

REPORT TO THE COMMISSIONER OF PUBLIC HEALTH

**COMMUNICATION BETWEEN
THE PRIMARY CARE PROVIDER, HOSPITALIST,
AND OTHER HEALTH CARE PROVIDERS**

Transitions of Care & Health Care Handoffs



Quality of Health Care Advisory Committee

Subcommittee on Best Practices and Adverse Events

January 2008

**Quality of Health Care Advisory Committee
Subcommittee on Best Practices and Adverse Events**

Members

Wendy Furniss, Chair, Connecticut Department of Public Health (DPH)
Ann Anthony, Connecticut Association for Home Care (through December 2006)
Liz Beaudin, Connecticut Hospital Association
Kathy Boulware, DPH
Carrie Brady, Connecticut Hospital Association (through September 2006)
Bonnie Capasso, Patient Advocate
Michael Deren, Connecticut State Medical Society
Anne Elwell, Qualidigm
Brian Fillipo, Connecticut Hospital Association
Alfred Herzog, Connecticut State Medical Society
Rachel Lovins, Waterbury Hospital
Susan Menechetti, Integrated Resources for the Middlesex Area
Jon Olson, DPH
David Pearson, Southern Connecticut State University
Julie Petrellis, Connecticut Hospital Association
Kimberly Skehan, Connecticut Association for Home Care and Hospice
Diane Smith, DPH
Bruce Wallen, DPH

The Subcommittee thanks the following persons who provided advice, information, or assistance

Norma Gyle, Deputy Commissioner, Connecticut Department of Public Health
Tina Budnitz, Society of Hospital Medicine (SHM)
Bernard Clark, St. Francis Hospital
Eric Coleman, Director, Care Transitions Program (www.caretransitions.org)
Margaret Drickamer, Veterans Affairs and Yale New Haven Hospitals
Crystal Jeter, graduate student, Southern Connecticut State University
James Judge, Evercare Connecticut
Surenda Khera, St. Francis Hospital
James Lai, Qualidigm, Yale New Haven Hospital, and SHM
Peggy Martino, Greenwich Hospital
Julie Moy, DPH
Wayne Paulekas, internist and medical director at an extended care facility
William Rifkin, Waterbury Hospital, Yale New Haven Hospital, and SHM
Lawrence Wellikson, CEO, Society of Hospital Medicine
Mark V. Williams, Past President, SHM

**Report to the Commissioner of Public Health
January 2008**

**COMMUNICATION BETWEEN THE PRIMARY CARE PROVIDER,
HOSPITALIST, AND OTHER HEALTH CARE PROVIDERS**

Transitions of Care & Health Care Handoffs

Table of Contents

	<u>Page</u>
Subcommittee members and acknowledgements.....	ii
Table of Contents.....	iii
Executive Summary.....	4
Purpose of this Report.....	4
Background.....	4
Communication Between Primary Care Physician, Hospitalist, and Other Medical Care Providers.....	5
Selected Developments.....	8
Related Activities of the Quality of Health Care Advisory Committee’s Subcommittee on Best Practices and Adverse Events.....	11
Recommendations.....	14
Next Steps.....	14
Appendices.....	15
A. Section 11 from the NQF-endorsed <i>Safe Practices for Better Healthcare</i>	16
B. Ideal Discharge for the Elderly Patient: A Hospitalist Checklist.....	18
C. Suggestions to Improve Communication and Information Transfer Between Inpatient and Outpatient Physicians at Hospital Discharge.....	19
D. Section from <i>Developing and Implementing New Safe Practices: Voluntary Adoption Through Statewide Collaboratives</i>	20
E. Discharge Preparation Checklist for Patients.....	21
References.....	22

EXECUTIVE SUMMARY

Communication between a patient's primary care provider and other care providers is often subject to errors and "voltage drops" where information is lost. Public Act 06-195 charges the Best Practices Subcommittee of Connecticut's Quality of Health Care Advisory Committee to study the problem and make recommendations to the Department of Public Health. The Subcommittee reviewed activities and developments at the national and state levels. The Best Practices Subcommittee recommends

- ❖ Use of national standards and toolkit issued by the Society of Hospital Medicine, the American Board of Internal Medicine, and others, that will appear in early 2008 (*Principles and Standards of Care Transitions*, *Stepping Up to the Plate*, and *Better Outcomes in Older Adults Through Safe Transitions--BOOST*).
- ❖ Wider use of existing resources, such as those mentioned in the Background section, to meet Joint Commission National Patient Safety Goals for handoff communications.
- ❖ Formation and participation in a future statewide collaborative to improve communication among health care providers and with patients.
- ❖ Cooperation with the Continuum of Care Subcommittee to improve care transitions.
- ❖ Patients or primary care givers, as well as home health agencies, should be given a copy of the discharge summary and told to bring it to their follow-up visit.

PURPOSE OF THIS REPORT:

Public Act 06-195, *An Act Concerning Revisions to Department of Public Health Statutes*, directs the Quality of Health Care Advisory Committee's Subcommittee on Best Practices ("The Subcommittee") to "not later than January 1, 2008, study and make recommendations to the department [of Public Health] concerning best practices with respect to communications between a patient's primary care provider and other providers involved in a patient's care, including hospitalists and specialists." The Subcommittee addressed communication at admission to a hospital, at "handoffs" (transfers) during a hospital stay, at discharge from a hospital or emergency department, and outside the hospital.

