PUSHING THE ENVELOPE ON TRANSITIONS OF CARE

16 APRIL 2019
INTRODUCTION

• Marjanna Barber-Dubois
• BA, Health: Science, Society, and Policy Brandeis University, 2009
• Part-time/Online MPH student Expected graduation May 2019
• Quality and Safety Clinical Specialist Rutland Regional Medical Center Rutland, Vermont
• Advanced EMT-Paramedic until 2016
SITE PRECEPTOR

• Timothy Gibbard, MBA, RRT
• Manager, Quality and Safety Department
Rutland Regional Medical Center
Rutland, Vermont

FACULTY ADVISOR

• Dr. Lilly Engineer
PROBLEM DEFINITION

• The average patient sees 4 different clinical providers in a year\(^1\)
• Transitions of care are one of the most common areas for loss of information transfer\(^2\)
  • Provider-to-provider
  • Interfacility transitions
• Medication record discrepancies constitute a large percentage of the errors associated with information transfer\(^3\)
BACKGROUND

• The Rutland Community Collaborative has been active since 2014 under several names

• Primary mission is to improve the health of the community by reducing all-cause 30-day readmission rates

• Rutland has participated in an all-payer model since 2008 with an emphasis on care coordination

• The Transitions of Care subcommittee has focused on improving the processes around care transfers between the hospital, other medical services, and the community at large
NARROWED FOCUS

• Document and improve processes between RRMC and local skilled nursing facilities in order to reduce 30-day all-cause readmissions

• Focus on discharge from RRMC, returning to skilled nursing via Regional Ambulance Service
STATISTICS

• Outpatient providers report having the complete information transferred only 22% of the time\(^4\)
• Up to 30% of hospital admissions and up to 15% of hospital discharges include medication record discrepancies\(^5\)
• One study of SNF admissions found a 71% medication record discrepancy\(^6\)
STAKEHOLDERS

• The Pines
• The Gables
• Mountain View
• Rutland Health and Rehab
• Regional Ambulance Service
• RRMC
• Transitions of Care Committee
• Community Collaborative
• Case Management
• Social Work
• Community Health Team
CURRENT STATE

• Recipient of verbal report and handoff dependent on facility and time of day

• Concerns from SNF
  • Medication list not always received or updated
  • Potential for lost paper-based prescriptions
  • Standard ED discharge paperwork does not include patient-specific notes
Secretary and charge RN prepare packet

Packet for EMS
- standard discharge paperwork
- medication list*
- EMS form clipped to front

Primary nurse calls SNF
Verbal Report (meds, labs, d/c instructions)

ED providers encouraged to give verbal handoff to SNF providers

EMS transports Patient and Information

The Pines Information packet
Direct Handoff to Front Desk Staff/Secretary

Other SNF Information Packet:
Direct Handoff to Unit Staff/Secretary

Staff Present for Handoff?

NO

Verbal Handoff Given to Unit Secretary/Staff, Relay from ED Staff

YES

Verbal Handoff Given to Staff in Room, Relay from ED Staff
## Perceptions on Transfer of Information

<table>
<thead>
<tr>
<th>Est. Time Incomplete Information Received</th>
<th>SNF</th>
<th>ED</th>
<th>EMS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>90%</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>85%</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>75%</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Priority of Missing Information</th>
<th>SNF</th>
<th>ED</th>
<th>EMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medications</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Medications</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Allergies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Physician notes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Code status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Code status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Allergies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Medications</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Allergies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Medications</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Code status</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Perceived Location of Loss of Information</th>
<th>SNF</th>
<th>ED</th>
<th>EMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED, EMS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SNF, EMS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SNF, Hospital</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
SUGGESTION

• Focus on process
• Develop a universal checklist for all SNF to receive complete and appropriate information from the Emergency Department
• Print checklist directly on envelope used to hold paperwork
RATIONALE

• Checklists are a system-oriented\textsuperscript{8}, evidence-based intervention often used in high-acuity situations such as surgery\textsuperscript{9,10} and increasingly in care transitions and care coordination\textsuperscript{5,11}

• Provide a “time-out:” a pause in the action to ensure everyone is on the same page with the same goal

• Provide documentation of items used or relayed

• Increases patient safety with clear, documented communication, roles, and expectations\textsuperscript{12}
IMPLEMENTATION

• Develop checklist with input from ED and SNF
• Print checklist directly on envelopes that are used for packaging transfer paperwork
• Use checklist to
  • Ensure complete and appropriate information is transferred safely and not lost in transit
  • Guide verbal handoff to SNF
NEXT STEPS

• Formal collaboration with ED, EMS, and SNF representatives
• Build off new ED form
• Have form approved by forms committee
• Educate all users at all facilities/organizations
• Development of measurement mechanisms
• Print and distribute
QUESTIONS?
REFERENCES


