PUSHING THE ENVELOPE ON TRANSITIONS OF CARE

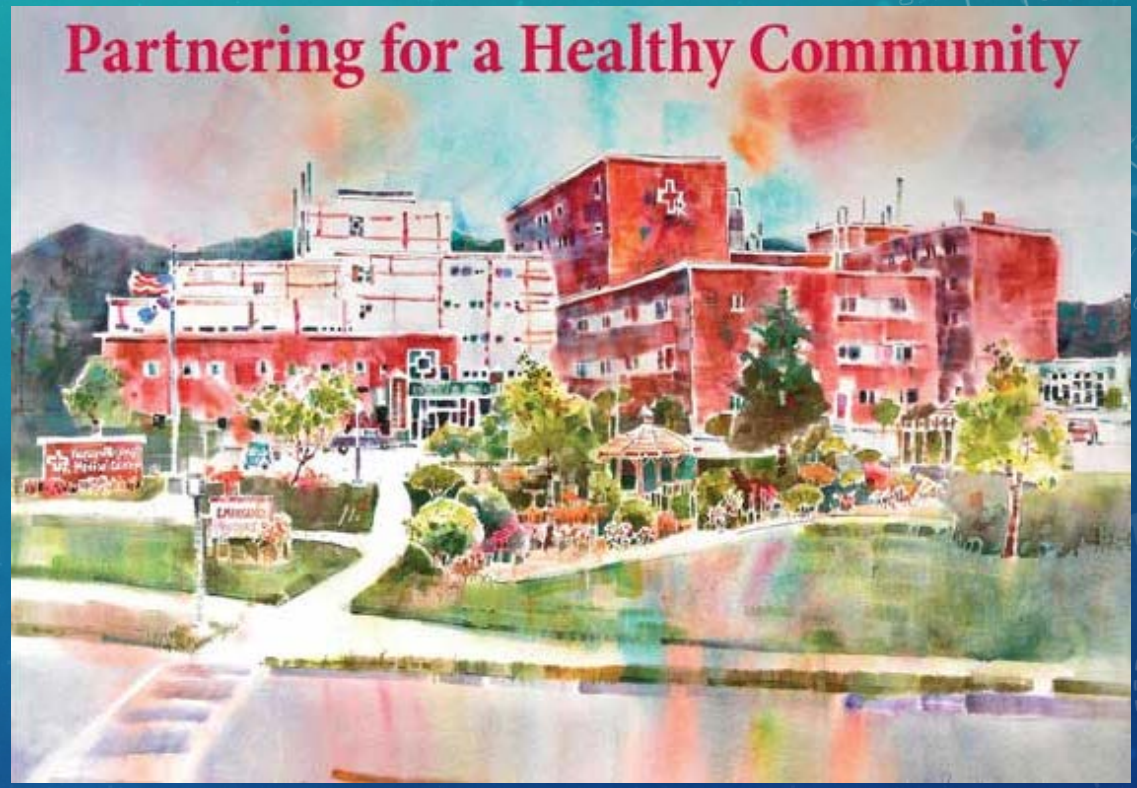
16 APRIL 2019

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 be 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

Community Collaborative

Transitions of Care Committee

SNF

RAS

RRMC

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]

