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Transfer of patients with psychiatric illness

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Abstract

The transfer of a patient with psychiatric illness from a general medical hospital to an extended care facility (ECF) can involve challenges and pitfalls. Planning should begin with the patient's admission to the hospital. Comprehensive communication among staff members and also between staff and the patient/family is critical. Errors in diagnoses and medications pose particular risks during the process of transfer. It is essential that the ECF selected for the patient be prepared to provide treatment not just for the patient's physical needs but also their psychiatric symptoms. Many ECFs do not have enough staff and/or consultants who are prepared to treat psychiatric problems. Once the patient has been established in the ECF, it is important that any changes in their psychiatric symptoms be included in their chart so that their diagnosis is current. The use of electronic medical records may contribute to errors in diagnosis when old, inaccurate information is retained through the inappropriate use of "cut and paste" tools. The purpose of this article is to identify these challenges and offer solutions for hospital staff, (e.g., integrated care providers, hospitalists), pre-transfer and ECF staff after transfer.

Keywords: psychiatric patients, extended care facility, communication, diagnosis, electronic medical record

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1. Introduction

The transfer of a patient from a general medical hospital to an extended care facility (ECF) usually signals a change in their status. For some, it may be a short term stay before returning home. For others, the length of stay may be indeterminate and could be life-long. In either case, careful planning is essential. Comprehensive communication among staff members and between staff and the patient/family is critical. Transferring patients with psychiatric comorbidities can be especially challenging.

For a transfer to be successful, the ECF must be able to provide appropriate care for both the physical and psychiatric needs of the patient. A successful placement will also allow for the monitoring of changes in patient functioning and diagnosis.

The purpose of this paper is to identify some of the challenges related to transfer from a hospital setting to an ECF, and to offer some considerations and solutions for hospital-based providers and ECF staff to improve patient care. Three areas will be examined: 1) discharge planning and communication; 2) mental health services in ECF; and 3) updating patient diagnoses.

2. Discharge Planning and Communication

As healthcare costs have risen, hospitals have been under increasing pressure from both insurance companies and the government to absorb the financial risk associated with treatment decisions (1). One of the major responses to this has been a reduction in the number of days patients remain hospitalized. The length of stay in the hospital has dropped from an average of 7.3 days in 1983 (2) to 4.7 days more recently (3). There is also considerable pressure to discharge patients earlier in the day rather than later (4). This is thought to reduce emergency department overcrowding by increasing bed availability at times that correspond to higher emergency department volume and demand for inpatient beds. The growing emphasis on shorter hospital stays necessitates more involved post-discharge care and requires increased planning and coordination on the part of providers (5, 6).

Given these increased demands with regard to discharge planning, coordination of care can be inadequate, with the potential for frequent coordination gaps and medical errors associated with discharge from the hospital (7). Delayed or poorly planned discharge appears to arise from several common factors: poor communication and/or coordination between health care providers and social workers, lack of adequate planning for discharge, short notice of discharge, and inadequate involvement of patient and family (8).

Poor communication can also lead to medical errors, which can be one of the more serious problems related to discharge (9, 10). Medical errors, including inaccurate diagnoses are relatively common. Auerbach and colleagues (11) reported that 23 % of all hospitalized adults experience some medical error. They also found that 17% of all hospitalized patients had either temporary harm, permanent harm or death, because of these errors.

A survey of 400 patients following discharge found that nearly 20% reported some form of adverse event, of which approximately two-thirds were medication-related (12). Prescribing errors at discharge represent nearly 80% of all prescribing errors during hospitalization and often persist post-discharge, increasing the risk of hospital readmission (13). Antipsychotics and other medications can have significant consequences when prescribed inappropriately or unnecessarily.

Another example of a medical error would be the inaccurate diagnosis of a medical condition. This can have significant ethical, clinical, and financial implications. Two of the primary ethical principles under which physicians operate are beneficence and non-maleficence. Succinctly, the respective goals of these principles are to maximize the good and minimize the harm that may result from treatment under a provider's care. The application of an inaccurate diagnosis threatens both of these principles, potentially preventing appropriate treatment for the true condition while exposing the patient to unnecessary medications or procedures. Treatment based on an inaccurate diagnosis may cause undue harm in the form of side effects and complications.

In the case of inaccurate mental health diagnoses, there is also a particular risk of stigmatization, as individuals with psychiatric diagnoses tend to be more severely discriminated against at both the structural and interpersonal level than those with other health conditions (14).

Those with psychotic disorders in particular appear to be more harshly judged by others than individuals with depression or anxiety. They are also more likely to be perceived as dangerous, unintelligent, and lazy (15). Individuals with mental

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illness are more likely to experience housing and employment discrimination compared to those without mental health diagnoses and are more likely to experience homelessness (16). Stigmatizing beliefs regarding these individual's competency may lead to a reduction in their autonomy with regard to their finances and living situation (17, 18)

Stigmatization concerns extend to the healthcare system as well, with healthcare workers more likely to report negative attitudes and perceived prognoses towards those with mental illness than those without (14). Individuals with mental illness tend to seek treatment for both psychiatric and physical conditions at a lower rate and are less likely to follow through with treatment than those without these conditions. People with mental illness cite stigma and negative attitudes from healthcare providers as a chief reason for not seeking treatment (19).

