

Background

It's a well-known fact that discharge transition is a very vulnerable time for patients. High quality discharge summaries (short, with all pertinent information and pending tasks), timeliness (at the day of discharge) and ability to transfer information to the appropriate next provider are three essential components of successful discharge. Although all residents understand and strongly agree with this, and every year interns received formal training by the Health Information Management Department, it was eye-opening for them to find out that only 53% of discharge summaries were dictated within 48 hours after discharge on our service.

Description of Innovation

- Structured training for interns including didactic session
- Mandated discharge summary time within 48 hours
- Checklist of required components of the Discharge Summary developed and implemented
- Faculty development session
- One-to-one mentoring by core faculty on every discharge summary during first three months of training
- Daily data provided to the Internal Medicine Residency by the Health Information Management department.
- Data compiled monthly and the best performers recognized
- Residents provided individual practice data on their compliance along with where they ranked within their class
- Our core faculty and both chief residents became members of hospital Medical Record Committee.

Discharge Summary Check List

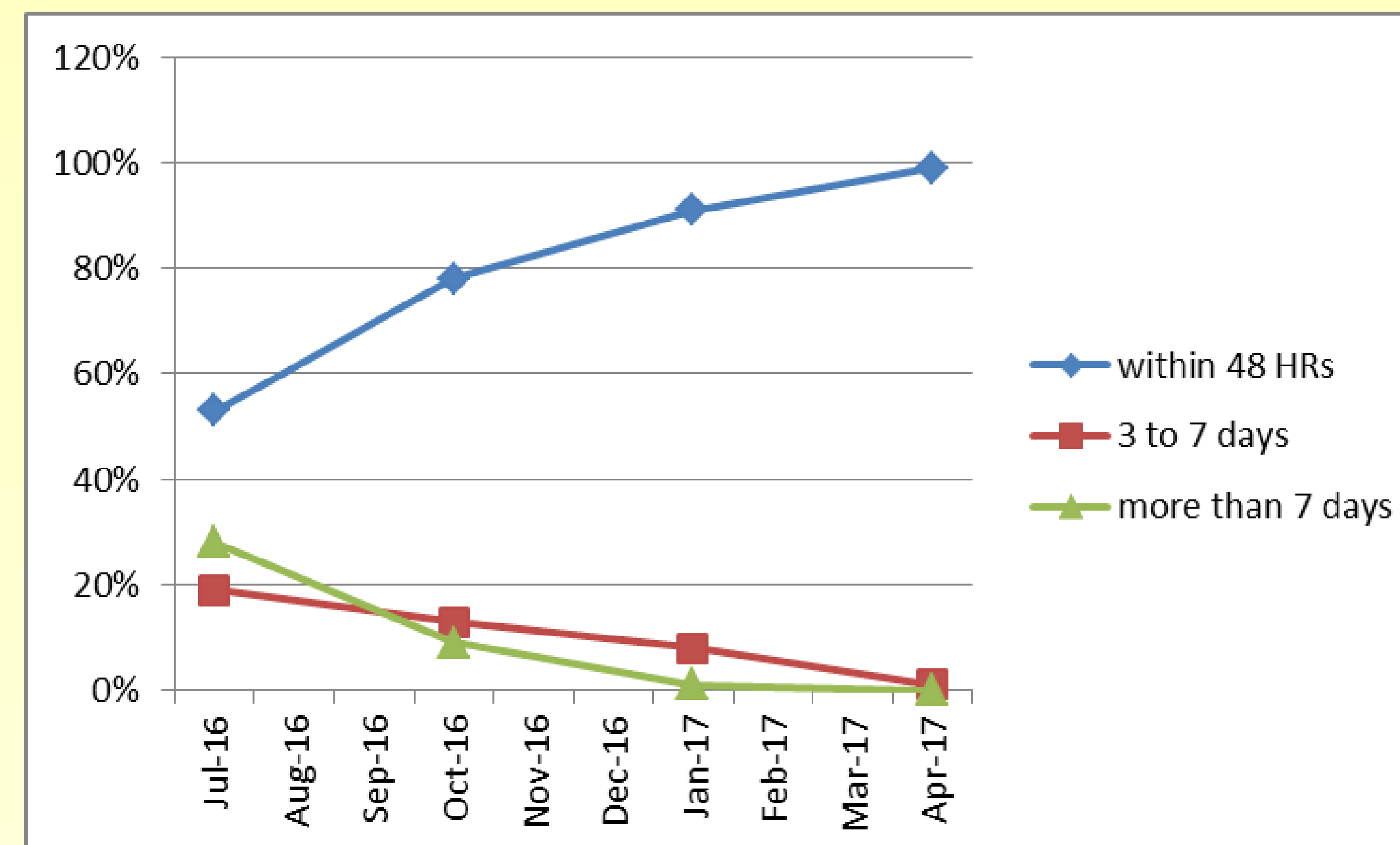
Discharge Summary Components. Join Commission. 2014