BACKGROUND

It has become increasingly common for patients to be cared for during a hospital stay by hospital-based physicians, termed *hospitalists*, most of whose specialty training is in internal medicine, and who also coordinate care for the patient during their hospital stay.¹

Compared with traditional inpatient care, the hospitalist model has a number of advantages, but it also introduces handoffs at the time of hospital admission and discharge.² Although the ideal communication of one clinician to another is assumed in the discussion below, ancillary personnel may also send or receive messages in practice.

COMMUNICATION BETWEEN PRIMARY CARE PHYSICIAN, HOSPITALIST, AND OTHER MEDICAL CARE PROVIDERS

Communication at Hospital Admission

“Many primary care physicians (PCPs) are not routinely notified about patient admissions or complications during the hospital course. Conversely, some PCPs may not provide sufficient information to hospitalists at admission, visit or call hospitalized patients, participate in discharge planning, or contact patients who have missed postdischarge follow-up appointments.”³

Sometimes a patient is admitted to the hospital through its emergency department (ED). Handoffs between the ED and the hospitalist who admits the patient are subject to particular ambiguities or difficulties.⁴ First, the emergency physician may perceive their obligations not to extend beyond triaging the patient to determine if admission is required. Thus the hospitalist may be asked to admit a patient whose test results are pending. The hospitalist, by contrast, may wish to delay admission until test results are ready and a diagnosis is made. Second, a decision may be made to admit a patient, but they remain in the ED until an inpatient bed becomes available. It is often not clear which physician is responsible for the patient during this time.

Information from the primary physician may also get lost in this transition. The PCP may have called the emergency room before the patient arrived and that information may not reach the treating ER physician, or the PCP may have spoken to the ER physician but information may not have been passed on to the treating hospital physician.

Communication During the Hospital Stay

Handoffs in health care (also called signouts or passoffs) are inevitable because no doctor can be in the hospital all day, every day, but are also a by-product of technological progress. Treatments have become so varied that no one doctor can keep up with all of them. While specialization results in increased competency in performing a procedure, specialization can lead to fragmentation of information between different care providers.

The potential barriers to accurate communication between doctors, hospital employees, and patients include cultural, educational, and language differences, distress, fatigue, authority gradient, time constraints, interruptions, complex medical conditions, limitations of the communication medium, incompatible information systems, lack of privacy, misinterpretations of privacy concerns related to the Health Insurance Portability

and Accountability Act (HIPAA), illegible writing, and nonstandard abbreviations. In one study, necessary information like code status and allergies were missing from 80% of written signouts. In another study, signout sheets were absent 25% of the time.⁵

The Joint Commission's National Patient Safety Goal 2E for 2007 is to implement a standard approach to handoff communications. It is applicable to ambulatory care, assisted living, behavioral health care, critical access hospitals, disease-specific care, home care, hospital, laboratory, long term care, and office-based surgery. Requirement 2E does not dictate how handoffs are to be conducted; the process can vary by organization and situation. A related National Patient Safety Goal is reconciliation of medications at care transitions.

Communication Surrounding Discharge from the Emergency Department or Hospital

Emergency Departments inconsistently transmit information about the patients they care for to PCPs. Duplicative testing at PCP follow-up was noted in one study to be about 10% each for blood work, imaging, and microbiology, and 3-4% for EKG. An internet and email-based intervention was compared to mailed copies of hand-written ED notes. The electronic communication increased PCPs' awareness of their patients' ED visits, but did not reduce duplicative testing.⁶ Another related problem is the reporting of test results that were still pending at the time the patient is discharged from the emergency room or the hospital.

Upon hospital discharge, patients often are expected to return to their primary care physician or another clinician who may not have direct knowledge about the hospital stay. The Connecticut Public Health Code states:

Medical records shall be completed within thirty days after discharge of the patient except in unusual circumstances which shall be specified in the medical staff rules and regulations. One of these specified circumstances shall be that the hospital discharge summary shall be completed and shall accompany patients at the time of discharge to another health care facility. (19-13-D3, Medical Records section)

The Centers for Medicare and Medicaid Services (CMS) Conditions of Participation for Hospitals require that:

The hospital must transfer or refer patients, along with necessary medical information, to appropriate facilities, agencies, or outpatient services, as needed, for followup or ancillary care.... The hospital must reassess its discharge planning process on an on-going basis. The reassessment must include a review of discharge plans to ensure that they are responsive to discharge needs. (42 CFR 482.43, Oct. 2004)

CMS and the Joint Commission (formerly, Joint Commission on Accreditation of Healthcare Organizations) require that members complete discharge summaries within 30 days of hospital discharge.⁷ Current Joint Commission standards for discharge summaries include:

- Reason for hospitalization
- Significant findings
- Procedures performed and care, treatment and services provided
- Patient's condition at discharge
- Information provided to the patient, and family, as appropriate.

Despite these regulatory and other standards, the hospital discharge too often is chaotic and unnecessarily risky. This claim is supported by a recent review of high risk care transitions.