Healthcare providers also appear to be susceptible to "diagnostic overshadowing" (20). In the case of individuals with documented mental illness, signs of physical illness may be mistakenly attributed to their psychiatric disorder. This may prevent or delay appropriate treatment for the patient's condition (20, 21). There is a significant mortality gap between those with severe mental illness and the general population (20 years for males and 15 years for females) and while there are many factors likely influencing this, it has been theorized to be at least partially the result of stigmatization (22).

There is a significant financial impact of misdiagnosis for patients and their families, who may bear the cost of lifelong care for permanent disabilities, lost income due to a patient's temporary or permanent disability, and the cost of the unnecessary treatments (23, 24). There is also a broader financial impact for the medical system, with diagnostic errors accounting for approximately 29% of malpractice claims and 35% of settlement payments, with a mean payout of $390,000 (25). Beyond the direct cost of identified diagnostic errors, there are significant costs to such errors which may not be acutely felt by either patients or medical providers, with an estimated 30% of healthcare spending in the United States (approximately $750 billion dollars) used on unnecessary services each year (26).

In summary, problems with communication and misdiagnosis can be critical obstacles in the first stage of transferring patients to ECF's. Early recognition and remediation of these problems could improve the entire transfer process.

3. Mental Health Services in ECFs

It has been reported that about one half of ECF residents have depression while about one quarter suffer from anxiety (27). Diagnoses of psychosis are also common (28). Limited access to adequate mental health services and lack of appropriate reimbursement have been identified as significant barriers to providing necessary care. Nearly three quarters of ECFs report difficulty obtaining consultation services for behavioral problems, due largely to a shortage of providers and difficulty providing competitive reimbursement for these services (29).

A considerable volume of literature has suggested the importance of Medicare and Medicaid reimbursement on nursing home quality (30). Providing quality care to those residents with mental illness requires more patient care hours relative to the care of other ECF residents (31). Medicare and the majority of state Medicaid programs adjust reimbursement to ECFs using a system that divides patients into payment groups based on their clinical complexity. Individuals with behavioral problems such as wandering, hallucinations, and delusions can qualify for a higher reimbursement rate, but only if physical limitations are minimal (30).

In instances where a patient has both considerable physical and mental health needs, no additional payment is made for the presence of behavioral problems. This may limit the incentive to adequately address these patients' needs. These patients are more likely to exhibit physical aggressiveness and socially inappropriate behavior, which has been found to negatively affect ECF staff job satisfaction and increase workload (32). ECF staff may therefore have decreased incentive to spend necessary time and care with these residents, who are likely to require more care and attention from staff than residents without mental illness. Therefore, ECF staff may not feel motivated to provide the adequate care needed with these patients, which may have considerable implications for their ability to receive appropriate evaluation and management of their illness. Orth and associates (33) have also noted the inadequate training to staff about psychiatric patients. The financial and systemic constraints on these facilities are considerable and the resulting limitations in care are understandable. However, there is a clear ethical duty on the part of these institutions and their staff to provide these basic tenets of medical care to their residents, and the failure to do so is not

ethically or medically justifiable. More research is needed to identify effective ways of providing satisfactory psychiatric care in ECFs (34).

Although the groundwork for a successful transfer is set while the patient is still hospitalized, the resources of the receiving facility must also be considered. It can be seen, after reviewing the information on psychiatric care in ECFs, that many patients are not receiving needed treatments to manage their psychiatric symptoms.

4. Failure to Update Diagnoses

Ensuring that a patient's medical record is up to date and accurate is important for patient safety and clinical decision making. This benefits the patient by preventing redundant testing, inaccurate diagnoses, and prescription of inappropriate or unnecessary treatments (35). The primary means by which this information is stored and updated at most medical centers and outpatient clinics is via the use of electronic medical records (EMR) (36).

While one of the purported benefits of EMR systems is improved accuracy, there is evidence suggesting a considerable amount of data error in EMRs, particularly with respect to medication lists, allergies, and medical histories (37, 38, 39). "Copy and paste" functions in modern EMR systems in particular may promote less accurate notes due to the inclusion of outdated information or propagation of inaccurate information (40, 41, 42).

While several professional organizations have released formal guidelines regarding the risks and appropriate use of these functions, a 2013 report by the U.S. Office of the Inspector General found only 24% of organizations had an official policy regarding these practices in place (43). A review of Veteran's Health Administration (VA) medical records found that copy and paste practices contributed to clinical diagnostic errors. The study found providers had copied and pasted previous information into a progress note in 7.4% of the errors identified, with the copied information contributing to the diagnostic error in 35.7% of these cases (44).