- ☐ Reason for hospitalization
- ☐ Significant findings
- ☐ Procedures and treatment provided
- ☐ Patient's discharge condition
- ☐ Patient and family instructions (as appropriate)
- ☐ Attending physician's signature

Discharge Summary: Check List

- ☐ Diagnosis (primary, secondary)
- ☐ HPI
- ☐ List of consultants, procedures, diagnostic tests.
- ☐ Hospital course
- ☐ Condition. Disposition.
- ☐ Medications list. Follow up plan.
- ☐ Attending physician's signature
- ☐ Advanced Directive/EOL status

Timing of Discharge Summaries Dictations



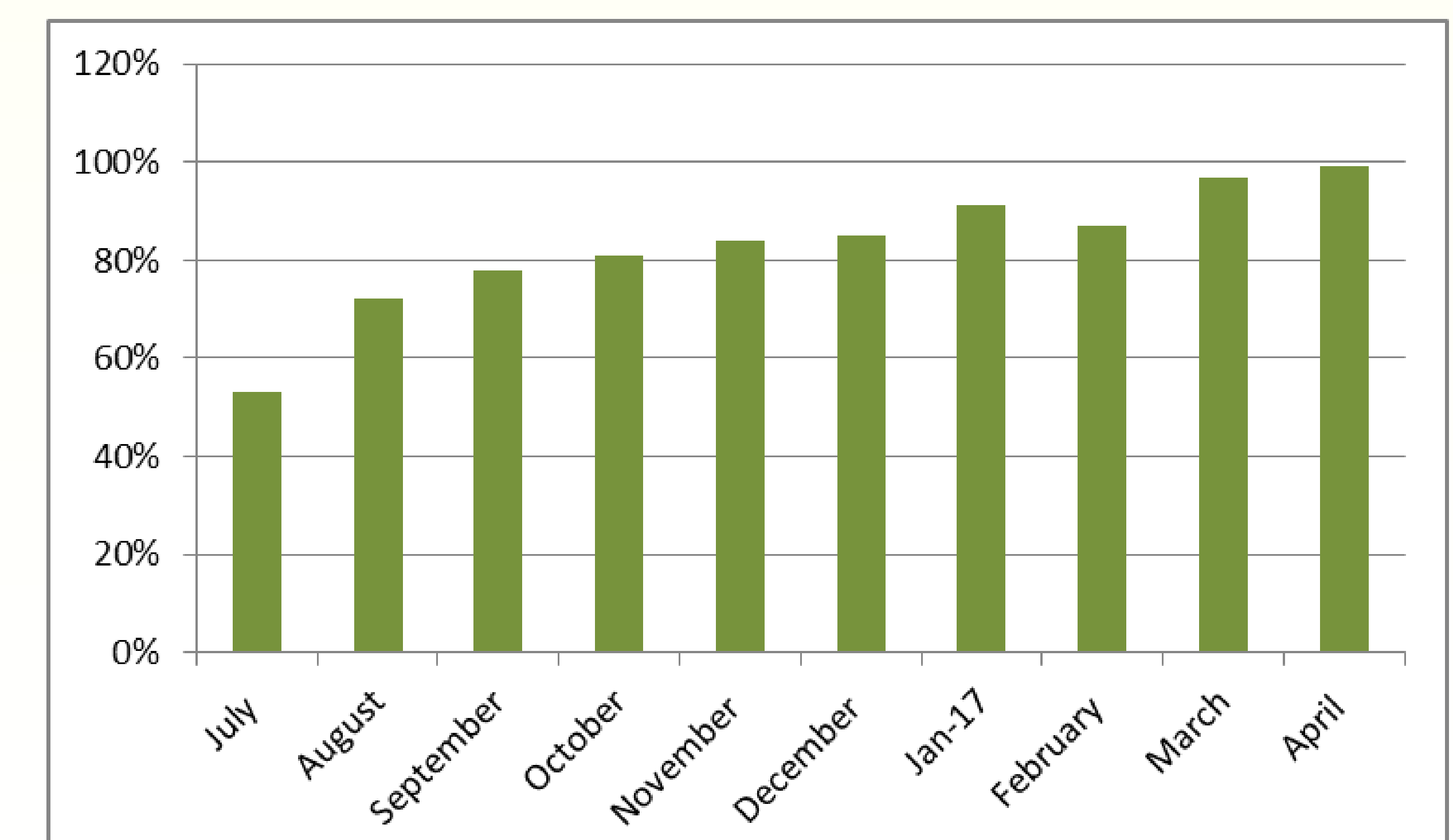
Results to Date

- During this project we developed a strong relationship with HIM.
- Percent of timely dictated discharge summaries improved from 53% in July to 78% in October to 99% by April 2017
- All discharge summaries were edited and signed by faculty only if they had all necessary components.
- The project was presented to the Medical Record Committee
- Our check list of required components of Discharge Summary was adopted by hospital.
- We proposed and later hospital policy was changed to reflect the best practice of dictating the Discharge Summary within 48 hours (although our state policy refers still to 30 days after discharge)
- We are currently piloting “stat” discharge summary dictation to provide a hard copy of discharge summary to patients who are transferred to another medical facility

Significance / Implications

- We strongly believe that first three months of the academic year are critical in developing life-long practice habits.
- To change physician habits, we need buy-in by residents and faculty, collaboration with hospital department and a several prong approach to implementation and follow-up on the process.
- Residents became very involved when they saw where they ranked within their peer group and were able to identify system issues that deterred them from timely completion.
- As members of the hospital committee we have made an impact on institutional culture to improve quality and safety of transition of patients from hospital
- Residents who were committee members felt empowered making changes on an important patient safety issue.
