Optimizing Transitions of Care – Hospital to Community

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Abstract

Discharging patients from the hospital is a complex process, and preventing avoidable readmissions has the potential to improve both the quality of life for patients and the financial sustainability of the healthcare system (Alper et al. 2016). Improving the discharge process is one method to mitigate readmission to the hospital. Historically, St. Thomas Elgin General Hospital (STEGH) consistently experienced higher-than-expected readmission rates, and only 41% of discharge summaries were sent from the hospital to the community primary care within 48 hours. In addition, the overall percentage of patients attending a follow-up appointment with a primary care physician within seven days of discharge from hospital was lower than the provincial average. Through engagement with primary care providers (PCPs) and clinical associates (CAs) and with the use of standard work and monitoring organizational metrics, STEGH has achieved significant improvements.

Introduction/Background

A gap in the discharge and transition of care process between hospital and community was identified at St. Thomas Elgin General Hospital (STEGH). Data revealed that only 41% of discharge summaries were being sent to primary care practitioners within 48 hours, and less than 25% of patients had a follow-up appointment arranged within seven days of discharge from hospital. This resulted in a care transition that was inadequate, inefficient and ineffective. Patients who did see their primary care physician within seven days of being discharged were not receiving optimal care, as the physician would likely not have the relevant information including diagnoses, interventions, test results, medication changes, etc.

Intervention

Discharge summary communication was a three-step process at STEGH including dictation, transcription and manual authentication. Physicians in the acute medical units (AMUs) were engaged in a detailed review of the patient discharge and discharge summary process. Completion of a current state analysis and collective development of an ideal "future state" enabled the team to identify key problems and prioritize change ideas for improvement to address the largest gaps. The review highlighted that there was a large variation in the average time that it took for discharge summaries to be sent from hospital to primary care practitioners, with many summaries never having been sent at all. As such, the first key change focused on improving dictation turnaround times by the CA physicians.

To ensure that the CA physicians had access to comparison data on how they were performing, a "scorecard" was created in December 2014 and shared to ignite a little friendly competition, as outlined in Figure 1.

FIGURE 1.
Physician scorecard – discharge summary timeliness
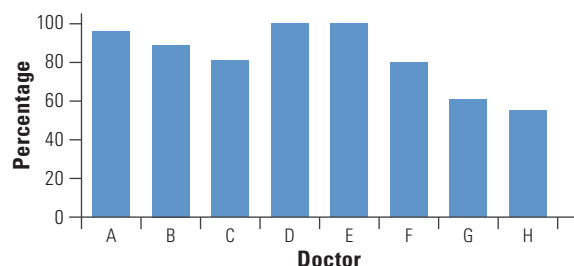
The manual authentication process was identified as an additional barrier to timely discharge summary communication. This process required physicians to log into the electronic health record after the discharge summary was dictated and transcribed to manually authenticate the discharge summary before it was sent to the final destination. This created lengthy delays as physicians were "batching" this work.

An "auto-authentication process" was developed and trialled by physicians, where the discharge summary was sent to primary care practitioners automatically and immediately after it was dictated and transcribed. Robust process planning ensured that physicians, partners, patients and the Medical Advisory Committee were engaged, and ongoing executive leadership support was a significant asset to the project. A process for ongoing monitoring and reporting of discharge summary timeliness was implemented at the board, senior leadership and front-line levels to drive focus and improvement.

While developing strategies to improve the timeliness of post-discharge communication, the team also identified an opportunity for the hospital to facilitate the scheduling of follow-up appointments for patients as they transitioned back to the community. Before the initiation of this project, patients were responsible for scheduling their own post-discharge follow-up appointments with primary care practitioners. In many cases, this did not happen in a timely manner or was not done at all. To support improvement, a process was trialled, where post-discharge follow-up appointments were coordinated by the unit ward clerks.

This process was adopted quite easily following a time study that confirmed there was capacity for the clerks to complete this task within their existing daily standard work. Initially, follow-up appointments were coordinated for patients with specific diagnoses consistent with chronic conditions because those groups were determined to be at the highest risk of readmission. The clinical resource nurse (charge nurse) informed the ward clerk of the discharges for the day and identified patients that needed an appointment booked. This often involved reading the patient's medical history to determine appropriateness of follow-up coordination. Because of reading the patients' charts, it was determined that many patients were being overlooked

because the admission diagnoses did not fall within the selected chronic conditions and the patient's medical history was not being read to determine if they had a relevant diagnosis.

A new plan–do–study–act (PDSA) was completed to inform improvements to the process with a target that 100% of patients discharged to home, a group home or a retirement home would have an appointment booked. Upon confirmation of a pending discharge, the ward clerk called the patient's primary care physician and booked an appointment prior to the patient leaving the unit. The goal was to have the appointment scheduled within seven days of discharge. Patients received appointment cards created by the team. A simple data point was added to communicate the importance of follow-up appointments and how it leads to decreasing readmissions (CIHI 2012).

