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Transitions of Care

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Repository Citation
Rabah, K. A. (2016). Transitions of Care. .
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Transitions of Care

Resident Education Presentation

Kelly Rabah, MSW, LISW-S, CPHQ, CPHRM, SSGB. Director of Patient Safety Quality Improvement for GME.

Objectives

- Define and Describe the various points of transition of care
- Define and Describe the potential risks for TOC
- Articulate the value of interdisciplinary team planning
- Demonstrate an effective patient hand- off via role play.

What is A Care Transition?

- “Set of Actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location.”

Coleman E.A, Boult C., *Improving the Quality of Transitional Care for Persons with Complex Needs*. Position statement of the American Geriatric Society of Health Care Systems Committee. JAM Geriatric Society 2003. 5:1(4): 666-7.

We also use the term to include Hand offs of care from one shift /caregiver to another.

Patient Handoffs…

- https://youtu.be/JzCdoQEYHkY

"Patient handoffs- a typical day on the wards"

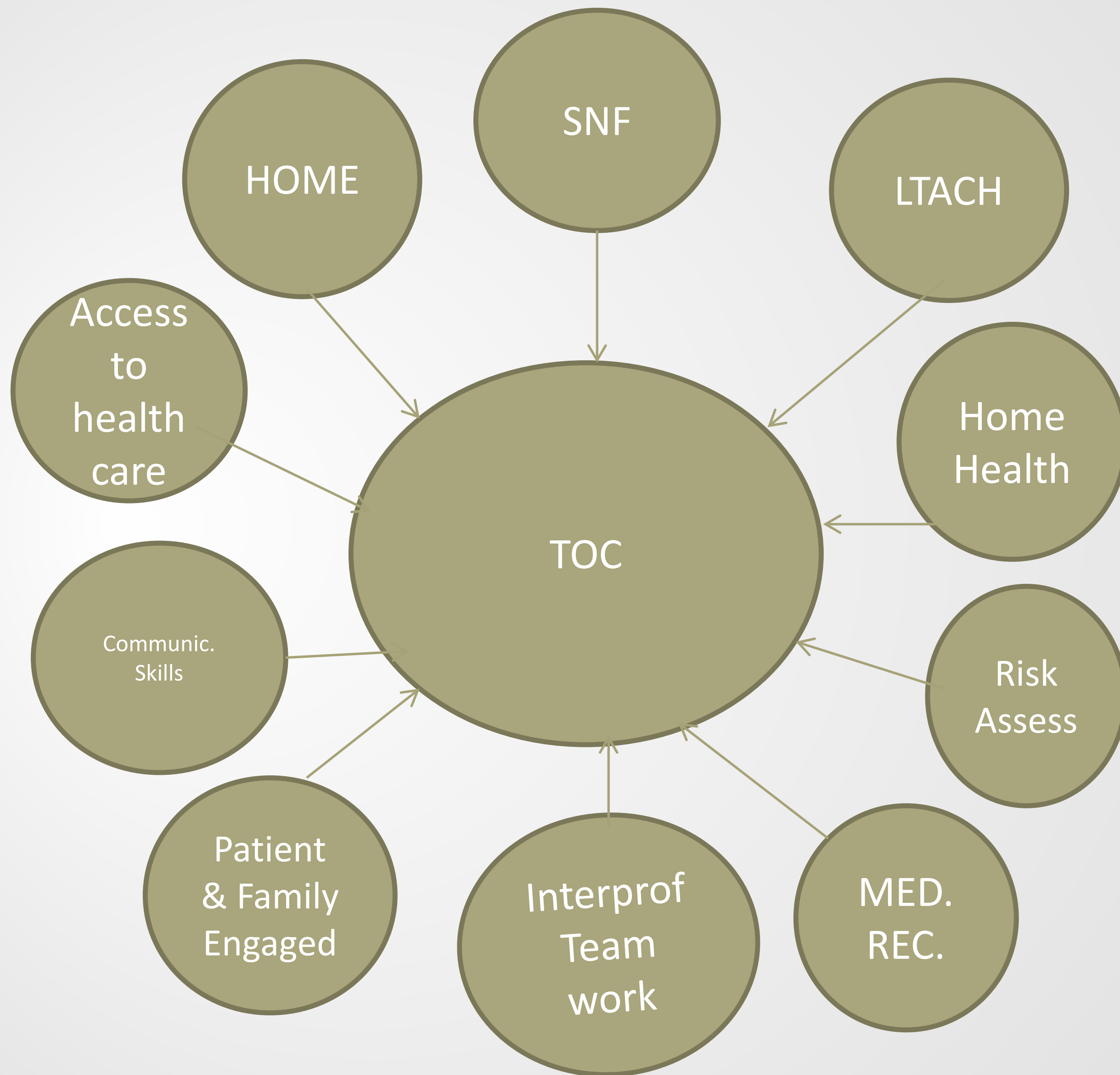
- https://youtu.be/RF4-bkpu41M

"Pitfalls of resident handoff"

- https://youtu.be/IhKVXGPdmtA

"Resident to resident patient handoff"

Influencing Factors…



The Joint Commission

- “Transitions of care refer to the movement of patients between health care practitioners, settings, and home as their condition and care needs change.”