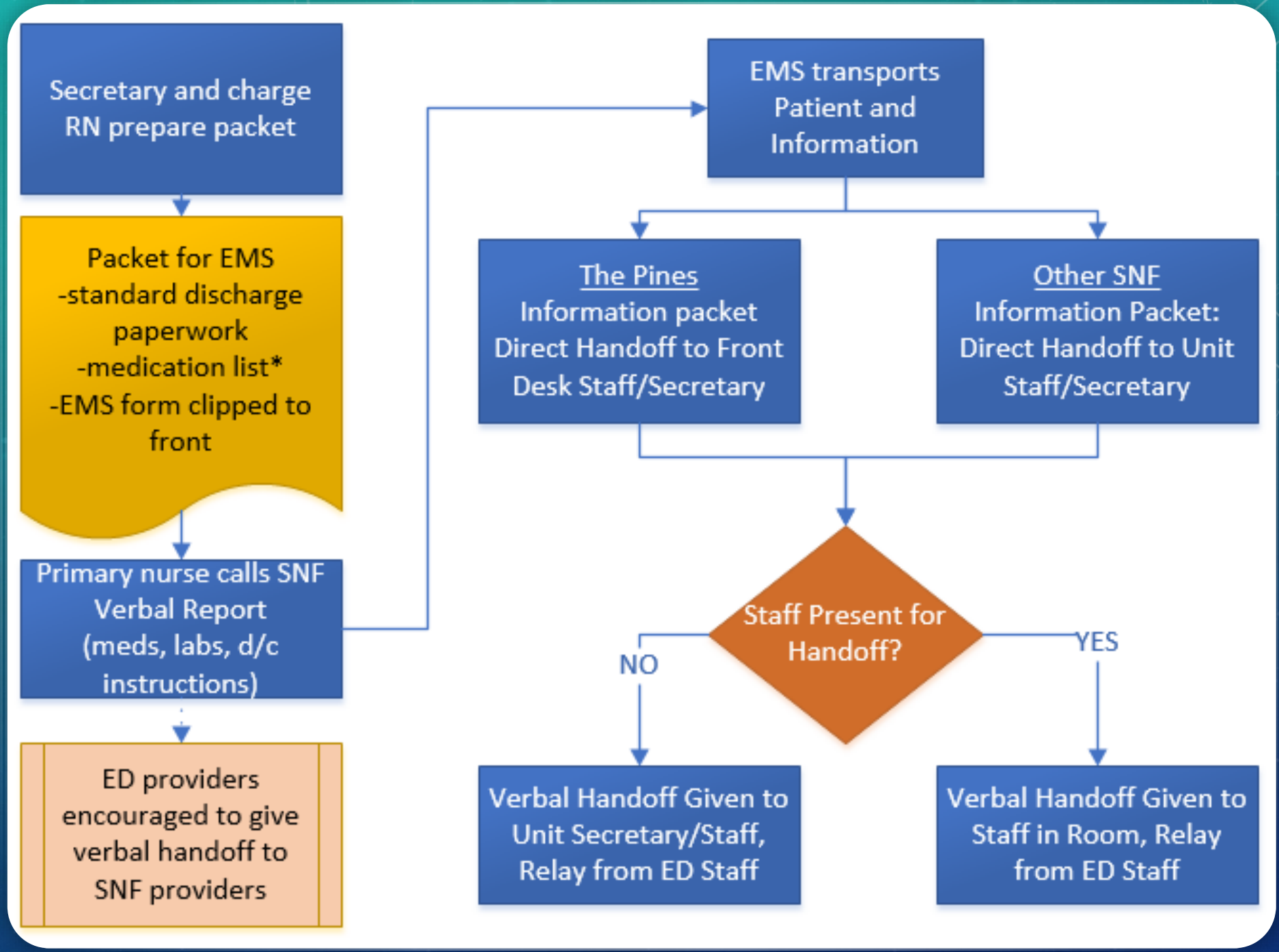
STAKEHOLDERS

- 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
YES
Verbal Handoff Given to Unit Secretary/Staff, Relay from ED Staff
Verbal Handoff Given to Staff in Room, Relay from ED Staff

PERCEPTIONS ON TRANSFER OF INFORMATION

	SNF	ED	EMS
Est. Time Incomplete Information Received	90%	85%	75%
Priority of Missing Information	1.Medications 2. Allergies 3. Physician notes	1. Code status 2. Allergies 3. Medications	1. Allergies 2. Medications 3. Code status
Perceived Location of Loss of Information	ED, EMS	SNF, EMS	SNF, Hospital

REACTION

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[8], evidence-based intervention often used in high-acuity situations such as surgery[9,10] and increasingly in care transitions and care coordination[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[12]