An additional challenge was that approximately 4% of patients admitted to AMUs did not have a primary care physician. To help facilitate all patients having a follow-up appointment with primary care, a process was developed with the Central Community Health Center (CCHC) so that unattached patients were scheduled to receive a follow-up appointment with a primary care physician or nurse practitioner at the CCHC.

Methodology/Change Process/Results

Change ideas were trialled using Lean principles and multiple PDSA cycles. The physicians liked the idea of the scorecard, as they were able to see how their dictation times compared with their peers. It became a friendly competition to see who could achieve the best dictation times (Figure 1). It also helped to see which physicians were consistently not meeting the 48-hour target. To keep the physicians engaged and accountable, the executive team played a key role in incorporating these data into the weekly leadership scorecard that is displayed on all key performance indicator boards within the organization (Figures 2 and 3).

Summary of Impacts/Results

A target of 80% of discharge summaries sent to primary care within 48-hours was set, and, to date, the target has been exceeded and sustained for more than one year at >93%, as shown in Figure 4. A standard policy is now endorsed by the Medical Advisory Committee. Physicians were originally skeptical about the auto-authentication process, as they would not have the opportunity to edit their dictations prior to them being sent to primary care practitioners. Data support that the number of addendums being made to discharge summaries is low, and primary care practitioners report positive feedback on the quality of the summaries they are receiving.

The auto-authentication process did experience many technical glitches at the time of initiation; however, we can now report that 100% of discharge summaries are now successfully auto-authenticated at STEGH.
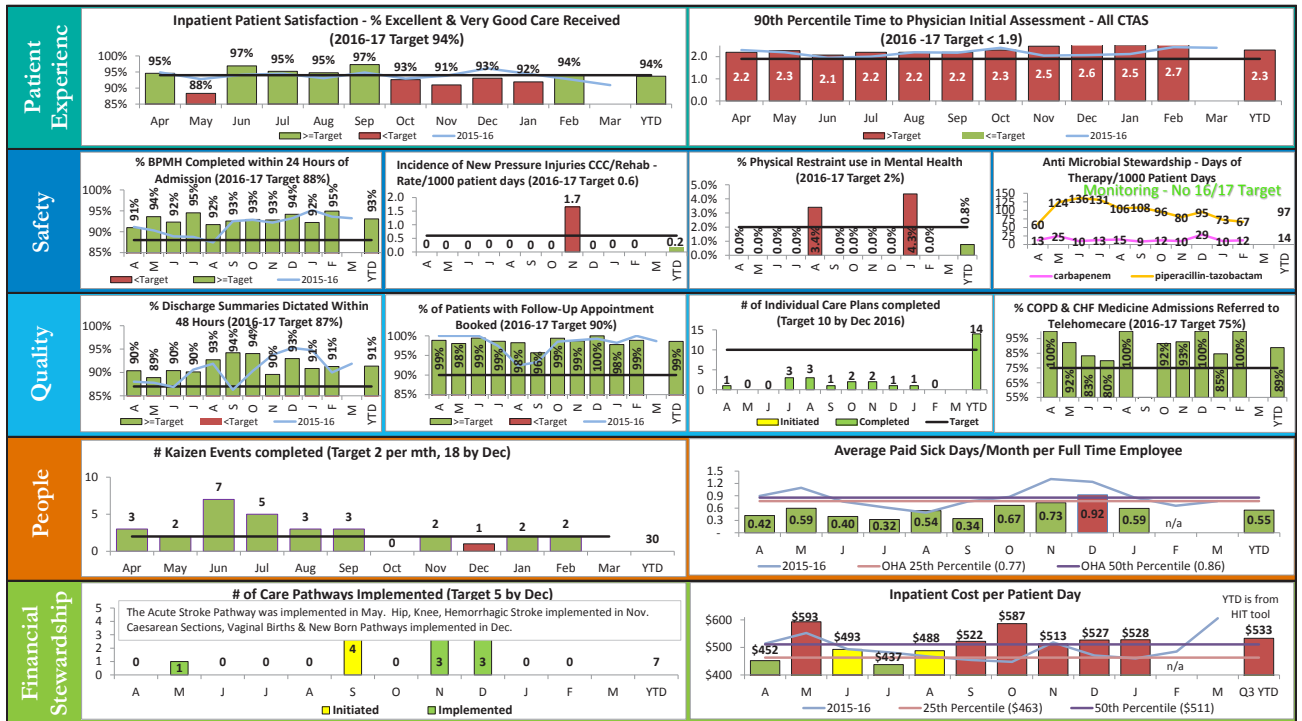
FIGURE 2.

Board scorecard (April 2016: April 2016–February 2017 or most recent 12 months data available shown)

FIGURE 3.

Leadership scorecard (March 13–19, 2017)

FIGURE 4.
Results' impact

Follow-up appointments are now booked for patients of AMU and many other units. A small barrier faced by the team involved two primary care physicians who have stopped accepting hospital-booked follow-up appointments for their patients because of patients not showing up for the scheduled visit. Regrettably, these physicians were reluctant to share their data or patient names, so STEGH was unable to study this further. Feedback from other physicians has been positive. They indicate that they appreciate the appointment bookings, as it informs them that their patient has been in the hospital and they should be expecting a discharge summary within 48 hours. Patient feedback has also been positive, as they appreciate having one less thing to do for themselves post discharge.