- Residents on the committee volunteered to pilot the new quality initiative to improve transition of care of patients discharged to other medical facilities. Their real time feedback helps the hospital committee to “iron out” process of “stat” discharge summaries in order for patients to have hard copy of discharge summary for the next provider.

Discharge Summary Compliance



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Background

The federal government reports one of every five discharged patients will return to hospital within 30 days. Poor coordination of health care during the most vulnerable time of transition places a patient at risk for readmission. One of the most challenging problems is the lack of standardization in Transitions of Care.

Methods

The curriculum of Transition of Care was developed in our program to focus on several domains:

1. Safety Net of Health Information Exchange:

A phone call to Primary Care Physician (PCP) at time of discharge.

Discharge summary dictation *on the day* of discharge, with request to fax it to the office of PCP.

Conducting Mortality and Morbidity (M&M) conferences with focus on poorly coordinated Transitions of Care.

2. Improvement of patient's comprehension of medical information

Focus on assessment of patient's health literacy.

Direct observation of resident discharge of patients by faculty, as a mini-CEX exercise.

Medication Reconciliation using “medication brown bag” instructions for every clinic visit.

3. Proactive end-of-life counseling in clinic to reduce readmission for patients with multiple comorbidities, poor prognosis and short life expectancy.

a) Selection of appropriate patients for initiation of conversation about goals of care

b) Education and implementation of Practitioner Order for Life-Sustaining Treatment (POLST) form.

4. Multidisciplinary team management of patients with high risk for readmission

a) Initiation of discharge plan discussion on day one of hospitalization in coordination with inter-professional team.

b) Collaboration with Trenton Health Team (local ACO of community providers) for high risk patients.

