacity to take medications. Therapists evaluate and work to enhance functional abilities. The social worker deals with the patient and family to match preferences and needs with identified resources.

Family caregivers are often crucial to a smooth transition to home or other setting of care. They may have unique information about prior physical and cognitive status and how the patient has functioned in the real world. Caregiver needs must be considered; the transition needs to accommodate work schedules and other family responsibilities. Since family caregivers provide the bulk of after-hospital care, we should strive to use community resources to facilitate family care.

**Implementing the care plan (transition).** Elements include selection of the appropriate post-acute care setting, coordination of plans, transfer, and prescriptions, and

communication with the next set of providers — physician, nurses, therapists, etc. Unfortunately, there is the potential for many fumbled handoffs along the way. Providers often lack training about how to make successful transition plans. Furthermore, physicians, hospital nurses and social workers may have little experience with other environments. The physician-patient relationship may not transcend site of care, so there is no single person who travels with the patient to the next place of care. This can result in an “out of sight, out of mind” mentality, the results of which are miscommunication, unreasonable expectations, and poor follow-up. The transition is a dynamic rather than a one-sided action, as there are both sending and receiving caregivers.

We must begin to anticipate the discharge plan at admission by asking such questions as:

- ♦ What will the patient's condition be when we're done?
- ♦ What could the patient do before admission?
- ♦ Have we informed key caregivers what to expect?
- ♦ Who else needs to know — consultants, home health, medical equipment, primary care?

Daily multidisciplinary rounds during the hospital stay give each team member a chance to ask questions and provide information. At the University of Missouri Hospital we have used such rounds to efficiently communicate about patients, yet we

spend an average of less than two minutes each day per patient.

We have also discovered a number of ways to make the discharge summary more useful to the next set of providers. We include comments about ADLs – not just driving, lifting and sex. We think about home nursing care. Almost all elderly patients merit at least one visit; many will benefit from home therapy to combat the deconditioning that occurs in the hospital. If sending the patient out on oxygen, we document the assessment, since this will be needed when completing forms in future. If going by ambulance, we must

also document this need (for example, on tubes, can't sit up, etc.).

Listed medications often do not include stop dates. (Warfarin is especially risky.) Always describe the indication, length of treatment, target INR, who will follow up, and when the next protime should be done. Make sure the patient can afford the medications prescribed. Give only needed prescriptions, but know all medications the patient will be taking. If discharge meds are different than those at admission, explain. Know why the patient is on each medication. To facilitate the transition, a list can be faxed to the phar-

macy, home health agency, or nursing home.

Nursing home transitions bring special issues. There should be nurse-to-nurse and doctor-to-doctor communication. Most facilities cannot accept transfers after 3 pm. Also, physicians should be reminded to write scripts for all Schedule 2 drugs, to send legible med lists (preferably before the patient arrives), to write orders for therapies, and to minimize the need to transfer for outside appointments. Don't forget to define goals of care and to include any advance directives or discussions about limitations of care.

In summary, to make transitions work smoothly, we must be patient-centered rather than unit-centered in perspective. While these ideas focus on transitioning from hospital care to outside, the same principles apply to any type of patient transition.

We should attend to patients' preferences and the needs of caregivers in order to advocate for safe and effective care after discharge. Work well with your team to assess, plan, and implement smooth transitions. The attending physician should know that implementing the transition means communicating well with those who will be taking over care and being available to them if needed. Be interested in how the process went so you can make changes the next time if needed.

### **Core Functions for Meeting the Needs of Patients in Transition**

#### *Sending and receiving teams must:*

- ♦ Shift perspective from discharge to continuous management
- ♦ Plan for transfer upon admission
- ♦ Elicit patient and caregiver preferences
- ♦ Communicate and collaborate across settings of care to formulate care plan
- ♦ Use preferred mode of communication

#### *Sending health care team ensures that:*

- ♦ Patient is stable enough to be transferred
- ♦ Patient and caregivers understand purpose
- ♦ Receiving team can meet the needs
- ♦ Relevant information is transmitted
- ♦ Time follow-up with continuity provider
- ♦ Sending provider available to patient, caregiver, new team after discharge
- ♦ Patient and caregiver understand financials