“The hospital discharge is poorly standardized and is characterized by discontinuity and fragmentation of care. Lack of coordination in the handoff from the hospital to community care, growth of the hospitalist movement that contributes to handoffs, gaps in social supports, high rates of low health literacy, and poor delineation of discharge responsibilities among hospital staff (often those early in training)—all place patients at high risk of postdischarge adverse events and rehospitalization.”⁸

A study from Denmark highlights the potential for miscommunication of critical data such as patient medications. Medication lists in hospital files and discharge letters were compared with lists obtained during interviews with elderly patients within one week after hospital discharge. One fifth of prescription-only medications (POM) were unknown to the hospital, and only half of used POM appeared in discharge letters. At least 7% of currently used POM were used in disagreement with the prescribed regimen at discharge.⁹

In a study involving medicine and geriatrics services in New York, discharge summaries were available to PCPs at affiliated medicine and geriatrics practices in 95% of cases; however, outpatient workups recommended by hospital physicians were documented in discharge summaries in only 46% of cases. Of the outpatient workups recommended to address unresolved medical problems, 36% were not completed within 2 months after hospital discharge.¹⁰

A review of 55 observational studies and 18 interventions to improve transfers concluded that direct communication between hospital physicians and primary care physicians occurred infrequently; the availability of a discharge summary at the first postdischarge visit was low and affected the quality of care in the follow-up visit, and discharge summaries often lacked important information (cf. Appendix C). Several interventions shortened the delivery time of discharge communications. However, only three randomized studies were included in the review.¹¹

Communication Outside the Hospital

A variety of communication difficulties outside the hospital have also been documented. In a study from an academic medical center, 63% of PCPs and 35% of specialists were dissatisfied with the outpatient referral process. The major problems were lack of timeliness of information and inadequate referral letter content. In two-thirds of referrals, the specialist received no information from the PCP prior to the visit, though more than a third said it would have been helpful. Conversely, one month after the referral visit, a quarter of PCPs had received no information back from the specialist.¹² In a later study of PCPs and home care clinicians, 79% of home care clinicians, but only 47% of PCPs reported satisfaction with their communication and collaboration.¹³

The following problems were reported in a survey of 361 PCPs in California: problems coordinating care sometimes or often in the last 12 months (40%), somewhat or very difficult to compile a comprehensive list of their patients' medications (57%), problems with receipt of referral results (41%), medical record/clinical information sometimes or often unavailable at time of patient visit (40%), sometimes or often repeated test or procedures because results were unavailable at time of visit (21%).¹⁴

Contributing to the poor or inefficient care is the reimbursement system. Eighteen percent of the average geriatrician's clinical work, in one survey, was between-visit work, which most fee-for-service payment systems do not pay for. Three quarters of the between-visit interactions were related to coordinating care. A study of family physicians found that 13% of the workday was spent on care coordination between visits.¹⁵ Conversely, with some exceptions, duplicated tests and care by different physicians are fully reimbursed.

There is a growing movement to "outsource" care-related tasks to patients and their informal caregivers. Patients benefit from good communication, which includes shared goals, shared knowledge, and mutual respect. Following knee surgery, coordination between formal and informal caregivers was positively associated with patient freedom from pain, functional status, and mental health.¹⁶

SELECTED DEVELOPMENTS

In 2006 the National Quality Forum (NQF) Consensus Standards Maintenance Committee was charged with the task of updating the *Safe Practices for Better Healthcare* developed in 2003. The committee decided to expand from a focus on promoting accurate communication about treatment and procedures at discharge, to a comprehensive approach that would be evidence-based and patient-centered, and target existing systems failures. The committee harmonized practices across the relevant requirements or initiatives of CMS, the Agency for Healthcare Research and Quality (AHRQ), the Joint Commission, the Leapfrog Group, and the Institute for Healthcare

Improvement (IHI). In October 2006 the national members endorsed the updated practices.¹⁷ (See Appendix A.)

The Care Transitions Program at the University of Colorado (www.caretransitions.org) aims to improve the quality and safety of handoffs among patients with complex care needs. The Center has published a study demonstrating that a transition coach may reduce re-hospitalization after discharge home. The Care Transitions Program offers measures, toolkits, training in the use of a transition coach, and a checklist for patients (see Appendix E). The Connecticut Geriatrics Society has established a workgroup on transitions in care, in cooperation with the Care Transitions Program.¹⁸

Similar to the transition coach, but operating in the primary care physician setting, is the Guided Care Program for older adults with multiple co-morbidities. Under Guided Care (presently undergoing clinical trials), a specially trained nurse coaches the patient in self-management, coordinates the efforts of all involved health care professionals, and facilitates transitions between sites of care.¹⁹

On April 11, 2007 the Society of Hospital Medicine (SHM), which represents hospitalists, announced that it had received a grant for a three-year project to develop interventions to improve care transitions for older adults at the time of hospital discharge. SHM partnered with national leaders to form a National Advisory Board (see BOOST below), create clinical tools, implementation guidelines, and provide technical support and training tools to hospitals across the U.S. The project aims to build capacity in at least 200 hospital sites to improve the discharge process, and ultimately health outcomes, for older adults.²⁰

In June 2007, AHRQ released *Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies. Volume 7—Care Coordination*.²¹ On pages 77-78 the investigators noted,

In summary, the reviews studying transition of patient care across different settings evaluated a wide variety of interventions. The included interventions were not clearly defined in most of the reviews and only one review provided clear evidence of the effectiveness of its intervention (multidisciplinary teams for hospital discharge and post-discharge of stroke patients). The heterogeneity of the included interventions and the lack of quantitative analysis do not permit any further synthesis that would allow us to determine the effectiveness of any particular care coordination intervention to improve patient care across settings.

