Transitions of Care and Rehabilitation After Fragility Fractures

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KEYWORDS

• Rehabilitation • Skilled nursing facility (SNF) • Inpatient rehabilitation facility (IRF)
• Transitions in care • Transitional care • Home health • Medicare • Fragility fracture

KEY POINTS

- Transitions in care are a vulnerable time for patients in which unintended errors may occur; understanding the potential risks and taking proactive measures to prevent these risks can greatly improve patient safety and outcome.
- Rehabilitation (rehab) can be done in a variety of settings; most common locations are home (via home health care), skilled nursing facilities (SNFs, commonly pronounced "sniffs"), and inpatient rehab facilities (IRFs), commonly called *acute rehab*.
- In the United States, reimbursement for rehab at home, SNFs, and IRFs for patients 65 and older is typically paid through Medicare Part A. SNFs and IRFs are reimbursed via bundled payment. Physician services (which are not part of this bundled payment) can be billed separately through Medicare Part B. Supplemental insurance may provide varying degrees of additional coverage.
- Medical management includes pain management, pressure sore prevention, thromboprophylaxis, nutrition, and delirium prevention.
- Rehab goals of patients (or of patients' families and caregivers)—particularly for patients who are frail with multiple, complex comorbidities and cognitive deficits—may not match actual rehab outcomes; some patients may not return to their prior baseline function.
- Realistic goals and expectations for a patient's rehab outcome are important for improving the satisfaction of patients and their families and caregivers.

TRANSITIONS IN CARE

Transitions in care are areas of opportunities for improving patient safety and outcome. A transition in care occurs when patients go from home to hospital, hospital to SNF, and/or SNF to home. A transition is a vulnerable time for patients during which

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unintended errors may occur. For patients discharged from the hospital to a SNF for rehab, for instance, poorly implemented care transitions can lead to adverse events, patient and family dissatisfaction, unnecessary use of emergency room services, and avoidable rehospitalizations.[1,2]

Unintended errors may also occur, including the following:

- Medications inadvertently omitted or added to a patient's list
- Inaccurate medication dosages dispensed
- Discontinued medications accidentally resumed
- End dates for medications omitted on interfacility transfer orders

End dates (and start dates) of certain medications, in particular antibiotics, temporary diuretics, steroid taper, and short-term anticoagulation, must be included on interfacility transfer orders and discharge summaries to prevent adverse patient outcomes. Other potential risks in care transitions include the following:

- Failure to prepare timely discharge summaries
- Failure to include all pertinent information in the discharge summaries
- Failure to follow-up on important laboratory tests and studies pending at time of discharge
- Failure to arrange specialty follow-up appointments
- Failure to communicate the need for follow-up laboratory tests or studies
- Incomplete or no handoffs between physicians and/or nurses

Other potential risks when transferring patients from hospital to SNF concern logistics and also should be avoided. For instance, pharmacies are often off-site in SNFs. If a patient is discharged from the hospital in the late afternoon or evening, that patient invariably arrives at the SNF after the pharmacy is closed, thus may not receive necessary medication (eg, pain medication, antibiotic, or cardiac medication) until the following day.

Becoming aware of the potential risks in transitions and taking proactive steps to prevent those risks can improve patient safety and outcome. Standardizing elements of the discharge process may help reduce unintended errors. For example, using a discharge checklist of the critical elements for an optimal handoff can help prevent adverse events in care transitions.[1]

When transferring a patient from a hospital to a SNF, 3 components are necessary[3]:

- An interfacility transfer form, including discharge medications, discontinuation dates for short-term medications, and any dosage changes in all medications
- A discharge summary that includes a patient's baseline functional status, a list of important tests for which results are pending, and a list of necessary next steps, including physician follow-up appointments
- Verbal physician-to-physician sign-outs to ensure that all questions that the receiving physician has can be answered

Following these steps ensures a safer handoff and helps apprise the receiving physician of any important discussions that may have previously occurred among the patient, patient's family, and primary providers. Some of these discussions may have focused on the patient's advance directives and goals of care, which influence the receiving physician's management of the patient. Similarly, when a patient is ready for SNF discharge to home, the same steps and principles should be applied to ensure safe transition.

Several programs have been developed and evaluated to ensure safe care transitions to nursing homes and home.[4,5] The Care Transitions Program includes a