#### *Receiving health care team must:*

- ♦ Review forms, summary, orders prior to or upon patient's arrival
- ♦ Ensure that patient's goals and preferences are incorporated into the care plan
- ♦ Clarify discrepancies in care plan, patient's status or preferences, and medications with sending health team

♦ Coleman E.A. *Aspen Transitional Care Conference proceedings 2002*

## AMDA House of Delegates 2005

Much important work was accomplished in the House of Delegates meeting at the 27th annual symposium, and in record time. Among several important subjects brought forth were: improving surveyor education using AMDA materials, better defining the role of the medical director in assisted living, and ensuring an annual reporting of past resolution status. A position paper on the role of video surveillance was approved. Bylaws were amended to correct deficiencies in disciplinary action, which theretofore had allowed all action to stop with member resignation. An accounting of the status of recent resolutions was given by the Chair.

House of Delegates meetings have become increasingly efficient the last several years thanks to the efforts of many individuals, including past Chairs Drs. Randy Huss and Buzz Baker. The preparation of the delegates also has been very helpful. The revised Policy Compendium, which will soon be available on the web, is a rich source of AMDA

history and philosophy. Remember, it is not too early to consider subjects for next year's meeting. State Chapter meetings will soon be upon us. The education, networking, and idea exchange that occurs there can be wonderful fodder for possible resolutions. If a potential resolution arises but you are not certain how to proceed, feel free to contact me (at [c\\_crecelius@msn.com](mailto:c_crecelius@msn.com)) or AMDA staff for guidance. We are a grassroots organization, and our best concepts and efforts often arise from what may seem to be a simple thought. Don't discount your ability to participate in the process! Now is the time to start planning for another productive House of Delegates meeting in Dallas next March.

To be effective, AMDA must stay in close contact with state chapters. To improve communication, we will be planning "Listening Post" meetings in conjunction with state chapter meetings. These will serve as regional gatherings of state presidents and other interested parties. Regional interests, mutual

concerns and recent national activity will be discussed. These meetings also should serve as breeding grounds for resolutions.

The new Medical Director F-Tag 501 is due any moment, and AMDA will be extremely active in its implementation. (See related story on Page 5.) AMDA's national efforts, however, will fall short if state leaders don't show commitment to resident care via an unbiased survey process on the local level. As per our resolution, we will work with all state chapters and state survey agencies (and the Association of Health Facility Survey Agencies, or AHFSA) to provide training material and speakers. Ensuring appropriate and equitable use of this regulation will require both national and state efforts. The new Medical Director F-Tag 501 provides a golden opportunity for state chapters and AMDA to demonstrate to surveyors and providers alike the value of well-trained medical directors. Please work with your national organization in this endeavor, and contact us with any questions or concerns.

♦Charles A. Crecelius, MD, PhD, CMD  
Chair, AMDA House of Delegates

## Dr. Kerr Chosen for Prestigious National Conference

MALTCP president Jeff Kerr, DO, CMD was selected as a delegate to the White House Conference on Aging, a program occurring once a decade to make aging policy recommendations to the President and Congress. It also

assists the public and private sectors in promoting dignity, health, independence, and economic security of current and future generations of seniors. The WHCoA will be held Dec. 11-14, 2005. For more, see [www.whcoa.gov](http://www.whcoa.gov).

The closing years of life  
are like the end of a  
masquerade party,  
when the masks are  
dropped.

Arthur Schopenhauer,  
philosopher (1788-1860)

## Medical Director F tag 501 to be Launched This Fall

The long awaited F tag on the medical director's role in long term care is now out in final form, and will be fully implemented in November 2005. It does not impose any new duties, but does elaborate in detail on the two current regulatory requirements of implementation of resident care policies and coordination of medical care. The F tag may be viewed at <http://www3.cms.hhs.gov/medicaid/survey-cert/sc0529.pdf>.

The goals of the new F tag are to better define the role of the medical director, standardize expectations for providers, and meet the needs of the contemporary long term care population. Much of the new language utilizes position statements of the American Medical Directors Association (AMDA) on the role of the medical director in LTC, and should come as no surprise to active long-term care physicians.