The August 2007 issue in the *Patient Safety Link* series of the Joint Commission International Center for Patient Safety included an excerpt from *Improving Hand-Off Communication*, a book with step-by-step instructions, sample forms, and insights to help standardize the patient transfer process.²² In September the Joint Commission hosted a Medication Reconciliation Summit. A document outlining suggestions of the summit attendees and next steps is being developed.²³

During October through December 2007, the IHI (www.ihl.org) hosted three interactive web-based sessions on “Hospital to Home: Optimizing the Transition.”

On December 5, AHRQ released toolkits related to communication at care transitions (<http://www.ahrq.gov/qual/pips/>). The Re-Engineered Hospital Discharge “Project RED” toolkit standardizes the hospital discharge process through a set of manuals and software designed to improve communication between patients and clinicians. The Medications at Transitions and Clinical Handoffs “MATCH” toolkit focuses on identifying patient risk factors frequently responsible for inaccurate medication reconciliation, including limited English proficiency and low health literacy, complex medication histories, or impaired mental status. The Patient Safe-D(ischARGE) project produced a patient-centered Discharge Patient Education Tool (DPET), a Discharge Knowledge Assessment Tool (DKAT), and medication reconciliation forms.

The December issue of AHRQ’s Morbidity & Mortality Rounds on the Web featured “Improving Transitions in Care” in its *Perspectives on Safety* (<http://webmm.ahrq.gov/>).

The Transitions of Care Consensus Conference hosted by the American College of Physicians, Society of General Internal Medicine, and SHM developed guidelines for transitions into and out of the hospital, “Principles and Standards of Care Transitions.”²⁴ One goal of the guidelines is to reduce costly hospital readmissions. In January 2008 these guidelines will become publicly available. In the same month, the American Board of Internal Medicine will release guidelines that deal with all care transitions, “Stepping Up to the Plate.”²⁵ A later toolkit called *Better Outcomes in Older Adults Through Safe Transitions* (BOOST) will take into account the guidelines from both documents.

The advisory board for BOOST includes representative from the SHM, the John Hartford Foundation, NQF, CMS, AHRQ, Blue Cross and Blue Shield, IHI, and several medical schools and medical, nursing, pharmacist, and case manager societies. In the spring of 2008 this advisory board will approve the toolkit and the SHM will make it available free online. The SHM will offer technical support and on-site consulting to individuals and organizations that wish to use the toolkit.²⁶

Electronic Health Information Exchange (HIE) is a promising avenue for improving communication across health care settings. In the 2007 legislative session, the Connecticut General Assembly passed Public Act No. 07-2, *An Act Implementing the Provisions of the Budget Concerning Human Services and Public Health*, authorizing in Section 68 of that Act, the Department of Public Health, in consultation with the Office of Health Care Access to contract, through a competitive bidding process, for the development of a state-wide health information technology plan. An HIE Request for Proposals was released on December 31, 2007. The selected organization will be designated as the lead HIE organization for the state of Connecticut from the contract start date until June 30, 2009, for the development and growth of HIEs in Connecticut.

As part of the Deficit Reduction Act of 2005, Congress requires CMS to establish a demonstration project to understand costs and outcomes across different post-acute care

sites, and to develop and test a standardized patient assessment instrument. CMS proposes to use the Continuity Assessment Record and Evaluation (CARE) in a three-year demonstration project, with the first demonstration site underway by January 2008.²⁷

Following recommendations to Congress,²⁸ the 9th Scope of Work for Quality Improvement Organizations, beginning August 2008, will include QIO collaboration with various types of providers to improve the coordination of patient care across multiple settings.

RELATED ACTIVITIES OF THE QUALITY OF HEALTH CARE ADVISORY COMMITTEE'S SUBCOMMITTEE ON BEST PRACTICES AND ADVERSE EVENTS

At the September 2006 meeting of the Subcommittee, expert speakers for future meetings were proposed.

At the November 2006 meeting, Drs. William Rifkin (hospitalist, Waterbury Hospital, and Yale faculty) and Laurence Wellikson (Chief Executive Officer, SHM) addressed the Subcommittee and answered questions from the Subcommittee. Discussion topics included: the effect on quality of the number of patients that a hospitalist is responsible for at one time, medication reconciliation, differing preferences about frequency and mode of communication between hospitalist and primary care physician, who is in charge of the patient, Intensive Care Unit staffing, and communication prior to hospital admission. Dr. Wellikson indicated that SHM participated in a consensus meeting with the Case Manager Society of America in October 2006, will be working with the NQF and the American Board of Internal Medicine in 2007, and hopes to participate in formulating standards for communication during care transitions in 2008. The SHM Media Kit and several articles about communication during care transitions were distributed to Subcommittee members. Among these, *Ideal Discharge for the Elderly Patient: A Hospitalist Checklist* is a consensus statement of hospital medicine physicians and pharmacists, process improvement, health quality, and patient safety specialists, and care transition researchers.²⁹ (A subsequent version of the *Checklist* is reproduced in Appendix B.)

At the January 2007 Subcommittee meeting, Dr. Wayne Paulekas (internist with a practice in Glastonbury and medical director of an extended care facility) reported that he stopped admitting patients himself to the hospital 2 years ago, and now uses hospitalists. While this is positive for patients, communication is a challenge, and patients may not know their hospitalist or what a hospitalist is.

In another discussion it was noted that the DPH attempts to coordinate state regulation with CMS requirements as well as to solicit facility input when drafting regulations. The Public Health Code does not specifically state that a discharge summary is required, but the intent of the regulation is that some form of a discharge summary be included in all patient transfers.

