Improving Safety At Discharge and Transition of Care

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Objectives

1. Define tactics in each stage of interaction; pre-hospital, intra-hospital and post hospital support a successful discharge.
2. Discuss the importance of “hand offs” in all aspects of discharge.
3. Identify processes that support coordination of care; patient transport, family engagement and interdisciplinary collaboration.
4. Identify community resources that can impact a safe discharge.

Background

- Poorly coordinated care transitions from the hospital to other care settings cost an estimated $12 billion to $44 billion per year
- Poor transitions result in poor heath outcomes.
  - Injuries due to medication errors
  - Complications from procedures
  - Infections
  - Falls
  - Hospital Readmission
- 2012 – CMS implemented penalties for facilities with high readmission rates within 30 days of discharge.
- 2013 – CMS issued new transitions of care codes for outpatient providers

System Pressures

- Estimated 80 million adults aged 65+ by 2040

- CDC 2012 Study – Half of all adults

  have one or more chronic health disorders

- Continued pressure to decrease hospital

  length of stay = faster throughput

- Only 12% of adults in US have proficient level of health literacy

Key Components to Successful Transitions

- Early and ongoing assessment of patient needs
- Communication of accurate patient information before, during and after a care transition
- Nurse skills to understand what the patient needs before, during and after transition
- Comprehensive transition collaboration

High Level Recommendations to get started

- Collect critical data
- Identify the root causes
- Start from the beginning
- Activate a multidisciplinary team
- Systematically respond to social determinants
- Focus on providing culturally competent communication
- Foster external partnerships and community linkages

Guide to Reducing Disparities in Readmissions (cms.gov)

Pre-Hospital Planning

- Effective pre-admission process
- Pre-hospital preparation

Pre-Admission Process

- Accurate assessment of patient current status and situation

- Medication reconciliation

  and teaching

- Effective written and oral education

In-Hospital Planning

- Accurate assessment of patient needs
- Interdisciplinary Team Rounds
- Hand Off communication during hospitalization and discharge
- Patient education
- Preparing patients with limited English language proficiency

Assessment of patient needs

- Identify patients at highest risk for readmission
  - 8 P's Risk Assessment Tool
    - Problem Medications
    - Psychological
    - Principal Diagnosis
    - Physical limitations
    - Poor health literacy
    - Patient Support
    - Prior hospitalization
    - Palliative care

Interdisciplinary team rounds

- Hospitalist
- Primary Nurse
- Social Work
- Case Management
- Physical Therapy
- Pharmacy
- Nutrition
- Charge Nurse

Handoff during hospitalization

- Bedside Shift Report
- Hospitalist to Hospitalist Report
- SBART
- Ticket to Ride
- Case manager to case manager

Handoff at time of discharge - barriers

- Poor Handoff of Information to Primary Care Physician = Process Breakdown
- 25% of patients require additional outpatient work ups
- 41% of patients discharged with pending test results
- Discharge summary not immediately available and lacking key components

Handoff at time of discharge – solutions

- Nurse to Nurse phone call for high risk patients
- Coordination of post-discharge phone call schedules
- Discharge Summary template

Patient education

- Teach back
- Tell me three
- Language barriers
- Health literacy barriers

Preparing patients with limited English language proficiency for discharge

- 25 million people in the US have limited English Proficiency
- Bedside interpreters; in person or telecommunication
- Translation of medication directions
- Translation of discharge instructions
- Include caregiver in all instructions
- Address cultural differences

Post discharge phone calls

- Opportunity to assess patient education
- Proactively address medication and patient care concerns
- Verify follow up appointments

Response to Social Determinants

- VIP Patient Transport Services
- Legal Aid Services
- Foundation engagement (Oxygen, Medication)
- Health Department/Clinics

Community Collaboration

- Transitions of Care Collaborative
- Medication Safety Collaborative

Transitions of Care Collaborative

- Mission: Improve care coordination and medication safety though community based interventions
  - Build and sustain a community group
  - Create communication network that supports transitions

Transitions of Care Collaborative

Quarterly meeting of key stakeholders:

- Hospital (Inpatient, Emergency Department, Case Management, Social Work)
- Skilled Nursing Facilities
- Assisted Living Facilities
- Home Health and Hospice Agencies
- Primary Care Clinics

Different viewpoints identify unique opportunities for improvement and highlight the many factors that impact readmissions. These opportunities might be missed if entities work in silos.

Transitions of Care Collaborative

- Issues addressed:
  - Handoff communication to facilities
  - Facility to physician communication
  - Medication reconciliation and orders
  - Nutritional needs
  - Emergency Department visits/handoff
  - Disaster preparedness

- Improved relationships foster great problem solving in times of need

Medication Safety Collaborative

- Developed in response to Medical Staff request to improve process for obtaining patient medication information on admission to the hospital.

- Stakeholders identified:
  - Hospital (ED, Inpatient, Pharmacy, Transitional Care)
  - Primary Care Providers
  - Retail Pharmacies
  - EMS/Transport

Medication Safety Collaborative

- Value stream map (Lean) utilized to identify two key problem areas
  - Patients do not present to providers with a medication list
  - Communication between providers re: medication changes is lacking

Medication Safety Collaborative

- Medication List Campaign
  - Consistent messaging throughout the community
    - Orange pockets
    - Signs & Billboards
    - Newspaper & Radio ads
    - Social Media
    - Community education tour

Medication safety starts with you.

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TO-DO LIST
MED LIST
(it could save your life)

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Medication Safety Collaborative

- Communication across the continuum
  - Developed better understanding across the continuum:
    - Changes to Rx without call to pharmacy (double dose, stop taking, etc.)
    - Discontinued medications and bubble packing risks
    - Patient education needs not being met

When there is a readmission

- Training for physicians re: 3 midnight/30 day rule (ED and Hospitalists)
- Appropriate but strategic use of observation status
- Reassessment of what may have been overlooked during first hospitalization

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