Medical directors will be expected to be involved in the functioning of the nursing facility, and to play an active role in problem solving. Core areas of their function include:

- ♦ Ensuring adequate, appropriate physician services
- ♦ Reviewing credentials; overseeing physicians and those who perform physician-delegated tasks
- ♦ Reviewing physician performance and provide feedback
- ♦ Overseeing and helping develop care-related policies and practices
- ♦ Participating in efforts to improve quality of care and services
- ♦ Serving as liaison between physicians and facility staff and management
- ♦ Acting as liaison with community
- ♦ Acting as a source of education, training, and information

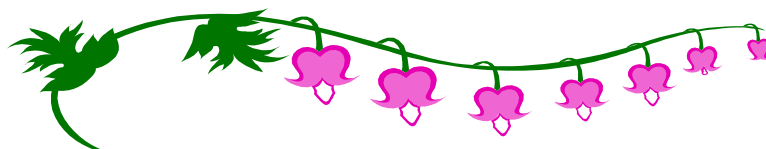
F501 will generally be cited with quality of care deficiencies; it is a "stand alone" deficiency only if there is no functioning medical director. Surveyors will be directed to communicate with the medical director about various concerns, and correlate quality of care issues with medical director involvement. A citation will occur if the medical director was not appropriately involved, and may include the medical director.

The medical director is not responsible for any individual outcome, but should be involved when care concerns are identified. It is expected that this may increase liability risk for medical directors who are not actively participating in quality of care concerns.

Medical directors and facilities can lessen their risks of citation in a number of ways. Physician performance needs to be defined with written expectations and regularly reviewed. Facility policies and procedures should be reviewed and kept current, with QA activities directed towards any that are potentially problematic. Regular contact about mutual issues of concern between the administrator and Director of Nursing should occur. If problems arise with resident care, the medical director needs to intervene as soon as possible, especially if immediate jeopardy is a concern.

More information about this F tag and its implementation can be obtained from AMDA's website, [www.amda.com](http://www.amda.com). Members of state AMDA chapters, including the Missouri Association of Long Term Care Physicians (MALTCP), will be in close contact with the state survey agency, and will be available to answer concerns about F tag 501.

*Charles A. Crecelius, MD, PhD, CMD*



## ◆◆News & Notes◆◆

### AMDA Secures CMS Recommendations on MMA Drug Benefit

AMDA representatives and other long-term care groups have met with CMS officials to request modifications of the new Medicare Part D prescription drug benefit for LTC. CMS recently issued specific MMA drug benefit guidance relating to long-term care and transition to the new drug benefit. The guidance continues to facilitate CMS's philosophy in its deference to drug plans to develop their own policies. However, the guidance does make important recommendations to drug plans that reflect some of AMDA's positions, including:

- ◆ Suggesting temporary "first fill" prescriptions for a limited quantity of medication prescribed by the attending physician until transition can be made to the new plan
- ◆ Recognizing that LTC patients are more likely to receive multiple medications for which simultaneous changes could significantly impact the condition of the enrollee, and suggesting a transition period of 90-180 days for nursing home residents on multiple medications who require changes to their medication regimens to accommodate plan formularies.
- ◆ Expecting drug plan sponsors to have procedures in place for addressing the needs of Part D enrollees

who reside in LTC facilities, with particular attention to disparities between Part D requirements and Medicare Conditions of Participation.

- ◆ Recommending that drug plans consider a one-time temporary or emergency prescription fill during exceptions or appeal requests.
- ◆ Clarifying that Part D enrollees may choose an agent of the LTC facility, such as a nurse or case manager, to act as a representative in pursuing coverage determinations and appeals.

CMS has committed to having regular conference calls with AMDA leadership to discuss Part D implementation.

- ◆ *AMDA Reports newsletter*

### AMDA CPGs on PDAs

AMDA is now offering three of its most popular guidelines – those addressing depression, falls and fall risk, and pain management – in handheld computer application, providing all content of paper copies in an easy-to-use design. Handheld CPGs allow quick reference to text sections, section tables, and the treatment algorithm. New and innovative functionality includes the ability to record a patient session while navigating and being guided through the care algorithm.

While tracking decision-making through the four stages of the care process (recognition, assessment/root cause analysis, treatment and monitoring), the program allows input of data such as

treatment selection, labs and other supportive rationale for decision-making. The session data can then be synchronized to a desktop PC to print for more efficient patient interaction and record keeping, eliminating the need for handwritten documentation.