At the March and May 2007 meetings, discussion continued regarding possibly revising the interagency referral form (W-10), which is used for transitions of care such as hospital discharge. The Continuum of Care Subcommittee will be reviewing the W-10, and may make recommendations for revisions. Additional articles were distributed, as well as material from the Joint Commission concerning communication during handoffs, which is applicable beyond hospital discharges, also involving patients and their families. Two handoff methodologies utilizing standardized communication are SBAR (Situation-Background-Assessment-Recommendation) and SHARED (Situation-History-Assessment-Request-Evaluate-Document).

The Continuum of Care Subcommittee has initiated a collaborative effort to evaluate pressure ulcer care across settings. The “Pressure Ulcer Campaign: Across the Continuum Pilot” will begin in January 2008 and includes one hospital, one skilled nursing facility and two home health agencies serving one Connecticut community. The goals of the pilot are to decrease the number of pressure ulcers and improve communication across the settings of care. The participants will work together to develop common language related to pressure ulcer assessment, prevention and treatment, and identify best practices. The results of the pilot will be reported to the DPH Quality Advisory Committee and will hopefully be used as a model for care across the continuum in other regions of the state and nationally.

At the June 2007 meeting, members discussed required admission and discharge information. Dr. James Lai, a clinical consultant for Qualidigm who practices in the hospitalist program at Yale, spoke and answered questions. Yale has a contract template in which for three days post discharge, a hospitalist takes calls, after that the primary care physician takes charge. However, each practice is different.

Drs. Bernard Clark and Surenda Khera from Saint Francis Hospital (SFH) addressed the Subcommittee at the August 2007 meeting and provided separate patient and clinician brochures about their hospitalist program. The SFH model involves communication between the hospitalist and PCP, specialists, nursing staff, and the patient. Upon admission, the hospital contacts the PCP to discuss the plan of treatment and PCP involvement. Handoff communication between shifts uses an electronic signout list of things to do that remains in the clinical record. Goals for 2009 include a total electronic medical record connected to the PCP and including handoff information. Dr. Clark recommended a standardized framework for hospitalist programs that adheres to core standards, yet also is individualized. Dr. Khera spoke favorably of the Veterans Affairs (VA) nationally standardized model for handoffs involving a hospitalist.

Dr. Margaret Drickamer, who practices geriatrics in the VA health system and Yale New Haven Hospital, addressed the Subcommittee in October 2007. Dr. Drickamer noted that public sector software is used in the VA but not often in other hospitals, that setting up an information system around billing limits clinical information, HIPAA concerns affect automation/data sharing, and that patient information she sends from the VA is often not read by clinicians at Yale.

Also in October, the Subcommittee received the hospitalist brochure from Greenwich hospital, and an expression of concern from a few state residents about another hospitalist program in the state because it conflicts with their desire to be seen in the hospital by their primary care physician.

The November 7, 2007 meeting concentrated upon discussion of a draft of this report. Suggestions included: clarify responsibility for the communication between community physician and the ED physician concerning patient history and/or ED findings prior to admission; use a standardized check-list which includes PCP notification. Area hospitals are working on individual protocols with similar core elements which will follow national standards.

On November 15, Drs. Eric Coleman and Mark Williams were guests of the Subcommittee on a conference call. They and Tina Budnitz, all representing SHM and the BOOST project, discussed current SHM and other national initiatives (see Selected Developments, above).

The draft of the report was further revised and approved at the January 9, 2008 meeting.

SUBCOMMITTEE RECOMMENDATIONS

In carrying out its charge to “make recommendations to the department [of Public Health] concerning best practices with respect to communications between a patient’s primary care provider and other providers involved in a patient’s care, including hospitalists and specialists” the Quality of Health Care Advisory Committee’s Subcommittee on Best Practices proposes the following recommendations:

- ❖ Implementation where possible of standardized communication protocols for internal use and patient handoffs, such as
 - SBAR (Situation-Background-Assessment-Recommendation)
 - SHARED (Situation-History-Assessment-Request-Evaluate-Document)
 - Wider use of the NQF-endorsed set of Safe Practices for Better Healthcare.
 - National standards and toolkit as they become available (*Principles and Standards of Care Transitions*, *Stepping Up to the Plate*, and *Better Outcomes in Older Adults Through Safe Transitions*, *BOOST*).
 - Wider use of Ideal Discharge for the Elderly Patient: a Hospitalist Checklist.
- ❖ Wider use of existing resources, such as those mentioned in the Background section, to meet Joint Commission National Patient Safety Goals for handoff communications.
- ❖ Formation and participation in a future statewide collaborative to improve communication among health care providers and with patients (cf. Appendix D).
- ❖ Cooperation with the Continuum of Care Subcommittee to improve care transitions.
- ❖ Patients or primary care givers, as well as home health agencies, should be given a copy of the discharge summary and told to bring it to their follow-up visit.

The Department of Public Health should post this document to its website, as should the three Patient Safety Organizations in Connecticut.

NEXT STEPS

The Best Practices Subcommittee will work with other stakeholders to:

1. Support the implementation of future Continuum of Care Subcommittee recommendations to the Department of Social Services for changes to the W-10 form, after these are considered and approved by the Quality of Health Care Advisory Committee; and
2. Encourage the use of future national standards for transitions of care and maintaining continuity of care within and across health care settings.

