



# Transitions of Care

September 2009

# Better Health *Greater* Cleveland

- An alliance of regional stakeholders, committed to improving the health and quality of care for Greater Cleveland's residents with common chronic medical conditions.
- The alliance was established in February 2007, with support from The Robert Wood Johnson Foundation's signature quality improvement initiative, *Aligning Forces for Quality*.

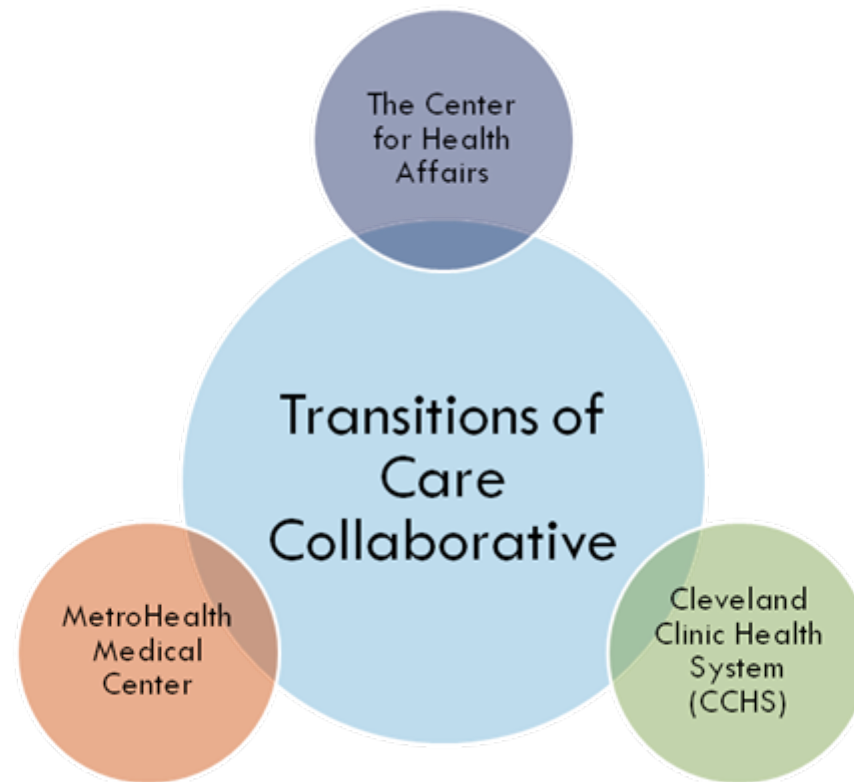
# The Goal & Strategy

- The Goal:
  - ▣ To reduce avoidable hospital readmission of patients discharged with selected chronic diseases.
  - ▣ To improve the patient experience.
- The Strategy:
  - ▣ To improve the transition of care from the hospital to the community.



# Transitions of Care Collaborative

- A working committee of Better Health *Greater Cleveland Alliance* led by nursing representatives.



# First Steps of Collaborative

- Completed fact finding research.
- Conducted face-to-face interviews with key stakeholders at partner hospitals.
- Developed survey to gain an understanding of the discharge and follow-up care processes.
- Identified gateways and barriers to successful transitions.

# Survey Categories

- The survey examined areas that are accepted as playing a key role in successful discharge and transition. These include:
  - Demographic Information
  - Medication Reconciliation
  - Hand-Off Communication Between Physician Providers
  - Staff-to-Patient Communication
  - Follow-Up Care
  - Post-Discharge Support
  - Readmissions

# Demographic Information

- Factors have been shown to have a strong tie with healthcare outcomes and would play a significant role in successful transitions of care include:
  - ▣ How information is collected on racial and ethnic background (patient self identifies or through personal observation at intake)
  - ▣ Preferred language
  - ▣ Health Literacy



# Medication Reconciliation

- In the period immediately following discharge, patients often experience difficulty with medical management. Issues include:
  - ▣ Not picking up prescriptions.
  - ▣ Not taking discharge medications.
  - ▣ Not understanding how to take the medications.
  - ▣ Discrepancies between what they are taking and what they should be taking.



# Hand-off Communication Between Physician Providers

- Measures for achieving effective transitions include:
  - ▣ Primary care physician or clinic notification of admission and discharge.
  - ▣ Discharge summary dictated within one day prior through seven days after discharge and sent to the primary care physician.
  - ▣ Diagnosis, results of procedures, pending tests, medications, follow-up arrangements, and suggested next steps are included in the discharge summary.
  - ▣ Previously unassigned cases referred to a primary care physician or clinic prior to discharge.

# Hospital Staff-to-Patient Communication

- Specific practices that support effective and safe patient handoffs include:
  - ▣ Providing complete discharge instructions and contact information.
  - ▣ Educating patients about their diagnosis throughout hospital stay.
  - ▣ Reviewing with patients what to do if a problem arises after discharge and providing instructions for contacting their primary care physician.
  - ▣ Assessing the patient's degree of understanding by asking the patient to explain in his or her own words the details of the plan.

# Hospital Staff-to-Patient Communication cont.

- Specific practices that support effective and safe patient handoffs include:
  - ▣ Provide information in the patient's preferred language.
  - Utilize translation services and interpreters.
  - Use effective tools to measure the patient's health literacy.
  - Provide easy to understand and clinically appropriate material in a layperson's language.

# Follow-Up-Care

- Coordination and continuity of care are critical to successful transitions. These include:
  - Having an accountable provider or team of providers during all points of transition.
  - Ensuring that a follow-up appointment with a physician is scheduled for every patient before he or she leaves the hospital.
  - Sending appropriate discharge information to providers, ensuring all transition services and care are coordinated, documented and verified, and giving patients a copy of their care plan.
  - Making follow-up calls to patients by a nurse 2-3 days post discharge to reinforce the discharge plan and review medications.



# Post-Discharge Support

- ❑ Providing information on support groups related to their disease.
- ❑ Support groups help people learn, share their experiences and become inspired to move forward.
- ❑ By meeting regularly members help one another face and overcome challenges.
- ❑ Survivors and caregivers can make friends, socialize, gain realistic feedback, and help others find meaning in life.



# Future Actions

- Respondents' top three priorities for improving transitions of care include:
  - ▣ Communication between hospital staff to patient and family, hand-off communication between physician providers, and hand-off communication between hospital and post acute care facilities.
  - ▣ Follow-up care, specifically, the discharge plan, continuity of care, and scheduling appointments with primary care physicians and specialists prior to discharge.
  - ▣ Resources to optimize discharge planning and decrease unplanned readmissions.

# Future Action



- Current hospital initiatives include:
  - ▣ Standardizing a discharge checklist.
  - ▣ Conducting daily rounds with case managers.
  - ▣ Conducting weekly rounds with a physician advisor.
  - ▣ Rounding by a discharge team for all discharged patients.
  - ▣ Redesigning the role of the case manager.
  - ▣ Completing discharge instructions.
  - ▣ Improving the patient satisfaction with discharge process.

# Questions?

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