Aspects of this functionality are often automated in EMR systems as well, carrying information about a patient's medical history, medications, allergies, and other historical data automatically into each progress note (45). These systems allow for the accelerated proliferation of inaccuracies when this information is not thoroughly reviewed at each patient encounter. Some EMR systems do not allow users to edit certain information that has been carried forward. Even when editing is permitted, users are often not provided with system features that promote efficient editing, providing additional barriers to ensuring the accuracy of the information contained in the patient's chart and potentially increasing the likelihood of subsequent medical errors (46). Given the risks associated with inaccurate medical diagnoses, current EMR systems represent an important potential cause of these risks and may even present active barriers to preventing and correcting these errors.

The important task of ensuring that the patient's diagnoses are current and accurate represents another aspect of a successful transfer. Continuity of the care provided in the hospital must be informed by an updated assessment of the patient's current diagnoses and treatment needs at the ECF.

5. Discussion

Given the pressures to discharge patients as quickly as possible, coordination of care between medical services is imperative, particularly in cases where discharge is sooner than anticipated. Means of communicating aspects of discharge planning as early as possible in a patient's stay may therefore be of help in preventing errors.

Recommendation: improve communication and coordination of care between medical services, including documentation about discharge planning. This would allow psychiatric consultants to communicate to the primary service much earlier in the hospitalization.

There may be a benefit in creating a standardized phrase (e.g. for inpatient use only) at institutions upon initiation of anti-psychotic medication, for example, that denotes that the medication is not intended to be used long term and should be discontinued when the patient's symptoms have improved or resolved. This would allow a psychiatry service to communicate to the primary service much earlier in the hospitalization when the medication should be discontinued to minimize chances of it being continued indefinitely. It also provides further protection against unintended continuation even if the patient is discharged unexpectedly or without proper discharge instructions from the consulting psychiatry service.

Recommendation: create a standardized phrase to denote that a particular medication, such as an antipsychotic, is intended for short term use only.

Because of the federal mandate to limit the use of antipsychotics for non-FDA approved indications in ECFs, these institutions may feel pressure to avoid associating the medication with a diagnosis other than schizophrenia or bipolar disorder. While this highlights the importance of discontinuing antipsychotic medications before discharge, ECFs should also continue to monitor the need for these medications and attempt to avoid assigning diagnoses that are inaccurate or misleading.

Recommendation: frequent monitoring by the ECF for accurate diagnosis and related appropriateness of antipsychotic (and other) medications is recommended.

One intervention that may help to minimize inappropriate continuation of a medication could occur while the patient is still in the hospital. Previous research (47) suggests that the type of antipsychotic prescribed for delirium and route of administration has an impact on the likelihood of the medication being continued following discharge. First-generation antipsychotics, such as haloperidol, have been found to be less likely to be continued in those patients with delirium than second-generation antipsychotics (48). While the reason for these findings is unclear, these medications may appear more obvious to providers to be short term medications because first generation antipsychotics such as haloperidol are more likely to be administered intramuscularly or intravenously. This may also occur because second generation antipsychotics presently make up approximately three quarters of the antipsychotics prescribed today for maintenance of psychotic and mood disorders, and these medications are more easily assumed to be part of a patient's existing medication regimen and continued at discharge (49). Route of antipsychotic administration such as intramuscular or oral dissolving tablets when possible, may help to implicitly communicate to both primary care teams discharging patients from the hospital as well as the staff at the admitting ECF, that the medication may not be intended for long term use.

Recommendation: when appropriate, it is recommended that intramuscular or oral dissolving routes for administration of antipsychotics be used. This would potentially help to communicate the short term use of the antipsychotic as intended.

A patient's misdiagnosis will likely be carried forward from the ECF's medical records to the EMR system in the hospital on readmission. At many hospitals, a nurse is typically responsible for manually entering diagnoses from a list provided by the ECF into the hospital EMR. These diagnoses are then listed in the hospital EMR problem list and automatically carried into each note written on the patient. This highlights one of the major areas of risk that has been identified in copy-forward features in EMR systems. Misinformation is more quickly and efficiently propagated in these systems. The lack of clear means to edit and correct this information may further exacerbate this issue. It is therefore crucial that EMR systems be designed such that diagnoses can be readily accessed and altered when indicated.

Recommendation: EMR systems should be designed to help facilitate information that is current and accurate.

6. Conclusion

Extensive resources are provided to patients with psychiatric needs while they are in the hospital. In order to ensure that the next phases of a patient's care build on and maintain gains made in the hospital, it is vital that attention be given to facilitation of a successful transfer. First of all, the inpatient providers must be in close communication and always have the patient's discharge in mind. Next, the facility to which the patient is transferred must have the psychiatric resources to meet the patient's physical and mental health needs. Finally, there should be frequent reviews of the patient's diagnoses to ensure that they are not being treated based on outdated and inaccurate information.

Altering the institutional practices and procedures that lead to transfer problems can be challenging. However, we have identified a number of interventions, some of which would be relatively simple to implement, that could meaningfully reduce the frequency and potential negative consequences of transfer issues. If these recommendations are followed, outcomes, including quality of life, will be improved for the patient.

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