Look for more CPSs on handheld computer application later this year. For more information or to order, go to [www.amda.com/info](http://www.amda.com/info).

- ◆ *AMDA Reports newsletter*

### Dementia Care Recommendations Now Available Online

The new Dementia Care Practice Recommendations for Assisted Living Residencies and Nursing Homes are now available for download at <http://www.alz.org/health/care/dcpr.asp>.

These new guidelines were developed by the Alzheimer's Association, working with 24 national organizations including the American Association of Homes and Services for the Aging, to build consensus on quality care for people with dementia. The result is a set of recommendations for practice which is based on the latest dementia care research and the experience of care experts.

The recommendations focus on food and fluid consumption, pain management, social engagement, and involvement in meaningful activities.

- ◆ *Missouri Association of Homes for the Aging "Hotline" newsletter*

## Research instrument will help providers, consumers and lawmakers measure quality of care in long term care settings

♦ Marilyn J. Rantz, PhD, RN  
Sinclair School of Nursing, University of Missouri

Since the early 1990s, researchers and clinicians of the MDS and Quality Research Team at the University of Missouri-Columbia (MU) have been working with the Missouri Department of Health and Senior Services to improve quality of care in nursing homes. Faculty and researchers at MU and the University of Wisconsin-Eau Claire (UWEC) recently completed a three-year research project testing a way to measure quality of nursing home care in a 30-minute facility inspection.

The research team conducted qualitative studies identifying the many dimensions of quality of care in nursing homes that are important to consumers, providers, and regulators. With that foundation, large-scale field testing of the *Observable Indicators of Nursing Home Care Quality Instrument (OIQ)* was funded by the National Institute of Nursing Research (NINR), part of the National Institutes of Health (NIH). Professors Marilyn Rantz from MU and Mary Zwygart-Stauffacher from UWEC, along with other investigators from their universities, visited 407 facilities in Missouri, Minnesota and Wisconsin.

As the researchers refined the instrument, an important relationship was detected between scores on the *OIQ* and citations facilities received from

regulators in state and federal oversight inspections. This suggested the possibility that the *OIQ* could serve as a valuable proxy for the full, resource-intensive team of regulators routinely needed for state and federal inspections. Based on these findings, it appears possible to conduct an abbreviated survey process which will give an adequate score using the *OIQ*. Thus scarce regulatory resources can be focused on facilities in need of closer scrutiny.

Nurses, consumers, and retired regulators acted as inspectors to score the instrument. As its name implies, each item on the instrument refers to some directly observable aspect of any nursing home. The instrument is designed to guide researchers, health care professionals, and potential consumers and regulators in appraising specific indicators of quality care in about 30 minutes.

After extensive testing, the *OIQ* was honed to 30 valid, reliable and discriminating items with a coherent seven-factor structure describing the multidimensional concept of nursing home care quality.

“We have an instrument that will provide researchers, surveyors and nursing home consumers with a fast, accurate and reliable way to measure the quality of

nursing home care. We encourage facility staff to use the *OIQ* in their quality improvement programs,” Rantz said. Adds Zwygart-Stauffacher, “We anticipate that consumers will find this particularly helpful as they make decisions about long term care services. We hope that regulators will consider possible options using the *OIQ* to target scarce survey resources.”

Copies of the instrument and user’s guide have been mailed to nursing homes that participated in the research project and are available from the authors upon request. Excerpts of the instrument and more information are available at [www.nursinghomehelp.org](http://www.nursinghomehelp.org), maintained by the MU MDS and Quality Research Team. A consumer version of the *OIQ* and guide for nursing home selection, *The New Nursing Homes: A 20-Minute Way to Find Great Long Term Care* is available from Fairview Press at 1-800-544-8207 or [www.fairviewpress.org](http://www.fairviewpress.org) and from online bookstores. A residential care version is under development, with additional field testing planned.

For more information contact Dr. Marilyn Rantz in the Sinclair School of Nursing at the University of Missouri-Columbia at [rantzm@missouri.edu](mailto:rantz@mmissouri.edu) or (573) 882-0258.

