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Enhancing Discharge Transitions at Gifford Health Care

Megan L. O'Brien

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INTRODUCTION

Background
Shorter hospital stays and more complex care regimens lead to errors in the discharge process
•Incomplete discharge instructions
•Medication list errors
•Preventable readmissions
•Poor follow-up appointment attendance

Purpose
Develop a discharge process based on evidence that improves outcomes and satisfaction

Aims
1) Increase patient preparedness for self-management
2) Timely access to follow-up appointments
3) Support interim transition of care

METHODS AND MATERIALS

Site
Gifford Health Care
•Rural
•Federally Qualified Health Center
•Critical Access Hospital
•Multidisciplinary Team

Sample
Adult patients discharged from the Medical-Surgical unit to home

Procedures
Using evidence based principles adopted from Project Re-Engineered Discharge (Project RED)
1) Redesign patient discharge instructions
2) Facilitate follow-up appointments
3) Implement follow-up phone calls

Measures
Process Measures
•Days from discharge to follow-up
•Follow-up appointment attendance
•Completed follow-up phone calls
Outcome measures
•HCHAPS Survey
○Readmission data
○Patient satisfaction scores

RESULTS

Improved
• Overall hospital rating (5.3%)
•Patient Satisfaction
•Care transitions
•Communication with doctors
•Discharge information
•Access to follow-up appointment (2 day reduction from baseline)
•Reduced readmissions (1%)

Limitations
•Small sample size
•Staff turnover
•Electronic health record limitations

Future Work
•<50% continue to be scheduled for a follow-up appointment at time of discharge
•Follow up appointment attendance dropped 3%
•<50% completed follow-up phone calls

DISCUSSION

Findings are consistent with previous research despite implementation in a small, rural institution without dedicated discharge personnel. Internal validity was supported by comparison to organizational baseline data. Use of standardized tools support generalizability, although was also limited by the small sample size. Additional confounding variables included the organization developing the 'patient experience team' and 'post acute clinic' to support discharge efforts and transitions after hospitalization.

Nearly 50% of discharges occurred during non-business hours. Previous research has shown increased follow-up attendance when working with patients to schedule prior to being discharged and could be addressed in the future to increase satisfaction and follow-up appointment attendance and revenue.

The new discharge follow-up phone call Eform provides the first opportunity to collect data for further discharge quality improvement projects.

CONCLUSIONS

Discharge planning that encompasses patient centered, multidisciplinary principles to enhance communication (written materials, phone calls, follow-ups) is positively associated with improved satisfaction and reduced readmissions which is alignment with the strategic vision and financial stability of the organization.

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