As shown in Figure 4, there is variation between the actual hospital readmission rate within 30 days and the expected readmission rate for selected case mix groups (chronic conditions) and we have seen a reduction in readmissions. That said, we recognize that readmission rates are multi-factorial and highly complex.

Discussion/Conclusion

Addressing readmissions is complex, and it is a large undertaking (Bradley et al. 2015). The impact that readmissions have is unfavorable for both the patient's quality of life and the healthcare system. Readmissions are costly and put patients at a higher risk of acquiring hospital infections, medication errors, decompensation, etc. Improving access to post-discharge follow-up care and providing the necessary information for the physician to give adequate follow-up care are crucial in keeping patients safe, healthy and at home (CIHI 2012).

On the basis of the outcomes and the opportunity for broad application of spread to better support patients transitioning from any hospital to their primary care provider following discharge, the South West Local Health Integration Network (LHIN) Clinical Quality Table (CQT) has identified this project as a key regional improvement workstream for spread across the South West LHIN. Leaders from this table, as well as the Chief Nursing Executive Leadership Forum, are supporting engagement with Medical Advisory Committees, Health Links and Primary Care teams to support action planning for improvement. The proportion of discharge summaries sent within 48 hours for all hospitals is being monitored on the CQT dashboard. In addition, successful change ideas from this project have been incorporated into the Health Links IDEAS Cohort curriculum to support adoption and update across the province. Moreover, a standardized measure has been added to the 2017–2018 Hospital Quality Improvement Plan(s). HQ

References

Alper, E., T.A. O'Malley and J. Greenwald. 2016. *Hospital Discharge and Readmission*. Retrieved December 13, 2016. <http://www.uptodate.com/contents/hospital-discharge-and-readmission>.

Bradley, E.H., A. Brewster and L. Curry. 2015. *National Campaigns to Reduce Readmissions: What have we Learned?* Retrieved December 13, 2016. <http://www.commonwealthfund.org/publications/blog/2015/oct/national-campaigns-to-reduce-readmissions?utm_content=buffer9ae4d>.

Canadian Institute for Health Information (CIHI). 2012. *All-Cause Readmission to Acute Care and Return to the Emergency Department*. Retrieved December 13, 2016. <https://secure.cihi.ca/free_products/Readmission_to_acutecare_en.pdf>.

About the Authors

Emily Sheridan, BScN, started her career on the Acute Medicine Unit at St. Thomas Elgin General Hospital (STEGH) as a staff nurse. In 2014, she moved into the role of clinical educator, working out of the Transforming Care Office, specializing in LEAN. She has received the Lean Six Sigma Yellow and Green Belts, and completed the IDEAS Advanced Learning Program (where the Optimizing Transitions of Care project was born). Since 2015, she has worked as a staff nurse in the Emergency Department, while still working on the Optimizing Transitions of Care project in her spare time.

Christine Thompson, MBA, BScN, has been employed by STEGH for 18 years. Christine graduated with her MBA in June 2014, and in 2015 received her Green Belt certification, graduated from the IDEAS Advanced Learning Program and was a recipient of the 2015 IDEAS Alumni Achievement Award for 'Optimizing Transitions of Care from Hospital to Primary Care for Acute Medical Patients.'

Tania Pinheiro is a process improvement specialist and has been in her role since 2012. Tania's background is in Human Resources, and her roles at STEGH have included Team Lead for Maintenance, MDRD, Central Registry and housekeeping. Tania also has Lean Six Sigma Yellow and Green Belt certificates. She is also a graduate of the IDEAS Advanced Learning Program and recipient of the 2015 IDEAS Alumni Award of Distinction.

Nicole Robinson, BSc, MASc, is currently the team lead for Performance Improvement at the South West Local Integration Network. She has 17 years of leadership, strategy management and improvement experience in both the manufacturing and health sectors (system level, regional cancer program, public health, and Local Health Integration Network). Nicole is a certified Black Belt (Shainin LLC) and a graduate of the 2014 IDEAS Program, and successful recipient of a 2015 IDEAS Alumni Achievement Award.

Karen Davies, RN, MHA, CHE, is vice president and chief nursing executive at STEGH. She has held a variety of progressive leadership positions. She is an active member of the Canadian College of Health Leaders with Certified Health Executive status. Karen is passionate about the importance of exemplary leadership in healthcare and patient- and family-centred care.

Nancy Whitmore, MD, FRCS (C), MBA, CHE, CCPE, is president and CEO of the St. Thomas Elgin General Hospital in Southwestern Ontario. Throughout her career she has held numerous leadership positions, and was appointed CEO in 2016. In 2010, Dr. Whitmore graduated from the Executive Training for Research Application(EXTRA) program of the Canadian Health Services Research Foundation where her team's project work focused on Lean process redesign in healthcare and its role in improving quality of care and patient safety.

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