APPENDICES

Appendix A. Section 11 from the NQF-endorsed *Safe Practices for Better Healthcare*

Appendix B. Ideal Discharge for the Elderly Patient: A Hospitalist Checklist

Appendix C. Suggestions to Improve Communication and Information Transfer Between Inpatient and Outpatient Physicians at Hospital Discharge

Appendix D. Section from *Developing and Implementing New Safe Practices: Voluntary Adoption Through Statewide Collaboratives*

Appendix E. Discharge Preparation Checklist for Patients

Appendix A.

Section 11 from the NQF-endorsed *Safe Practices for Better Healthcare*³⁰

A “discharge plan” must be prepared for each patient at the time of hospital discharge, and a concise discharge summary must be prepared and relayed to the clinical caregiver accepting responsibility for postdischarge care in a timely manner.

Additional Specifications:

- Discharge Policies and Procedures should be established, resourced, and address:
 - Explicit delineation of roles and responsibilities regarding the discharge process;
 - Preparation for discharge occurring with documentation throughout the hospitalization;
 - Reliable information flow from the PCP [Primary Care Provider] or referring caregiver, on admission, to the hospital caregivers and back to the PCP after discharge using standardized communication skills;
 - Completion of discharge plan and discharge summaries before discharge;
 - Patient or, as appropriate, family perception of coordination of discharge care;
 - Benchmarking, measuring, and continuous quality improvement of discharge processes.
- A written discharge plan must be provided to each patient at the time of discharge that is understandable to the patient and/or his or her family or guardian and appropriate to each individual’s health literacy and English language proficiency. At a minimum, the Discharge Plan must include:
 - Reason for hospitalization;
 - Medications to be taken postdischarge, including, as appropriate, resumption of preadmission medications, how to take them and how to obtain the medication;
 - Instructions on what to do if their condition changes; and
 - Coordination and planning for follow-up appointments that the patient can keep and follow-up of tests and studies for which confirmed results are not available at the time of discharge.
- A discharge summary must be provided to the ambulatory clinical care provider accepting each patient’s care after hospital discharge. At a minimum, the Discharge Summary should include:
 - Reason for hospitalization;
 - Significant findings;
 - Procedures performed and care, treatment, and services provided to the patient;
 - The patient’s condition at discharge;
 - Information provided to the patient and family;
 - A comprehensive and reconciled medication list; and

- A list of acute medical issues, tests, and studies for which confirmed results are unavailable at the time of discharge and require follow-up.
- Original source documents (e.g., laboratory or radiology reports or medication administration records) should be in the transcriber's immediate possession and be visible when it is necessary to transcribe information from one document to another.
- The organization should ensure and document receipt of discharge information by caregivers assuming responsibility for postdischarge care. This coordination may occur through telephone, fax confirmation, email response, or electronic response through health information technologies.”

Appendix B.

Ideal Discharge for the Elderly Patient: A Hospitalist Checklist³¹

X = required element; O = optional element

Data elements	Processes		
	Discharge Summary	Patient Instructions	Communication to Follow-up Clinician on Discharge Day
Presenting problem that precipitated hospitalization	X	X	X
Key findings and test results	X		X
Final primary and secondary diagnosis	X	X	X
Brief hospital course	X		X
Condition at discharge, including functional status and cognitive status if relevant	X	functional status O-cognitive status	
Discharge destination (and rationale if not obvious)	X		X
Discharge medications:			
Written schedule	X	X	X
Include purpose and cautions (if appropriate) for each	O	X	O
Comparison with pre-admission medications (new, changes in dose/freq., unchanged, “meds should no longer take”)	X	X	X
Follow-up appointments with name of provider, date, address, phone number, visit purpose, suggested management plan	X	X	X
All pending labs or tests, responsible person to whom results will be sent	X		X
Recommendation of any sub-specialty consultants	X		O
Documentation of patient education and understanding	X		
Any anticipated problems and suggested interventions	X	X	X
24/7 call-back number	X	X	
Identify referring and receiving providers	X	X	
Resuscitation status and any other pertinent end-of-life issues	O		

Appendix C.

Suggestions to Improve Communication and Information Transfer Between Inpatient and Outpatient Physicians at Hospital Discharge³²

On the day of discharge, a summary document should be sent to the primary care physician by email, fax, or mail. If a complete discharge summary cannot be sent on the day of discharge, then an interim discharge should be sent. At minimum, it should include the diagnoses, discharge medications, results of procedures, follow-up needs, and pending test results.

Discharge summaries should include the following:

- Primary and secondary diagnoses
- Pertinent medical history and physical findings
- Dates of hospitalization, treatment provided, brief hospital course
- Results of procedures and abnormal laboratory test results
- Recommendations of any subspecialty consultants
- Information given to the patient and family
- The patient's condition or functional status at discharge
- Reconciled discharge medication regimen, with reasons for any changes and indications for newly prescribed medications
- Details of follow-up arrangements made
- Specific follow-up needs, including appointments or procedures to be scheduled, and tests pending at discharge
- Name and contact information of the responsible hospital physician

Discharge summaries should be structured with subheadings to organize and highlight the information most pertinent to follow-up care and to ensure that all essential topics are addressed.

To the extent possible, hospitals should use information technology to extract information into discharge summaries to ensure accuracy (e.g. medication names and doses) and to facilitate rapid completion of summaries.

☼ If possible, patients should be given a copy of the discharge summary or note and told to bring it to their follow-up visit.

Appendix D.