- Examples…

- **Do not always go smoothly * highest rate of error when leaving hospital***

POOR COMMUNICATION } Adverse events
Readmission
Medical Errors

https://www.jointcommission.org/toc.aspx

The Joint Commission TOC Portal https://www.jointcommission.org/toc.aspx

Transitions of Care Portal

www.jointcommission.org/toc.aspx

The Joint Commission

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Tuesday 11:34 CST, April 29, 2014

Transitions of Care (TOC) Portal

TOC Portal Content

- TOC Portal Home
- Performance Measurement and TOC
- Articles and Publications
- Publications by Provider Type
- Other Sites to Visit
- Webinars and Education

Welcome to the Transitions of Care Portal. The content on the portal has been expanded and updated. This portal is a valuable source of information from The Joint Commission enterprise and other healthcare organizations, related to the topic of transitions of care (the movement of patients between various health care settings.) We hope you find the information helpful!

Examples of Programs with TOC

- Advanced Certification - Comprehensive Stroke Certification Program
- Advanced Certification - Heart Failure
- Behavioral Health Care Accreditation Program
- Nursing Care Center
- Primary Care Medical Home Certification/Ambulatory Health Care Program
- Primary Care Medical Home Certification/Critical Access Hospitals
- Primary Care Medical Home Certification/Hospital

Patient Information

- Speak Up: Planning Your Follow-up Care
- Speak Up: Tips for Your Doctor's Visit
- Speak Up: Home Care
- Speak Up: What you need to know about your serious illness and palliative care
- Speak Up: Help Prevent Errors in Your Care
- Speak Up: Understanding Your Doctors and Other Caregivers
- Speak Up: Help Avoid Mistakes With Your Medicines

Podcast

Take 5 with The Joint Commission: Understanding transitions of care

By Joint Commission

View More

Joint Commission Center for Transforming Healthcare

- Hand-off Communications
- Facts about the Hand-off Communications Project
- Hand-off Communications Solutions
- Hand-off Communications and TST FAQs
- Targeted Solutions Tool
- TST for Hand-off Communications Video
- TST for Hand-off Communications Webinar Playback – July 26, 2012
- Preventing Avoidable Heart

Hot Topics

- Transitions of Care: The need for collaboration across entire care continuum
- Transitions of Care: The need for a more effective approach to continuing patient care

TOC Resources and Tools

- IHI Improving Transitions Guide: Hospital to Community Settings
- Access to Recovery Implementation Toolkit (SAMHSA)

Joint Commission Resources

- Tracer Methodology 101: Effective Discharge Planning
- Handoff Communication Between Hospital and

32

12:36 PM 4/29/2014

Why Is this SO Important?

- Since 2006, TJC requires Standardized Hand off procedures in Hospitals
- TOC is a NPSG,(National Patient Safety Goal 2016), Under improving effectiveness of communication (among caregivers)
- TOC is specifically addressed in the ACGME Common Program Requirements
- TOC is a focal area for CLER Surveyors

"An estimated 80% of serious medical errors involve miscommunication during hand off of care among providers…"
https://www.jointcommission.org/toc.aspx

Causes of Ineffective TOCs

Root Causes Include:

- Communication Breakdowns that include care providers, patient and family
- Expectations
- Culture (team work and ethnic)
- Inadequate time to execute
- Lack of standardized process Ex. SBAR
- Patient Education Breakdowns
- Accountability Breakdowns

ACGME on Transitions of Care (Included in Milestones And the NAS)

- Supervised
- Feedback should be given to residents
- Interdisciplinary
- Scheduling allows participation
- Standardized
- Consistent
- Opportunity for residents to ask questions
- Minimize frequency

ACGME Common Program Requirements

VI.B. Transitions of Care

VI.B.1. Programs must design clinical assignments to minimize the number of transitions in patient care. (Core)

VI.B.2. Sponsoring institutions and programs must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety. (Core)