15<sup>th</sup> Annual  
**Caring for the Frail Elderly Conference**  
14<sup>th</sup> Annual Meeting  
Missouri Association of Long-Term Care Physicians

**Holiday Inn Select Executive Center**  
**Columbia, Missouri**  
**August 26-27, 2005**

*Planned Presentations Include:*

**Physicians and Consultant Pharmacists: Partners for Better Long Term Care** – Diane Crutchfield, Pharmacy Consulting Care, Knoxville, TN; and Daniel Swagerty MD, Center on Aging, University of Kansas Medical Center

**Anemia in the Elderly** – David Thomas MD, St. Louis University Health Sciences Center

**Swallowing Disorders in the Elderly** – Troy Scheidt MD, Dept of Otolaryngology, MU School of Medicine

**Constipation** – David Thomas MD

**LIFE: an intergenerational program** – Karli Echterling, Program Director, Conley Scholar, University of Missouri

**Update on Dementia** – David A. Smith MD, 2005 AMDA President, Geriatric Consultants of Central Texas

**Preventing Fragility Fractures** – David Klachko MD, Professor Emeritus, Dept of Endocrinology, MU School of Medicine

**Legal Capacity and Vulnerability among the Frail Elderly: Protection and Exploitation Issues** – Reginald H. “Reg” Turnbull, Turnbull Law Office, Jefferson City MO

**Tube Feeding in the Elderly** – James Birch Jr., MD, Geriatric Medicine Fellow, MU School of Medicine

**Risk Management** – Jeffrey A. Kerr DO, President, Missouri Association of Long-Term Care Physicians and Chairman, Board of Senior Services, Missouri Department of Health and Senior Services

**Hospice in the Nursing Home** – Charles Crecelius MD, Medical Director, Delmar Gardens, St. Louis MO

**Psychosocial Care in the Nursing Home** – Patricia Gleason-Wynn PhD, Baylor University, Arlington, Texas

**F-Tags for Medical Direction** – David A. Smith MD

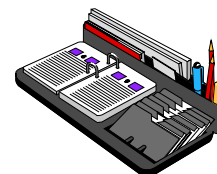
**Complementary Therapy in Palliative Care** – Dorreen Rardin, RN, Palliative Care Program, Boone Hospital Center, Columbia MO

**Effects of Regulations on Medication Management for LTC Residents** – Charles Crecelius MD

**Exploring the Impact of Technology upon Nursing Home Medication Safety Practices** – Jill Scott-Cawiezell PhD, MU Sinclair School of Nursing

**Preventing and Treating Diabetic Foot Ulcers** – Joseph LeMaster, MD, Assistant Professor, Dept of Family Medicine, MU School of Medicine

**Part D Medicare (the Prescription Benefit) and Impact on the Frail Elderly** – Laurie Hines, Deputy Director, Division of Senior Services & Regulation, Department of Health and Senior Services, Jefferson City MO



***For your Calendar***

Missouri Association of Homes for the Aging Conference/Expo, Sept. 7-9. Lodge of the Four Seasons, Lake Ozark MO.

“Missouri: It’s About How You Live” Summit, Oct. 6, 2005. Ramada Inn, Jefferson City MO. Speakers include Missouri’s Attorney General Jay Nixon. For information contact Ann Corley at the Missouri End-of-Life Coalition, (816) 525-4739, or [acorley@mo-endoflife.org](mailto:acorley@mo-endoflife.org).

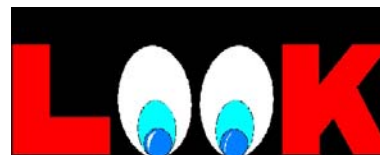
Midwest Regional Conference on End-of-Life Care, November 14-15, 2005. Hyatt Regency Crown Center, Kansas City MO. For more information call (816) 350-7702 or e-mail [cindy@mohospice.org](mailto:cindy@mohospice.org).

8th Annual Scientific Meeting, Gerontological Society of America, Nov. 18-22, 2005. Hilton New Orleans Riverside [http://www.eshow2000.com/geron/about\\_the\\_meeting.cfm](http://www.eshow2000.com/geron/about_the_meeting.cfm)

American Medical Directors 2006 Annual Symposium, March 23-26, 2006. Dallas TX.



*Take a*



at MALTCP’s new website!

**[www.maltcp.org](http://www.maltcp.org)**

Find info and register for the Caring for the Frail Elderly Conference at: <http://www2.muhealth.org/~cme/frailelderly/index1.shtml>