Section from *Developing and Implementing New Safe Practices: Voluntary Adoption Through Statewide Collaboratives*³³

Experience from two voluntary statewide collaboratives confirms that implementing new safe practices is a difficult and complex task for hospitals. Nonetheless, the collaborative process is a powerful way to motivate and support change. The ideas, enthusiasm, and creative solutions that our clinical teams implemented within their systems were impressive. Small changes fuelled excitement and enthusiasm for larger changes and served as pilots for larger scale projects. Teams learned the value of sharing innovations with others, and to avoid being stalled by the complexity of the project or to wait for the automated solution. Our experience suggests that, if they receive support from hospital leadership, clinical teams of front line caregivers can develop creative methods for improving teamwork and communication. These skills should enhance patient safety.

Because each practice is in fact a collection of multiple subpractices, these elements need to be carefully developed and separate strategies must be designed for making the multiple changes needed for implementation. Few, if any, hospitals have the resources to do this on their own. Even with extensive advance planning and careful attention to the design of the subpractices and strategies, teams found making changes difficult.

Lack of sufficient development and understanding of subpractices may be one of the reasons many hospitals have found it difficult to implement the new safe practices recently required by JCAHO. While we applaud and support the move by JCAHO to require hospitals to implement safe practices, our experience suggests that such mandates might better be deferred until after the development of the needed subpractices and recommendations, and after they have been “field tested” through large scale feasibility demonstration projects such as we have described here. This testing could be commissioned by JCAHO or AHRQ (as this project was) and contracted to IHI, QIOs, or regional coalitions.

Sufficient resources need to be made available for these types of efforts to succeed. Even when the best practices and toolkits are available, complex organizational change requires dedicated staff time to test the changes, measure the impact, refine the approach, and spread the changes throughout the organization. Payers and policymakers should seek innovative ways to make funding available for these investments.

Appendix E.

Discharge Preparation Checklist for Patients³⁴

Before I leave the care facility, the following tasks should be completed:

- I have been involved in decisions about what will take place after I leave the facility.
- I understand where I am going after I leave this facility and what will happen to me once I arrive.
- I have the name and phone number of a person I should contact if a problem arises during my transfer.
- I understand what my medications are, how to obtain them and how to take them.
- I understand the potential side effects of my medications and whom I should call if I experience them.
- I understand what symptoms I need to watch out for and whom to call should I notice them.
- I understand how to keep my health problems from getting worse.
- My doctor or nurse has answered my most important questions prior to leaving the facility.
- My family or someone close to me knows that I am coming home and what I will need once I leave the facility.
- If I am going directly home, I have scheduled a follow-up appointment with my doctor, and I have transportation to this appointment.

References

-
- ¹ Robert Wachter speculates that in the future, “there will be some hospitalist mission-creep in the form of post-discharge clinics staffed by hospitalists, to which patients can return within a few days or weeks for a single check to be sure they're improving.” See http://the-hospitalist.org/blogs/wachters_world/archive/2007/10/25/are-hospitalists-killing-primary-care-redux.aspx
- ² Lindenauer PK, Rothberg MB, Pekow PS, Kenwood C, Benjamin EM, Auerbach AD. Outcomes of care by hospitalists, general internists, and family physicians. *New Engl J Med* 2007;357:2589-2600. Dec. 20.
- ³ Kripalani S, LeFevre F, Phillips CO, Williams MV, Basaviah P, Baker DW. Deficits in communication and information transfer between hospital-based and primary care physicians: implications for patient safety and continuity of care. *JAMA* 2007;297:831-41. On admissions, see *Guidelines for Interaction in “Hospitalist” Models: Communication Between the Receiving Inpatient Care Management Physicians and the Referring Primary Care Physician*. American Academy of Family Physicians, 2006. <http://www.aafp.org>.
- ⁴ Apker J, Mallal LA, Gibson SC. Communicating in the “gray zone”: perceptions about emergency physician-hospitalist handoffs and patient safety. *Academic Emergency Medicine* 2007;14:884-94.
- ⁵ Vidyartha A. “Fumbled Handoff,” AHRQ Web M&M, March 2004
- ⁶ Lang ES, Afilalo M, Boivin J-F, et al. A standardized communication system (SCS) linking the Emergency Department with Primary Care Physicians: impact on continuity of care. *Acad Emerg Med* 2003;10(5): 505.
- ⁷ These standards may be inadequate. For example, patients with multiple chronic illnesses who have been discharged from the hospital typically may need to see their PCP within a week or two, and the standard of 30 days for discharge summary completion does not provide the PCP with a timely description of the hospitalization.
- ⁸ Greenwald JL, Denham CR, Jack BW. The hospital discharge: a review of a high risk care transition with highlights of a reengineered discharge process. *Journal of Patient Safety* 2007; 3:97-106. June.
- ⁹ Glintborg B, Andersen SE, Dalhoff K. Insufficient communication about medication use at the interface between hospital and primary care. *Quality and Safety in Health Care* 2007;16:34-9.
- ¹⁰ Moore C, McGinn T, Halm E. Tying up loose ends: discharging patients with unresolved medical issues. *Archives of Internal Medicine* 2007;167:1305-1311.
- ¹¹ Kripalani S, LeFevre F, Phillips CO, Williams MV, Basaviah P, Baker DW. Deficits in communication and information transfer between hospital-based and primary care physicians: implications for patient safety and continuity of care. *JAMA* 2007;297:831-41.
- ¹² Gandhi TK, Sittig DF, Franklin M, Sussman AJ, Fairchild DG, Bates DW. Communication breakdown in the outpatient referral process. *J Gen Intern Med* 2000;15(9):626-31. Most family doctors and specialists, in a different study, found peer assessment of letters feasible and desirable. See Keely E, Myers K, Dojeiji S, Campbell C. Peer assessment of outpatient consultation letters—feasibility and satisfaction. *BMC Med Educ* 2007;7:13.
- ¹³ Fairchild DG, Hogan J, Smith R, Portnow M, Bates DW. Survey of primary care physicians and home care clinicians. *J Gen Intern Med* 2002;17(4):253-61. On communication between the primary care physician and specialists outside the hospital, see McDonald KM, Sundaram V, Bravata DM, et al. *Care Coordination*. Volume 7 of: Shojania KG, McDonald KM, Wachter RM, Owens DK, editors. *Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies*. Technical Review 9 (Prepared by the Stanford University—UCSF Evidence-based Practice Center under contract 290-02-0017). AHRQ Publication No. 04(07)-0051-7. Rockville, MD: Agency for Healthcare Research and Quality. June 2007
- ¹⁴ Uncoordinated care: a survey of physician and patient experience. California HealthCare Foundation, 2007. <http://www.chcf.org/documents/hospitals/UncoordinatedCareSnapshot07.pdf>
- ¹⁵ Bodenheimer T. Coordinating care: a major (unreimbursed) task of primary care. *Ann Intern Med* 2007;147:730-1.
- ¹⁶ Weinberg DB, Lusenhop RW, Gittel JH, Kautz CM. Coordination between formal providers and informal caregivers. *Health Care Manage Rev* 2007;32(2):140-9.
- ¹⁷ Safe Practices for Better Healthcare—2006 Update: a Consensus Report; www.qualityforum.org.
- ¹⁸ <http://www.americangeriatrics.org/affiliates/connecticut.shtml>
- ¹⁹ Boyd CM, Boulton C, Shadmi E, et al. Guided care for multimorbid older adults. *The Gerontologist* 2007;47(5):697-704.