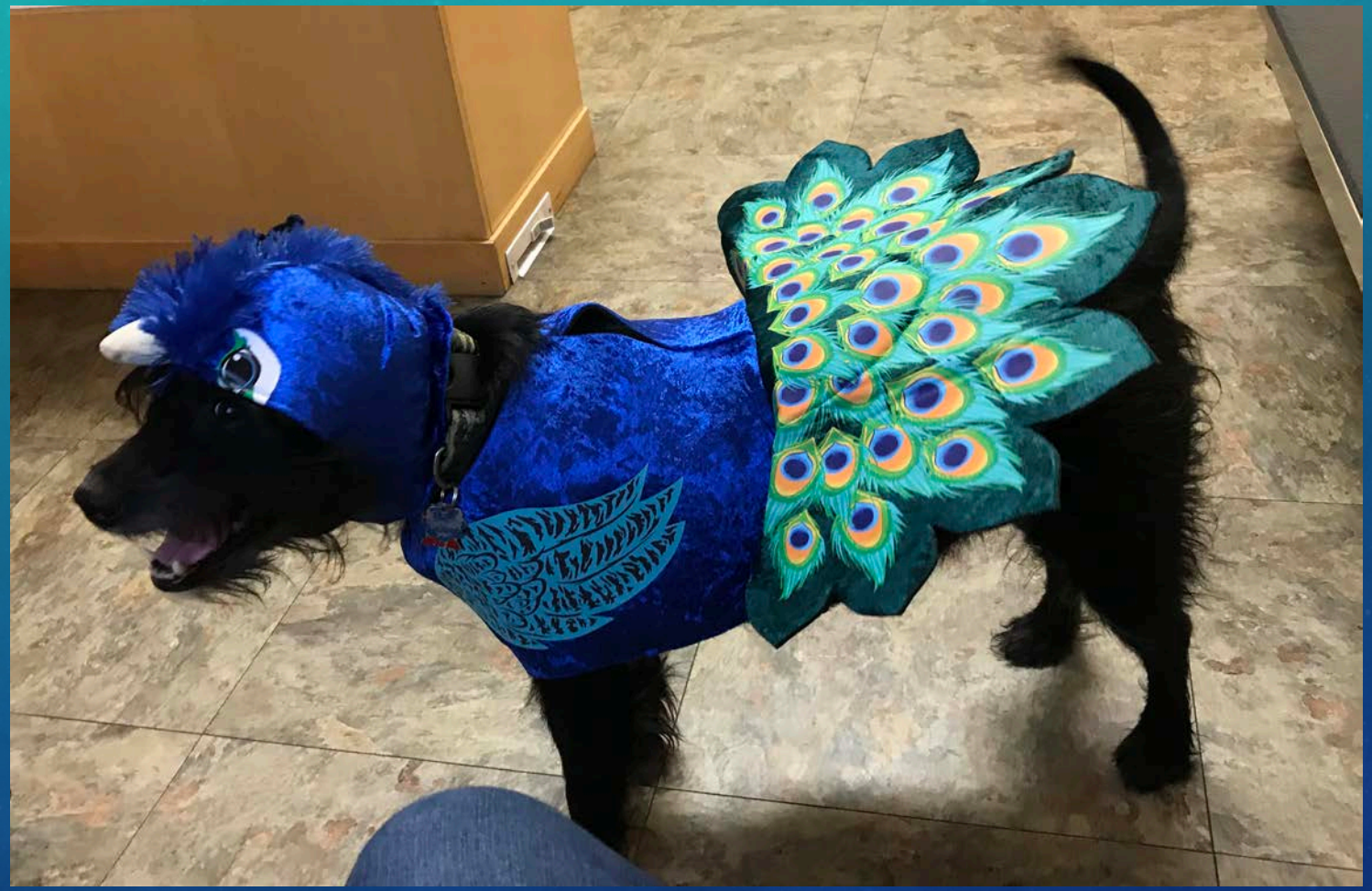
IMPLEMENTATION

- 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

1. Gamache, R. (2018) personal correspondence, 20 December 2018
2. Kwan, J. L., Lo, L., Sampson, M., & Shojania, K. G. (2013). Medication reconciliation during transitions of care as a patient safety strategy: A systematic review. *Annals of Internal Medicine, 158*(5)
3. Sinvani, L. D., Beizer, J., Akerman, M., Pekmezaris, R., Nouryan, C., Lutsky, L., . . . Wolf-Klein, G. (2013). Medication reconciliation in continuum of care transitions: A moving target. *Journal of the American Medical Directors Association, 14*(9), 668-672. doi:10.1016/j.jamda.2013.02.021.
4. Forster, A. J., Murff, H. J., & Peterson, J. F. e. a. (2003). The incidence and severity of adverse events affecting patients after discharge from the hospital. *Annals of Internal Medicine, 138*, 161-167.
5. van Walraven, C., Taljaard, M., Bell, C. M., & et al. (2008). Information exchange among physicians caring for the same patient in the community. *CMAJ, 179*, 1013-1018.
6. Wachter, R. (2012). In Shanahan J. F., Davis K. J. (Eds.), *Understanding patient safety* (second ed.). New York: McGraw-Hill.
7. Tjia, J., Bonner, A., Briesacher, B. A., McGee, S., Terrill, E., & Miller, K. (2009). Medication discrepancies upon hospital to skilled nursing facility transitions. *Journal of General Internal Medicine, 24*(5), 630-635. doi:10.1007/s11606-009-0948-2

REFERENCES

8. Kohn, L. T., Corrigan, J. M., & Donaldson, M. S. (Eds.). (2000). *To err is human: Building a safer health system*. Washington: National Academies Press.
9. Robbins, J. (2011). Hospital checklists. transforming evidence-based care and patient safety protocols into routine practice. *Critical Care Nursing Quarterly, 34*(2), 142-149. doi:10.1097/CNQ.0b013e31820f7467
10. Gawande, A. (2009). *The checklist manifesto*. Washington: Picador.
11. Mathews, W. A. (2014). Care coordination measures of a family medicine residency as a model for hospital readmission reduction. *American Journal of Managed Care, 20*(11)
12. Sponsler, K. C., Neal, E. B., & Kripalani, S. (2015). Improving medication safety during hospital-based transitions of care *Cleveland Clinic Journal of Medicine, 82*(6) doi:10.3949/ccjm.82a.14025