VI.B.3. Programs must ensure that residents are competent in communicating with team members in the hand-over process. (Outcome)

VI.B.4. The sponsoring institution must ensure the availability of schedules that inform all members of the health care team of attending physicians and residents currently responsible for each patient's care. (Detail)

Wright State University BSOM…

Patient Handoff Communication Policy Item 512

http://www.med.wright.edu/fca/gme/rm512

Levels of Evaluation

? Less handoff errors
? Culture of safety
re: handoffs

Evaluation of results
(transfer or impact on society)

Evaluation of behavior
(transfer of learning to workplace)

Direct Observation:
1. Peer Evals
2. Resident Evals

Evaluation of learning
(knowledge or skills acquired)

Assess this during the simulation using a check-list

Evaluation of reaction
(satisfaction or happiness)

Curriculum w/ videos + simulation:
Feedback –
formal & informal

Penn Handoff Curriculum
2009-present

Airan-Javia, Myers, et al. J Grad Med Educ, 2011
Dine, et al. J Gen Intern Med, 2013

What it takes to get it right

*Current Challenges…

- 40% of older adults experience two or more care transitions within 30 days of hospital discharge

- 1 in 5 older adults who are discharged from the hospital are re-hospitalized within 30 days.

- 1/3 are re-hospitalized within 90 days.

- Significant problems attributed to suboptimal communication around D/C planning and TOC include:
  - Medication errors
  - Delayed diagnosis
  - Duplicative testing and medical services
  - Safety issues not addressed resulting in injury
  - D/C summaries not available or reviewed by caregivers resulting in readmission and poor care

*www.Geriatricscareonline .org. 20- Transitional Care

*Troubling Statistics…

- Estimated 98,000 Americans may die each year as a result of preventable medical error
- 8th overall leading cause of error is failure in communication
- Failure to communicate is one of most frequent contributing causes to sentinel events(TJC):

    2011 – 760 (N=1243).   61%

    2012- 532 (N=901). 59%

* Presentation to ACGME February 28 2014. Ses005. "Transitions of Care Competency Using Standardized Patient Encounters". By J. Sapp, MD, & M. Short, MD.

How do We Improve?

- Environment
  - Face to face
  - Adequate time and space
  - Minimize Interruptions
  - Interprofessional collaboration

  - Standardize
    - Content
    - Process
    - Use Template
    - Documentation Process

Technological Solutions…

- Digital hand offs
- Linked to hospital information system
- Relevant and up to date information is shared

Communication…

- Utilize patient and family input
- Optimize IPE and team work (SW, Nursing, Chaplaincy , Pharmacy, Physical and Occupational therapy)
- Read backs
- Close the loop
- Interactive questions
- SBAR
- Written and Verbal communication
- Quality Audits
- Faculty training
- Get feedback from the person to whom care is transferred/handed off.

Other Ways to Improve…

Engagement in interactive learning

- Didactic instruction
- OSCEs
- Role Plays

Consult Other Resources

- Hand outs from www. Geriatricscareonline.org
- Press Ganey and Associates
- Case studies
- National Transition of Care Consortium
- The Joint Commission Transitions of Care Portal
- ACGME Common Program Requirement Updates (V.1B)

Beyond Medline
(and med school)

- Some published curricula for residents
  - Emory: Discharge Summaries and Handoffs
    - http://www.pogoe.org/productid/21636
    - https://www.mededportal.org/publication/9101
  - Emory: Post discharge follow-up visits
    - https://www.mededportal.org/publication/9757
  - Emory: Interprofessional care coordination
    - https://www.mededportal.org/publication/9821
  - BAAHM: Teaching transitions toolkit
    - http://www.hospitalmedicine.org/Web/Quality___Innovation/Implementation_Toolkit/Boost/Clinical_Tools/Toolkits.aspx

RESOURCES – Reprinted from
"Teaching Safe Transitions of Care"
Jeff Greenwwald, MD, SFHM; and
Jennifer S. Myers, MD QSEA 2015

Med Ed Portal

- An Interactive Workshop to Increase Resident Readiness to Perform Patient Hand-offs (IPASS)
- Teaching Video: "Handoffs: A Typical Day on the Wards“

Sample of the Published Literature

- Reisenberg, et al. Resident and attending physician handoffs: A Systematic Review. Acad Med, 2009.
- Wohlauer, et al. Patient Handoff: Comprehensive curricular blueprint for resident education to improve continuity of care, 2012.
- Farnan, et al. Handoff education and evaluation: Piloting the observed, simulated handoff experience, J Gen Int Med, 2009.

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