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Exploring Barriers to Care Continuity During Transitions

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Background

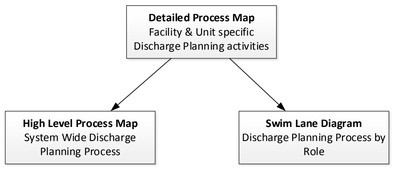
- The hospital discharge process requires multiple health care disciplines working in concert to safely transition patients from the acute care setting.
- Gaps in care continuity can occur for multiple reasons, including: a lack of home support, inadequate understanding of care needed at home, errors in medication reconciliation, and follow up care needs that go unmet.
- Communication and coordination of the care team is critical to developing effective discharge plans and achieving positive patient outcomes.

Purpose and Aims

- The purpose of this study was to determine the current methods hospitals employ to move patients safely through the hospital and the discharge process.
- Identify barriers to effective care coordination in current discharge planning methods and their impact on patient outcomes.
- Develop recommendations for improving care coordination during discharge planning that improve patient health outcomes and workflow.

Methods

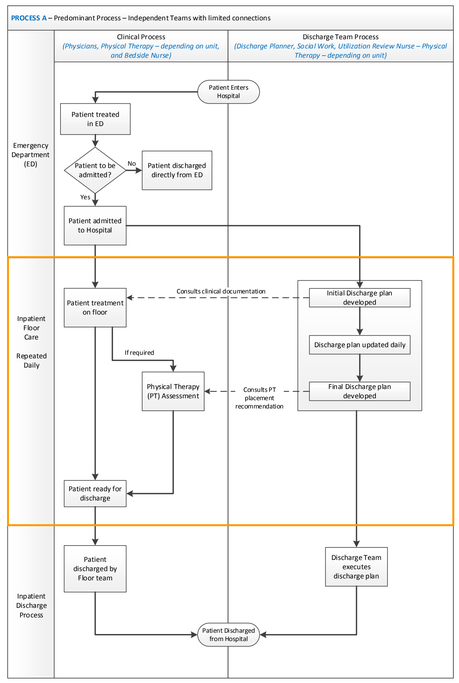
- Observation in two Buffalo area hospitals provided a thorough understanding of the discharge planning and care transition process including: roles, workflow, communication, and documentation.



Process Mapping Approach

- Observational data was translated into process maps at three levels of understanding.
- Key barriers identified and recommendations for improvement developed.

Process Maps

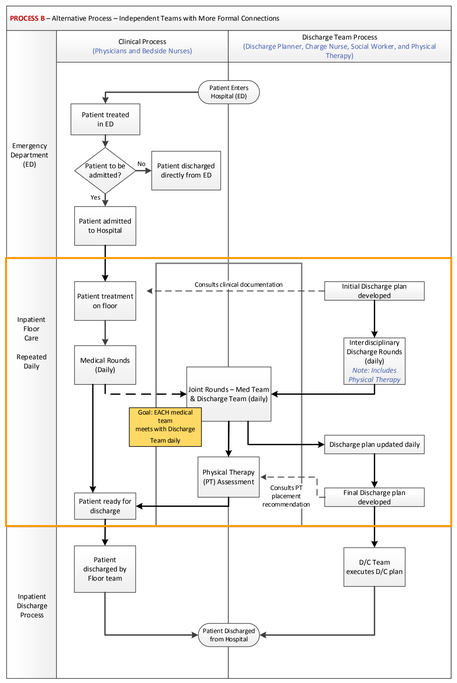


Key Similarities

- Physical Therapy is the bridge between the clinical team and the discharge team
- Individual teams round daily

Key Differences

- Use of joint rounds with medical team and discharge team
- Differing reliance on EHR documentation
- Composition of clinical and discharge teams



	Observations	Impact
Workflow & Roles	• Two distinct teams caring for the patient • Information sharing between the teams is imbalanced • Physical Therapy is the primary connection between teams	• Workflow connections exist primarily during the discharge event • Workflow adapted to reflect challenges of obtaining required information
Communication	• Discharge Planner (RN) guides the process, interprets clinical team notes, and predicts clinical course • Interprofessional communication is challenging and focused predominately on EHR documentation	• Challenging processes requires staff that are experts in managing their role and interpreting other's work • Workarounds compensate for challenges in data retrieval and processing but create redundancy, role conflicts, and delay
Documentation	• Information required by discharge team was obtained through review of clinical notes or direct contact • Many interdisciplinary discussions that contribute to critical decisions go undocumented in EHR	• Difficulties in retrieving and processing data leads to workarounds and redundancies • Undocumented information, which provides needed context for current and future encounters, causes redundancies and delays in care
Discharge Process	• There is significant variation in the discharge planning process based on unit, clinical roles, staffing level, and day of the week • The complexity and needs of each patient are not used to determine the intensity of discharge planning	• Process variability leads to inconsistent and potentially suboptimal results • Processes inflexible to patient complexity lead to wrong focus (i.e. less focus on highly complex patients)

Recommendations

- Create an EHR based solution that effectively "translates" information important to discharge planning
  - → Eliminate reliance on expert team members to interpret EHR data thereby improving efficiency
  - → Improve consistency of documentation and comprehension
- Clearly define roles and responsibilities to support discharge planning
  - → Define for various staffing situations
- Determine most appropriate communication channel
  - → Redesign EHR documentation and structure to support this choice
- Strategically use templates, checklists, and free text documentation forms to effectively capture data, provide context, and contribute to a shared understanding of patient needs
- Standardize process based upon patient complexity or risk level
  - → Flex resources based upon complexity or risk
  - → Define acceptable flexibility based upon day of week and staffing levels
- Push data collection to its earliest and most effective point

Future Research

1. Quantitatively measure the impact of different discharge processes on patient outcomes
2. Identify the best practices for the discharge planning process related to:
   - Communication
   - Documentation
   - Workflow
3. Develop a framework for implementing these best practices

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