Significance / Implications

Implementation of “Transitions of Care” curriculum and dynamic adjustment of it is an important teaching tool in our residency program and can be effectively implemented in other teaching institutions. The curriculum will instill needed skills and help develop a lifelong habit to effectively communicate with members of multidisciplinary team, patients and their families, and prevent readmissions.

References

Chung A, Williams MV, Griggsby J, Coleman, EA. Better Transitions: Improving Comprehension of Discharge Instructions. *Frontiers of Health Management*, 2009 Spring; 25(3): 11-32

Project BOOST – Better Outcomes for Older Adults Through Safe Transitions. Implementation Guide to Improve care transitions. Society of Hospital Medicine, 2010

Naylor MD, Sochalski JA: Scaling up: Bringing the Transitional Care Model into the Mainstream. *The Commonwealth Funs*, November 2010; Pub.1453, Vol. 103

Holland DE, Hemann MA: Standardizing Hospital Discharge Planning at the Mayo Clinic. *The Joint Commission Journal on Quality and Patient Safety*, January 2011; 37 (1):29-36

Objectives

To teach the new generation of physicians concepts about Transitions of Care and train them to develop good skills of health information exchange. This in turn should lead to a high standard of patient care and decrease readmissions.

Results

A survey was conducted to assess an effectiveness of the Transitions of Care Curriculum.

Results and suggestions:

Implementation of the new curriculum significantly improved the resident's confidence in providing health care coordination.

To conduct more M&M conferences on poor Transitions of Care as the root cause of many near misses.

To schedule Workshop sessions on end of life counseling and completion of POLST form in the clinic.



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F CARE

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Background

Objectives

To develop a multi-pronged approach to teaching patient safety, and improving quality of care across the continuum of care.

Methods

The program focused on three key elements: hand-off communication, discharge summaries and tracking labs and care issues.

Hand-off communication:

At hospital discharge, the intern makes a follow-up clinic appointment with the patients' primary resident or with themselves if the patient is new. Verbal hand-off is given to the primary clinic resident, including pending labs/care issues.

Discharge Summaries:

The institution set a 30 day limit for completion of the discharge summary. The program encourages residents to dictate within 48 hours of discharge. A system was developed to allow faculty to leave comments on the electronic discharge summary, giving residents real-time feedback on what to improve and revise. The program also conducted a workshop on Required Elements of the Discharge Summary.

Post-discharge labs/care issues:

The clinic maintains a log of post-discharge issues which are followed daily. For high-risk issues such as anticoagulant therapy, a process was implemented where the Ambulatory Care resident reviews INRs, discusses with faculty, communicates with patients, and logs interactions. The log is available for review by primary residents.



Results

Weekly reports on discharge summaries not completed in 30 days shows a decrease to practically zero.

Compliance is evaluated under "Record Management" by the Clinical Competency Committee.

There are on going discussions with the institution to change the requirement of completion of discharge summaries within 48 hours of discharge.

Improved patient outcomes have been noted since the implementation of the revised discharge summary process & the INR/task review log.

The process allows the system to ensure timely follow-up of laboratory results, decreasing urgent clinic and ER visits and improving patient satisfaction.

Significance / Implications

To achieve improvements in quality and safety, residency programs must teach residents best practices in their educational and operational roles across the continuum of care. Residents must understand that hand-off communication promotes patient safety and is an ongoing process that contributes to fewer readmissions. Patient safety should be an integral component of the curriculum.

References

- Chung A, Williams MV, Griggsby J, Coleman, EA. Better Transitions: Improving Comprehension of Discharge Instructions. *Frontiers of Health Management*, 2009 Spring; 25(3): 11-32
- Project BOOST – Better Outcomes for Older Adults Through Safe Transitions. Implementation Guide to Improve care transitions. Society of Hospital Medicine, 2010
- Naylor MD, Sochalski JA: Scaling up: Bringing the Transitional Care Model into the Mainstream. *The Commonwealth Funds*, November 2010; Pub.1453, Vol. 103
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