²⁰ News release, April 11, 2007, Society of Hospital Medicine; www.hospitalmedicine.org. The principal investigator is Dr. Mark V. Williams of Northwestern University School of Medicine and the project coordinator is Tina Budnitz of the Society of Hospital Medicine.

²¹ McDonald KM, Sundaram V, Bravata DM, et al. Care Coordination. Vol 7 of: Shojania KG, McDonald KM, Wachter RM, Owens DK, editors. Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies. Technical Review 9 (Prepared by the Stanford University—UCSF Evidence-based Practice Center under contract 290-02-0017). AHRQ Publication No. 04(07)-0051-7. Rockville, MD: Agency for Healthcare Research and Quality. June 2007.

<http://ahrq.gov/downloads/pub/evidence/pdf/caregap/caregap.pdf>.

²² <http://www.jcipatientsafety.org/26054/>

²³ http://www.jointcommission.org/Library/jconline/jo_11_07.htm

²⁴ Also see the National Transitions of Care Coalition www.ntocc.org.

²⁵ http://www.abimfoundation.org/publications/pdf_issue_brief/F06-05-2007_6.pdf

²⁶ Thanks to Tina Budnitz, of SHM and BOOST, for this information. You can download the toolkit from: <http://www.hospitalmedicine.org/AM/Template.cfm?Section=Home&Template=/CM/HTMLDisplay.cfm&ContentID=17122>

²⁷ <http://www.slideshare.net/nashp/post-acute-care-patient-assessment-instrument-and-payment-reform-demonstration/>

²⁸ http://www.cms.hhs.gov/QualityImprovementOrgs/downloads/QIO_Improvement_RTC_fnl.pdf

²⁹ Greenwald JL, Denham CR, Jack BW. The hospital discharge: a review of a high risk care transition with highlights of a reengineered discharge process. *Journal of Patient Safety* 2007; 3:97-106. June.

³⁰ Ibid. A free download of the material is located on pages 27-28, #11 of Table 1, Practice, Care Settings, and Other Relevant Safe Practices, in *Appeals Draft: Background and Updated Safe Practices*,

<http://www.qualityforum.org/pdf/projects/safe-practices/AppealsDraft-Background-and-UpdatedSafePractices.pdf>. The full NQF document can be purchased for download at www.qualityforum.org.

³¹ Halasyamani L, Kripilani S, Coleman E, et al. Transition of care for hospitalized elderly patients—development of a discharge checklist for hospitalists. *Journal of Hospital Medicine* 2006;1:354-60. According to the authors, “Each institution will need to further refine the list according to local factors such as patient population, resources, and culture.... Elderly patients discharged home from the hospital are the primary patient population targeted by this checklist; there may be unique and additional elements necessary for the ideal discharge for a patient who is discharged to a subacute or acute rehabilitation facility.”

³² Kripalani S, LeFevre F, Phillips CO, Williams MV, Basaviah P, Baker DW. Deficits in communication and information transfer between hospital-based and primary care physicians: implications for patient safety and continuity of care. *JAMA* 2007;297:831-41.

³³ Leape LL, Rogers G, Hanna D, et al. Developing and implementing new safe practices: voluntary adoption through statewide collaboratives. *Quality and Safety in Health Care* 2006;15:289-95. The collaborative in Massachusetts involved reconciling medications and communicating critical test results. The Joint Commission subsequently adopted both practices as mandatory.

³⁴ Modified from Eric Coleman, MD, MPH; www.caretransitions.org.