Exploring Barriers to Care Continuity During Transitions
William Waller, BSN(c), BS\(^1\), Cortney Cardinal, PharmD(c)\(^2\), Sabina Casucci, PhD\(^1,3\), Sharon Hewner, PhD, RN\(^1\)
University at Buffalo, \(^1\)School of Nursing, \(^2\)School of Pharmacy and Pharmaceutical Sciences, \(^3\)Department of Industrial and Systems Engineering

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

**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 level
  - 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

**Funding and Acknowledgements**
- This project was funded by a University at Buffalo Office of the Vice President for Research and Economic Development IMPACT award.
- The authors gratefully acknowledge the contributions of Kaleida Health, Scott Monte, PharmD, Li Lin, PhD, Peter Elkin, MD, and Sashank Kaushik, MD

---

**Observations**
- **Workflow & Roles**
  - Two distinct teams caring for the patient
  - Information sharing between the teams is imbalanced
  - Physical Therapy is the primary connection between teams
- **Communication**
  - Discharge Planner (RN) guides the process, interprets clinical team roles, and predicts clinical course
  - Interprofessional communication is challenging and focused predominately on EHR documentation
- **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
- **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

**Impact**
- **Workflow**
  - Workflow connections exist primarily during the discharge event
  - Workflow adapted to reflect challenges of obtaining required information
- **Communication**
  - Challenging processes require 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**
  - Difficulties in retrieving and processing data lead to workarounds and redundancies
  - Undocumented information, which provides needed context for current and future encounters, causes redundancies and delays in care
- **Discharge Process**
  - 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)

**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